



Montana Department of Public Health and Human Services

Montana Health and Economic Livelihood Partnership (HELP) Program

Section 1115 Research and Demonstration Waiver Application

Posted for Public Comment Prior to Submission to CMS

July 7, 2015

Corrections to 1115 Waiver

7/7/2015: Page 15 - Milestone - Submit waiver application to CMS - Date corrected from September 11, 2015 to September 15, 2015

Section I. Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and or title XXI of the Social Security

On April 29, 2015, Governor Steve Bullock signed into law Senate Bill 405, an Act establishing the Montana Health and Economic Livelihood Partnership (HELP) Program (hereinafter referred to as the HELP Program) to expand access to health coverage for over 70,000 new adults with incomes up to 138 percent of the Federal Poverty Level (FPL). The goals of the HELP Program are to:

- Increase the availability of high-quality health care to Montanans;
- Provide greater value for the tax dollars spent on the Montana Medicaid program;
- Reduce health care costs;
- Provide incentives that encourage Montanans to take greater responsibility for their personal health;
- Boost Montana's economy; and
- Reduce the costs of uncompensated care and the resulting cost-shifting to patients with health insurance.

The Montana Department of Public Health and Human Services (DPHHS) is responsible for overseeing the implementation and operation of the HELP Program. Pursuant to the HELP Program, DPHHS will contract with a Third Party Administrator (TPA) to administer the delivery of and payment for healthcare services for most new adults, with the exception of participants who are exempt from TPA enrollment, such as medically frail and American Indian/Alaskan Native residents.¹ Montana's goal in using the TPA model is to leverage an existing commercial insurance market vehicle to administer efficient and cost-effective coverage for new Medicaid adults.

The HELP Program also requires premiums and copayments for new adults with incomes below 138 percent of the FPL who are enrolled through the TPA. These individuals will be required to pay monthly premiums equal to 2 percent of household income and maximum copayment amounts allowed under federal law. In accordance with federal law, premiums and copayments combined may not exceed 5 percent of family household income. Additionally, participants with incomes above 100 percent of the FPL who fail to pay premiums will be dis-enrolled from coverage until they pay overdue premiums or until the Department of Revenue assesses the premium debt against their income taxes. Certain participants may be exempt from disenrollment if they engage in a wellness program.

¹ The following individuals are exempt from enrollment through the TPA: individuals who have exceptional health care needs, including but not limited to medical, mental health or developmental conditions; individuals who live in a region, including an Indian reservation, where the TPA was unable to contract with sufficient providers; individuals who require continuity of coverage that is not available or could not be effectively delivered through the TPA; and, those otherwise exempt under federal law.

The Demonstration will further the objectives of Title XIX by expanding Medicaid coverage—increasing the number of Medicaid enrolled adults in the State by more than half—and ensuring quality, affordable access to coverage for low-income Montana residents. The Demonstration will also promote continuity of coverage and access to providers by leveraging the efficiencies and expertise of the private market.

2) Include the rationale for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment)

The proposed 1115 Demonstration waiver supports implementation of the HELP Program by enabling Montana to implement two central features of its HELP Program: (1) use of a TPA arrangement to provide efficient and cost-effective coverage; and (2) participant premiums and copayments to encourage personal responsibility and cost-conscious behaviors.

Efficient and Cost Effective Coverage – Montana is a primarily rural state, with a small population dispersed over a large geographic area. Indeed, it is one of three states along with Alaska and Wyoming that have been designated a Frontier State, which is defined by the Affordable Care Act as a State in which at least 50 percent of the counties have a population density of less than six people per square mile. Additionally, the State’s existing network of fee-for-service Medicaid providers is sparse, particularly in remote rural regions. For these reasons, the State faces unique provider network development and administration challenges in implementing the major coverage expansion contemplated by the HELP Program.

Montana’s goal in using the TPA model is to leverage an existing commercial insurance company with established, statewide provider networks and turnkey administrative infrastructure and expertise to administer efficient and cost-effective coverage for new Medicaid adults. This approach will allow rapid implementation of and adequate provider network capacity for the HELP Program for coverage beginning as early as January 1, 2016, assuming timely federal approval of necessary waivers.

An additional benefit of the TPA approach is that it supports continuity and integration of Montana’s Medicaid Program and the commercial insurance marketplace in the State. Nearly one-third of low-income families experience frequent income fluctuations that cause “churning” or changes in insurance affordability program eligibility that shift these families from the Medicaid Program to eligibility for subsidies to purchase private coverage (and vice versa). Churning leads to coverage gaps and discontinuities in the insurance plans and provider networks available to consumers. These gaps are detrimental to improving efficiency and quality of health care for low-income Montanans. By using a TPA anchored in the commercial insurance market, Montana will provide Medicaid coverage through a provider network that is more likely to be available to lower-income residents even as they gain economic independence and transition to private market coverage.

Personal Responsibility and Cost Conscious Behavior – HELP Program participants enrolled through the TPA will be required to pay premiums and copayments. These out-of-pocket requirements are crafted to encourage HELP Program participants to:

- Understand the value of their insurance coverage;
- Be discerning health care purchasers;
- Take personal responsibility for their health care decisions;
- Develop cost-conscious behaviors as consumers of health care services; and,
- Engage in healthy behaviors.

To promote use of high value health services, the State will not apply copayments for preventive health care services, immunizations provided according to a schedule established by the DPHHS that reflects guidelines issued by the Centers for Disease Control and Prevention, medically necessary health screenings, or any other services for which federal law bars copayments.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration’s approval period and the plan by which the State will use to test them (if additional space is needed, please supplement your answer with a Word attachment)

Evaluation Question	Hypothesis	Waiver Component Being Addressed	Data Source
What are the effects of applying premiums for newly eligible adults enrolled through the TPA?	Premiums will not pose a barrier to eligible participants enrolling in Medicaid.	Premiums for participants with incomes from 0-138 percent FPL. Comparability of premiums.	Enrollment data.
What are the effects of dis-enrollment for failure to pay premiums for participants with incomes above 100 percent FPL?	The disenrollment penalty will encourage consistent premium payment experience, and will result in continuity of care.	Waiver of reasonable promptness to permit disenrollment of participants who fail to pay premiums.	Disenrollment and re-enrollment data.
	The proposed disenrollment exemption will promote participant engagement in		

Evaluation Question	Hypothesis	Waiver Component Being Addressed	Data Source
	healthy behaviors.		
What are the effects of contracting with a TPA to administer benefits for most HELP Program participants?	HELP Program participants who receive coverage through the TPA will have appropriate access to care and will have equal or greater provider access than they would otherwise have absent the TPA.	Freedom of choice.	Medicaid claims and TPA claims data. TPA participant and provider surveys. Medical Expenditure Panel Survey from AHRQ (MEPS).

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate (if additional space is needed, please supplement your answer with a Word attachment)

The Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment)

The State seeks approval for a Demonstration effective date of January 1, 2016 through December 31, 2020, pending reauthorization of the HELP Program beyond June 30, 2019 by the State Legislature. If the HELP Program is not reauthorized, Montana will terminate the waiver.

6) Describe whether the Demonstration will affect and/or modify other components of the State’s current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems (if additional space is needed, please supplement your answer with a Word attachment).

No. The Demonstration will not modify the State’s current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing, or delivery systems.

Section II. Demonstration Eligibility

- 1) **Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included). Please refer to Medicaid Eligibility Groups: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf> when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.**

The Demonstration will affect the new adults eligible for the HELP Program as described in the chart below.

Expansion Populations		
Eligibility Group Name	Social Security Act and CFR Citations	Income Level
HELP Program New Adults	Social Security Act § 1396(a)(10)(A)(i)(VIII) 42 C.F.R. § 435.119	<ul style="list-style-type: none"> ▪ Childless adults: 0-138 percent of the FPL ▪ Parents: 50-138 percent FPL

- 2) **Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan (if additional space is needed, please supplement your answer with a Word attachment)**

When determining whether an individual is eligible for the HELP Program, Montana will apply the same eligibility standards and methodologies as those articulated in the State Plan.

- 3) **Specify any enrollment limits that apply for expansion populations under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment)**

There are no enrollment caps in the Demonstration. To be eligible to participate in the Demonstration, an individual must be: (1) a childless adult between 19 and 65 years of age, with an income at or below 138 percent of the FPL or a parent between 19 and 65 years of age, with an income between 50-138 percent of the FPL; (2) not enrolled in Medicare; (3) a United States citizen or a documented, qualified alien; and, (4) a resident of Montana. However, individuals who have exceptional health care needs, including but not limited to a medical mental health or developmental condition, live in a region, including an Indian reservation, where the TPA is unable to contract with sufficient providers, or require continuity of coverage

that is not available or could not be effectively delivered through the TPA, or are otherwise exempt under federal law (including American Indians), are not eligible for this Demonstration, and will instead be served through the State's current Medicaid program.

- 4) **Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs (if additional space is needed, please supplement your answer with a Word attachment)**

The state estimates over 70,000 individuals will be eligible for the Demonstration.

- 5) **To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment).**

The State will have two Alternative Benefit Plan (ABP) State Plan Amendments reflecting the following: (1) an ABP administered by the TPA which will not include long term care services; and (2) an ABP administered outside of the TPA (for individuals who are TPA exempt) that will include long term care services; the same post eligibility treatment of income and spousal impoverishment rules, as outlined in the Medicaid State Plan, shall apply.

- 6) **Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment).**

To further advance State goals with regard to minimizing churning and promoting continuity of coverage and access to care, Montana will apply for a Fast Track Express Lane Eligibility Waiver under Section 1902(e)(14)(A) and is seeking 1115 Waiver approval to implement twelve month continuous eligibility for all newly eligible adults.

- 7) **If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if additional space is needed, please supplement your answer with a Word attachment).**

N/A

Section III. Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

Yes No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

Yes No (if no, please skip questions 8 – 11)

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Benefit Package Chart

Eligibility Group	Benefit Package

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

- Federal Employees Health Benefit Package
- State Employee Coverage
- Commercial Health Maintenance Organization
- Secretary Approved
-

Individuals in the new adult group are required to receive coverage through the ABP and the State will provide the federally required benefit package. The Montana ABP State Plan Amendment will outline its selection of Secretary-approved ABP.

5) In addition to the Benefit Specifications and Qualifications form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

Benefit Chart

Benefit	Description of Amount, Duration and Scope	Reference

Benefits Not Provided

Benefit	Description of Amount, Duration and Scope	Reference

6) Indicate whether Long Term Services and Supports will be provided.

___ (if yes, please check the services that are being offered) X No

In addition, please complete the: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf> and the: <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf>.

- | | |
|---|---|
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Home Health Aide |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Personal Care Services |
| <input type="checkbox"/> Adult Day Health Services | <input type="checkbox"/> Habilitation – Residential Habilitation |
| <input type="checkbox"/> Habilitation – Supported Employment | <input type="checkbox"/> |
| <input type="checkbox"/> Habilitation – Day Habilitation | <input type="checkbox"/> Habilitation – Pre-Vocational |
| <input type="checkbox"/> Habilitation – Other Habilitative | <input type="checkbox"/> Habilitation – Education (non-IDEA Services) |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Day Treatment (mental health service) |
| <input type="checkbox"/> Psychosocial Rehabilitation | <input type="checkbox"/> Clinic Services |
| <input type="checkbox"/> Environmental Modifications (Home Accessibility Adaptations) | <input type="checkbox"/> Vehicle Modifications |
| <input type="checkbox"/> Non-Medical Transportation | <input type="checkbox"/> Special Medical Equipment |

(minor assistive devices)

- | | |
|--|---|
| <input type="checkbox"/> Home Delivered Meals Personal | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> Emergency Response | <input type="checkbox"/> Nursing Services |
| <input type="checkbox"/> Community Transition Services | <input type="checkbox"/> Adult Foster Care |
| <input type="checkbox"/> Day Supports (non-habilitative) | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Supported Living Arrangements | <input type="checkbox"/> Private Duty Nursing |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Adult Companion Services |
| <input type="checkbox"/> Supports for Consumer Direction/Participant Directed Goods and Services | |
| <input type="checkbox"/> Other (please describe) | |

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

- Yes (if yes, please address the questions below)
 No (if no, please skip this question)

- a) **Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program (if additional space is needed, please supplement your answer with a Word attachment).**

The DPHHS operates a federally approved voluntary employer sponsored insurance (ESI) premium assistance program under its State Plan. Montana intends to amend the State Plan Amendment to add the newly eligible adults to the voluntary ESI premium assistance program..

- b) **Include the minimum employer contribution amount (if additional space is needed, please supplement your answer with a Word attachment).**

N/A

- c) **Describe whether the Demonstration will provide wrap-around benefits and cost-sharing (if additional space is needed, please supplement your answer with a Word attachment).**

N/A

- d) **Indicate how the cost-effectiveness test will be met (if additional space is needed, please supplement your answer with a Word attachment).**

N/A

- 8) **If different from the State plan, provide the premium amounts by eligibility group and income level (if additional space is needed, please supplement your answer with a Word attachment).**

The State will impose monthly premiums equal to 2 percent of household income for all new adults with incomes below 138 percent of the FPL whose coverage is administered through the TPA.

- 9) **Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):**

HELP Program participants whose coverage is administered through the TPA will be required to pay copayments. The DPHHS will adopt through a State Plan Amendment a copayment schedule that reflects the maximum allowable copayment amounts under federal law for all individuals with incomes below 138 percent of the FPL. Providers will collect applicable copayments at the point of care. Total premium contributions and copayments will be capped at 5 percent of quarterly income.

Copayment Chart

Eligibility Group	Benefit	Copayment Amount

If the state is proposing to impose cost sharing in the nature of deductions, copayments or similar charges beyond what is permitted under the law, the state should also address in its application, in accordance with section 1916(f) of the Act, that its waiver request:

- a) **will test a unique and previously untested use of copayments;**
- b) **is limited to a period of not more than two years;**
- c) **will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients;**
- d) **is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and**
- e) **is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.**

N/A

10) Indicate if there are any exemptions from the proposed cost sharing (if additional space is needed, please supplement your answer with a Word attachment).

The State will not apply copayments for: preventive health care services; immunizations provided according to a schedule established by the DPHHS that reflects guidelines issued by the Centers for Disease Control and Prevention; medically necessary health screenings ordered by a health care provider, or, any other services that are legally exempt. Additionally, all individuals who are statutorily required to be exempt from cost sharing will be exempt from cost sharing under the Demonstration, including pregnant women.

Section IV. Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

Yes

No (if no, please skip questions 2-7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms (if additional space is needed, please supplement your answer with a Word attachment).

As noted above, Montana's goal in using the TPA model is to leverage an existing commercial insurance company to administer efficient and cost-effective coverage for new Medicaid adults, allowing rapid implementation of and adequate provider network capacity for the HELP Program. This approach will also supports continuity and integration of Montana's Medicaid Program and the commercial insurance marketplace in the State to reduce churning and related coverage gaps and discontinuities in the insurance plans and provider networks available to consumers. By minimizing churning, the State expects to improve efficiency and quality of health care for low-income Montanans. Through implementation of cost-sharing requirements for most participants, the Demonstration will promote use of high value health services and encourage personal responsibility and informed purchasing of health care services.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- Managed care
 - Managed Care Organization (MCO),
 - Prepaid Inpatient Health Plans (PIHP)
 - Prepaid Ambulatory Health Plans (PAHP)
- Fee-for-service (including Integrated Care Models)
- Primary Care Case Management (PCCM)
- Health Homes
- Other (please describe)

Montana will contract with a TPA to administer the delivery of and payment for healthcare services provided to new adults. The TPA will be responsible for administering services and functions in compliance with State and federal Medicaid requirements including, but not limited to, establishing networks of healthcare providers, reimbursing providers on behalf of the State, collecting participant premiums, and additional administrative functions such as preparing all necessary reports for the DPHHS. The TPA contract start date will be on or about October 1, 2015.

- 4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:**

Delivery System Chart

Eligibility Group	Delivery System	Authority
HELP Program New Adults	TPA administered fee-for-service program	1115 Waiver
HELP Program New Adults who are exempt from enrollment in the TPA	DPHHS administered fee-for-service program	State Plan Amendment

- 5) If the Demonstration will utilize a managed care delivery system:**
- f) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if**

additional space is needed, please supplement your answer with a Word attachment)?

- g) Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment);**
- h) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment);**
- i) Describe how will the state assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment); and**
- j) Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).**

N/A

- 6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion (if additional space is needed, please supplement your answer with a Word attachment).**

N/A

- 7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).**

Yes No

- 8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology (if additional space is needed, please supplement your answer with a Word attachment).**

On July 1, 2015, the State released a TPA Request for Proposal (RFP) that requires, to the extent

possible, that rates under the State's TPA contract will be comparable to those paid under the current Medicaid program. The TPA RFP respondents must offer the State their lowest contracted provider reimbursement rates. The TPA RFP respondents must also indicate the methodology and rates for inpatient hospital, outpatient hospital, and professional codes. If rates vary according to specific provider, the TPA RFP respondents must indicate the low and high rate for each code.

- 9) **If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438 (if additional space is needed, please supplement your answer with a Word attachment).**

N/A

- 10) **If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected (if additional space is needed, please supplement your answer with a Word attachment).**

N/A

Section V. Implementation of Demonstration

- 1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone (if additional space is needed, please supplement your answer with a Word attachment).**

Under the State's targeted timeline, applications for the expansion population will begin on November 15, 2015 for coverage effective January 1, 2016, assuming timely federal approval of the HELP Program Section 1115 Waiver. A proposed implementation timeframe is included below:

Milestone	Timeframe
Issue public notice of waiver	July 5, 2015
Accept comments on waiver	July 7, 2015- September 7, 2015
Conduct tribal consultation	August 19, 2015
Submit waiver application to CMS	September 15, 2015
Receive waiver approval	By November 1, 2015
Launch Medicaid enrollment through the FFM	November 15, 2015
Medicaid expansion coverage becomes effective	January 1, 2016

- 2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).**

Notices

Upon Medicaid eligibility determination, HELP Program participants will receive a notice from the DPHHS advising them of the following:

- Medicaid eligibility determination.* The notice will include the basis of the eligibility determination, effective date of eligibility, information on copayments and premiums, a review of covered services, information regarding procedures for reporting a change in circumstances and website access to a participant handbook and participant newsletters.

- *Appeals*. The notice will also include information regarding the Medicaid appeals process as required under federal law.
- *TPA*. The notice will include information regarding TPA services and provider networks.

Enrollment

Assuming timely federal approval of necessary waivers, individuals eligible for enrollment under the HELP Program will begin to enroll during the open enrollment period starting November 15, 2015 for coverage effective January 1, 2016, through the following process:

- Individuals will submit the single streamlined application for Insurance Affordability Programs—Medicaid, CHIP, Advance Premium Tax Credits/Cost Sharing Reductions—via phone, online, by mail, or in-person.
- An eligibility determination will be made through the Federally Facilitated Marketplace or the DPHHS.
- Once individuals have been determined eligible for coverage under Title XIX, they will enter the State’s eligibility and enrollment system.
- The DPHHS will transfer file information to the TPA of individuals who are determined eligible to receive coverage through the TPA.
- The TPA will send out a welcome packet and issue a card to those who are eligible.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action (if additional space is needed, please supplement your answer with a Word attachment).

N/A

Section VI. Demonstration Financing and Budget Neutrality

Demonstration of budget neutrality is required only for continuous eligibility for newly eligible adults. This population will receive continued benefits within a twelve month eligibility period. Consistent with CMS guidance provided in a State Medicaid Director Letter on February 21, 2014, to reflect that the regular matching rate is applicable for a proportion of these demonstration expenditures, the State will make a downward adjustment of 2.6 percent in claimed expenditures at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.

All other requested waivers do not implicate federal expenditures.

Section VII. List of Proposed Waivers and Expenditure Authorities

Waiver Authority	Use of Waiver	Reason for Waiver Request
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§ 1902(a)(17)	To waive Medicaid comparability requirements allowing different treatment of newly eligible adults, such as the application of copayments and premiums on newly eligible adults enrolled in Medicaid through the TPA.	This waiver authority will enable the State to apply copayments and premiums to new adults enrolled in Medicaid coverage through the TPA and to test the impact of copayments and premiums on access to care.
§ 1902(a)(14)	To impose monthly premiums that are equal to 2 percent of annual income on newly eligible adults enrolled through the TPA.	This waiver authority will enable the State to impose premiums on Demonstration populations that exceed statutory limitations and to test the impact of premiums on access to coverage.
§ 1902(a)(23)	To waive Medicaid freedom of choice requirements relative to the TPA.	This waiver authority will allow the State to require that certain HELP Program eligible participants receive coverage through the TPA.
§ 1902(a)(8)	To waive the reasonable promptness requirement and permit disenrollment of participant's with incomes above 100 percent of the FPL who fail to pay required premiums.	This waiver will enable Montana to dis-enroll certain participants who fail to pay required premiums for HELP Program participation.
§ 1902(e)(12)	To apply 12 month continuous eligibility to newly eligible adults.	This waiver will enable Montana to allow for 12 months continuous eligibility for newly eligible adults.

Section VIII. Public Notice

- 1) **Start and end dates of the state's public comment period (if additional space is needed, please supplement your answer with a Word attachment).**

The State's comment period will be July 5, 2015 through September 7, 2015.

- 2) **Certification that the state provided public notice of the application, along with a link to the state’s web site and a notice in the state’s Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS (if additional space is needed, please supplement your answer with a Word attachment).**

Montana certifies that it will provide public notice of the application on the State’s Medicaid website (<http://dphhs.mt.gov/medicaidexpansion>) beginning on July 5, 2015. Montana also certifies that it will provide notice of the proposed Demonstration in the Bozeman Daily Chronicle, Missoulian and Great Falls Tribune, on July 5, 2015.

Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted (if additional space is needed, please supplement your answer with a Word attachment).

Montana certifies that it will convene at least two public hearings at least twenty days prior to submitting the Demonstration application to CMS. Specifically, on August 18, 2015, 3:30 p.m., in the Billings Public Library, 510 North 28th Street, Billings, MT 59101 and on August 20, 2015, 1:00 p.m., in the Sanders Building Auditorium, 111 North Sanders Street, Helena, MT 59601.

- 3) **Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used. If additional space is needed, please supplement your answer with a Word attachment).**

Montana certifies that it will use an electronic mailing list to provide notice of the proposed Demonstration to the public. Specifically, Montana intends to provide notice through email lists of stakeholders, including payers, providers, and advocates, as well as legislators.

- 4) **Comments received by the state during the 30-day public notice period (if additional space is needed, please supplement your answer with a Word attachment);**

To be attached upon completion of the notice and comment period.

Section IX. Demonstration Administration

Please provide the contact information for the state’s point of contact for the Demonstration application.

Name and Title: Mary E. Dalton, Montana State Medicaid Director
Telephone Number: (406) 444-4084
Email Address: mdalton@mt.gov



Montana Department of Public Health and Human Services

Montana Health and Economic Livelihood Partnership (HELP) Program

Section 1915(b) (4) Waiver Fee-for-Service Selective Contracting Program Application

*Posted for Public Comment Prior to Submission to CMS
July 7, 2015*

Corrections made to 1915(b)(4) Waiver:
7/7/15 Page 3 Corrected

"The State provided written notification to all federally-recognized Tribal Governments by standard mail and email on July 17, 2015, 28 days in advance of the State's submission of the 1915(b)(4) Selective Contracting Waiver to CMS."

to: "The State will provide written notification to all federally-recognized Tribal Governments by standard mail and email at least 28 days in advance of the State's submission of the 1915(b)(4) Selective Contracting Waiver to CMS. "

Application for Section 1915(b) (4) Waiver Fee-for-Service (FFS) Selective Contracting Program

Facesheet

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

The **name of the waiver program** is Montana Health and Economic Livelihood Partnership (HELP) Program.

(List each program name if the waiver authorizes more than one program.)

Type of request. This is:

an initial request for new waiver. All sections are filled.

a request to amend an existing waiver, which modifies Section/Part _____

a renewal request

Section A is:

replaced in full

carried over with no changes

changes noted in **BOLD**.

Section B is:

replaced in full

changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of 5 years beginning January 1, 2016 and ending December 31, 2020.

The State seeks Waiver approval through December 31, 2020, pending reauthorization of the HELP Program beyond June 30, 2019 by the State Legislature. If the HELP Program is not reauthorized, Montana will terminate the Waiver.

State Contact: The State contact person for this waiver is Jo Thompson and can be reached by telephone at (406) 444-4146, or fax at (406) 444-1861, or e-mail at jothompson@mt.gov.

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The State will provide written notification to all federally-recognized Tribal Governments by standard mail and email at least 28 days in advance of the State's submission of the 1915(b)(4) Selective Contracting Waiver to CMS. This timeframe includes 21 days for Tribal Governments to send responses to the Department of Public Health and Human Services (DPHHS) for consideration before Waiver submission. The notification provided a summary of the Waiver request, a copy of the draft Waiver, and an opportunity to comment on the proposal. In addition, an in-person consultation with Tribal Government, Indian Health Service, and Urban Indian Center representatives will be held on August 19, 2015.

Program Description:

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

On April 29, 2015, Governor Steve Bullock signed into law Senate Bill 405, an Act establishing the Montana Health and Economic Livelihood Partnership (HELP) Program (hereinafter referred to as the HELP Program) to expand access to health coverage for over 70,000 new adults with incomes up to 138 percent of the Federal Poverty Level (FPL). DPHHS is responsible for overseeing the implementation and operation of the HELP Program.

Montana is submitting this 1915(b)(4) FFS Selective Contracting Program Waiver to allow the State to selectively contract with a Third Party Administrator (TPA) as required by the Help Act.

The TPA will administer the delivery of and payment for healthcare services for most new adults, with the exception of individuals who are exempt from TPA enrollment, such as medically frail and American Indian/Alaskan Native residents and those otherwise exempt by federal law.¹

Montana is a primarily rural state, with a small population dispersed over a large geographic area. Indeed, it is one of three states along with Alaska and Wyoming that have been

¹ The following individuals are exempt from enrollment through the TPA: individuals who have exceptional health care needs, including but not limited to medical, mental health or developmental conditions; individuals who live in a region, including an Indian reservation, where the TPA was unable to contract with sufficient providers; individuals who require continuity of coverage that is not available or could not be effectively delivered through the TPA; and, those otherwise exempt under federal law.

designated a Frontier State, which is defined by the Affordable Care Act as a State in which at least 50 percent of the counties have a population density of less than six people per square mile. Additionally, the State's existing network of fee-for-service Medicaid providers is sparse, particularly in more remote rural regions. For these reasons, the State faces unique provider network development and administration challenges in implementing the major coverage expansion contemplated by the HELP Program.

Montana's goal in using the TPA model is to leverage an existing commercial insurer with established, statewide provider networks, turnkey administrative infrastructure and expertise to administer efficient and cost-effective coverage for new Medicaid adults. This approach will allow rapid implementation of and adequate provider network capacity for the HELP Program by start of coverage on January 1, 2016, assuming timely federal approval of the 1915(b)(4) Selective Contracting Waiver. As in the standard Medicaid program, services will be provided on a fee-for-service basis; the TPA will be paid an administrative fee for its services.

An additional benefit of the TPA approach is that it supports continuity and integration of Montana's Medicaid program and the commercial insurance marketplace in the State. Nearly one-third of low-income families experience frequent income fluctuations that cause "churning" or changes in insurance affordability program eligibility that shift these families from the Medicaid program to eligibility for subsidies to purchase private coverage (and vice versa). Churning leads to coverage gaps and discontinuities in the insurance plans and provider networks available to consumers. These gaps are detrimental to improving efficiency and quality of health care for low and modest income Montanans. By using a TPA anchored in the commercial insurance market, Montana will provide Medicaid coverage through a provider network that is more likely to be available to lower-income residents even as they gain economic independence and transition to private market coverage.

On July 1, 2015, DPHHS released a Request for Proposal (RFP) to solicit proposals for the TPA to support the Medicaid expansion population. As part of this RFP, DPHHS anticipates awarding a contract that will cover the program statewide. The targeted TPA contract start date will be on or about October 1, 2015 to allow the TPA to be fully operational and begin offering services to the expansion population on a target implementation date of January 1, 2016, assuming timely federal approval of the Waiver. The contract period for TPA services ends December 31, 2017. The Department and TPA may mutually agree to the renewal of the contract.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

All individuals enrolled in the Demonstration will receive all federally required benefits as set forth in the State's Alternative Benefit Plan State Plan Amendment.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

1915(b) (4) - FFS Selective Contracting program

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

- a. **Section 1902(a) (1) - Statewideness**
- b. **Section 1902(a) (10) (B) - Comparability of Services**
- c. **Section 1902(a) (23) - Freedom of Choice**
- d. **Other Sections of 1902 – (please specify)**

The State is submitting an 1115 Waiver that addresses all additional waivers necessary to implement the HELP Program.

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

the same as stipulated in the State Plan

is different than stipulated in the State Plan (please describe)

DPHHS will competitively procure a TPA for its selective contracting program. To the extent possible, the rates under the State's TPA agreement TPA will be comparable to those paid under the current Medicaid program. The TPA RFP respondents must offer the State their lowest contracted provider reimbursement rates. The TPA RFP respondents must also indicate the methodology and rates for inpatient hospital, outpatient hospital, and professional codes. If rates vary according to specific provider, the TPA RFP respondents must indicate the low and high rate for each code.

2. **Procurement.** The State will select the contractor in the following manner:

- Competitive** procurement
 Open cooperative procurement
 Sole source procurement
 Other (please describe)

C. Restriction of Freedom of Choice

1. **Provider Limitations.**

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

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

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

The program will be implemented statewide.

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

There will be no difference between the State standards that will be applied under this Waiver and those detailed in the State Plan coverage and reimbursement documents.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

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

- Section 1931 Children and Related Populations
- Section 1931 Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Medicaid Expansion (Group VIII)
- Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

- Dual Eligibles
- Poverty Level Pregnant Women
- Individuals with other insurance
- Individuals residing in a nursing facility or ICF/MR
- Individuals enrolled in a managed care program
- Individuals participating in a HCBS Waiver program
- American Indians/Alaskan Natives
- Special Needs Children (State Defined). Please provide this definition.
- Individuals receiving retroactive eligibility
- Other (Please define):

The following populations are excluded from the TPA waiver:

- Individuals who have exceptional health care needs, including but not limited to medical, mental health or developmental conditions, and
- American Indians/Alaska Natives.

The State may also exempt the following individuals from the TPA waiver:

- Individuals who live in a geographical area, including an Indian reservation, for which the TPA is unable to make arrangements with sufficient health care providers to offer services to the individuals,
- Individuals who need continuity of care that would not be available or cost-effective through the arrangement with the TPA, and
- Individuals who are otherwise exempt under federal law

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

The State will ensure that all services are available and accessible to HELP Program Participants in a timely manner. The State will require the TPA's network of providers to offer hours of operation that are the same as hours of operations for all other Medicaid and commercial patients.

The State will require the TPA to ensure that the following timely access to care standards are met by network providers:

- A maximum wait time for routine-care appointment with a primary care provider to be 45 days.
- A maximum wait time for urgent care with a primary provider to be 2 days.
- A maximum wait time for routine-care appointment with a specialist to be 60 days.
- A maximum wait time for urgent care with a specialist to be 4 days.

Timely access will be articulated in the TPA contract.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

The State will monitor these timely access standards to determine compliance through monthly management reports submitted by the TPA. The State will also ensure compliance by analyzing claims data, calculating and reporting HEDIS measures related to access and availability of care, reviewing annual TPA provider and beneficiary surveys, and systematically evaluating the reasons for complaints to the TPA and DPHHS's customer service lines.

The State will require a corrective action plan for the TPA if it fails to meet timely access standards. In the event the TPA fails to meet timely access standards, the State will take action based on procurement rules.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

- 1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.**

The TPA provider network will be comparable to or broader than the State's fee-for-service network. The State will ensure that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs consistent with federal fee-for-service requirements and State law. The State will ensure that the TPA establishes and maintains a provider network and the network will be approved by DPHHS. The network must include only providers that are screened and enrolled consistent with Medicaid requirements as outlined in 42 C.F.R. 455 Subpart E. Provider and facility networks must be available throughout Montana and must include out-of-state providers for services not available in Montana.

- 2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.**

As a Frontier State, distance and time standards that may be meaningful in other states do not apply to Montana's large and primarily rural geography. The State will evaluate and ensure on an on-going basis that providers are appropriately distributed throughout the geographic regions covered by the TPA by reviewing quarterly provider network reports submitted by the TPA to the DPHHS. The TPA must notify the DPHHS within three days when the ratio of providers to HELP Program participants changes by 5% or more within provider types, by Montana county, out-of-state, overall number of providers, and other significant network changes. The DPHHS will regularly compare the TPA's network to the Standard fee-for-service network to ensure that it is at least comparable.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

- 1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?**

The State will be expanding coverage to the newly eligible population and does not have prior utilization experience nor utilization standards for this population. Over time and with experience in managing this new population, the State will develop utilization standards. While these standards are under development, the State will compare the utilization experience of the newly eligible population to the current fee-for-service parents/caretaker relatives through review of claims data to ensure that utilization for the new adults is at least comparable to utilization of current parent/caretaker relative enrollees.

The TPA will conduct prior authorization, as approved by the DPHHS and memorialized in the Alternative Benefit Plan State Plan Amendment, to ensure services provided to new adults are medically necessary. The TPA will conduct prior authorization consistent with federal mental health parity requirements and conduct utilization review for inpatient services, emergency admissions, and timely discharge to ensure services are medically necessary. The State has structured the TPA arrangement to ensure that the TPA has no incentive to limit services. The TPA is not assuming insurance risk nor is its administrative fee based on performance related to total medical expenses for the new adult population.

The State will regularly monitor the selective contracting program to determine appropriate Medicaid beneficiary utilization consistent with federal and State requirements and its utilization standard by reviewing and analyzing claims data. The TPA will monitor and report on measures to the DPHHS on a quarterly basis. The State will also evaluate claims data against HEDIS utilization and relative resource use measures as an additional monitoring mechanism.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

The State will require a corrective action plan for the TPA if beneficiary utilization falls below utilization standards. In the event the TPA fails to meet timely beneficiary utilization standards, the State will take action based on procurement rules.

Part III: Quality

A. Quality Standards and Contract Monitoring

- 1. Describe the State's quality measurement standards specific to the selective contracting program.**
 - a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):**
 - i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.**

The DPHHS will work with the TPA to define specific quality standards and reporting processes that will be memorialized in the TPA contract. These measures will likely include HEDIS measures related to quality and access. The DPHHS will regularly monitor the TPA to determine compliance with the State's quality standards. The TPA will prepare and submit to the State for its review:

- Quarterly Program Management Reports detailing utilization, expenditures, service category, quality of participant health, wellness program, and program overview;
- An annual Self Audit Report to DPHHS rating its services performed under the TPA contract;
- Quarterly utilization and access reports;
- Quarterly wellness program reports; and
- Results from its annual survey of HELP Program participants and providers on participant access to primary and specialty care, quality of care, and evaluation of the TPA's customer service center.

ii. Take(s) corrective action if there is a failure to comply.

The State will require a corrective action plan for the TPA if it fails to comply with quality standards. In the event the TPA fails to meet contract standards, the State will take action based on procurement rules.

2. Describe the State's contract monitoring process specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

The State will regularly monitor the TPA to determine compliance with contractual requirements based on its on-going oversight of the selective contracting program and a review of the quarterly reports outlined above. The DPHHS will review quarterly and annual reports, as described above, and will dedicate a full-time contract manager to oversee and monitor the TPA's compliance with the contract.

ii. Take(s) corrective action if there is a failure to comply.

The State will require a corrective action plan for the TPA if it fails to comply with quality standards. In the event the TPA fails to meet contract standards, the State will take action based on procurement rules.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

The State will assure that beneficiary coordination and continuity of care is not negatively impacted by the selective contracting program through monitoring and oversight of TPA case management activities and review of quarterly utilization review reports.

The TPA will conduct a Health Risk Assessment (HRA) that assesses each beneficiary's health status within 90 days of enrollment. The TPA will use findings from the HRA to target beneficiary outreach and interventions and will coordinate treatment plans with all providers involved in high risk and complex individual cases. Should the TPA identify beneficiaries who are medically frail, they will be referred to the DPHHS. The DPHHS will review regular reports prepared by the TPA on beneficiary outreach and results to ensure continuity of care is not negatively impacted by the selective contracting program.

The TPA case management lead will oversee all activities related to case management and coordination and continuity of care, ensuring that all beneficiaries have sources of care appropriate to their needs. The DPHHS will review the results of the TPA's annual survey of beneficiaries and providers to determine beneficiaries' self-assessment of access to primary and specialty care and subsequently work with the TPA to address any deficiencies.

In its processes to coordinate beneficiary care, the TPA must ensure that each beneficiary's privacy is protected in accordance with HIPAA privacy regulations found at 45 C.F.R. Parts 160 and 164, including future revisions and additions to these regulations. The TPA must establish, maintain, and use appropriate safeguards to prevent use or disclosure of beneficiary and provider personal information.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Upon Medicaid eligibility determination, HELP Program participants will receive a notice from DPHHS advising them of the following:

- *Medicaid eligibility determination.* The notice will include the basis of the eligibility determination, effective date of eligibility, information on copayments and premiums, a review of covered services, information regarding procedures for reporting a change in circumstances and website access to a participant handbook and participant newsletters.
- *Appeals.* The notice will also include information regarding the Medicaid appeals process as required under federal law.
- *TPA.* The notice will include information regarding TPA services and provider networks. As noted above, individuals receiving care through the TPA network will receive all services delineated in the State's ABP SPA and the services will be provided on a fee-for-service basis. A limited number of services, such as nonemergency medical transportation and dental services, will be provided outside the TPA contract and network; beneficiaries will be notified about these services and how to access them.

B. Individuals with Special Needs.

The State has special processes in place for persons with special needs
(Please provide detail).

The following populations are excluded from participating in the TPA:

- Individuals who have exceptional health care needs, including but not limited to medical, mental health or developmental conditions; and
- American Indians/Alaska Natives.

The State may also exempt the following individuals from the TPA:

- Individuals who live in a geographical area, including an Indian reservation, for which the TPA is unable to make arrangements with sufficient health care providers to offer services to the individuals; and
- Individuals who need continuity of care that would not be available or cost-effective through the arrangement with the TPA.

Individuals with special needs will be identified upon application and will be enrolled in coverage under the Medicaid State Plan.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

The DPHHS will competitively procure a TPA for its selective contracting program. To the extent possible, rates under the State's agreement with the TPA will be comparable to those paid under the current Medicaid program. The TPA will provide the DPHHS with the lowest provider reimbursement rates while still maintaining a sufficient provider network. The TPA will indicate in its RFP response its methodology and rates for inpatient hospital, outpatient hospital, and professional codes. If rates vary according to specific provider, the TPA will indicate the low and high rate for each code. The bidders response to the RFP related to reimbursement rates will account for one-third of the total RFP score. As such, this analysis is pending the RFP award which will be on or about October 1, 2015.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: __/__/__ to __/__/__

Trend rate from current expenditures (or historical figures): _____%

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____

Year 2 from: __/__/__ to __/__/__

Trend rate from current expenditures (or historical figures): _____%

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____

Year 3 (if applicable) from: __/__/__ to __/__/__

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____

Year 4 (if applicable) from: __/__/__ to __/__/__

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____

Year 5 (if applicable) from: __/__/__ to __/__/__

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost _____
Projected Waiver cost _____
Difference: _____