



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 jthompson@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: _____