Application for

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

April, 2024

Table of Contents

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

Facesheet

The **State** of Maryland 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 programs** are *Mental Health Targeted Case Management: Care Coordination for Adults* and *Mental Health Targeted Case Management: Care Coordination for Children and Youth*.

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 ____
_X_ a renewal request

Section A is:
___ replaced in full
___ carried over with no changes
_X__ changes noted in **BOLD**.

Section B is:
___ replaced in full
_X__ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of _5_ years beginning _**10/01/2024**__ and ending __**9/30/2029**__.

State Contact: The State contact person for this waiver is _**Ryan Moran**__ and can be reached by telephone at **(410) 767-5343**, or fax at (___) _____, or e-mail at **ryan.moran@maryland.gov**.

Section A – Waiver Program Description

Part I: Program Overview

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

In accordance with Section 1902(a)(73) of the Social Security Act, Maryland Medicaid seeks advice on a regular, ongoing basis from designees including Maryland's Urban Indian Organization. In November, 2010, the State appointed a designee of the Urban Indian Organization to the Maryland Medicaid Advisory Committee (MMAC). The MMAC meets monthly and receives updates on demonstration projects, pertinent policy issues, waivers, regulations and State Plan Amendments (SPAs) for all Medicaid Programs. These communications occur prior to the submission of waivers, amendments and other policy changes. Maryland also consults with the Urban Indian Organization on an as needed basis to develop SPAs and regulations which will have a direct impact on access to health care systems as well as the provision of care/services for Indian populations. The State sent this waiver proposal to a representative from Maryland's Urban Indian Organization, Kerry Lessard and Stephanie Cassidy, for review and comments on **May 15, 2024**.

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.

In 2014, CMS approved applications for Maryland's Mental Health Targeted Case Management (TCM) State Plan Amendments (SPA) for the adult population, as well as children and youth. These provide care coordination services to adults with Serious Mental Illness (SMI) and children and youth with Serious Emotional Disturbance (SED). Under the 1915(b)(4) authority, the State waived the freedom of choice of providers for case management services. From Federal Fiscal Years **2021** through **2023** the program has served a combined **average of 5,329** participants per year, including approximately **1,881** children and youth, and **3,448** adults.

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

This 1915(b)(4) waiver covers two services— Case Management Services for Individuals with Serious Mental Illness, and Mental Health Case Management: Care Coordination for Children and Youth.

A. Statutory Authority

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

   _X_ **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._X_ **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:

   _X_ 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:

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

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

   _X_ Beneficiaries will be limited to a single provider in their service area.
   _X_ Beneficiaries will be given a choice of providers in their service area.

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

   The programs **are** implemented statewide. Each **Core Service Agency (CSA) or** Local Behavioral Health Authority (LBHA)**,** the local health **authorities** for mental health and or substance use disorder, acting as the Department's designee, will complete a competitive procurement process for their jurisdiction, resulting in contracts with one or more service provider(s). Depending on an individual's service area, they may have a single provider to which they are limited, or multiple providers from which to choose. **If individuals wish to select a provider in a neighboring jurisdiction, they may.**

2. **State Standards.**

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

   There will be no differences in the state standards that are applied under this waiver and those detailed in the State Plan coverage and reimbursement documents.

D. Populations Affected by Waiver

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

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

   _X_ Section 1931 Children and Related Populations
   _X_ Section 1931 Adults and Related Populations
   _X_ Blind/Disabled Adults and Related Populations
   _X_ Blind/Disabled Children and Related Populations
   _X_ Aged and Related Populations
   _X_ Foster Care Children
   _X_ Title XXI CHIP Children

   The TCM programs must serve all individuals who meet the functional and financial eligibility requirements. The Adult TCM program serves those 18 years and older with a SMI diagnosis and meets medical necessity criteria for the program. The TCM program for children and youth must serve **individuals through 21 years of age if they were continuously enrolled prior to turning 18 and have** similarly met the criteria for participation, including SED or SMI. All individuals who are determined eligible for Medical Assistance coverage under the State Plan, will be financially eligible for TCM.

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
   _X_ Other (Please define):

Individuals who do not meet the medical, technical, or financial criteria are excluded from participation. Individuals participating in the Health Home program are excluded from participation in TCM as well.

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?

Requirements for timely access are monitored by the **CSA/**LBHA, the same entity that conducts the selective procurement. The Behavioral Health Administration (BHA) delegates provider oversight to **CSA/**LBHAs to ensure provider compliance is maintained.

The CSA/LBHA monitors compliance during annual site visits which includes an audit of the documentation for each TCM program in their jurisdiction. The CSA/LBHA reviews a statistically appropriate set of casefiles during the annual monitoring visits that compares the provider's performance against the timely access standards set forth in COMAR 10.09.45 for mental health case management for adults and COMAR 10.09.90 for mental health case management for children and adolescents.

For adult participants, State regulations require TCM providers to complete an assessment within 20 days of an individual receiving authorization for TCM services, followed by the completion of an initial plan of care within 10 days of the assessment. **For child and youth participants, State regulations require TCM providers to schedule a meeting with the child and family team within 72 hours of enrollment in the program, and complete an initial meeting within 30 days to develop a plan of care.**

The Hilltop Institute completed an Independent Assessment (IA) of Maryland's 1915(b)(4) waiver for TCM in **March 2024** and found that annual audit visits provide ongoing assurance that individuals are receiving services in a timely manner **as outlined in the waiver application and in accordance with the Code of Maryland Administrative Regulations (COMAR) 10.09.45 and 10.09.90.**

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

The **CSA/**LBHA uses statewide forms to monitor adherence to each provision of the COMAR regulation**, including timely access standards.** If any deficits are noted during a site visit, a **Corrective Action Plan (CAP) is required from the provider to bring the program into compliance, and is submitted to the CSA/LBHA. After CAPs are reviewed and approved, the CSA/LBHA conducts a follow-up site visit at a mutually agreed upon time frame. The issuance of the Certificate of Approval (COA) is delayed until the CAP requirements are met.**

Providers who reported being unable to meet the required timeline attributed the delay to limited staffing capacity at the time of referral. The IA found that there were two providers who serve children and youth reported having a waitlist and experiencing challenges with meeting service provision timelines.

Hilltop recommended in the IA that BHA require providers with a waitlist to notify their LBHAs and for the providers and LBHAs to work together to ensure there are the resources necessary to meet service needs and eliminate deficient capacity. BHA will establish requirements for providers who report having a waitlist.

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.

Each **CSA/**LBHA**,** acting as the Department's designee, completes a competitive procurement process for its jurisdiction. The number of providers selected is dependent upon the population and needs of the region**.** The IA found that **CSA/**LBHAs reported **implementing several monitoring strategies to ensure that providers meet the capacity needs of the jurisdiction. This included periodic auditing, analysis of utilization data, and oversight of referral volume and waitlists when applicable.** TCM providers must demonstrate their capacity to serve the region's population during the bid process in order to be selected. Urban areas such as Baltimore City may include more than one TCM provider to ensure adequate coverage. On the rural Eastern Shore, a five county consortium selects the vendor through a single bidding process. In other rural areas of the State, jurisdictions have partnered to conduct joint solicitation for providers in a single process. It should be noted that a number of TCM providers are selected by multiple jurisdictions. Each **CSA/**LBHA procures providers that are able to serve both adults and children and youth, although separate provider organizations may be selected for each age group. Over the past three years **of the waiver, 9** Children and Youth TCM

providers and **29** Adult TCM providers have been **covering all jurisdictions of the state.** Within the Children and Youth program, it should be noted that several providers have offices in a number of jurisdictions where they have been selectively contracted. This is particularly true in rural areas of the state.

The **CSA/**LBHA selects a mental health case management provider through a competitive process, once every five years. The selected case management program is designated by the **CSA/**LBHA and subject to the requirements set forth **in** COMAR 10.09.45 Mental Health Case Management: Care Coordination for Adults and 10.09.90 Mental Health Case Management: Care Coordination for Children and Youth. The BHA has created a template for the Request for Proposals (RFP) for the local authorities to use. The **CSA/**LBHA advertises the procurement including expectations and deadlines for submission of the proposals, offers a pre-bidders conference, convenes a review committee in order to select the provider, and following selection, announces the award. The **CSA/**LBHA sends BHA a letter identifying the selected case management program(s). When the provider submits an application to Medicaid for a Medicaid provider number, the provider must submit the CSA/LBHA letter of support/selection in order to be enrolled as a Mental Health Case Management provider. Providers are required to have a separate MA and NPI number for each service location. The provider is also required to submit a letter of attestation stating their commitment to adhere to consumer choice and to other relevant regulations regarding documentation governed by Medicaid. Once approval by Medicaid is obtained, the selected provider must register with the State's Administrative Service Organization (ASO) in order to obtain authorizations and bill for services rendered.

The IA found **adequate monitoring efforts to ensure provider capacity and service access. While there was a growth in the number of available providers compared with the first waiver period along with stable utilization, there were jurisdictions with lower than expected use of services across highly populated areas of the state with high concentrations of Medicaid participants. Hilltop recommended BHA promote education and outreach to these areas as well as ensure CSAs/LBHAs have competitively procured sufficient provider capacity. Jurisdictions are required to submit annual plans to BHA and must elaborate on outreach efforts and plans to increase utilization. BHA will provide additional technical assistance and support to CSAs/LBHAs who report lower utilization in their jurisdiction.**

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 evaluates the distribution of providers on a regular basis through its statutorily mandated local jurisdictional planning process. Through this process, the local designated authorities describe their behavioral health planning, management and monitoring efforts

to ensure access to and availability of quality services and to promote comprehensive and cost-effective service delivery and desired outcomes for individuals and families. Jurisdictions are required to submit an annual plan for the upcoming fiscal period as a condition of funding, including a summary of highlights and accomplishments from the prior year. The plans must address the needs of individuals and minority populations delineated by the Maryland Department of Health (MDH) /Behavioral Health Administration (BHA). Plans must describe how local behavioral health entities plan, develop, and manage the full range of prevention, intervention , treatment and recovery services including discussions that identify issues and gaps, as well as initiatives in the jurisdictions to address those gaps. As a component of this local planning process, the local authorities are able to provide comprehensive three year data sets on a wide number of services, including TCM covered by this waiver, using the Administrative Services Organization (ASO) platform to download data reports of consumer counts and claims/service expenditures using standardized data templates. The TCM specific data set includes the following: individual utilization numbers, total costs, and average cost per individual served. This three year data trend is provided to jurisdictions both for the jurisdiction itself, and in comparison of the jurisdiction against the statewide average for TCM. **CSAs/**LBHAs are required to compare their data with the statewide average in determining the adequacy of their program and the need to expand the number or capacity of providers in their selective contracting program. The state-issued guidelines for the local plans require jurisdictions who fall below the statewide average to provide analysis about local factors that may account for lower than average utilization and to provide strategies for addressing improved utilization in the upcoming year.

BHA, in turn, compiles and aggregates the data from each jurisdiction's response to these specific plan requirements to identify underperforming jurisdictions. These aggregated data from the local planning inputs are then used to drive coordinated state remediation and technical assistance for underperforming jurisdictions.

Each **CSA/**LBHA completes a procurement process at least once every five years. The State reviews on an annual basis through the BHA planning process described above, the distribution of enrollees and applicants to TCM and may revise the number of TCM providers accordingly. The State monitors provider capacity and may solicit additional TCM providers more frequently if needed. The **CSA/**LBHA monitors service delivery, with oversight by the BHA, to ensure participants receive services in a timely manner on an ongoing basis. The BHA, when possible, will participate with the **CSA/**LBHA on the annual site visit. Following each visit, the BHA will issue the provider a certificate of approval that is valid for a year.

Hilltop recommended that BHA develop and implement a comprehensive annual report of the TCM program, which would provide additional information on whether providers are properly distributed throughout the state and whether participants have timely access to services. BHA will establish ongoing TCM oversight meetings to discuss processes, monitoring strategies, deliverables, and data points for the TCM program. Development and implementation of a comprehensive annual report will be discussed during these meetings.

C. Utilization Standards

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

The State has established utilization standards in the State Plan Amendment for each TCM program. Participants are pre-authorized by the State's ASO to receive TCM services at a specified level of intensity. Targeted Case Management services for adults include two levels of intensity. Participants in Level I receive a minimum of 30 minutes of face to face contact monthly, and a maximum of three hours. Level II participants receive a minimum of one hour of face to face contact monthly, and a maximum of 10 hours.

Services for children and youth mirror the first two levels, and include an additional third level of intensity, with a minimum of 90 minutes of face to face contact monthly and a maximum of 15 hours. Maximum service limits may be exceeded **depending** upon ASO review and authorization.

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?

Mental Health Case Management services are available to any individual who is enrolled in Medicaid and meets the technical and financial criteria outlined in COMAR 10.09.45 or COMAR 10.09.90.The provider uses the information from referral, referral documentation, and the initial assessment to determine the level of care that is needed, either General or Intensive for adults, or General, Moderate, or Intensive for children and youth. The provider then submits the authorization request to the ASO who reviews the medical necessity criteria (MNC) and approves the request for the level of care. The provider reassesses the need every 6 months and submits an authorization request for concurrent review. The level of care (LOC) has standards for the number of monthly encounters and lengths of time spent with the individual to meet their needs. Adult participants in the General LOC receive 2 encounters per month and participants in the Intensive LOC receive 5 encounters per month. Children and youth participants in the General LOC receive **up to** 12 **15-minute units of service (UOS)** per month, participants in the Moderate LOC receive **up to** 30 **15-minute UOS** per month, and participants in the Intensive LOC receive **up to** 60 **15-minute UOS** per month.

As the State's designee, the ASO approves and monitors participants' plans of care which detail the medical necessity for the authorization at a particular level of service. The State in turn monitors ASO performance annually through a **medical necessity criteria (MNC) audit** process that samples casefiles from a sample of the TCM programs operating under this waiver to assure that **MNC** are appropriately applied. The ASO provides training to its staff to assure that the clinical criteria are applied in a consistent manner. **During the waiver period, the ASO's compliance levels for TCM fell within**

the "Needs Improvement" range for two of the three MNC audits, and one year the compliance level fell within the "Meets Standards" range. Hilltop recommended that BHA more closely monitor the quarterly ASO MNC audits to ensure compliance levels meet standards. BHA will review this internally and make changes based on Hilltop's recommendations.

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.

In addition to the ASO review noted above, service utilization for TCM is monitored by the ASO through concurrent authorization review, post payment review, and/or provider audits. If utilization falls below the level of care authorized over the course of a month based on the individual's plan of care, a corrective action plan will be required by the provider. In the event the ASO does not adequately authorize services based on the established utilization standards, it will be required to take corrective action to remedy its performance.

Hilltop recommended that BHA promote education and outreach to address lower than expected service utilization for jurisdictions. The IA found that a small number of recipients received more than the maximum allowed units of service for TCM and a subset of providers billed for services prior and after the approved period. Hilltop recommended closer tracking of the service-level authorizations, payments beyond the maximum allowed service units, and oversight of efforts that include monitoring provider billing. A new ASO vendor will begin effective 1/1/2025. The State will establish utilization monitoring protocol for the incoming ASO vendor to address this recommendation.

Part III: Quality

A. Quality Standards and Contract Monitoring

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

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

        i. Regularly monitor(s) contracted providers to determine compliance with the State's quality standards for the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

All providers must meet service delivery requirements specified in the Code of Maryland Regulations 10.09.45 for adult case management services, and 10.09.90 for children and youth case management services.

The **CSA/**LBHAs, with BHA oversight, are responsible for regularly monitoring selected providers against the COMAR quality standards and take action in the case of failure to comply. This include**s** a corrective action plan (CAP) that must be completed satisfactorily within an allotted period of time.

The **CSA/**LBHA schedules an annual site visit for each TCM program in their jurisdiction. The **CSA/**LBHA reviews **policies** and procedures, staff credentials and backgrounds, consumer satisfaction and charts to assure they meet COMAR 10.09.45 standards for mental health case management for adults and COMAR 10.09.90 standards for mental health case management for children and youth. **The CSA/LBHA uses standard, statewide forms that follow each aspect of the COMAR regulation.** If **providers** do not meet the regulatory standards, the provider is required to submit a CAP to the **CSA/LBHA.** CAPs are reviewed and approved, and the **CSA/**LBHA follows up at **a mutually agreed upon time frame.**

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

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

        i. Regularly monitor(s) contracted providers to determine compliance with the contractual requirements of the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

The site visit procedure has been described above. The contracting **CSA/**LBHA, in concert with BHA, schedules an annual site visit and selects a random sample of participant case files for review against established criteria. In the event that it is determined that the provider has not adequately met the standards, a CAP is required and subsequent review initiated. The State requires a CAP for a provider that fails to meet contractual/provider agreement requirements. A total of **four** CAPs were required from **2020** through **2023** for Adult TCM providers. **All four** of the CAPs have currently been resolved. A total of **17** CAPs were required from **2020** through **2023** for Children and Youth TCM providers. **Five** of the CAPs have currently been resolved and one was reopened. In the event a provider fails to meet contractual requirements under the CAP, the State will take action based on procurement rules.

Hilltop recommended in the IA that BHA develop and implement a comprehensive annual report that compiles audit results, conditions of awards, and comprehensive documentation of all quality oversight activities to align with quality assurance measures, analyze trends in deficiencies across the state, outline plans for improvement, and inform targeted training and technical assistance. BHA will establish ongoing TCM oversight meetings to discuss processes, monitoring strategies, deliverables, and data points for the TCM program. Development and

implementation of a comprehensive annual report will be discussed during these meetings.

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 selective contracting program improve**s** quality and continuity of care by ensuring that only the most qualified and capable providers are enrolled to deliver case management services to the TCM population. Individuals with SMI and SED are an especially vulnerable population, and it is vital that case management providers are carefully reviewed and held to a particularly high standard. The selective contracting process allow**s** the state to enroll only providers who meet this standard, and maintain regular oversight through the role of the **CSA/**LBHAs. The process **ensures** adequate coverage, high-quality services, and regular oversight and accountability among providers. The IA **analysis found adequate monitoring efforts to ensure provider capacity and service access, which suggested that the availability of and access to providers has not been negatively affected by implementation of selective contracting.**

Part IV: Program Operations

A. Beneficiary Information

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

Upon approval for TCM services, the **CSA/**LBHA provide**s** applicants with information regarding the TCM provider(s) in their region. The providers identified through the competitive solicitation are also responsible for providing required information to enrollees.

B. Individuals with Special Needs.

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

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.

Mental Health Targeted Case Management Services aim to facilitate community-based supports and services for individuals with SMI and SED, in order to avoid the need for a residential level of care. The competitive procurement process proposed will ensure that the State will enroll only the most high-quality providers with full capacity to meet the coverage needs of the region. Additionally, procurement and oversight by the **CSA/**LBHAs ensures that those procuring and monitoring these services are extremely familiar with the needs and resources of the local communities. As a result, the State anticipates quality of care will improve, assisting more participants in successfully avoiding the need for **more intensive** level**s** of care, increasingly stabilizing to lower levels of case management intensity, and ultimately lowering costs to the State. The IA found that **by selectively contracting highly qualified providers with extensive knowledge of local service systems, there has been no negative impact on the cost of services to the state. Selectively contracted providers demonstrate the ability to increase access to services for individuals of all ages, engage in marketing and outreach to increase awareness of the availability of services, and expand capacity to meet the needs of participants with no negative impact on cost effectiveness. Hilltop recommended that the methodology to calculate cost-effectiveness include the procedure code (CPT code H0031) to bill adult assessments in both the pre and post-waiver costs as well as analysis of current utilization and cost trends to establish the trend rates for the renewal period to more closely align the projected waiver costs with the actual waiver costs. These recommendations were incorporated for this renewal.**

The projections below are based on the difference between the **estimated** pre-waiver cost **and the projected post waiver cost for renewal FY 2025 to FY 2029. The pre-waiver cost was calculated using total paid claims for FFY 2014 ($7,199,765.65) as the base year and trended 12.26% annually for each renewal year to align with the average increase in total TCM costs based on program claims from FY 2015 through FY 2023. The projected waiver cost was calculated using FY 2023 total paid claims as the base year costs, and an estimated trend of 6.39% in cost for adult services and 8.02% in cost for children and youth services. This percentage increase is based on the TCM program claims for FY 2019 through FY 2023 for each renewal year.**

Projected Cost	**Estimated Trend**
Pre-Waiver	**12.26%**
Adult Services	**6.39%**
Children & Youth Services	**8.02%**

The total estimated projected waiver cost is the sum of the estimated adult services cost and the estimated children and youth services cost for each renewal year. The difference between the estimated pre-waiver costs and projected post waiver costs was calculated. The difference between the estimated pre-waiver costs for the TCM program without selective contracting and the projected post waiver costs for the TCM program with selective contracting would save the State an average of $6,235,242.00 per year for a total savings of $31,176,208.00 over the 5 year waiver renewal period.

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

Year 1 from: **10/01/2024** to **09/30/2025**

Trend rate from current expenditures (or historical figures): **see table above**___%

Projected pre-waiver cost **$25,691,755.00**
Projected Waiver cost **$22,484,941.007**
Difference: **$3,206,814**

Year 2 from: **10/01/2025** to **09/30/2026**

Trend rate from current expenditures (or historical figures): **see table above**___%

Projected pre-waiver cost **$28,841,565.00**
Projected Waiver cost **$24,365,317.00**
Difference: **$4,476,248.00**

Year 3 (if applicable) from: **10/01/2026** to **09/30/2027**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost **$32,377,540.00**
Projected Waiver cost **$26,404,452.00**
Difference: **$5,973,088.00**

Year 4 (if applicable) from: **10/01/2027** to **09/30/2028**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **$36,347,027.00**
Projected Waiver cost **$28,615,873.00**
Difference: **$7,731,154.00**

Year 5 (if applicable) from: **10/01/2028** to **09/30/2029**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **$40,803,172.00**
Projected Waiver cost **$31,014,268.00**
Difference: **$9,788,907.00**