

State of Michigan - Managed Specialty Services and Supports Program Section D. 1915(b) Cost-Effectiveness Preprint Submission

Cost-effectiveness is one of the three elements required of a 1915(b) waiver. The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of “with waiver” and “without waiver” costs. Instead, States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

The 1915(b) Cost-Effectiveness Preprint and Instructions are divided into 4 major sections:

Section I. Definitions and Terminology

Section II. General Principles of the Cost-Effectiveness Test

Section III. Instructions for Appendices

Section IV. State Completion Section

In addition there are seven Appendices:

Appendix D1. Member Months

Appendix D2.S Services in the Actual Waiver Cost

Appendix D2.A Administration in the Actual Waiver Cost

Appendix D3. Actual Waiver Cost

Appendix D4. Adjustments in Projection

Appendix D5. Waiver Cost Projection

Appendix D6. RO Targets

Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. The Appendices included with the Preprint have been filled in with a completed actual example from the State of Nebraska. Each State should modify the spreadsheet to reflect their own program structure and replace the Nebraska information with its own data. *Note: the example is for illustrative purposes only. It does not reflect Nebraska’s actual experience or program structure.*

In addition, technical assistance is available through each State’s CMS Regional Office. Each Regional Office has a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests.

Actual Waiver Service Cost + Actual Waiver Administration Cost <= Projected Waiver Cost

IV. State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
 - The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
 - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
 - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to RO prior approval.
 - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
 - The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances: **Stephen Fitton**
- c. Telephone Number: **517-241-7181**

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

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

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

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

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

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

The response to this question should be the same as in **A.II.e.**

- a. Risk-comprehensive (fully-capitated--MCOs, HIOs)
- b. Partial risk/ PIHP
- c. Partial risk/ PAHP
- d. Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers **NA To This Waiver**

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only: **NA To This Waiver**

For Conversion or Renewal Waivers:

- a. [Required] Population in the base year data is the population under the waiver.
- b. For a renewal waiver, because of the timing of the waiver renewal submittal, the State estimated up to six (6) months of enrollment data for R2 of the previous waiver period. Note the length of time estimated: _____
- c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time: **The increase in member months is attributable to growth in Medicaid eligibles, which are the “covered lives” under the (b) waiver program. This growth is due in part to growth in overall state population, in part due to the slowing of the state’s economy, with its related workforce downsizing, loss of private insurance, etc., and in part due to the state’s enhanced Medicaid information/outreach efforts.**
- d. [Required] Explain any other variance in eligible member months from BY to P2: **None**
- e. [Required] Specify whether the BY is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: **SFY.**

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

For Initial Waivers: **NA To This Waiver**

For Conversion or Renewal Waivers:

- a. [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: **None**
- b. [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: **No Managed Specialty services or supports are excluded from the CE analysis. Each 1915(b) waiver reports on separate CMS 64.9 Waiver forms and separate lines of the Waiver summary forms.**

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

[Required] The State allocated administrative costs between the **Fee-for-service** and managed care program depending upon the program structure. The allocation method is explained below:

- a. The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. Other (Please explain). **There is NO FEE FOR SERVICE coverage for any of the benefits covered under the managed specialty services and supports program. The state administrative costs included are limited to MMIS, MDCH/State staffing (CAP), Independent Assessment, Consumer/Beneficiary Satisfaction surveys, consumer involvement on quality review teams, and professional contracts associated with the administration of the managed care program. All administrative costs have been allocated to the managed care MEGs listed herein on a PMPM basis.**

H. Appendix D3 – Actual Waiver Cost

- a. The State is requesting a 1915(b)(3) waiver in **Section A.II.g.2** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

In addition to Michigan using a portion of its waiver savings to fund the additional 1915(b)(3) services listed in Appendix D2.S, Michigan's contract

with the PIHPs under this program allows the PIHPs to use savings (unexpended capitation payments) from one year to fund the implementation of an approved reinvestment strategy in the following year. Under the shared risk provisions of this contract, the PIHP may retain unexpended Medicaid capitation funds up to 7.5% of the Medicaid pre-payment authorization. These funds must be included in the PIHP reinvestment strategy, which must be directed to the Medicaid population, receive prior approval from the state and CMS, and be invested in accordance with the following criteria:

- A. Development of new treatment, support and/or service models; these shall be additional 1915(b)(3) services to Medicaid beneficiaries as allowed under the cost savings aspect of the waiver;
- B. Expansion or continuation of existing state plan or 1915(b)(3) approved treatment, support and/or service models to address projected demand increases
- C. Community education, prevention and/or early intervention initiatives
- D. Treatment, support and/or service model research and evaluation
- E. The PIHP may use up to 15% of Medicaid savings for administrative capacity and infrastructure extensions, augmentations, conversions, and/or developments to: (1) assist the PIHP (as a PIHP) to meet new federal and/or state requirements related to Medicaid or Medicaid-related managed care activities and responsibilities; (2) implement consolidation or reorganization of specific administrative functions related to the Application for Participation and pursuant to a merger or legally constituted affiliation; or (3) initiate or enhance recipient involvement, participation, and/or oversight of service delivery activities, quality monitoring programs, or customer service functions.
- F. Identified benefit stabilization purposes. Benefit stabilization is designed to enable maintenance of contracted benefits under conditions of changing economic conditions and payment modifications. This enables the PIHP to utilize savings to assure the availability of benefits in the following year.

The PIHP reinvestment strategy must receive approval by the PIHP Board of Directors, MDCH, and CMS. The reinvestment strategy becomes a contractual performance objective. The PIHP shall document for audit purposes the expenditures that implement the reinvestment plan according to approved plans. Unexpended Medicaid savings shall be returned to the MDCH as part of the year-end settlement process.

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

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

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
<i>Individualized Specialty MH & SA Services (Inclusive of the PIHP Reinvestment Strategy Funding):</i>	\$295,433,024	2.75%/yr BY to P1; 2.6%P1 to P2	\$332,950,188 in P1 \$353,009,299 in P2, for a P1 &P2 total of \$685,959,487

b.____ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. X Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost. **The state requires the PIHPs to demonstrate financial risk protections sufficient to cover the PIHP’s determination of risk. To this end, the State allows PIHPs to use one or a combination of measures including pledged assets, stop loss insurance, and “Internal Service Funds.”**

Basis and Method: Shared Risk/risk corridor.

1. The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. **The state requires the PIHPs to demonstrate financial risk protections sufficient to cover the PIHP's determination of risk.** No adjustment was necessary.

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

d. **NA To This Waiver** Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

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

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

2. For the fee-for-service portion of the waiver **[There is no fee-for-service portion of this waiver]**, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.IV.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.IV.H.e and D.IV.I.f**)

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

H. Appendix D4 – Adjustments in the Projection

Initial Waiver Cost Projection & Adjustments **NA To This Waiver (If this is a Conversion or Renewal waiver , skip to I. Conversion or Renewal Waiver Cost Projection and Adjustments):**

I. Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the

adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

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

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

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

1. [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual **annual** trend rate used is: **MCHIP 2.75%, TANF 2.75%, DAB 2.75%, and Waiver (c) 2.5%**. Please document how that trend was calculated: **These trends were calculated to reflect the expected change in capitation payments between the base year and Projected Year 1. The calculation of the trend excludes program changes.**
2. [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
 - i. State historical cost increases. Please indicate the years on which the rates are based: base years _____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 - ii. National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____.

Milliman utilized trend rates developed from a Medicaid fee-for-service database. The database included comparable mental health related services and Medicaid populations.

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

3. ___ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
 - ii. Please document how the utilization did not duplicate separate cost increase trends.

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

Others:

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

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

1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. An adjustment was necessary and is listed and described below:
 - i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

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

For each change, please report the following:

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

For each change, please report the following:

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

vi. Other (please describe):

- A. _____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
- B. _____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
- C. _____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
- D. Other (please describe): **As instructed by CMS, Milliman/the state modified the rates based on the significant restructuring of this Waiver's capitation payment system and re-distribution of payments among a revised set of MEGs required to meet the actuarial soundness requirements of the Balanced Budget Act. Please see Milliman letter Re: Documentation of Managed Specialty Services and Supports Waiver Capitation Rates – Version 5 to Patrick Barrie dated November 20, 2003 for a discussion of the adjustments.**

- c. **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.
1. _____ No adjustment was necessary and no change is anticipated.
2. An administrative adjustment was made.
- i. Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe: **The structural changes to this waiver program caused by the Balanced Budget Act requirements necessitate additional time in both P1 and P2 from the State's Actuary as well as from the state's implementation training and technical assistance advisors/contractors.**
- ii. _____ Cost increases were accounted for.
- A. _____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
- B. _____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C. _____ Other (please describe):
- iii. _____ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the

future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

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

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

1. [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: The actual **annual** trend rate used is: **MCHIP 2.75%, TANF 2.75%, and DAB 2.75%**. Please document how that trend was calculated: **These trends were calculated to reflect the expected change in capitation payments between the base year and expected year 1. The calculation of the trend excludes program changes.**

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

State Plan Service trend

- A. Please indicate the State Plan Service trend rate from **Section D.IV.I.a.** above: **Milliman utilized trend rates developed from a Medicaid fee-for-service database. The database included comparable mental health related services and Medicaid populations. MCHIP, TANF, and DAB @ 2.75% per year from BY to P1; and 2.6% from P1 to P2.**

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

f. **Other Adjustments** including but not limited to federal government changes. (Please Describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1. No adjustment was made.

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

J. Appendix D5 – Waiver Cost Projection

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

K. Appendix D6 – RO Targets

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

L. Appendix D7 - Summary

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

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.IV.E. c & d**: The reason for the increase in member months projections from the base year through P2:

The increase in member months is attributable to growth in Medicaid eligibles, which are the “covered lives” under the (b) waiver program. This growth is due in part to growth in overall state population, in part due to the slowing of the state’s economy, with its related workforce downsizing, loss of private insurance, etc., and in part due to the state’s enhanced Medicaid information/outreach efforts.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.IV.H and D.IV.I**: The overall annualized rate of change in **Appendix D7 Column I** is attributable to **annual** cost trend rates of

MCHIP 2.75%, TANF 2.75%, DAB 2.75%, and Waiver (c) 2.5%. Please document how that trend was calculated: **These trends were calculated to reflect the expected change in capitation payments between the base year and Projected Year 1. The calculation of the trend excludes program changes.**

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.IV.H and D.IV.I:** The reason for the increase in utilization projections from the base year through P2: **The increase in utilization/member months is attributable to growth in Medicaid eligibles, which are the "covered lives" under the (b) waiver program. This growth is due in part to growth in overall state population, in part due to the slowing of the state's economy, with its related workforce downsizing, loss of private insurance, etc., and in part due to the state's enhanced Medicaid information/outreach efforts.**
4. Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.** **As instructed by CMS, Milliman/the state modified the rates based on the significant restructuring of this Waiver's capitation payment system and re-distribution of payments among a revised set of MEGs required to meet the actuarial soundness requirements of the Balanced Budget Act.**