

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Suite 900
Dallas, Texas 75202



Medicaid and CHIP Operations Group

April 14, 2020

Matt Anderson
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Mr. Anderson:

The Centers for Medicare & Medicaid Services (CMS) approves the Minnesota Department of Human Services' (DHS) §1915(b) renewal waiver application for the Consolidated Chemical Dependency Treatment Fund (CCDTF) Program, CMS control number MN-01.R14. The CMS authorizes the state to utilize §1915(b)(4) authority within the Social Security Act (the Act) to operate the CCDTF program. The state has also chosen to waive §1902(a)(23) of the Act. The effective dates of this waiver are July 1, 2020 to June 30, 2022.

The CMS has based this decision on evidence the state submitted that demonstrates that the information contained in the §1915(b) waiver application is consistent with the purposes of the Medicaid program, as well as other assurances that the state will meet all applicable statutory and regulatory requirements in the operation of this §1915(b) waiver program.

If you have any questions related to this renewal, please contact Eowyn Ford at (312) 886-1684 or Eowyn.Ford@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Bill Brooks". The signature is written in a cursive, slightly slanted style.

Bill Brooks
Division Director
Division of Managed Care Plan Operations

cc: Ann Berg, DHS
Jan Kooistra, DHS

Application for

Section 1915(b) (4) Waiver

Fee-for-Service

Selective Contracting Program

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

Facesheet

The **State** of Minnesota 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 the [Consolidated Chemical Dependency Treatment Fund \(CCDTF\)](#).

(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 2 years beginning [July 1, 2020 and ending June 30, 2022](#)

State Contact: The State contact person for this waiver is [Jan Kooistra](#) and can be reached by telephone at [\(651\) 431-2188](#) or e-mail at jan.kooistra@state.mn.us. (List for each program)

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.

On February 20, 2020, a letter was sent to all tribal chairs, tribal health directors, tribal social service directors, the Indian Health Services Area Office Director, and the Director of the Minneapolis Indian Health Board clinic informing them of the State's intent to submit a request to renew the CCDTF waiver. The letter provided an overview of the impact that the waiver would have on American Indian people, tribes and tribal providers, and invited them to comment on the proposed waiver renewal. A Copy of the tribal consultation letter is provided at Attachment A.

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.

Background:

In 1986, the State began a dialogue with CMS to implement a comprehensive chemical dependency treatment fund, CCDTF. CCDTF has two main components: (1) consolidating multiple funding sources; and (2) streamlining service authorization based on recipients' Substance Use Disorder (SUD) assessment. The reason to consolidate funding sources was to reduce or eliminate service duplication and overlap, and to expedite service authorizations.

CCDTF covers SUD treatment services, defined as a planned program of care for the treatment of chemical dependency or abuse intended to minimize or prevent further substance use, for eligible individuals regardless of their primary funding source. The primary payer is billed after the service is provided. Based on an individualized evaluation, the county or the governing body of a federally recognized American Indian tribe (the "locality") authorizes services to be provided by the most appropriate and cost-effective provider.

A waiver of the requirement of section 1902(a)(23) regarding the choice of provider is necessary to allow recipients to be directed to the provider designated by the locality.

In January, 1988, the State received approval of the 1915(b) waiver and implemented CCDTF program statewide. State laws and regulations govern the program's operation including provider licensing, recipient assessment and funding management.

The 2019 Minnesota Legislature revised the law to end county financial responsibility for SUD services for people enrolled in fee-for-service Medical Assistance (MA) effective on July 1, 2020. This change in financing is another step in Minnesota's reform efforts. The CCDTF will

remain the primary public funding source for SUD treatment for those not enrolled in MA and to fund room and board and other services ineligible for Medicaid reimbursement.

Substance Use Disorder (SUD) Reform Minnesota is reforming the state's provider and delivery system for SUD treatment with the goal of providing a more person-centered approach that allows beneficiaries to more quickly access services and that supports a longer trajectory for recovery for people with SUD.

The 2016 Minnesota Legislature directed the Department of Human Services (DHS) to transition its care model to one in which people can directly access care without a county or tribe as an intermediary. This new model will still require an individual to receive a comprehensive assessment to determine the level of intensity and duration of services. The legislature also enacted other changes in 2017 to further transform the state's SUD treatment system, including a requirement to conduct utilization review of services provided; an expansion of direct reimbursement for services provided in settings outside treatment programs, such as schools, jails and primary care, and the addition of new services to the Medicaid benefit set including early treatment intervention, peer support services, and withdrawal management.

DHS continues to work toward full implementation of a direct access model. This reform effort brings with it a broad and complex set of changes required to fully transition to a model that expands access options for beneficiaries beyond the traditional county and tribal-based delivery model.

The shift to a direct-access model requires redefining the roles of counties, tribal human service agencies and providers, developing and maintaining statewide capacity of trained and qualified assessors, and assuring consumers are informed of their options for accessing the services they need. It also demands an awareness of statewide interactions between provider capacity and beneficiary access so that the system may respond to the complex needs of its Medicaid population. Systems upgrades necessary to operationalize a direct-access model must also be completed in order to fully implement statewide.

Therefore, DHS intends to continue its 1915(b)(4) waiver authority for an additional two-year period while it completes the transition to a system that better facilitates access to treatment.

DHS is taking steps to ensure the state has an adequate supply of qualified assessors while moving toward full implementation of direct access. The state recently expanded the provider types eligible to conduct comprehensive assessments and is currently working on standards to allow SUD assessments via telehealth. The counties and tribes will continue making placements during the two year transition to direct access. Following this transition, counties and tribes will continue supporting beneficiaries through assessments and treatment coordination.

DHS continues to monitor access to SUD services across the state. The Department has contracted with a vendor to conduct a statewide provider capacity assessment and create a baseline set of measures to assess the SUD service capacity. With the resulting data, the state can take measures to build capacity where gaps exist. The state also funds an online tool called

Fast Tracker, a platform that allows providers to consistently update whether they are accepting new clients, enabling placing entities to search for available mental health and SUD services.

Minnesota is also taking steps to address potential workforce shortages that would impact beneficiary access particularly in rural and underserved urban areas of the state. The Minnesota Department of Health Office of Rural Health and Primary Care supports the SUD workforce in multiple ways. The office:

- Collects health professional licensing data and publishes reports with analysis of the workforce.
- Funds loan forgiveness awards to mental health professionals, which includes professionals providing SUD services in rural and underserved urban areas.
- Funds grants to expand clinical training for Mental Health Professional educational programs, particularly those who send students to rural and underserved areas.
- Funds grants to safety net clinics that provide care to underserved populations throughout the state, including SUD services.
- Funds grants to clinics that serve American Indian communities.
- Funds grants to mental health safety net clinics, many of which provide SUD services.

I. Funding

In 2015, the MinnesotaCare program became a basic health program (BHP) and is no longer a Medicaid program. This waiver applies to recipients enrolled in the Medical Assistance (MA) program. SUD treatment services are authorized by the locality based on an individual assessment and the services are covered fee-for-service.

The CCDTF program is not a managed care model and there is no capitated payment for SUD treatment services provided under this waiver. The payment rates established by the State were not designed to reimburse for room and board. Payments for treatment and room and board are calculated separately and are not claimed as Medicaid expenditures.

For Medicaid recipients who are enrolled in managed care organizations (MCOs), all SUD treatment services are provided through the MCO and the provision of services is governed by the managed care authority of the §1115 PMAP waiver, §1932 State Plan, or the §1915(b) waiver for seniors.

II. SUD Treatment Services Covered

SUD treatment services are covered in accordance with the amount, duration, and scope of the services defined in the State Plan.

III. Recipient Assessments

Recipients are assessed for SUD treatment services by county social service agencies or the governing bodies of federally recognized tribes. State regulations provide statewide criteria for placement in SUD treatment services, including an individualized assessment. The assessment

includes a personal interview with the recipient and collateral contacts, and review of relevant records and reports in order to make a finding regarding the extent of the substance use problems.

IV. Service Planning

The locality develops a service plan based on the recipient's assessment. The recipient's drug use history, demographic data, behavioral data, family information, previous treatment history, medical and/or psychological complications, legal involvement and employment status are taken into account.

The locality may also consider the following factors: the (1) level of involvement of family members and significant others in the recipient's treatment; (2) rehabilitative philosophy of the service provider; (3) extent to which specialized services are available; (4) client preference, and (5) location of the provider as it relates to such things as employment, and family involvement.

The locality also determines whether the recipient requires service provided in a residential or non-residential setting or specialized services for co-occurring conditions based on standards established in regulation.

V. Provider Referrals and Service Authorizations

When the locality refers a recipient to a service provider, the locality completes a client placement authorization. The authorization includes the maximum number of authorized units of service, payment rate, and the maximum total payment. The authorization also includes recipient demographic and payer information. The information from the authorization is entered into the Medicaid Management Information System (MMIS) in the form of a service agreement. Payment rates are at Att. 4.19-B, Section 13.d of Minnesota's approved State Plan.

Entry of the service agreement generates a letter to the provider of the service that includes authorization and delivery information. Providers submit claims for Medicaid recipients to the State on a standardized billing form for processing and payment. Only localities may change a service agreement and any change generates a new provider notification letter identifying what changes were authorized. Localities monitor service authorization and payment activity through MMIS reports.

VI. Locality Responsibilities

Localities are the placing authorities, with responsibility to provide the full continuum of SUD treatment services covered under the State Plan.

Each county is responsible for:

- The assessment and placement of county residents who need SUD treatment services; and

- Monitoring of the services.

Each tribal government is responsible for:

- The assessment and placement of American Indians living on a reservation who need SUD treatment services; and
- Monitoring of the services.

County and tribal governments have direct access to the "Reports" section of MMIS, and have been trained on how to access and use the reports to effectively monitor services delivered.

VII. Fair Hearing Notice

All Medicaid recipients are provided advance notice of negative action and of their right to a fair hearing in accordance with state and federal regulations. Recipients may appeal if they disagree with localities' assessment determinations or service authorizations. Recipients also receive notification of their privacy rights.

VIII. Quality Management

SUD treatment providers must be licensed by the department according to applicable state rules, or be a program operated by an American Indian tribal organization that would require licensure if it were located outside federally recognized tribal lands. All providers, including tribal providers, must meet the same standards and must enroll as a Medical Assistance provider.

IX. Provider Contracts

Effective July 2011, contracts between localities and providers were discontinued and providers instead contract directly with the State. Providers receive payment rates identified in the State Plan. The rates are graduated based on the client's level of acuity and complexity.

Necessary services are prior-authorized in MMIS based on the individual service plan. Appropriate claims for authorized services from approved providers are paid based on the information provided in the claim. The level of payment depends on the type and amount of services rendered. The coding structure in MMIS reports allows identification of the level and complexity of services provided and the payment level for each unit of service paid.

Waiver Services:

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

Medical Assistance covers SUD treatment services, defined as a planned program of care for the treatment of SUD intended to minimize or prevent further substance use.

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)**

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)

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.

Recipients are limited to the providers that the locality determines to be most appropriate. There may be multiple providers in the service area. As appropriate, localities take into account recipients' preferences when making placement determinations. The service area is statewide and includes the local trade areas of bordering states.

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)

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.

Minnesota's state plan does not address assessment or placement determinations for individuals seeking services for substance use disorders.

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:

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

X Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

Includes pregnant women, parents and caretaker relatives under Section 1931, poverty-level pregnant women and SCHIP

X Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

Does not include members of the Section §1931 adult population

X Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

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

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

X Title XXI CHIP Children is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program. Includes unborn children of noncitizen mothers who are ineligible for federally funded Medicaid.

X Individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled in, benefits under Part A of title XVIII, or enrolled in benefits under part B of title XVIII, and not described in 1902(a)(10)(A)(i)(I) through 1902(a)(10)(A)(i)(VII) of the Act, who are adults who are not disabled, do not have minor children, and who do not have any other categorical or medically needy basis of eligibility under the Medicaid State Plan and do not have a basis of eligibility under the State’s PMAP+ section 1115 waiver.

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):

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?

Regulations require that a face-to-face assessment interview using a standardized assessment tool be conducted within 20 days of the request. The recipient must be informed whether the service was denied or authorized within ten days of the assessment interview. If the recipient’s treatment is not initiated within 45 days of the referral to the provider, the locality must update the assessment.

Localities are required to submit assessment and service authorization dates to the department. This data allows the department to track localities’ responsiveness to referrals and enrollees’ access to services. MMIS data allows the department to monitor what types of services were authorized and the corresponding time span.

MMIS edits only allow authorized providers to bill for services within the parameters approved by the locality.

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.

Enrollees may appeal placements that are not timely or appropriate. State law requires the placing authority to inform members of their right to appeal. The state tracks the appeals through the DHS Appeals and Regulations Division. Appeals and Regulations Division maintains a database of appeals, and Behavioral Health Division (BHD) staff check the database at least annually. We typically see two to three cases per year.

The state investigates beneficiary complaints and reports of non-compliance, and has notified the placing authorities of findings of non-compliance. Through written communication, telephone communications and site visits, the state works with placing authorities to clarify compliance requirements. The Department reviews and approves corrective action plans. The state continues to monitor progress on corrective action plans until the state is assured that the problem has been resolved.

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.
 - a. While the State does restrict recipients' access to providers by directing them to the most appropriate and cost effective provider, we do not limit the number of providers. All qualified providers may enroll. By "cost effective provider" we mean the selection of a provider that meets the treatment needs of a member without incurring additional, unnecessary costs. Although provider payment rates have been set by the state since July 1, 2011, cost variations between providers persist. Programs that provide mental health services are paid at an enhanced rate, as compared with a provider of standard treatment. Consequently, for a member who does not have a co-occurring disorder, selection of a standard program results in the use of a more cost-effective provider in that the extra cost of the enhanced rate is avoided.
 - b. All SUD treatment providers must be Minnesota Health Care Program (MHCP) enrolled providers. A directory of all MHCP-enrolled SUD treatment providers,

along with specific services they offer and their rates for each service, is available to placing authorities through the state's electronic provider communication system, called MN-ITS.

- c. BHD and Provider Enrollment Unit staff are in regular contact regarding provider enrollment and the number of providers. If any unplanned or significant change in the number or type of providers were to occur, the department would be aware of the change and could take appropriate action. The list and number of enrolled providers is continuously updated by the Provider Enrollment Unit.
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.

The State does not limit the number of providers. All qualified providers may enroll.

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?
 - a. In addition to contracting directly with the State, each provider must be enrolled as a Medicaid provider, which includes signing a provider agreement with the State, and must participate in a recipient data collection and reporting systems, Drug and Alcohol Abuse Normative Evaluation System (DAANES).
 - b. Department staff review service authorization and treatment episode data (i.e., length of time enrollees participate in treatment) to analyze any differences in service access and utilization based on race and ethnicity. Reports are generated at least every two years. Staff from the Performance Measures and Quality Improvement Division generate and analyze the data, which is then reviewed by BHD staff. The data provides percentage comparisons and can be used to evaluate specific factors such as type, location, and length of service, as they relate to race and ethnicity
 - c. The State operates an enrollee hotline. BHD staff address calls from recipients, localities, and providers. Staff respond to questions and concerns and provide information and technical assistance. Staff review calls in weekly meetings to determine if policy clarifications or trainings are needed. The information from the calls is anecdotal but it provides staff with on-going feedback concerning program implementation and related issues.

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 does not limit the number of providers. All qualified providers may enroll.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

All SUD treatment providers must meet state or tribal licensing requirements. Licensing criteria for inpatient hospital services includes JCAHO accreditation.

Each provider must be enrolled as a MHCP provider, which includes signing a provider agreement with the State, must attest to meeting CD standards for the types of CD services they provide, and must participate in a recipient data collection and reporting systems, Drug and Alcohol Abuse Normative Evaluation System (DAANES).

- 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 Licensing Division reviews provider applications, issues licenses, and monitors providers through licensing reviews that occur on average every three years. The Provider Enrollment Unit reviews all provider applications and determines whether each provider meets applicable provider standards.

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

During regular licensing reviews, providers are evaluated to determine if they continue to meet established program standards. If these standards are not met, negative licensing action may be taken or the provider's license may be revoked depending upon the nature and severity of the noncompliance.

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 restriction on recipients' choice of providers is for the purpose of directing recipients to the most appropriate and cost-effective providers, based on the recipients' assessed needs. The purpose of the waiver is not to limit the total number of SUD treatment providers.

Through assessing recipients substance use problems, directing recipients to appropriate providers, and authorizing SUD treatment services, localities are able to monitor the recipients' response to services and assist with transitioning recipients through the continuum of SUD treatment services.

The State consolidated its licensing standards SUD treatment providers, creating one set of standards for both residential and outpatient services. The purpose of the consolidation was to provide more seamless services to recipients and streamline provider standards, resulting in improved service continuity and coordination of care, a broader array of services offered by some providers, and reduced need for some recipients to transition from one provider to another as their service needs change.

Part IV: Program Operations

A. Beneficiary Information

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

All Minnesota Health Care Programs (MHCP) recipients receive a member card with their enrollment number. The card lists the phone number to the MHCP help desk managed by the department. Depending upon the issue raised by the enrollee, help desk staff will provide direct assistance or will link the person with the applicable ombudsman's office or to BHD staff. The department's web site provides a list of all SUD treatment providers by county. All localities must assure that recipients have access to SUD treatment services. The department also tracks the number of visits to the web site. This data indicates that program information is being disseminated.

The BHD also provides information on the department's website. The information includes general information as well as instructions regarding how to request an assessment, file a licensing complaint, or submit a fair hearing request. It also includes a list of current providers by county, funding information, and links to other applicable web sites such as SAMHSA's.

When people access SAMHSA's internet site they may elect to be linked to a state contact. These contacts are directed to BHD staff. Callers receive personal assistance to link them with appropriate local resources.

B. Individuals with Special Needs.

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

People with special health care needs may access this program. The state does not have specific special health needs requirements within the substance abuse provider rules, however providers may offer specialty health care services in compliance with applicable statutory and rule requirements. In addition, programs may receive rate enhancements if they meet requirements to serve specific populations, including parents with their children, special population groups, and persons with co-occurring mental illness and SUD, or if they offer medical services delivered by appropriately credentialed health care staff.

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.
 - a. State’s economic or clinical rationale for providing these services to this population under this authority.

Restriction on recipients’ choice of providers is for the purpose of directing recipients to the most appropriate and cost-effective providers, based on the recipients’ assessed needs. Through assessing treatment needs, directing recipients to appropriate providers, and authorizing treatment services, localities are able to monitor the recipients’ response to services and assist with transitioning recipients through the continuum of treatment and recovery.

The Department is submitting this renewal to maintain the placing authority for two years while transitioning to a direct access model. Under the direct access model, counties and tribes will continue linking beneficiaries with treatment providers through assessment and treatment coordination services, but will no longer authorize services.

- b. The State’s methodology for developing the trend rates used for projecting costs, or any discrepancies the State chooses to have considered in the review of this data.

The five year PMPM cost trend of 14.7% is derived from actual expenditures divided by actual member months for SFY 2019 (ending June 30, 2019) compared to SFY 2014 (ending June 30, 2014), using the standard formula for average percentage change over multiple periods. The relevant PMPM values are \$33.87 for SFY 2019 and \$17.09 for SFY 2014.

Aggregate member month projections for July 1, 2019 through June 30, 2022 are based on the February 2020 State forecast for all eligible MA fee-for-service recipients. Projected overall waiver PMPMs for the same period are based on the \$33.87 PMPM for SFY 2019 trended at 14.7%.

Additional waiver costs are shown separately for the SUD waiver proposal previously submitted by the State, based on the fee-for-service residential services portion of that application, using an unchanging PMPM of \$3,132.04 per fee-for-service member month in the waiver proposal.

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

Year 1 from: 07/01/2020 to 06/30/2021

Trend rate from current expenditures (or historical figures): 14.7%

Projected pre-waiver cost	–	
Projected Waiver cost	\$118,044,111	
Difference:	–	
P1 Aggregate PMPM		\$ 44.57
Added cost for SUD waiver	\$ 37,821,464	
Total cost with SUD waiver	\$155,865,575	
P1 Aggregate PMPM with SUD waiver		\$ 57.98

If the State exceeds the estimated aggregate expenditures, cost-effectiveness can be met on a PMPM basis.

Year 2 from: 07/01/2021 to 06/30/2022

Trend rate from current expenditures (or historical figures):		14.7%
Projected pre-waiver cost	–	
Projected Waiver cost	\$136,918,450	
Difference:	–	
P2 Aggregate PMPM		\$ 51.12
Added cost for SUD waiver	\$ 44,550,533	
Total cost with SUD waiver	\$181,468,983	
P1 Aggregate PMPM with SUD waiver		\$ 66.37

If the State exceeds the estimated aggregate expenditures, cost-effectiveness can be met on a PMPM basis.

Year 3 from:

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