

Section D. COST EFFECTIVENESS

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: Suzi Ballinger
- c. Telephone Number: (614) 466 8740

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. X 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

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe). Responses must match those provided in **Section A.II.c.6:**

- a. Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
 - 1. First Year: \$ per member per month fee
 - 2. Second Year: \$ per member per month fee
 - 3. Third Year: \$ per member per month fee
 - 4. Fourth Year: \$ per member per month fee
- b. Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under D.IV.H.d.2, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to

savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. Response can be included in

- d. ___ Other reimbursement method/amount. \$_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

- a. ___ Population in the base year data
1. ___ Base year data is from the same population as to be included in the waiver.
 2. ___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b. ___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c. ___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
- d. ___ [Required] Explain any other variance in eligible member months from BY to P2:
- e. ___ [Required] List the year(s) being used by the State as a base year: ____. If multiple years are being used, please explain: _____
- f. ___ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.
- g. ___ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

For Conversion or Renewal Waivers:

- a. X [Required] Population in the base year and R1 and R2 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. X [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 from the BY (SFY 2002) to P1 (SFY 2004) is due to the expected expansion of managed care into Mahoning and Trumbull counties as well as increases in the number of eligibles due to economic factors.

In addition to the expansion of managed care into these counties, managed care penetration is projected to increase in the established managed care counties as these counties move from voluntary enrollment to mandated or preferred option managed care enrollment, or from preferred option enrollment to mandatory enrollment. The impact of penetration changes is expected to increase penetration from an average of 60% in SFY 2002 to 74% in SFY 2004.

- d. X [Required] Explain any other variance in eligible member months from BY/R1 to P2:

The variance in eligibles between BY and P2 (SFY 2005) reflects the changes discussed above as well as increases in the number of eligibles due to economic factors.

- e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

The periods related to the analysis are BY: SFY 2002, P1: SFY 2004, and P2: SFY 2005.

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

For Initial Waivers:

- a. [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.

For Conversion or Renewal Waivers:

- a. X [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**:

Chiropractic and independent psychologist services for adults will be eliminated from coverage effective January 1, 2004. These service changes have been included in the projection of P1 and P2. These adjustments to services are included in the Program Adjustments for

P1 and P2 in Appendix D5 and are listed in Appendix D4 and later within Section IV.

- 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: _____

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. X Other (Please explain).

The following direct costs are allocated to Managed Care:

- **BMHC**
- **Enrollment Broker (Automated Health)**
- **EQRO (DelMarva)**
- **Actuarial Contract (Mercer)**
- **BMHC Quality Staff**
- **County Expenditures**

Costs for BMHC, Enrollment Broker and the Actuarial Contract are allocated between SCHIP and Title XIX based on enrollment. EQRO, County Expenditures, and BMHC Quality staff are allocated 100% to Title XIX.

Indirect Costs were allocated as follows:

- **Cost Pool 1 – Computer Usage will allocate the Medicaid percentage (Medicaid vs. Managed Care) on the following basis:
Managed Care XIX Claims Paid ÷ Total Number of XIX Claims Paid
S-CHIP Managed Care Claims Paid ÷ Total Number of S-CHIP Claims Paid
Note: Paid claims is more reflective of MIS effort versus enrollees divided by eligibles.**
- **Cost Pool 6 – State Level Indirect will allocate the Medicaid percentage (Medicaid vs. Managed Care) on the following basis:
BMHC FTEs ÷ Total OHP FTEs**

- **Cost Pool 15 – CRIS-E will allocate distributed XIX and S-CHIP costs on the following basis:**
 $\text{XIX MC Enrollees} \div \text{Total XIX Eligibles}$
 $\text{S-CHIP MC Enrollees} \div \text{Total S-CHIP Eligibles}$
- **Cost Pool 22 – MMIS, DA, and STFO methodology will allocate costs on the following basis:**
Number of Medicaid Regular, CHIP Regular, Managed Care Medicaid, Managed Care CHIP, and GA/DA claims
- **Cost Pool 36 – Statewide Indirect will allocate the Medicaid percentage (Medicaid vs. Managed Care) on the following basis:**
 $\text{BMHC FTEs} \div \text{Total OHP FTEs}$
- **Cost Pool 37 – MIS Indirect will allocate the Medicaid percentage (Medicaid vs. Managed Care) on the following basis:**
 $\text{Managed Care XIX Claims Paid} \div \text{Total Number of XIX Claims Paid}$
 $\text{S-CHIP Managed Care Claims Paid} \div \text{Total Number of S-CHIP Claims Paid}$
Note: Paid claims is more reflective of MIS effort versus enrollees divided by eligibles.
- **Cost Pool 45 – BMHC costs will be excluded from Cost Pool 45 and XIX and S-CHIP costs will be allocated to new Cost Pool 63 on the following basis:**
 $\text{BMHC FTEs} \div \text{Total OHP FTEs}$
- **New Cost Pool 63 – BMHC staff and other costs will be distributed to Medicaid and S-CHIP on the following basis:**
 $\text{XIX MC Enrollees} \div \text{Total MC Enrollees}$
 $\text{S-CHIP MC Enrollees} \div \text{Total MC Enrollees}$
Indirect costs are allocated between SCHIP and Title XIX on the same basis used to determine the FFS and managed care split

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.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation Projected	Amount projected to be spent in Prospective Period
Total	(PMPM in Appendix D5 Column T x projected member months should correspond)		(PMPM in Appendix D5 Column W x projected member months should correspond)

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 for R1 and R2 (BY for Conversion) 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>Not Applicable</i>	<i>\$0 BY</i>		<i>\$0 P1</i> <i>\$0 P2</i>
Total	\$0 BY (PMPM in Appendix D3 Column H x member months should correspond)		\$0 P1 \$0 P2 (PMPM in Appendix D5 Column W x projected member months should correspond)

- b. X 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:

The development of the managed care capitation rates is based on Ohio historical FFS experience for the managed care counties and the population eligible for the managed care program. Voluntary populations are included under the 1915(b) waiver. In counties with Voluntary or Preferred Option managed care programs where there are concurrently running managed care and fee-for-service (FFS) programs, the Cost Effectiveness exhibits only include costs for members enrolled in a MCO.

Since Ohio has counties with voluntary enrollment, this FFS data reflects the experience of the individuals not electing managed care. Based on studies and other state experience, an adverse selection adjustment was applied to this data to reflect the FFS experience if all eligibles were enrolled in FFS. This adverse selection adjustment is based on actual managed care penetration levels by county during the data period.

As a result of the adverse selection adjustment, the FFS data already reflect the risk of the entire Medicaid program, i.e., FFS and managed care individuals. To reflect solely the risk of the managed care program, the FFS data was further modified to reflect the projected managed care penetration levels. This voluntary selection adjustment modifies the FFS data to reflect the risk to the managed care organizations (MCOs), i.e., only those individuals who enroll in a health plan. This adjustment is based on data from other states as well as the actuarial principle that costs associated with enrolled managed care members are generally lower. This adjustment varied by county based on the projected MCO penetration level for the contract period.

Column E of Appendix D3 is pulled from the Medicaid database for SFY 2002. It includes the total dollar amount spent on excluded services (those services marked as FFS on Appendix D2.S) rendered to recipients who were enrolled in managed care during that period. It only captures payment for these services used while the enrollees were in managed care.

- 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.

Basis and Method:

1. X The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. The State provides stop/loss protection (please describe):

d. X Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. X [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.

The Ohio managed care program provided two separate performance incentives for its MCOs. The first incentive includes 0.5% of the capitation rate which is placed at risk based on several measurements further described in the attached Appendix L, Provider Agreement. The second incentive is paid to MCOs attaining a "Superior" performance rating.

The at-risk portion of the capitation payment is paid to MCOs monthly, along with the portion of the capitation payment not at risk. The potential additional incentive

amount is in addition to the at-risk amount and is funded by MCOs that pay monetary sanctions and return their at-risk amount. As described in Appendix L of the provider agreement, the overall level of performance achieved determines whether or not a MCO retains the at-risk amount and whether or not a MCO receives any additional incentive dollars.

A MCO that performs at the 'Excellent' performance level is rewarded with the full at-risk amount that has already been paid to the MCO. MCOs that perform at this level do not qualify for any additional incentive dollars. If a MCO achieves a 'Superior' performance level, then they are rewarded with the full at-risk amount that has already been paid to the MCO and with an additional incentive amount. The dollars available for the additional incentive are split among all plans that achieve 'Superior' performance. This additional amount is capped at \$250,000 per MCO. In P1, it is projected that two MCOs will receive the full \$250,000 in possible incentives. This amount equates to \$0.09 PMPM. This amount is then trended at the State Plan Services trend rate to obtain the P2 incentive amount.

- 2.____ For the fee-for-service portion of the 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 (If this is a Conversion or Renewal waiver , skip to I. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of

the preprint. Where noted, certain adjustments should be mathematically accounted for in **Appendix D5**.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. 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 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 trend rate used is: _____. Please document how that trend was calculated:
 2. ____ [Required, to trend BY 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 rate setting regulations) (*i.e., trending from present into the future*).
 - i. ____ State historical cost increases. Please indicate the years on which the rates are based: _____. 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 _____. 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 the BY and the beginning of the 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:** This adjustment should account for any programmatic changes that are not cost neutral and affect that the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. 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.*

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 increases or pricing (+/-)

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. The adjustment(s) is(are) 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. ___ 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): _____
- iv. ___ 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 _____
 - Other (please describe): _____
- v. ___ 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): _____

- e. Administrative Cost Adjustment*: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *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 fee-for-service 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. ___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

- 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):
- ii. _____ FFS 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.H.a.** above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.IV.H.a** above. 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: _____. Please provide documentation.

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.
- i. State Plan Service trend
 - A. Please indicate the State Plan Service trend rate from **Section D.IV.H.a.** above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.IV.G.d.2**, then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.IV.H.a.** _____
2. List the Incentive trend rate by MEG if different from **Section D.IV.H.a** _____
3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. ____ We assure CMS that GME payments are included from base year data.
2. ____ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3. ____ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1. ____ GME adjustment was made.
 - i. ____ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
 - ii. ____ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2. ____ No adjustment was necessary and no change is anticipated.

Method:

1. ____ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).

2. ___ Determine GME adjustment based on a pending SPA.
3. ___ Determine GME adjustment based on currently approved GME SPA.
4. ___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any payments or recoupments made should be accounted for in Appendix D5.

1. ___ Payments outside of the MMIS were made. Those payments include (please describe):
2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3. ___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. ___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. ___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. ___ No adjustment was necessary and no change is anticipated.
2. ___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1. ___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. ___ Determine copayment adjustment based on pending SPA.
3. ___ Determine copayment adjustment based on currently approved copayment SPA.
4. ___ Other (please describe):

- i. Third Party Liability (TPL)* **Adjustment:** This adjustment should be used only if the State will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. ___ No adjustment was necessary
 2. ___ Base Year costs were cut with post-pay recoveries already deducted from the database.*
 3. ___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
 4. ___ The State made this adjustment:*
- i. ___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in Appendix D5.
 - ii. ___ Other (please describe):

*For Combination Capitated and PCCM Waivers: If the MCO/PIHP/PAHP will collect and keep TPL recoveries, then the PCCM Actual Waiver Cost must be calculated less the TPL recovery amount expected in the PCCM program. For additional information, please see Special Note at end of this section.

- j. Pharmacy Rebate Factor Adjustment *: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population.* Please account for this adjustment in **Appendix D5**.
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.
3. ___ Other (please describe):

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of rebate collections, then the PCCM Actual Waiver Cost must be calculated less the pharmacy rebate amount expected in the PCCM program. For additional information, please see Special Note at end of this

section.

- k. Disproportionate Share Hospital (DSH) Adjustment: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.
1. ___ We assure CMS that DSH payments are excluded from base year data.
 2. ___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
 3. ___ Other (please describe):
- l. Population Biased Selection Adjustment (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.
1. ___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
 2. ___ This adjustment was made:
 - a. ___ Potential Selection bias was measured in the following manner:
 - b. ___ The base year costs were adjusted in the following manner:
- m. FQHC and RHC Cost-Settlement Adjustment: Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
1. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
 2. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
 3. ___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is

reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a. ___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. ___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The three most common offsetting adjustments that will be needed are noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).
Third-Party Liability	The MCO will collect and	The PCCM Actual Waiver

Adjustment	Capitated Program	PCCM Program
Adjustment	keep TPL recoveries. The Capitated Waiver Cost Projection is created less the Third-Party Liability amount. That adjustment is subtracted from the combined Waiver Cost Projection adjustment.	Costs must be calculated less the TPL recovery amount expected in the PCCM program.
Pharmacy Rebate Adjustment	The Capitated Waiver Cost Projection is created less the pharmacy rebate amount. That adjustment is subtracted from the combined Waiver Cost Projection adjustment.	The PCCM Actual Waiver Costs must be calculated less the pharmacy rebate amount expected in the PCCM program.

- n. Other adjustments: Federal law, regulation, or policy change: 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.
 2. ___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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. X [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 trend rate used is: **4.2% on an annualized basis over the entire period of the cost effectiveness analysis. The annualized trend rate to get to P1 is 4.1% and 4.4% from P1 to P2.** Please document how that trend was calculated:

See #2 and #3 below.

COS	CY '02 Trend		CY '03 - '04 Trend		CY '04 - '05 Trend	
	Unit Cost Trend	Util Trend	Unit Cost Trend	Util Trend	Unit Cost Trend	Util Trend
Inpatient	2.5%	0.5%	0.5%	0.5%	2.2%	0.5%
Outpatient	3.0%	1.0%	3.0%	1.0%	3.0%	1.0%
Physician	1.0%	2.0%	1.0%	2.0%	1.0%	2.0%
Pharmacy	11.0%	2.0%	12.0%	2.5%	12.0%	2.5%
Other	-4.0%	7.5%	-4.0%	7.5%	-4.0%	7.5%

- 2. X [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 rate setting regulations) (*i.e.*, *trending from present into the future*).

- i. State historical cost increases. Please indicate the years on which the rates are based: *Calendar year 1998 through calendar year 2000*. 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.

Inflation trend is developed using a multiple regression methodology. Inflation trend is based on analysis of the cost per unit of service in broad categories of service: Inpatient, Outpatient, Physician, Pharmacy, and Other. This trend is also developed removing any impact of program changes, such as fee schedule changes, that have been reflected separately in the rate development. For example, if a 10% increase to the physician fee schedule was implemented on January 1, 2000, the cost per unit of service for physician claims from January 1, 2000 and later would be reduced by 10% prior to performing the trend analysis.

It should be noted that, as a result of recent legislative action, the inpatient hospital fee schedule freeze for general hospitals, excluding children's hospitals, will end on January 1, 2005. This fee schedule change was reflected in the CY04 – CY05 trend as listed in the table above rather than treated as a programmatic change.

- ii. National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. 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).

Utilization trend is based on State historical FFS data from

calendar year 1998 through calendar year 2000.

In addition, based on more recent data provided by ODJFS, the cesarean rate assumed in developing the delivery payment was increased from 16% to 17% effective 7/1/03 and is reflected in the utilization trend analysis.

- ii. Please document how the utilization did not duplicate separate cost increase trends.

Utilization trend is developed separately from inflation trends by analyzing only the number of services performed by broad categories of service: Inpatient, Outpatient, Physician, Pharmacy, and Other. The methodology for determining the utilization trend is identical to that described for inflationary trend.

b. X **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. X 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. X 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.
 - D. X Other (please describe):

Ohio's legislature passed Am. Sub. H.B. 95 in late June 2003 that eliminated chiropractic and independent psychologist services for adults effective January 1, 2004. The impact of this change is outlined in the table below. The State of Ohio is in the process of filing a

State Plan Amendment for these service changes.

In addition, the legislature passed inflationary inpatient increases for children's hospitals as follows: 1) a 2.9% increase effective January 1, 2003, 2) a 3.3% increase effective January 1, 2004, and 3) a 3.9% increase effective January 1, 2005. These adjustments are cumulative and have been reflected in the analysis. These adjustments were not included in the trend rates.

The final biennium budget as passed by the legislature also provided for an increase of \$9.8 million per year for each SFY 2004 and SFY 2005 to DRG outpatient facilities, excluding children's hospitals. This increase in funds was effective July 1, 2003. This allocation of additional funds was reflected in the analysis by increasing the outpatient category of service for all non-delivery rate cells by 1.85%. These adjustments were not included in the trend rates.

Ohio historical FFS data was available to evaluate the impact of these service exclusions and fee increases. The following table outlines each program change, the effective date, and the overall impacts. The combined impact of these changes is approximately a 0.7% PMPM increase for PI and a 0.2% PMPM increase for P2.

The following table outlines each program change, the effective date, and the adjustments used.

Proposed Program Change	Services	Effective Date	COS	Adjustment
Independent Psychological Services	All independent psychological services eliminated for adults (>21)	Jan. 1, 2004	PCP, Specialist, and OB/GYN	HF, Age 19-44 M -0.1% HF, Age 19-44 F -0.1% HF, Age 45+ M&F -0.1% HST, Age 19-64 F -0.1%
Chiropractic Services	All chiropractic services eliminated for adults (>21)	Jan. 1, 2004	Other	HF, Age 19-44 M -8.6% HF, Age 19-44 F -9.8% HF, Age 45+ M&F -8.3% HST, Age 19-64 F -3.7%
Children's Hospitals	All Children's Hospitals are to receive a fee schedule increase	Jan. 1, 2003 Jan. 1, 2004 Jan. 1, 2005	Inpatient	All kids' rate cells, Age <19 1.1% All kids' rate cells, Age <19 1.3% All kids' rate cells, Age <19 1.5%
General Outpatient Hospitals, excluding Children's facilities	All general outpatient hospitals are to receive \$9.8 million in additional funds in SFY 2004 and SFY 2005	July 1, 2003 & July 1, 2004	Outpatient	All non-delivery rate cells 1.85%

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):

Years P1 and P2 also reflect an adjustment to the voluntary selection included in the BY. This adjustment is to reflect the expansion of managed care as discussed in D.IV.H.b. The overall adjustment is a 0.13% decrease in the PMPM.

An additional adjustment was made to reflect performance incentives that may be made to MCOs participating in the PremierCare program. Please see item D.IV.H.d.1 for more details on this program. The adjustment increases costs by 0.05% in P1. For P2, State Plan Services trend was applied to this increase.

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:

ii. Cost increases were accounted for.

A. Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

An expanded actuarial services contract has been approved beginning in SFY 2003. The increase amount was \$399,699 in addition to the original SFY 2003 amount of \$314,300. This increase in administrative cost

adds an additional 0.2% to trend for one year in calculating P1 trend. This increase reflects only the amount above the State Plan Services trend rate.

B. _____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. _____ Other (please describe):

iii. X [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.

The trend rate used for administrative services is the State Plan Services trend documented below. This trend is lower than the historical trend in administrative costs which ranges from 8% to 15% during SFY 1999 through SFY 2002.

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:

4.3% on an annualized basis over the entire period of the cost effectiveness analysis. The annualized trend rate to get to P1 is 4.2% and 4.4% from P1 to P2.

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. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY 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 or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 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: _____ . Please provide documentation.

2. _____ [Required, when the State's BY or R2 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 lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
- i. State historical 1915(b)(3) trend rates
 - 1. Please indicate the years on which the rates are based: base years _____
 - 2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
 - ii. State Plan Service Trend
 - 1. Please indicate the State Plan Service trend rate from **Section D.IV.I.a.** above _____.

Incentives (not in capitated payment) Trend Adjustment: Trend is limited to the rate for State Plan services.

- 1. List the State Plan trend rate by MEG from **Section D.IV.I.a** above:
- 2. List the Incentive trend rate by MEG if different from **Section D.IV.I.a**.
- 3. Explain any differences:

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.
- 2. _____ 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 increase in member months from the BY (SFY 2002) to P1 (SFY 2004) is due to the expected expansion of managed care into Mahoning and Trumbull counties as well as increases in the number of eligibles due to economic factors.

In addition to the expansion of managed care into these counties, managed care penetration is projected to increase in the established managed care counties as these counties move from voluntary to mandated or preferred option managed care enrollment, or from preferred option enrollment to mandated enrollment. The impact of penetration changes is expected to increase penetration from an average of 60% in SFY 2002 to 74% in SFY 2004.

The variance in eligibles between BY and P2 (SFY 2005) reflects the changes discussed above as well as increases in the number of eligibles due to economic factors.

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**:

Inflation trend is based on State historical FFS data from calendar year 1998 through calendar year 2000.

Inflation trend is developed using a multiple regression methodology. Inflation trend is based on analysis of the cost per unit of service in broad categories of service: Inpatient, Outpatient, Physician, Pharmacy, and Other. This trend is also developed removing any impact of program changes, such as fee schedule changes, that have been reflected separately in the rate development. For example, if a 10% increase to the physician fee schedule was implemented on January 1, 2000, the cost per unit of service for physician claims from January 1, 2000 and later would be

reduced by 10% prior to performing the trend analysis.

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**:

Utilization trend is based on State historical FFS data from calendar year 1998 through calendar year 2000.

Utilization trend is developed separately from inflation trends by analyzing only the number of services performed by broad categories of service: Inpatient, Outpatient, Physician, Pharmacy, and Other. The methodology for determining the utilization trend is identical to that described for inflationary trend.

4. Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I**.

Additional factors contributing to the rate of change would be the impact of program changes discussed in D.IV.I.b.2.v and the voluntary selection adjustment discussed in D.IV.I.b.2.vi.

Several program changes will be effective during SFY 2004 and SFY 2005 as a result of recent legislative action. Ohio historical FFS data was available and used to evaluate the impact of each of these changes. Refer to the table included in D.IV.I.b.2.v that outlines each program change, the effective date, and the overall impacts. The combined impact of all of these changes is an approximate 0.7% PMPM increase to P1 and a 0.2% PMPM increase to P2.

Years P1 and P2 also reflect an adjustment to the voluntary selection included in the BY. This adjustment is to reflect the expansion of managed care as discussed in D.IV.I.b.2.vi. The overall adjustment is a 0.13% decrease in the PMPM.

The Ohio managed care program provided two separate performance incentives for its MCOs. The first incentive includes 0.5% of the capitation rate which is placed at risk based on several measurements further described in the attached Appendix L, Provider Agreement. The second incentive is paid to MCOs attaining a "Superior" performance rating.

In P1, it is projected that two MCOs will receive the full \$250,000 possible in incentives. This amount equates to \$0.09 PMPM. This amount is then trended at the State Plan Services trend rate to obtain the P2 incentive amount.

An expanded actuarial services contract has been approved beginning in SFY 2003. The increased amount was \$399,699 in addition to the original SFY 2003 amount of \$314,300. This increase in administrative cost adds an additional 0.2% to trend for one year in calculating P1 trend. This increase reflects only the amount above the State Plan Services trend rate.