Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Idaho** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program	
Idaho Smiles	Idaho Smiles Dental Plan	PAHP;	

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):

Idaho Smiles Dental Services

C. Type of Request. This is an:

☒ **Renewal request.**

☒ **The State has used this waiver format for its previous waiver period.**
The renewal modifies (Sect/Part):

Requested Approval Period:*(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year**

○ **2 years**

○ **3 years**

○ **4 years**

◉ **5 years**

Draft ID:ID.017.02.00
Waiver Number:ID.0003.R02.00

D. Effective Dates: This renewal is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Proposed Effective Date: (mm/dd/yy)

01/01/23

Proposed End Date:12/31/27
Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name:

Charles Beal

Phone: (208) 364-1887 **Ext:** ☐ **TTY**

Fax: (208) 364-1811

E-mail:

Charles.Beal@dhw.idaho.gov

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **Idaho Smiles Dental Plan**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The State seeks regular, ongoing consultation with designees of Idaho Indian Health (IH) programs in accordance with section 1902(a)(73) of the Act. The State provides appropriate noticing to the five Idaho Tribes and engages in tribal consultation through quarterly routine meetings and ad hoc meetings at the request of the tribes to ensure Idaho Tribes are fully informed regarding proposed state plan amendments, waivers or demonstration projects, or when federal or state Medicaid regulations will likely have a cost or direct impact on Idaho Native Americans or Idaho IH programs.

Idaho Medicaid seeks consultation from and participation by representatives of tribal governments in implementation of policy, which promotes government-to-government relationships. Idaho Medicaid requests consultation with the appropriate tribal contacts at the earliest opportunity to allow for an appropriate amount of time to consider the impact and respond to the consultation request. Whenever possible, the State will provide notification 60 days prior to submission of changes to the Centers for Medicare and Medicaid Services (CMS) and allow 30 days for Tribal response.

2022 Renewal
The State continues to work collaboratively with the Tribes to ensure all managed care requirements are met for the tribes within Idaho. The tribal solicitation for this waiver renewal was extended to the Tribes and posted to the website for the Tribes on January 11, 2022 . Discussions with the Tribes were held during the Department's routine quarterly meetings in on February 23, 2022. Ongoing discussions will continue during our routine meetings until CMS approves this renewal.

Comments Received
The State received four comment letters from Idaho Tribes in response to this solicitation. Idaho Medicaid is dedicated to collaborating with the Tribes to resolve the identified issues. Feedback was received in response to the Tribal Representative Notification Letter requesting the state work through the Tribal consultation process to develop Special Terms and Conditions for this waiver. The state intends to work with Idaho Tribes through consultation on these Special Terms and Conditions and submit with a waiver amendment no later than September 2023.

Program History.
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

2022 Renewal
Idaho Medicaid is seeking approval of the renewal of this waiver from the Centers for Medicare and Medicaid Services for the period of July 1, 2022 through June 30, 2027. The current Contractor Managed Care of North America (MCNA) originally implemented on October 3, 2016. The contract with MCNA terms on October 2, 2023.

The MCNA network is an open network, which allows all willing dental providers to enroll. The current network consists of 660 providers with 429 provider locations. The network has seen significant growth in the number of providers since the renewal of the waiver in 2017, as well as the number of Medicaid enrollees covered under the plan.

The network provides care for 144,980 Medicaid eligible children in our Basic Plan and 24,135 in our Enhanced Plan. As well as 83,602 Medicaid eligible Adults and 120,729 Medicaid Expansion Adults.

2022 Prior Historical
Since the implementation of the waiver in 2017, Idaho Medicaid has re-instated coverage under the direction of the Idaho legislature for disabled adults and added coverage for adults from a citizen driven initiative for the population known as the Adult Group or Medicaid Expansion.

Shown below is milestone activity since July 1, 2017, the effective date of the prior renewal:

Effective Date: 01/01/2020
Waiver: ID.0719.R01.02
Summary of Changes
2019 Amendment
On November 6, 2018, Idaho voters passed Proposition 2, a statewide citizen initiative purposed to close the health insurance gap in Idaho by expanding Medicaid coverage to those not otherwise covered under Idaho Medicaid up to 138% of the federal poverty level, as authorized under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, otherwise known as the Adult Group.

November 20, 2018, Idaho's Governor-Elect Brad Little signed Proposition 2 into law creating Section 56-267, within Idaho Code, setting forth the conditions under which Medicaid eligibility would be expanded to the group. Funding for this new group was approved by the 2019 Idaho Legislature. This amendment, to the Idaho Smiles waiver, implements eligibility under the waiver for dental services for this population and makes some minor technical updates. This amendment was approved on September 15, 2020.

Effective Date: 07/01/2018
Waiver: ID.0719.R01.00
2018 Amendment
This amendment is in response to legislation passed by the 2018 Idaho Legislature. House Bill 465, signed by Governor Otter on March 20, 2018, directed Idaho Medicaid to re-instate dental benefits to this population of adult, Basic Plan members, effective July 1, 2018. This legislation adds dental benefits to an additional 23,330 adult members in the Basic Plan, which will greatly impact the overall health of our adult members.

The trailer bill to House Bill 465 was Senate Bill 1376, which appropriated the funding to support the services. This bill was not passed until March 22nd and subsequently not signed by the Governor until March 27th, providing Idaho Medicaid with a very narrow window for implementation of these benefits. This amendment was approved on December 23, 2019.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):
    a. ☒ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

-- *Specify Program Instance(s) applicable to this authority*

☐ **Idaho Smiles**

b. ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
-- *Specify Program Instance(s) applicable to this authority*

☐ **Idaho Smiles**

c. ☐ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
-- *Specify Program Instance(s) applicable to this authority*

☐ **Idaho Smiles**

d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
-- *Specify Program Instance(s) applicable to this authority*

☒ **Idaho Smiles**

The 1915(b)(4) waiver applies to the following programs

☐ **MCO**

☐ **PIHP**

☒ **PAHP**

☐ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

☐ **FFS** Selective Contracting program
Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. Sections Waived. Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a. ☐ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
-- *Specify Program Instance(s) applicable to this statute*

☐ **Idaho Smiles**

b. ☐ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid

beneficiaries not enrolled in the waiver program.
-- *Specify Program Instance(s) applicable to this statute*

☐ **Idaho Smiles**

c. ☒ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
-- *Specify Program Instance(s) applicable to this statute*

☒ **Idaho Smiles**

d. ☒ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

-- *Specify Program Instance(s) applicable to this statute*

☒ **Idaho Smiles**

e. ☐ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

-- *Specify Program Instance(s) applicable to this statute*

☐ **Idaho Smiles**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Idaho Medicaid was directed by Idaho Code, Section 56-261 to incorporate managed care systems for high-cost services as an effort to improve access, effectiveness, and efficiency of services. To comply with this statute, Idaho Medicaid implemented a prepaid ambulatory health plan (PAHP) previously approved by CMS on May 25, 2006, under the establishment of Idaho Benchmark Plans. Idaho Medicaid's goal for the dental program PAHP is to provide for members dental needs while ensuring quality service, maintaining consistency of care, maximizing use of technology, providing timely and dependable service delivery, preventing fraud, and containing costs. Idaho assures CMS that it’s goals are in compliance with section 1901 of the Social Security Act, which directs state Medicaid Agencies to furnish medical assistance and rehabilitation and other services to retain capability for independence or self-care.

Idaho Medicaid followed the state's procurement process to identify a qualified vendor by issuing a Request for Proposal (RFP) to provide dental services to eligible members within a reasonable per-member-per-month cost plan. The RFP was posted to the State's IPRO (https://purchasing.idaho.gov/iprologin.html:)web site to allow all interested bidders access to the solicitation. Idaho uses a standardized review and evaluation process with specific scoring criteria noted in the RFP. Bid submissions were reviewed and scored independently by appointed evaluation team members. The RFP was posted on November, 22, 2006. After review and evaluation of the submitted responses, the contract was awarded to Blue Cross of Idaho on April 19, 2007. The second RFP was issued February 17, 2010, and was also awarded to Blue Cross of Idaho for a contract period of August 9, 2010 through August 8, 2013. After eight contract amendments, the expiration date of the contract was February 28, 2017.

A new RFP was issued in late 2015. After review and evaluation of the submitted responses, the contract was awarded to MCNA. Blue Cross of Idaho appealed this decision, which delayed the implementation of the new vendor and the transition process. The fourth district court upheld the State’s awarding of the contract to MCNA Insurance Company and on February 1, 2017 MCNA officially implemented the delivery of dental services for Idaho Medicaid members. The current contract was issued on 10/03/2016 and expires on 10/02/2023.

Idaho determines eligibility and conducts annual redetermination for every member for ongoing Medicaid services. All members are enrolled into the Idaho Smiles dental plan when Medicaid eligibility is established. Idaho is responsible for ongoing eligibility determinations, enrollment and dis-enrollment. The Contractor provides covered services which includes equal access to services, ensures quality services, maintains consistency, contains costs, maximizes use of technology, provides timely and dependable service delivery, and fraud prevention. As of January 20, 2022, the statewide provider network consists of 660 network providers in 429 unduplicated provider locations serving over 370,000 members.

Idaho requires the Contractor to ensure that they do not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the member. They may place appropriate limits on a service on the basis of medical necessity criteria or for the purpose of utilization control, provided the services furnished can be reasonably expected to achieve their purpose. Medically necessary procedures for all covered populations are listed in the contract. The list of dental codes in the contract which codes require a prior authorization and what required information and documentation is needed for the prior authorization review.

The criteria required for prior authorization varies depending on the procedure, however treatment authorization criteria must show medical necessity and generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, and descriptive narrative. In some instances, the State Dental Guidelines will define the requirements for dental procedures. Criteria were formulated from information gathered from practicing dentists, dental schools, American Dental Association (ADA), clinical articles and guidelines, insurance companies and other dental organizations. The Idaho Smiles Provider Manual describes which procedures require authorization, criteria for authorization, utilization control criteria, and other relevant information.

Idaho has separate adult and child specific definitions within our administrative rules for medical necessity.

Medically necessary adult services are defined as: a) It is reasonably calculated to prevent, diagnose, or treat conditions in the member that endanger life, cause pain, or cause functionally significant deformity or malfunction; b) There is no other equally effective course of treatment available or suitable for the member requesting the service which is more conservative or substantially less costly; c) Medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records, including evidence of such medical necessity and quality. Those records must be made available to the Department upon request.

Medically necessary services for members under the age of 21 are defined as: Health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Services must be considered safe, effective, and meet acceptable standards of

medical practice.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. Delivery Systems. The State will be using the following systems to deliver services:

a. ☐ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. ☐ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

- ○ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

c. ☒ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

- ◉ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

d. ☐ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

f. ☐ **Other:** (Please provide a brief narrative description of the model.)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. Procurement. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

☐ **Procurement for MCO**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PIHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☒ **Procurement for PAHP**

- ◉ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PCCM**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for FFS**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

The Idaho Medicaid dental contract provides services through a network of 660 dental providers for over 370,000 Idaho Medicaid members, as of January 20, 2022. Provider specialties include 447 General Dentists, 107 Pediatric Dentists, 25 Oral Maxillofacial, 24 Denturists, 6 Endodontic Dentists, 46 Orthodontic Dentists, 5 Periodontic Dentist, and 1 Prosthodontic Dentist. Dental providers in the network are required by the Contractor to complete a credentialing process following the guidelines of Utilization Review Accreditation Commission (URAC) or the National Committee for Quality Assurance (NCQA)and sign a network contract. Reimbursement is paid to the Contractor as a Per-Member-Per-Month (PMPM) rate. Federally Qualified Health Centers FQHCs and Indian Health Service (IH) providers are paid an encounter rate which is equal to the FQHC encounter rate as required in Section 1902(bb) of the Act. FQHCs and IH clinics are required to bill the Contractor with supporting Code on Dental Procedures and Nomenclature (CDT) codes, which Idaho reports on the CMS 416 report for Early, Periodic, Screening and Diagnostic Services (EPSDT).

The Contractor is prohibited from subcontracting with providers who are excluded from participation in federal health care programs in accordance with section 1128 or section 1128A of the Act. Idaho's Medicaid program for fraud or abuse is responsible for verifying provider’s eligibility to provide services based on their exclusion status. At IDHW's request, the Contractor must terminate any substantial contractual relationships with individual(s) identified as in continued violation of laws governing Idaho Medicaid.

Idaho's PAHP contract requires a quarterly report titled "Availability of Service", which is monitored by Idaho. A contract performance metric under Availability of Service defines the time allowed for the Contractor to find a provider, in or out of network, who will agree to treat a member if the participant cannot find a provider on their own. Idaho monitors the required standards by reviewing reports, feedback from providers and members, on-site monitoring and performing random testing of the system of accountability as part of the quality assurance process.

Idaho assures CMS that no payment is made to a provider other than the PAHP for services available under the contract as directed by 42 CFR §438.60. The Contractor must ensure that any compensation to individuals or entities that are subcontracted by the Contractor to conduct utilization management activities is not structured so as to provide incentives to deny, limit or discontinue medically necessary services to members as stated in 42 CFR §438.210(e). Members are not held liable for debts for covered services if the Contractor becomes insolvent, the State does not pay the Contractor or if the PAHP does not pay the dental provider that furnished the services (42 CFR §438.106). The Contractor must give members the right to participate in decisions regarding their health care as provided within 42 CFR §438.102, including the right to refuse treatment.

The Contractor must comply with all provisions of state and federal laws, rules, regulations policies and guidelines as indicated, amended, or modified that govern delivery of the services. The Contractor specifically agrees to comply with regulations applicable to PAHP contracts as set forth in 42 CFR Section §438.3 to ensure participants are not discriminated against based on health status, need for health care services, race, color, national origin, sex, or disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex or disability. The Contractor must comply with applicable requirements for PAHP contracts as set forth in 42 CFR Part 438 and ensure the requirements of 42 CFR §440.100 are met for dental services being provided by or under the supervision of a dentist. The contract covers dental screenings performed by dental hygienists through district health departments under dental code D0191 in addition to the codes which are within their licensure regulations. Other dental providers use other oral evaluation/examination codes that are specific to services performed by or under the supervision of a dentist. Physicians may also provide fluoride varnish under CPT 99188 for members up to the age of 21, which is outside of the Idaho Smiles contract.

The Contractor must ensure they will adhere to requirements of 42 CFR §438.102 regarding provider-member communications. The Contractor must report to IDHW all aspects of their programming, network functioning, service delivery, member response to services, operations, and claims processing, as well as the specific performance areas required in the contract. The reported data is used monthly and quarterly to monitor the Contractor's ongoing compliance with all contract terms and for analysis of the data in order to identify and report the Contractor's level of adherence to performance requirements. This data is also used by the State to report on compliance with Federal guidelines and assurances.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. Assurances.

☒ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a

State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

☒ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries ability to access services.

The Idaho Smiles program is administered by one managed care entity which provides services statewide. Ongoing recruitment of general and specialized care professionals is necessary in order to ensure that a comprehensive provider network is maintained in accordance with the access to care requirements of the contract. As of January 20, 2022, the Idaho Smiles network consists of 660 dental providers; 99.89% of members have a choice of dentists within 30 miles of their residence in urban areas, and within 60 miles of their residence in all other counties in Idaho. The contract defines 7 urban counties. In cases where there is no dentist within the required radius of the member's home, the Contractor must assist in finding an appropriate dentist even if the Contractor must contract with an out-of-network dentist to provide care. The Contractor has significantly expanded access to care in some areas with the usage of telehealth, as statutory authority and the networks ability to provide telehealth has evolved over the past five years.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

Program: " **Idaho Smiles Dental Plan.** *"*

☐ **Two or more MCOs**

☐ **Two or more primary care providers within one PCCM system.**

☐ **A PCCM or one or more MCOs**

☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☒ **Other:**
please describe

Dental providers are not constrained to practice in a predesigned geographical service area. They may provide services wherever they choose within the state. Providers are not limited to the number of clinics they operate within the geographical network. The Contractor is required to aid members through the use of member placement specialists to assist in locating a provider. If an in-network provider cannot be found, the member placement specialist will locate a provider to perform needed treatment until an in-network solution is found.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. Rural Exception.

☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting.

○ **Beneficiaries will be limited to a single provider in their service area**
Please define service area.

◉ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Idaho requires the Contractor to ensure adequate statewide access for eligible members to medically necessary dental services. The Contractor operates an open network but is required to utilize providers outside of their network if the services needed are not available within the established network. This information is included in the member handbook. The Contractor is required to track the dental network providers on an ongoing basis to determine those who are accepting new Medicaid members. Additionally, the Contractor is required to provide a quarterly report to the state for availability of services. The Contractor must ensure members with disabilities have physical access to receive dental services and interpretive services are available to those with hearing impairment and those with limited English proficiency. The Member Handbook also instructs members how to request interpreter services for an appointment with the dental provider.

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- *Specify Program Instance(s) for Statewide*

     ☒ **Idaho Smiles**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*

     ☐ **Idaho Smiles**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
All Counties in the State of Idaho	PAHP	Managed Care of North America

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the States specific circumstances.

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

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

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

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

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Childrens Health Insurance Program (SCHIP) through the Medicaid program.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Other** (Please define):

All Medicare-Medicaid dual eligible and Blind/Disabled Adults and Aged and Related populations receive dental benefits through the Idaho Smiles program.

Adult Group defined in 42CFR 435.119 as: Non-pregnant individuals age 19 to 64, not otherwise mandatorably eligible for Medicaid, with income at or below 133% federal poverty level not entitled to coverage under Medicare Part A or B.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the Aged population may be required to enroll into the program, but Dual Eligibles within that population may not be allowed to participate. In addition, Section 1931 Children may be able to enroll voluntarily in a managed care program, but Foster Care Children within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☐ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

☐ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

☐ **Other Insurance** --Medicaid beneficiaries who have other health insurance.

☐ **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

☐ **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐ **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☐ **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

☐ **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

☐ **SCHIP Title XXI Children** Medicaid beneficiaries who receive services through the SCHIP program.

☐ **Retroactive Eligibility** Medicaid beneficiaries for the period of retroactive eligibility.

☒ **Other** (Please define):

1. Qualified Medicare Beneficiaries (QMB) who don't qualify for Medicaid benefits based on income
2. Special Low Income Medicare Beneficiaries (SLMB) who don't qualify for Medicaid based on income
3. Qualified Individual (QI) special low income Medicare Beneficiaries
4. Qualified Disabled Working Individual (QDWI)
5. Undocumented aliens including non-qualified, undocumented and qualified aliens who have not met the five year bar, are eligible for care and services related to the treatment of an approved emergency medical condition.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

☐ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☒ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

☒ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

Emergency Services Category General Comments (optional):

Access to urgent care dental services is given to members. They are informed in the member handbook of the extent to which, and how, after hours and urgent dental care is provided, including how to contact a network dental provider 24/7 for urgent dental care. The Contractor makes arrangements with any out-of-network provider with respect to payment and ensures there is no cost to the member. The Contractor's Call Center staff are also trained to help members with these needs.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

☐ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.

☐ Other (please explain):

☒ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Access to family planning services is not part of this dental contract.

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. FQHC Services. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

☒ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

Idaho Medicaid requires the Contractor to comply with federal law regarding access to FQHCs.

☐ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

5. EPSDT Requirements.

☒ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT Requirements Category General Comments (optional):

Idaho has adopted the American Academy of Pediatric Dentistry's (AAPD) Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling table found in the AAPD's Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children and Adolescents. This schedule is specifically referenced in the dental contract and in the Dental Provider Office Reference Manual which is used by all network dental providers. The Contractor is required to develop and implement policies and procedures for EPSDT. MCNA and Idaho Medicaid work together collaboratively to clarify EPSDT requirements, including medical necessity criteria.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

☐ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider

type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

7. Self-referrals.

☒ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

Idaho Medicaid does not require prior authorization for preventive and restorative services with the exception of crowns for participants under 21 years of age. Prior authorization is required for some surgical removal of teeth, selected periodontics, prosthodontics, orthodontics and maxillofacial prosthetics. A participant may make an appointment without a referral. However, the procedures they need, may require prior authorization.

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

The PAHP does not use national published criteria for utilization management, but has created its own set based on the procedure code definition in the ADA's Current Dental Terminology manuals (CDT) and generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. Criteria are formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, and insurance companies, as well as other dental organizations.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. ☐ **Availability Standards.** The States PCCM Program includes established maximum distance and/or travel time requirements, given beneficiarys normal means of transportation, for waiver enrollees access to the following providers. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

b. ☐ **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The States PCCM Program includes established standards for appointment scheduling for waiver enrollees access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The States PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures timely access to the services covered under the selective contracting program.

Timely access is defined in the contract under "Availability of Services". Waiting time for an appointment for periodic dental evaluations or prophylactic care is 45 calendar days.

Wait time for an appointment for non-urgent dental appointments including simple restorative procedures and crowns is seven (7) calendar days. Wait time for urgent appointments for treatment of specific problems requiring immediate attention involving pain, infection or urgent diagnostic needs is twenty-four (24) hours (routine referral to the local emergency room or urgent care is not acceptable).

Time allowed for the Contractor to find a provider, in or out of network, who will treat a member, if a member cannot find a provider on their own is seven (7) calendar days for non-urgent cases and two (2) business days for urgent cases. There must be no additional cost to the member for out-of-network providers.

Additionally, the contract requires the Contractor to make appropriate efforts to provide an adequate number of in network providers to meet the needs of the adult expansion population (added in 2020), as provided in this section.

Idaho monitors by review of complaints from providers, beneficiaries, the state dental association, and other stakeholders to ensure that timely access requirements are met. The State also monitors timeliness of access by reviewing the quarterly "Availability of Services" report which is submitted based on the contract requirements:
1. Meet standards for timely access to care and services, taking into account the urgency of the need for services.
2. Track each of the time frames established in the contract to ensure time frames are not exceeded.
3. Ensure network providers offer hours of operation that are no less than the hours of operation offered to private fee-for-service patients.
4. Ensure the covered services are available 24 hours a day, seven days a week, when medically necessary.
5. Ensure providers inform their patients of the extent to which, and how, after hours and urgent dental care is provided, including how to contract a network provider 24 hours a day, seven days a week for urgent dental care.

Idaho will notify the Contractor when a performance issue is identified. Failure to resolve the performance issue may require Idaho to impose remedies outlined in Standard Terms and Conditions, and the Special Terms and Conditions: Failure to resolve an identified performance issue may require any of the following remedial actions: 1) take corrective action to ensure that performance conforms to contract requirements; 2) reduce payment to reflect the reduced value of services received; 3) subcontract all or part of the services at no additional cost to the Department; or 4) terminate the contract.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to

which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

b. ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the States standard:

c. ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

d. ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal	

Please note any limitations to the data in the chart above:

e. ☐ The State ensures adequate **geographic distribution** of PCCMs.

Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

f. ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) for facility programs, or vehicles (by type, per contractor) for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Idaho monitors and enforces the Contractor's performance with respect to timeliness and adequacy of access statewide. The focus of these efforts is around access metrics as determined by quarterly surveys rather than just the number of providers. Idaho had an Independent Assessment conducted in March 2022 which is currently used as a monitoring tool for timeliness and network adequacy.

To better meet the needs of its Medicaid population, Idaho reviews the number of participating dentists throughout the state on a quarterly basis. The Contractor produces a Network Validation report which shows the number of dentists by type and each county. Performance metrics in the contract require a sufficient number of dental providers to ensure that at least 90% of members in urban counties have access to a general or pediatric dentist within 30 miles of their home if living in one of the 7 urban counties, or 60 miles of their home if living in one of the 37 rural counties. The Contractor must meet these standards and will add more dentists in a specific area when needed.

The PAHP first reported 490 providers in Network in 2017. In December 2019, there were 619 providers in the MCNA network. At the time of the renewal submission there were 660. Network capacity has increased, but capacity has been challenging due to the increased demand of expansion. The State will continue to require regular reporting from the MCO, which has been updated to require the MCO to provide the total number of unique providers in the state by unique providers and type of specialty. This reporting allows the state to look at availability by area. Data will also be gathered by the Plan from providers to obtain wait times for appointments based on whether the need is for urgent or regular visits by members.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ☐ The plan is a PIHP/PAHP, and the State has determined that based on the plans scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

b. ☒ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

Idaho identifies participants with special health care needs. The Contractor is required to maintain dental coverage for all participants, taking into consideration any special health care needs. Communication is in a language the participant understands and interpretive services are offered by the Call Center and provider offices if needed. This information is listed in the member handbook on how to request services.

The contractor receives participant Medicaid Plan type (in Idaho, this is either Basic or Enhanced) and can differentiate if the participant is enrolled in a Medicaid Waiver Program (for example, 1915c DD or 1915c A&D). Adults and children are assigned to basic or enhanced based on: receipt of Home and Community Based (HCBS) 1915c waiver services, or due to medical conditions that qualify (such as requiring a transplant).

This information determines if the participant receives basic or enhanced dental benefits.

c. ☒ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

Idaho's Contractor is required to provide a specific benefit package with direct access to specialists for members identified with special health care needs. The Contractor must provide benefits that are based on evidence-based standards of practice within the dental community. The benefit package is listed in the contract within the Scope of Work.

For the different adult populations, there are no benefit differences. Enhanced eligibility is an indicator used by the contractor to identify individuals who are potentially at a higher need for care coordination or case management services for initial outreach.

For the different children populations, there are minimal benefit differences. A few procedure codes are covered for enhanced that aren't covered for basic. Two codes are covered for enhanced child that are not covered for basic: D9410 which is a house/extended care office call and D9920 which is behavior management.

d. ☒ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. ☐ Developed by enrollees primary care provider with enrollee participation, and in consultation

with any specialists care for the enrollee.

2. ☐ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☒ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

The PAHP must provide for medically necessary screening and dental services.

e. ☒ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollees condition and identified needs.

Please describe:

The contractor provides assistance in scheduling appointments with providers who can fit the member's specific needs. The contractor maintains a Case Management Department whose primary function is to assist members with special needs, including autism spectrum disorder. The state provides in-office translators and interpreters to assist members with LEP and those who are deaf or hard of hearing who use ASL to communicate.

The member can access an online provider network search and select the appropriate provider type and the area of desired service. The site is www.mcnaid.net.

For members enrolled in Case Management, the contractor follows up on care when the member has an identified need referral. This coordination referral occurs with various care partners including the medical providers/specialists, dental providers/specialists, health plans, and state partners.

The plan reviews referrals, records, and assists in coordinating services with specialists, appointment scheduling, and if a network provider cannot be found they will identify an out of network provider and ensure care is covered at no cost to the member.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.

b. ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees overall health care.

c. ☐ Each enrollee is receives **health education/promotion** information.

Please explain:

d. ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. ☐ There is appropriate and confidential **exchange of information** among providers.

f. ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ☐ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ☐ **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.

i. ☐ **Referrals.**

Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Idaho closely monitors the Contractor's performance with respect to coordination and continuity of services.

The Contractor is required to ensure providers inform their patients of the extent to which, and how, after hours and urgent dental care is provided, including how to contact a network dental provider 24/7 for urgent dental care. A directory of network dentists name, locations and telephone numbers must be provided to members. The Contractor provides necessary dental services covered under the contract to members when the services cannot be provided by a network provider. The Contractor is required to cover the services with an out-of-network dentist for as long as the services are unable to be provided with the network with no cost to the member.

The Contractor is also required to submit a quarterly report on access and oral health improvement activity costs and outcomes to the State. The contract also requires the Contractor to seek prior approval from the state to initiate or terminate such activities.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on: (mm/dd/yy)

☐ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.
Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP				

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ☐ The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

b. ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
2. ☐ Initiate telephone and/or mail inquiries and follow-up
3. ☐ Request PCCMs response to identified problems
4. ☐ Refer to program staff for further investigation
5. ☐ Send warning letters to PCCMs
6. ☐ Refer to States medical staff for investigation
7. ☐ Institute corrective action plans and follow-up
8. ☐ Change an enrollees PCCM
9. ☐ Institute a restriction on the types of enrollees
10. ☐ Further limit the number of assignments
11. ☐ Ban new assignments
12. ☐ Transfer some or all assignments to different PCCMs
13. ☐ Suspend or terminate PCCM agreement
14. ☐ Suspend or terminate as Medicaid providers
15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ☐ Initial credentialing

B. ☐ Performance measures, including those obtained through the following (check all that apply):

- ☐ The utilization management system.
- ☐ The complaint and appeals system.
- ☐ Enrollee surveys.
- ☐ Other.

Please describe:

4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

1. How the State assures quality services in selective contracting & provider selection process: A Request for Proposal was issued using the State's Division of Purchasing process and posted on the website, which is available to all interested bidders, regardless of location, via the internet. Idaho uses the State's open competitive procurement process which is mandated by the Department of Administration's Division of Purchasing for all state purchases. Criteria used to select providers under the Waiver with weights: Idaho utilized a standardized review and evaluation process with specific weighted scoring criteria that was incorporated in the contents of the RFP document. Bid submissions were reviewed and scored independently by members of the appointed evaluation team and then through the use of consensus scoring, a single score was determined using the evaluation criteria.

Evaluation criteria for the dental services RFP Response by the bidders is as follows:
Mandatory Submission Requirements Met: Pass or Fail
Business Information: 100 points
Organization and Staffing: 100
Scope of Work: 400 points
Cost: 400 points
Total Points: 1000

The scores for the technical proposal section are normalized as follows: The proposal with the highest overall total technical score will receive a score of 600. Other proposals will be assigned a portion of the maximum score using the formula: 600 X technical proposal being evaluated/highest Technical Proposal. The scores for the Cost Proposal section are normalized as follows: The cost evaluation will be based on the total Administrative Costs proposed for required services as itemized in Appendix C. The proposal with the lowest overall total cost proposed will receive a score of 400. Other proposals will be assigned a portion of the maximum score using the formula: 400 X lowest cost proposal/cost proposal being evaluated.
The RFP, all attachments and amendments, the successful proposer's proposal submitted in response to the RFP, any negotiated changes to the same, will become the contract. The Division of Purchasing requires on-going monitoring of required Performance Metrics and contract deliverables. Idaho performs monthly and quarterly review and reports on that review to Division Administration. Idaho follows up on all concerns, complaints and appeals that come directly from members.

2. Quality and Performance standards: Idaho requires the Contractor to provide and maintain a quality assurance plan which includes a methodology for obtaining customer satisfaction information from members and the provider network. A Department approved Policies and Procedures Manual for network providers is required. Twelve monthly reports include a complaint resolution and a grievance report with information showing how these issues were resolved and handled. A Program Integrity Activities report and reinvestment activity costs and outcomes are also required. The following are performance metrics in the contract: 1) Initial Deliverables 2) Administration/Operations Readiness Review 3) Administration and Operations 4) Policy & Procedures Manual 5) Customer Service 6) Network of Dental Providers 7) Eligibility Verification 8) Availability of Services 9) Communications 10) Information Technology System 11) Data Tracking and Utilization 12) Encounter Data 13) Complaint Resolution and Tracking System 14) Grievance, Denial, Appeals & Hearings. Idaho monitors all monthly and quarterly reports, reviews member and provider grievances and appeals, complaint resolution and customer satisfaction findings and how the information is used to improve services and ensure compliance with quality standards. Idaho will take corrective action if there is a failure to comply, following the remedies outlined in the contract Standard Terms and Conditions and Special Terms and Conditions section.

The Contractor administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. These standards are adhered to as the standards apply to dental managed care. It includes, but not limited, to: Provider credentialing and re-credentialing, Member and Provider satisfaction surveys, Random chart audits, Complaint monitoring and trending, Peer review process, Utilization management and proactive patterns, Site reviews, Dental record reviews, Quarterly quality indicator tracking (complaint rate, appointment waiting time, access to care). The Contractor’s quality improvement team meet quarterly with IDHW contract monitors and managers, and the Medicaid Program Integrity Unit to discuss the results of tips, audits, and prepayment reviews.

The Contractor is required to provide a Dental Home for members ages 0 - 3 years of age. The Dental Home program is modeled after the American Academy of Pediatric Dentistry guidelines and promotes continuity of care by encouraging dental providers to manage the preventive, diagnostic and restorative dental needs of their patients. This is a place where a child's oral health care is delivered in a complete, accessible and family-centered manner by a licensed dentist. The Dental Home visit can be initiated as early as 6 months of age.

3. IDHW updated the Managed Care Quality Strategy to Include all managed care programs, including Idaho Smiles, in 2022. IDHW is following CFR 438.340(b) to develop and maintain a quality strategy to assess and improve the quality of managed care services offered within a state. The strategy will be reviewed annually and updated no less than once every 3 years. The strategy is intended to serve as a blueprint or roadmap for IDHW and their contracted health plans in assessing the quality of care that beneficiaries receive as well as for setting measurable goals and targets for improvement.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

☒ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

Marketing activities 42 CFR 438.104 Enrollment is mandatory, based on the State's eligibility determination, therefore marketing to Medicaid participants is not needed or allowed by the Contractor. Participation for dental services is mandatory, so there is no incentive to market by the Contractor. The Contractor can not disenroll participants.

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. ☒ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. ☐ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

   Please list types of indirect marketing permitted:

3. ☐ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS

providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the States procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ☐ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☐ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b. ☐ The languages comprise all languages in the service area spoken by approximately ☐ percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:

Idaho does not permit direct or indirect marketing by its PAHP contractor. Because participation is mandatory for all participants for dental service they are enrolled with the Contractor when they are covered by Medicaid. There is no incentive to market. Participants also can not be disenrolled by the contractor.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

☒ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. ☒ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

Spanish, Arabic, Swahili

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines significant.:

b. ☒ The languages spoken by approximately 5.00 percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

2. ☒ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

The Contractor ensures participants have access to oral interpretive services. Oral interpretation is available for any language. Call Center representatives offer interpretation services to participants who call. The Member Handbook also includes information on how to obtain interpretive services for appointments.

3. ☒ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

Member program information is sent to enrollees within 5 business days of enrollment. Enrollees have access to customer service staff who can answer questions about the program materials in a language they can understand. Written notice of any changes in procedures for the program is sent at least thirty (30) calendar days before the effective date of the change.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☐ State

☐ Contractor

Please specify:

☒ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

☐ the State

☐ State contractor

Please specify:

☒ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

The Contractor provides information materials to members regarding their dental benefits. The State collaborates with the Contractor to ensure the information within the member handbook, Contractor website, and provider materials are accurate and current. The Contractor has committed to enhancing its efforts to fully educate members, families, providers and other stakeholders about EPSDT services.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

☐ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

☒ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements

listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The State has requested a waiver of 1902(a)(4) provisions as Idaho Smiles requires mandatory enrollment into a single, statewide PAHP.

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the States enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☒ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

There are no special populations distinguished in this waiver. Idaho Medicaid will automatically enroll Medicaid beneficiaries on a mandatory basis into the dental PAHP under this waiver authority. Daily eligibility files are sent to the Contractor, and these files are loaded into the Contractor's system within 4 hours of availability of the file. The Contractor must report any errors in the eligibility load within 6 hours of availability of the file. The Contractor may not disenroll a participant for any reason other than loss of Medicaid eligibility.

IDHW provides general program information about Idaho Smiles through the IDHW website and through publications and web posting of the Idaho Medicaid participant handbook and the Idaho Medicaid provider handbook.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☒ State staff conducts the enrollment process.

☐ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment

process and related activities.

☐ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name:

Please list the functions that the contractor will perform:

☐ choice counseling

☐ enrollment

☐ other

Please describe:

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☐ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. ☐ Potential enrollees will have ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

☒ The State automatically enrolls beneficiaries.

☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).

☒ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).

☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides **guaranteed eligibility** of ☐ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☒ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☐ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i. ☐ Enrollee submits request to State.

ii. ☐ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii. ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☒ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☐ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of [ ] months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollees health care needs):

☐ The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

☐ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

i. ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

ii. ☐ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ☐ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCMs caseload.

iv. ☐ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

☒ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C

Enrollee Rights and Protections.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

☒ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Member rights information is distributed to members by the Contractor in the member handbook in accordance with the contract requirements and 42 CFR 438.10(f)(6).

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

    a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

    b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

    c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

    ☒ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an

enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

☐ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

☐ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

☐ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

☐ The States timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is ☐ days (between 20 and 90).

☐ The States timeframe within which an enrollee must file a **grievance** is ☐ days.

c. Special Needs

☐ The State has special processes in place for persons with special needs.

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. Optional grievance systems for PCCM and PAHP programs. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not

interfere with a PCCM, or PAHP enrollees freedom to make a request for a fair hearing or a PCCM or PAHP enrollees direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☒ The State has a grievance procedure for its ☐ PCCM and/or ☒ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure): The grievance procedures are operated by:

- ☐ the State
- ☐ the States contractor.

  Please identify:
- ☐ the PCCM
- ☒ the PAHP

☒ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

The Contractor must provide a grievance and appeals tracking system and process. The system must allow a member, members authorized representative, or provider to file a grievance relating to an expression of dissatisfaction about any matter other than an adverse benefit determination. An appeal may also be submitted for service or benefit denials known as adverse benefit determinations.

☒ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

The Contractor ensures that individuals who review each appeal were not involved in any previous review or decision of the action. If the appeal is related to a denial based on medical necessity or involving clinical issues, the reviewer must be be health care professionals who have the appropriate clinical expertise.

☒ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

The grievance can be filed at any time.

☒ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

The contractor shall review and resolve complaints received within ten (10) business days and ensure IDHW receives complaints that may need resolution at that level. For grievances, the contractor shall make a decision within thirty (30) days of receipt and notify the participant in writing.

☒ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

An expedited appeal review is conducted if the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. In such case, a decision will be made not later than seventy-two (72) hours after the request. and can be extended by an additional fourteen (14) days at the request of the member or if it is in the member’s interest.

☒ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☒ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

The Contractor must provide a grievance and appeals tracking system and process.

Grievances:
The system must allow a member, members authorized representative, or provider to file a complaint and/or grievance relating to an expression of dissatisfaction about any matter other than an adverse benefit determination. These may include but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested.

The grievance can be filed at any time. Those filing a grievance may file either orally or in writing and receive acknowledgement of receipt from the Contractor within five (5) business days and a decision within thirty (30) calendar days. The Contractor will conduct an investigation or inquiry into the allegations and give due consideration and deliberation to information. Grievance includes a member's right, whether submitted by a member, members authorized representative, or provider to dispute an extension of time proposed by the Medicare and Medicaid Contractor to make an authorization decision. The Contractor ensures that individuals who investigates each grievance were not involved in any previous review or decision of the action.

Appeals:
An appeal or review consideration may also be submitted by a member(s), member(s) authorized representative, or provider(s) to the department or Contractor for service or benefit denials known as adverse benefit determinations. Considerations can be made for denial of coverage of, or payment for, medical assistance. The appeal must be submitted within sixty (60) calendar days from the date of the adverse benefit determination was made. For services denied by a Managed Care Contractor, appeals must be submitted to the Contractor first, then if an appeal is denied the member has the option to challenge the decision, submitting an appeal to Medicaid directly. The Contractor must resolve the appeal and provide notice to the appellant or their representative within thirty (30) calendar days from the receipt of the appeal, unless the appeal is an expedited appeal.

Expedited Review Process:
An expedited appeal review is conducted if the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. In such case, a decision will be made not later than seventy-two (72) hours after the request. and can be extended by an additional fourteen (14) days at the request of the member or if it is in the member’s interest.

The Contractor ensures that individuals who review each appeal were not involved in any previous review or decision of the action. If the appeal is related to a denial based on medical necessity or involving clinical issues, the reviewer must be a health care professional who has the appropriate clinical expertise.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCOs, PCCMs, PIHPs, or PAHPs equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCOs, PCCMs, PIHPs, or PAHPs obligations under its contract with the State.

☒ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
    a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
    b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☐ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

☐ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the

State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS
Other	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☒ PAHP ☐ PCCM ☐ FFS	☒ PAHP ☐ PCCM ☐ FFS	☒ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO	☐ MCO	☐ MCO

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☒ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
Idaho Smiles	PAHP;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Idaho Smiles Dental Plan

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**
Please describe:

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

Idaho's Contractor reports quarterly on their quality assurance activities. plan. It includes a customer satisfaction survey for participants and providers. The report includes level of customer service provided, ease of finding a provider and timely scheduling information. If there is a deficiency in any area, the State works with the Contractor through a corrective action plan process.

☐ **CAHPS**

Please identify which one(s):

☒ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

Idaho's contract requires submission of monthly, quarterly, semi-annual, and annual reports, and additional financial monitoring reports. These reports are received, analyzed, and tracked by the IDHW contract monitor. The contract monitor will also review the annual External Quality Review (EQR) for the PAHP to identify any areas of opportunity for improvement. If any deficiencies are identified, the contract monitor addresses those areas with the Contractor via the corrective action process outlined in the Standard Terms and Conditions, contract scope of work, and contract cost billing section.

☒ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

☐ **From plan**

☐ **From PCP within plan**

☒ **Grievances and appeals data**

☒ **Other**

Please describe:

see above

e. ☒ **Enrollee Hotlines**

Activity Details:

Idaho's contract requires a staffed toll-free phone line (Monday-Friday) with a voicemail option for after-hours calls. Voice messages are returned within one business day. Call center staff are trained on the Idaho program and hold time is not to exceed two minutes. Language assistance services are provided for members with identified Limited English Proficiency as required by 45CFR Part 92. Monthly reports are reviewed regarding number of calls received, hold time, and abandonment rate. The contract monitor reviews these reports monthly. If Contractor is not meeting contract requirements, the contract monitor will work with the Contractor through the corrective action process.

f. ☐ **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

h. ☒ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

An independent assessment was completed in March 2022. The assessment evaluated the availability of providers, ease of appointment scheduling with dental providers, and the member's perspective of their benefits. The contract monitor has reviewed and shared the report with the Contractor. Operational discussions are planned to implement recommendations.

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☒ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

Idaho requires the Contractor to ensure that at least 90% of urban members have a dental provider within 30 miles of their residence, and within 60 miles in rural counties. This metric is monitored on the network access report provided by the Contractor and by member's feedback. The Contractor works to ensure the network has sufficient capability to accept new Medicaid members. If there is an access issue, IDHW will work with the Contractor on a corrective action plan to increase access in those areas.

k. ☐ **Ombudsman**

Activity Details:

l. ☒ **On-Site Review**

Activity Details:

Idaho's contract monitor reviews monthly reports either via conference call or a virtual meeting with the Contractor, including any outstanding action items. The contract monitor has direct access to the Contractor's web portal. This allows for eligibility verification, claims review, or to address issues. The Contractor sends any requested documentation to the State when a complaint or appeal is received.

m. ☒ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

Idaho requires the Contractor to conduct ongoing oral health improvement services. In the 2021 EQR, the contractor submitted a Program Improvement Project titled Increasing the Rate of Enrollees Accessing Preventive Dental Services. This project ran from 10/2018-9/2020, and saw an increase in utilization in year 1, but a decrease in year 2 due to COVID-19 related service disruptions. The PIP has since been extended due to the impacts of COVID-19 on dental services and a continued need to address low utilization of preventive services and access issues in Idaho. The Contractor also regularly reports on other program improvement initiatives. Currently these initiatives include an outreach program for pregnant women to educate on the importance of oral health during pregnancy. The contract monitor receives a quarterly report indicating the level of outreach and involvement by members. Any deficiencies are identified and discussed with remedies utilized implemented as needed.

☐ **Clinical**

☐ **Non-clinical**

n. ☒ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

Idaho reviews multiple performance measures, including utilization of services, financial reporting, network adequacy and customer service center metrics. These items are delivered in monthly, quarterly, semi-annual, and annual reports to the State and are discussed with the Contractor. Any deficiencies are identified and discussed with remedies implemented as needed.

☒ **Process**

☒ **Health status/ outcomes**

☒ **Access/ availability of care**

☒ **Use of services/ utilization**

☒ **Health plan stability/ financial/ cost of care**

☒ **Health plan/ provider characteristics**

☒ **Beneficiary characteristics**

o. ☒ **Periodic Comparison of # of Providers**

Activity Details:

Idaho's Contractor provides a report showing the number of licensed dental providers.

p. ☒ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

Idaho's Contractor provides a report showing the number of licensed dental providers.

q. ☒ **Provider Self-Report Data**

Activity Details:

Idaho requires the Contractor to provide a quarterly reporting of survey data for providers as well as provider complaint reports. The contract monitor reviews the complaints and looks for any outliers or consistent areas of concern and addresses those with the Contractor.

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☒ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

The Contractor is required to provide a prior authorization process that ensures consistent application of review criteria based on AAPD, ADA and EPSDT guidelines. Individuals who apply these guidelines must have the required qualifications (licensed dental provider with appropriate clinical expertise) to review the service requests. Network providers receive policies and procedures when entering the network, and members receive a summary of benefits annually. Notice of decision letters must detail the reason for any service denials. The notice must advise the member of their appeal rights.

t. ☒ **Other**

Activity Details:

The following program areas are not included in the PAHP monitoring activities: a) Choice of a PAHP – Idaho is requesting a waiver of section 1902(a)(23) regarding freedom of choice in order to continue with a single statewide PAHP; and b) Enroll/Disenroll: IDHW automatically enrolls members in the PAHP on a mandatory basis upon eligibility determination and does not allow disenrollment.

The Contractor provides the state results of required surveys conducted with members and providers throughout the state as part of the monitoring process. Current survey only asks about provider locating assistance, not provider choice.

MCNA maintains an ongoing system-generated care gap alert for overdue dental checkups, sealants and fluoride treatment wherein Member Service Representatives (MSRs) notify the member they are overdue for a dental visit and or preventive service. The MSR offers to locate a provider if the member does not already have one and performs a three-way call, if necessary, with the provider office to schedule an appointment.

MCNA disseminates monthly preventive text messages to members who have not received a dental checkup within the last six months to educate and encourage the member to schedule an appointment.MCNA disseminates a quarterly MCNA's Practice Site Performance Summary (PSPS) Report which offers the network of primary dental providers (PDPs) comparative operational and clinical results for their practice. The tool is designed to assist providers in understanding how their clinical and operational performance compares with that of their peers. The report also provides recommendations and best practices from MCNA's highest performing providers to improve performance and decrease the time spent correcting administrative errors. The specific items measured in this report were chosen by MCNA's Quality Improvement Staff and MCNA's Idaho Dental Advisory Committee (DAC) based upon information deemed most helpful in managing their overall practice. The report includes a preventive services section that showcases the percent of assigned children receiving a preventive visit in accordance with the American Association of Pediatric Dentistry's Periodicity (AAPD) Schedule.

MCNA's Member newsletter, "Tooth Tribune " is published bi-annually and provides members with the latest news and developments regarding their oral health, preventive services, and the importance of seeing a dentist routinely.

MCNA participates and/or supports community outreach events/health fairs in geographical areas that have a high population of members. Member Advocate Outreach Specialists (MAOS) provide oral health education and oral hygiene instruction to all attendees including members, potential members, and member advocacy groups.MCNA created a Member Outreach Form which is located in the Provider Manual, and Provider Portal and allows providers to communicate with MCNA when a member is behind on their six-month follow-up care according to AAPD Periodicity Schedule, non-compliant with their treatment plan, failing appointments, etc. and upon receipt of the form via mail, email, or fax, an MCNA representative contacts the member and provides the assistance needed.

MCNA's Quality Improvement team conducts targeted outbound calls to members who have not received preventive services in the last six (6) and/or twelve (12) months in order to provide education and assist with scheduling an appointment.

MCNA provides a quarterly Dental Network Validation report to IDHW. The state monitors all providers who leave the network. DentalTrac™ maintains an audit trail from credentialing date through termination. The system also captures why the provider chose to leave when that information is available. Unless the provider is involuntarily terminated, the state continues to reach out through the Network Development team to try and bring providers back into the program when possible.

Section C: Monitoring Results

Renewal Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the States Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is a renewal request.

- ○ **This is the first time the State is using this waiver format to renew an existing waiver.**The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ◉ **The State has used this format previously**The State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

Consumer Self-Report data
Idaho's Contractor completed the activity of "Consumer Self-Report Data" on time every quarter. Overall, members surveyed were satisfied with their dentist, dental plan and customer service provided by the Contractor. No problems were identified, and no corrective action was necessary.

Data Analysis
Idaho's Contractor received 26 complaints from members, 0 from providers, and 13 appeal requests Jan-Dec 2021. No appeals were overturned by IDHW. 7 were withdrawn, 5 went to hearing and IDHW's decision was affirmed, with 1 pending a hearing. No problems were identified, and no corrective action was necessary.

Enrollee Hotlines
Idaho's Contractor utilizes a member hotline and a provider hotline.

Total 2021
Calls Received 39,633
Hold Times, average 95 seconds
Abandonment Rate, average 22.30%
The Contractor is currently under corrective action (Performance Improvement Plan) due to not meeting metrics.

Independent Assessment
An independent assessment was completed in March 2022. The assessment evaluated the availability of providers, ease of appointment scheduling with dental providers, and the member's perspective of their benefits. The contract monitor has reviewed and shared the report with the Contractor. Operational discussions are planned to implement recommendations.

Network Adequacy
Idaho's Contractor reported that at the end of 2021, 99.9% of members living in an identified urban county had access to a dental provider within 30 miles of their home and that 99.8% of member's living in an identified rural county had access to a dental provider within 60 miles of their home.

On-Site Review
The contract states the Contractor must meet with Idaho contract monitors monthly with the Contractor to review reports, action log items, and performance improvement projects (quarterly). The Contractor has not been providing all required reports on time or in the appropriate format. The Contractor is also currently working under a Performance Improvement Plan for inadequate metrics related to customer service and call wait times. The Idaho contract monitor has been tracking these issues and communicating about performance improvement with the Contractor. If the deficiencies are not improved, the next step is to take corrective action.

Performance Improvement Projects
Idaho's Contractor is working on several performance improvement activities. One area includes promotion of sealant visits for children ages 6-9 and 10-14. As part of this project, Medicaid staff and Contractor staff are currently participating in an affinity group in partnership with IDHW's Division of Public Health, the Idaho Oral Health Alliance, the Idaho Primary Care Association, and dentists in Idaho. The affinity group is implementing a pilot project with healthcare providers to provide sealant services in the healthcare setting. Another area of performance improvement is establishing of a dental home, specifically for children under 3. During the fourth quarter of 2021, 42,903 children ages 0-3 were assigned a dental home. The contractor will be establishing baseline data in CY 2021, and will compare cost of care for children with preventive care services to those without a history of recent preventive care. The Contractor is also responsible for promoting the importance of oral health care for pregnant women and encouraging members to enroll with a dental home. In March 2022, they have 4,327 pregnant women participating in the program. The contract monitor receives quarterly reporting on progress and improvement. No problems have been identified, and no corrective action has been necessary.

Performance Measures
The Idaho contract monitor reviewed the monthly and quarterly reports with the Contractor throughout the life of the contract. During 2021, the Contractor performed at the expected level or above on the reported metrics, except the customer service report. A performance improvement plan is currently in place for the call center. The Contractor regularly reports on metrics, details and activities to improve performance.

Periodic Comparison of # of Providers
The Contractor had 660 unique providers enrolled in their network in the beginning of 2022. This translates to approximately half of the dentists licensed in the State of Idaho. The breakdown of the provider network by specialty is below:

Specialty # of Unique Providers
General Dentists 447
Pediatric Dentists 107
Oral Surgeons 25
Denturists 21
Endodontics 6
Orthodontics 46

Profile Utilization by Provider
The contract monitor reviews the Contractor's monthly and quarterly reports for claims, cost, and access rates to identify any deficiencies or concerns. No issues were reported or identified by the contract monitor in these areas during 2021.

Provider Self-Report Data
The contract monitor reviews the Contractor's data from the member surveys as well as the complaint reports received from both members and providers. There were no major areas of concern to address with the Contractor during 2021.

Utilization Review
The Contractor is required to provide a prior authorization process that ensures consistent application of review criteria based on AAPD, ADA and EPSDT guidelines. Individuals who apply these guidelines must have the required qualifications (licensed dental provider with appropriate clinical expertise) to review the service requests. Network providers receive policies and procedures when entering the network, and members receive a summary of benefits annually. Notice of decision letters must detail the reason for any service denials. The notice must advise the member of their appeal rights. If there is a special circumstance where the member doesn't meet criteria, but it is otherwise medically necessary for the member to receive services, the contract monitor works with the Contractor to have the appropriate level of services approved.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
ENHANCED CHILD	
ENHANCED CHILD 64.21U WAIV	
BASIC ADULT	
ENHANCED ADULT & WAIVER EXPANSION	
BASIC CHILD	
BASIC CHILD 64.21U WA	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/2020	09/30/2021	10/01/2021	09/30/2022
Enrollment Projections for the Time Period*	01/01/2023	12/31/2023	01/01/2024	12/31/2024

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Dental Services	☒	☐	☐	

Section D: Cost-Effectiveness

Part I: 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 States 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 CMS 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 States submitted CMS-64 forms.

Signature: Charles Beal

State Medicaid Director or Designee

Submission Date: Dec 16, 2022

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Cost-effectiveness spreadsheet is required for all 1915b waiver submissions.

b. Name of Medicaid Financial Officer making these assurances:

Aaron Howard

c. Telephone Number:

(208) 287-1141

d. E-mail:

Aaron.Howard1@dhw.idaho.gov

e. The State is choosing to report waiver expenditures based on

○ **date of payment.**

◉ **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. 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.

b. ☐ The State provides additional services under 1915(b)(3) authority.

c. ☐ The State makes enhanced payments to contractors or providers.

d. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver.

e. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. *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 (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete ***Appendix D3***
- 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.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

The response to this question should be the same as in A.I.b.

a. ☐ **MCO**

b. ☐ **PIHP**

c. ☒ **PAHP**

d. ☐ **PCCM**

e. ☐ **Other**

Please describe:

The contract currently covers capitation rates for six populations:
1. Basic Child
2. Basic Child 64.21U Wa
3. Enhanced Child
4. Enhanced Child 64.21U Waiv
5. Basic Adult
6. Enhanced Adult & Waiver Expansion

Section D: Cost-Effectiveness

Part I: State Completion Section

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):

a. ☐ **Management fees are expected to be paid under this waiver.**

The management fees were calculated as follows.

1. ☐ **Year 1: $** [ ] **per member per month fee.**
2. ☐ **Year 2: $** [ ] **per member per month fee.**
3. ☐ **Year 3: $** [ ] **per member per month fee.**
4. ☐ **Year 4: $** [ ] **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.I.H.d.**, 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.

d. ☐ **Other reimbursement method/amount.**
$ [ ]
Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☒ [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 did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. ☒ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

The increase/decrease in member months projections is nominal.

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

no other variances

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

R1 and R2 are Federal Fiscal Year (FFY)

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

For Conversion or Renewal Waivers:

a. ☐ **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**
Explain the differences here and how the adjustments were made on Appendix D5:

b. ☒ **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**
For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

No services are excluded from analysis.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Dental Services	☐	☐	☐	☐	☐	☒	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

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. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*
The allocation method for either initial or renewal waivers is explained below:

a. ☐ **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees***Note: this is appropriate for MCO/PCCM programs.*

b. ☒ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*

c. ☐ **Other**
Please explain:

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

a. ☐ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** 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.

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

c. ☒ **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. ☒ **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**
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

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

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

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

2. ☐ **For the fee-for-service portion of the waiver, 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.I.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.I.I.e and D.I.J.e)

   Document:
   - **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.

Appendix D3 Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

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

1. ☒ **[Required, if the States 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: 0.02

   Please document how that trend was calculated:

   The adjustment in the PMPM was calculated for each eligible population/MEG and then averaged based on covered state plan services.

2. ☒ **[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations)** *(i.e., trending from present into the future).*

   i. ☒ **State historical cost increases.**

   Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

   linear regression was utilized and we included the adult expansion group

   ii. ☐ **National or regional factors that are predictive of this waivers future costs.**

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

3. ☐ **The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**
Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

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

Appendix D4 Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment 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
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ☒ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. ☐ An adjustment was necessary. 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.
   Please list the changes.

For the list of changes above, 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. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☐ 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 list the changes.

For the list of changes above, 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 list the changes.

For the list of changes above, 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. ☐ 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

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

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 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. ☐ 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).

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

C. ☐ State Historical State Administrative Inflation. THe actual trend rate used is PMPM size of adjustment

Please describe:

D. ☐ 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 States 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.I.J.a. above

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

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.I.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 States 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 States 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 lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. A. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years

2. Please provide documentation.

B. State Plan Service trend

Please indicate the State Plan Service trend rate from Section D.I.J.a. above

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** 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.I.I.a

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

3. Explain any differences:

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

p. ***Other adjustments*** including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States 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.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)** *: 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 **which includes accounting for Part D dual eligibles**. 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 contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
  3. ☐ Other

     Please describe:

1. ☒ No adjustment was made.

2. ☐ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 Waiver Cost Projection

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

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 RO Targets

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

Appendix D6 RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. 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.I.E.c & d:

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 States explanation of cost increase given in Section D.I.I and D.I.J:

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 States explanation of utilization given in Section D.I.I and D.I.J:

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

Appendix D7 - Summary