

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
IBHP	Idaho Behavioral Health Plan	PAHP;

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

Idaho Behavioral Health Plan

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):

In Section A, Part I: Program Overview, the State has updated narratives describing Tribal Consultation and Program History, but has made no changes to coverage and reimbursement in the present submission.

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.011.02.00

Waiver Number:ID.0002.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

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(208) 364-1811

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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 Behavioral Health 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.

In 2023, the State plans to award a new contract for delivery of Idaho Behavioral Health Plan (IBHP) services to Medicaid enrollees. This will expand the scope of the IBHP to include inpatient as well as outpatient behavioral health services.

To capture the input of Tribal members regarding this expanded contract, Idaho Medicaid has increased the opportunities for periodic Tribal input beyond the regular schedule of quarterly Tribal meetings between Tribal representatives and Medicaid staff. Beginning March 24, 2021, the State has held a recurring series of Tribal-DHW Monthly Medicaid Meetings to discuss and address Tribal concerns.

The State is also planning amendments to the Tribal Special Terms and Conditions (STCs) to coincide with the 2023 launch of the new IBHP contract. In accordance with the current approved STCs, the State is currently working with the Tribes to finalize a list of members who will serve on a Tribal Technical Advisory Board. Periodic meetings of the Tribal Technical Advisory Board will become a channel for delivery and receipt of Tribal feedback regarding revisions to the STCs. This will be in addition to formal Tribal consultation around the STCs which is planned to begin in January, 2022.

As a result of the noticing process around this current submission, the State received Tribal comment letters from three Tribes as well as the Northwest Portland Area Indian Health Board (NPAIHB), requesting minor changes to the STCs including extending the STCs another year and engaging in Tribal consultation to review and amend the existing STCs. The State held a call with the Tribes to discuss this request, during which the State and the Tribes discussed utilizing the current approved STCs for another year. During that year, the State and Tribes will review and amend the STCs through a Tribal consultation before the STC expiration date of March 31, 2023. The Department and Tribal Leadership will work towards agreed-upon amendments through the consultation process by this date.

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).

Brief History of the IBHP

The Idaho Behavioral Health Plan (IBHP) was implemented on September 1, 2013, with United Behavioral Health (dba: Optum Idaho) as the managed care contractor chosen to administer the plan. Services were gradually transitioned through October, with full implementation achieved in November 2013.

Amendment History—Includes requested information for new populations added, major new features of existing programs, and new programs added

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

Effective Date: 9/1/2018

Waiver: ID.0002.R01.01 - Jul 01, 2018

Summary of Changes

1) Added the following benefits to Services Included in the Waiver:

- * Respite
- * Intensive Outpatient Program
- * Case Consultation
- * Psychoeducation

2) Made a technical correction to remove the following benefit from Services Included in the Waiver:

- * Inpatient Psychiatric Hospitalization

3) Added the following new program (description added to Program History narrative)

- * Medicaid SED Program

Effective Date: 1/1/2020

ID.0002.R01.02 - Jan 01, 2020

Summary of Changes

1) Added the following new eligibility group to Populations Included in the Waiver:

- * Adult Expansion Population Group

2) Added the following benefits to Services Included in the Waiver:

- * Partial Hospitalization
- * Peer Support

3) Removed the following benefit from Services Included in the Waiver:

- * Case Consultation

Effective Date: 7/1/2021

ID.0002.R01.02 - Jan 01, 2020

Summary of Changes

1) Removed dual withhold and incentive.

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*

IBHP

- 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*

IBHP

- 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*

IBHP

- 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*

IBHP

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)** - Statewide--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*

IBHP

- 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

IBHP

- 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

IBHP

- 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

IBHP

- 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

IBHP

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 State Legislation (56-261 Idaho Code; 2011) to incorporate managed care systems for high-cost populations. With the approval of Idaho's initial 1915(b) waiver request, the State implemented a Prepaid Ambulatory Health Plan (PAHP) for the management of outpatient behavioral health services for eligible children and adults. By implementing a managed care structure, the State moved away from fee-for-service reimbursement for Medicaid outpatient behavioral health services. During Idaho's initial waiver period, the State was required to amend its State Plan benefit structure of benchmark plans into Alternative Benefit Plans (ABPs). The approved ABP amendments allowed the State to combine the behavioral health services previously captured under a Basic Benchmark Plan and an Enhanced Benchmark Plan to be delivered under a managed care delivery system.

Idaho Medicaid has worked with the IBHP contractor to develop and manage a statewide provider network in order to administer behavioral health services to eligible Medicaid members. The Division of Medicaid within the IDHW maintains oversight of the Idaho Behavioral Health Plan (IBHP) to assure compliance with federal financing requirements and federal waiver assurances. The State has designated an IDHW employee as the IBHP Contract Manager. The Contract Manager is responsible to lead ongoing contract administration and contract performance monitoring with overall responsibility for the management of the IBHP contract.

Idaho's goals for the IBHP managed care waiver program are:

- * Increase positive outcomes for members that result in members' recovery and/or resiliency;
- * Increase the number of members who receive behavioral healthcare treatment that accurately matches their behavioral healthcare needs;
- * Increase standardized use of evidence-informed treatment practices by network providers;
- * Promote effective communications between the IDHW, Contractor and all other stakeholders;
- * Implement utilization management and quality assurance processes that demonstrate improved operations/services and improved payment approaches;
- * Improve coordination with all other treatment providers and programs that members access for behavioral health needs;
- * Decrease use of inappropriate higher cost services (hospital, emergency departments, crisis);
- * Promote effective administrative efficiencies to include telehealth technology, cost-effective management of IBHP, and decreasing the amount of waste and fraud;
- * Achieve greater satisfaction among all stakeholders in the administration of the outpatient behavioral health services.

Idaho Medicaid is responsible for the enrollment of all Medicaid beneficiaries into the Idaho Behavioral Health Plan once Medicaid eligibility is determined (unless otherwise excluded from this program). Idaho Medicaid determines the eligibility of individuals for Medicaid-funded services, and is responsible for all enrollment and disenrollment into the PAHP. The IDHW automatically enrolls Medicaid beneficiaries on a mandatory basis into the PAHP, under the 1915(b) waiver authority pertaining to choice of plans. There are no potential enrollees in this program, as IDHW automatically enrolls beneficiaries into the single PAHP (42 CFR § 438.10(a)).

Idaho Medicaid requires the Contractor to report on all aspects of programming, including network functioning, service delivery, participant response to services, operations, and claims processing as well as the specific performance measure areas identified in this application and included in the contract. This performance data is used by the State to monitor the Contractor's ongoing compliance with all contract terms and to analyze the Contractor's level of adherence to specific performance requirements. This data will also be used by the State to report the State's 1915(b) waiver compliance in accordance with Federal guidelines and waiver assurances.

The initial reporting criteria identified in the managed care contract have been recently amended in coordination with the contractor in order to enhance, and more accurately capture, the data requirements needed to demonstrate the required compliance measures.

Noting for clarity that the respite service is delivered through SSA 1915i authority.

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:

12/16/2022

Idaho Medicaid procured the IBHP managed care contract through the competitive bidding process initiated by the issuance of a request for proposal (RFP).

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 IBHP is administered by one statewide managed care entity. 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 IBHP contract. Establishment of a state network of providers with appropriate professional training who are consistently available to provide outpatient behavioral health services rural and frontier areas of the State has proven challenging. The contractor has committed to providing further education to network providers about the use of telehealth practices in order to expand service access to members in all geographic locations of the State and has dramatically increased telehealth availability since June 2014.

Telehealth is successfully expanding access to care in some of the most underserved rural and frontier regions and counties in the state. The State will continue monitoring activities of the contractor to ensure compliance with the revised report deliverables contained in the amended contract. The contractor provides a monthly suite of network reports including geo access and network provider density reports. Geo access reports allow the state to monitor member access to a provider down to the regional and county level, while provider density reports provide the state data to review industry standard provider to member ratios.

Collaborative communication efforts will continue between the State and the contractor to enhance mutually understood language and the consistent reporting of access measures that meet the expected contract deliverables.

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

Program: " Idaho Behavioral Health 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

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:

The IBHP was implemented with one statewide managed care contractor. The contractor began building the IBHP provider network by enrolling previous Medicaid-enrolled mental health service providers to their established mental health and substance use disorder provider network. The vision introduced by the contractor projected a future of "community behavioral health centers" that would include a full array of professionals including:

- 1) licensed psychiatrists and psychologists
- 2) clinically licensed therapists
- 3) master-level licensed behavioral health professionals
- 4) certified Community-based Rehabilitation Service providers
- 5) certified Alcohol and Drug Treatment professionals and
- 6) licensed nursing and therapeutic professionals.

This established provider network developed by the contractor offers a broad group of behavioral health providers across the state that eligible participants can choose from. As previously mentioned, some of the State's rural and frontier locations with limited provider access still need focused recruitment work and alternative service provision options established in order to provide consistent statewide access.

It has been beneficial for IBHP participants that the Contractor has affiliation with a national healthcare corporation and has access to out-of-network professionals who can help provide behavioral health services for participants who do not have established network providers in their area. The contractor authorizes out-of-network services when a treatment service required by a member is either not provided by a network provider, or there are no appropriate network providers available within a reasonable distance that can provide the required service within industry standard time frames.

It has been, and remains the goal of the contractor, to enroll out-of-network providers rather than continuing single case out-of-network agreements so that members can have access to a consistent provider and to continuously improve the array of services available.

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*

IBHP

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

IBHP

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)
Statewide	PAHP	United Behavioral Health dba Optum Idaho

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):

Former foster care children, up to age 26, are included in this waiver.
Adult Expansion Population Group is included in this waiver.
1915(i) eligible Medicaid SED program participants up to 300% FPL.

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):

The following population groups are not eligible for enrollment in the Idaho Behavioral Health Plan:

- A. Qualified Medicare Beneficiaries (QMB)
- B. Special Low Income Medicare Beneficiaries (SLMB)
- C. Qualified Individual (QI/SLMB2) Special Low Income Medicare Beneficiaries
- D. Qualified Disabled Working Individual (QDWI)
- E. Individuals who reside in an inpatient hospital setting except for discharge planning
- F. Dual-eligible individuals enrolled in a Medicare-Medicaid Coordinated Plan (MMCP) or Idaho Medicaid Plus plan.
- G. Ineligible non-citizens including non-qualified, undocumented and qualified aliens who have not met the five (5) year bar and are eligible for Federal Medicaid 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):

Emergency services are not covered under this waiver.

- 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):

Family planning services are not covered under this waiver.

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:

The IBHP contract 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):

The contractor is required to develop and implement policies and procedures for each program and performance requirement, and EPSDT is no exception. Optum and Idaho Medicaid continue to work together collaboratively to clarify EPSDT requirements, including medical necessity criteria.

The IBHP contractor has incorporated an EPSDT reporting component into its utilization review process, and continues to manage all outpatient EPSDT requests with oversight from Idaho Medicaid contract monitors.

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:

The IBHP Contractor has established as clinical model that identifies available services in three categories. Basic outpatient behavioral health services are referred to as "Category One Services" and include assessment and treatment planning; evaluation and management services; and individual psychotherapy services. These basic services require no authorization. Members may directly contact an IBHP network provider to obtain immediate access to treatment.

8. Other.

Other (Please describe)

The respite service is delivered through SSA 1915i authority. Respite care is short-term or temporary care for a child/youth with SED provided in the least restrictive environment that provides relief for the usual caretaker and is aimed at de-escalation of stressful situations. Respite may be provided by a credentialed behavioral health agency in the participant's home, another private residence, the credentialed agency, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers.

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:

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 beneficiary's 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.

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.

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:

The IBHP is focused on outpatient behavioral health services, and the IBHP contract requires the contractor to coordinate with the Idaho Medicaid primary care case management (PCCM) program to ensure the best possible outcomes for coordinated physical and behavioral health services. Coordination of care is included as a contractual requirement.

- 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:

- 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:

- 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:

- 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:

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.

The contract issued by Idaho Medicaid requires the contractor to coordinate the provision of behavioral health care services with Medicaid's Primary Care Case Management program to ensure the best possible outcomes for coordinated physical and behavioral health services. The contractor is also required to coordinate with other providers and programs that deliver behavioral health services outside of the contractor's delivery system and with the State's physical health coordination programs. Coordination of care practices will be enhanced by the following contractual requirements:

The Contractor must:

- a. Ensure a member's primary care provider (PCP) has the opportunity to participate in the process used to diagnose and plan treatment for the Member;
- b. Ensure ongoing communication and collaboration with a member's PCP throughout the time period that the member receives services through the Idaho Behavioral Health Plan, including the sharing of all screenings, assessments and treatment plans;
- c. Ensure coordination of use of medications;
- d. Operate a PCP hotline, or equivalent service, for PCPs real-time telephonic consultation with a licensed behavioral health professional at the master's level or higher for either of the following two (2) purposes:
 - i. Provide information to support the PCP in the provision of behavioral health interventions/services that the PCP and Member choose;
 - ii. Provide information for the PCP to use for referring the Member to the Contractor's services. Provide on-line access to standardized screening tools for PCPs to use for identifying behavioral health issues.

Idaho has two existing Medicaid programs that focus on care coordination. The State monitors the coordination activities of the IBHP contractor monthly to ensure outreach and ongoing coordination efforts continue to occur throughout the state.

The IBHP contract contains requirements to coordinate services with the State's physical health coordination programs. The IBHP contract requires the contractor to: (1) conduct ongoing communication and collaboration with a member's primary care physician throughout the time the individual receives services through the IBHP; and (2) coordinate participation of the PCP in the process used to diagnose and plan treatment for the individual, including medications.

The IBHP contractor has initiated a care management process with regional staff members who are responsible for coordination of services to ensure medically necessary services are identified and provided for eligible members with significant needs, including children with a Serious Emotional Disturbance (SED) diagnosis.

Additionally, the IBHP contractor routinely conducts quality audits to ensure multidisciplinary teams' involvement with an emphasis on coordination with the PCP. The state monitors coordination activities of the IBHP contractor to ensure eligible members in need are receiving a comprehensive array of specialized behavioral health services, as appropriate.

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	<div style="border: 1px solid black; height: 25px;"></div>	<div style="border: 1px solid black; height: 25px;"></div>	<div style="border: 1px solid black; height: 25px;"></div>	<div style="border: 1px solid black; height: 25px;"></div>
PIHP	<div style="border: 1px solid black; height: 25px;"></div>	<div style="border: 1px solid black; height: 25px;"></div>	<div style="border: 1px solid black; height: 25px;"></div>	<div style="border: 1px solid black; height: 25px;"></div>

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):**

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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 does the State assure Quality in the services?

The State requires the Contractor to report on all aspects of programming, network functioning, service delivery, participant response to services and operations and claims processing as well as all other areas of performance required by the contract. The Contractor is required to provide a Data Tracking and Utilization System to collect and compile data, analyze the data, generate both electronic and hard copy reports in an Excel format, and store, maintain and manage data as specified in the IDHW RFP. The Contractor must ensure the PAHP's electronic system is functional and accessible to allow the IDHW to retrieve reports via Secure File Transfer Protocol (SFTP) from the Contractor.

The State also requires the Contractor to develop and operate a complaint and grievance system which includes trained personnel to handle all complaints received. The system must include intake, investigation, and resolution processes as well as reporting requirements to IDHW. This information will be reviewed in conjunction with all complaint and grievance information that has been directly received by the State to assure compliance with health and safety standards as well as other compliance requirements.

The purpose of the performance monitoring being implemented by the State is to: 1) determine the degree to which the state-funded programs and activities are accomplishing their goals and objectives; 2) provide measurements of program results and effectiveness; 3) evaluate efficiency in the allocation of resources; and 4) assess compliance with the contract, laws, and regulations. It is the intent of IDHW to use the performance indicators to not only monitor compliance with the contract elements indicated, but also to determine when substandard performance outcomes are subject to actual and liquidated damages. The State regularly monitors and reviews the data provided by the Contractor. Results of the review are shared with the Contractor to include the level of adherence to the contracted performance requirements. If substandard compliance issues are identified, the Contractor is required to submit a response to the State that describes how compliance will be achieved and quality improvement will be achieved. The State will continue working with the Contractor to achieve improvement efforts as described.

2. Quality and Performance Standards

- * The Contract requires the managed care entity to engage in ongoing quality assurance work that includes establishing a quality assurance committee, reporting on quality of care concerns and submitting plans for how the deficits in quality will be addressed.
- * The Contractor is required to adopt and implement practice guidelines and must ensure its provider network is informed of them and is trained to meet them.
- * The Contractor must produce Performance Improvement Projects annually and must adhere to the identified needed improvements.
- * The Contractor must maintain an Outcomes Assessment process and must establish processes for improving outcomes.
- * The Contractor must conduct participant and provider satisfaction surveys and must incorporate such feedback into its policies, procedures and operations.
- * The Contractor must report its performance annually to the State using standard measures provided by the State.
- * The Contractor must use industry-recognized methodologies to analyze quality assurance data such as Six Sigma.
- * The Contractor must monitor performance of its provider network and have a plan for improving the networks performance.
- * The Contractor must conduct utilization management activities and respond to over and under-utilization.
- * The Contractor must establish a compliance program and conduct surveillance activities for fraud and abuse issues and must report on these findings.
- * The Contractor must develop a Disaster Recovery Plan that describes how they will manage services in the event of a disaster.

3. Provider Selection Process

Idaho Medicaid must follow the State's formal procurement process to select the managed care provider. This involves publishing a request for proposal (RFP) on the Internet for worldwide solicitation of bids for proposals. The Contractor that submits the proposal that most closely meets all of the requirements defined in the RFP will be awarded the contract. The specific requirements are defined in the RFP, subsection 3.8, Business Information.

4. Criteria Used to Select the Provider Under the Waiver (with weights)

The proposals that are submitted in response to the RFP are evaluated according to the following weighted categories:

- * Business Information 240 points
- * Organizational and Staffing 80 points
- * Scope of Work 480 points

* Cost	200 points
* Total Points	1000

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:

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:

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

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 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 IBHP contract requires the Contractor to establish policies to ensure members have access to oral interpretive services that are available throughout the statewide provider network. The IBHP contract was amended to ensure oral interpretation services are offered to members free of charge and members are informed that oral interpretation is available in any language.

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

Please describe:

Program materials are provided to newly enrolled members when they receive Medicaid and periodically thereafter. They are instructed how to access customer service staff who can answer questions either face-to-face or by telephone. The handbook is also available on the website or by hard copy if they request it.

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 IBHP Contractor provides informational materials to members regarding the IBHP benefits and management. The State has collaborated with the Contractor to ensure the information contained in the member handbook, contractor website, and provider materials is accurate and current. The Contractor has committed to enhancing its efforts to fully educate members, families, providers, and other stakeholders about EPSDT services and processes for requesting services. Contract amendments were completed to ensure members are fully informed of language services and access to program staff who can address questions and explain IBHP benefits, in accordance with 42 CFR 438.10(c).

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 the Idaho Behavioral Health Plan 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.

Prior to the implementation of the approved IBHP waiver, the State notified all current eligible members, and mental health and substance use disorder providers enrolled under IDHW's current network of the following:

1. Creation of the Idaho Behavioral Health Plan;
2. An explanation of how the new managed care plan works; and
3. The Contractor's contact information: toll-free number, mailing address, and website.

Idaho Medicaid automatically enrolls eligible Medicaid beneficiaries on a mandatory basis into the PAHP under this waiver authority. IDHW provides general program information about the IBHP to stakeholders through the IDHW website and through publication and web posting of the Idaho Medicaid participant handbook and Idaho Medicaid provider handbook.

Program materials developed by the Contractor are reviewed and approved by IDHW prior to being distributed to enrolled members by the Contractor, as required in the contract.

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 IBHP contractor's grievance process offers one level of appeals. Reviews are conducted by a board-certified psychiatrist or addiction-medicine specialist employed by the contractor. An appellant must exhaust the contractor's grievance process before advancing to State fair hearing, compliant with the Managed Care Final Rule.

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:

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 participant, or person acting on behalf of the participant, must file a grievance within 60 days of the IBHP contractor's action. Once the grievance is resolved, or not decided within the specified time frame, the participant has exhausted the contractor's appeals process, and can then choose to request a fair hearing with the State directly.

Has time frames for resolving requests for review.

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

Grievance decisions must be made within 30 days of receipt. An expedited grievance review is done if the standard time frame could seriously jeopardize the participant's life or health or ability to attain, maintain, or regain maximum function. In such a case, a decision will be made no later than three business days after the request.

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 review process for appeals exists when it is determined that standard processing time could seriously jeopardize the participant's life, health or ability to attain, maintain, or regain maximum function. The Contractor must resolve each request for expedited appeal and provide notice within three (3) working days after the Contractor receives the appeal.

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:

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	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Accreditation for Participation	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Consumer Self-Report data	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Data Analysis (non-claims)	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Enrollee Hotlines	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Focused Studies	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Geographic mapping	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Independent Assessment	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
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
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

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
Profile Utilization by Provider Caseload	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Provider Self-Report Data	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Test 24/7 PCP Availability	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Utilization Review	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Other	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	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 PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP 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	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

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

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	PCCM FFS	PCCM FFS	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 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	Quality of Care
Accreditation for Non-duplication	MCO	MCO	MCO

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	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 FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP 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

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
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 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
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	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	FFS	FFS	FFS
Provider Self-Report Data	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Test 24/7 PCP Availability	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Utilization Review	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Other	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	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
IBHP	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 Behavioral Health 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

AAAHHC

Other

Please describe:

b.

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

Activity Details:

The State requires the Contractor to be accredited by a national accreditation agency and to maintain that accreditation throughout the contract term. This requirement is one of the prerequisites for a managed care entity to be eligible for the contract award.

PERSONNEL RESPONSIBLE: State Contract Monitor

DESCRIPTION OF ACTIVITY: State will review Contractor's initial and ongoing accreditation status and will review data regarding provider network management, and reports related to PAHP's coordination of services for members.

FREQUENCY OF USE: Annual

INFORMATION OBTAINED: Current accreditation of providers and accumulation of specialties throughout the statewide network. Data regarding the Contractor's established coordination of service activities related to each participant's treatment needs. Analysis of this information will contribute to the monitoring of the PAHP's overall program integrity.

NCQA

JCAHO

AAAHHC

Other

Please describe:

c.

Consumer Self-Report data

Activity Details:

The State requires the Contractor to utilize the CAHPS survey tools and guidelines to obtain input from participants and their families about their service quality. Per amended contract, the Contractor must report this data to the State both quarterly and annually.

PERSONNEL RESPONSIBLE: State Contract Monitor

DESCRIPTION OF ACTIVITY: The State will review CAHPS survey data and will use this information to monitor the participants' experience of the program, and identify service improvements that will be made to achieve greater participant satisfaction with the services, administration and operations of the IBHP.

FREQUENCY OF USE: Quarterly and Annually

INFORMATION OBTAINED: Participant self report data that reflects participants' experience with the program services, including coverage of needed services and overall quality of care, as well as timely access to such services.

CAHPS

Please identify which one(s):

"Health Plan Survey"

State-developed survey

Disenrollment survey

Consumer/beneficiary focus group

d.

Data Analysis (non-claims)

Activity Details:

The State requires the Contractor to submit monthly reports in order to demonstrate compliance with the contractual standards of timely access and complaint and grievance tracking. The reports identify and categorize all complaints received by the Contractor. Documentation of each complaint shall include: type of complaint, date received, description, tracking identification number, receipt method, Member name and ID number, provider name and ID number, provider specialty, staff assigned, date resolved, decision summary, either the number of days to resolve or the number of days pending at the end of the month. The report shall also include summary information for the complaints by category, description, count, average number of days pending and average number of days to resolve with subtotals and grand totals.

The grievance resolution and tracking report will identify all grievances resolved the previous month and those unresolved at month's end. The report shall list grievances by date received as either Level 1 or 2 and shall provide a description of each grievance, the date resolved, a description of the resolution or the state of a pending resolution, how the grievance was received, sufficient provider information to accurately identify the provider, staff name(s), days taken to resolve each grievance or number of days pending, percent of resolved grievances and whether or not the grievance was resolved prior to hearing.

PERSONNEL RESPONSIBLE: State Contract Monitor

DESCRIPTION OF ACTIVITY: The State will review reports submitted by the Contractor to determine compliance with standards and requirements identified in the contract regarding grievances and timely access to services

FREQUENCY OF USE: Monthly and Annually

INFORMATION OBTAINED: The State will analyze the data provided by the Contractor to measure the Contractor's compliance with contractual requirements specific to grievance procedures and timely access to services throughout the state.

Denials of referral requests

Disenrollment requests by enrollee

From plan

From PCP within plan

Grievances and appeals data

Other

Please describe:

e.

Enrollee Hotlines

Activity Details:

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:

The State will contract with or arrange for an entity to perform an independent assessment of the waiver. The entity shall be external to and independent of the IDHW and the contracted MCE.

PERSONNEL RESPONSIBLE: State Contract Monitor

DESCRIPTION OF ACTIVITY: The Independent Assessor will assess the components of the IBHP as designated by federal requirements in accordance with the Independent Assessment contractual agreement issued by the State.

FREQUENCY OF USE: Biennial

INFORMATION OBTAINED: The Independent Assessor will provide the State with a written report with an analysis of the management and administration of the PAHP with a focus on the identified waiver assurances regarding access to care and quality of care.

i.

Measure any Disparities by Racial or Ethnic Groups

Activity Details:

j.

Network Adequacy Assurance by Plan [Required for MCO/PIHP/PAHP]

Activity Details:

The State requires the Contractor to develop and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of participants in each service area.

PERSONNEL RESPONSIBLE: State Contract Monitor

DESCRIPTION OF ACTIVITY: The State will monitor provider development, including enrollment, selection, and maintenance of the network to specifically identify the capacity to deliver state plan services.

FREQUENCY OF USE: Annually

INFORMATION OBTAINED: The reports supplied by the Contractor must identify the enrollment of network providers in relation to their location in the state and ability to meet participants needs. The Contractor provides an annual report that identifies providers with expertise to deliver services to Members with developmental disabilities, non-English speaking members, crisis response, and other specialties as requested. This report will also quantify the number of qualified specialty providers for each area of expertise.

k.

Ombudsman

Activity Details:

l.

On-Site Review

Activity Details:

m.

Performance Improvement Projects [Required for MCO/PIHP]

Activity Details:

Clinical

Non-clinical

n.

Performance Measures [Required for MCO/PIHP]

Activity Details:

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:

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

Activity Details:

- q. Provider Self-Report Data**

Activity Details:

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 State requires the Contractor to adopt and implement utilization management practices sufficient to meet the needs of participants. The Contractor is specifically required to provide the State with this information via encounter claims submissions.

PERSONNEL RESPONSIBLE: State Contract Monitor

DESCRIPTION OF ACTIVITY: The State will monitor utilization of behavioral health services derived from analyses of encounter claims data.

FREQUENCY OF USE: Annual

INFORMATION OBTAINED: The State will obtain administrative claims data from the encounter claims submitted by the PAHP.

- t. Other**

Activity Details:

A. The following program areas are not included in the PAHP monitoring activities:

- 1. CHOICE:** Idaho Medicaid is requesting a waiver of section 1902(a)(23) regarding freedom of choice of qualified providers to establish a single statewide PAHP.
- 2. MARKETING:** The contract issued by the State indicates the contractor is not permitted to conduct direct or indirect marketing.
- 3. ENROLL/DISENROLL:** The State automatically enrolls Medicaid beneficiaries into the PAHP on a mandatory basis upon eligibility determination and does not allow disenrollment.

B. Information to Beneficiaries

The Contractor is required to develop program materials that are reviewed and approved by the State prior to the Contractor distributing the behavioral health services program information to participants.

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:

Accreditation for Participation: Idaho confirmed the Contractor maintains NCQA full accreditation status under the parent company of United Behavioral Health.

Consumer Self-Report Data: The Contractor conducts quarterly surveys to obtain satisfaction information from members. The Optum survey tools are provided in written format and are available to access online as well. Overall satisfaction ratings have increased from 79.2% in 2017 to an average 89% in years 2018 through 2021.

Data Analysis: Idaho monitors timely access and the Contractor's process for documenting/resolving complaints and grievances (Optum refers to appeals as "grievances"). The volume of quality-related grievances has reduced significantly over the life of the waiver.

Monthly reporting of grievance activity has demonstrated the effectiveness of the Contractor's management and tracking of service authorization appeals. Compliance Reviews showed the contractor demonstrated 100 percent compliance with the requirements reviewed within the grievances standard.

Independent Assessment: Idaho utilized its EQRO contractor, Telligen, to complete the work identified in the CMS Guidance document for Independent Assessments. Their report is being sent under separate cover to the RO as part of this submission.

Network Adequacy Assurance: Idaho has monitored the Contractor's development of its provider network for sufficiency in number, mix, and geographic distribution. We confirm by reports the increased number of providers for all provider types in IBHP since implementation. According to the 2021 Independent Assessment report, Telligen confirms by reports the increased number of providers for all provider types in IBHP since implementation. The current data reveals an adequate network well within industry standards and contract obligations. The data demonstrates an average of 98.2% access for Area 2 counties (rural and frontier), and an average of 99.7% access for Area 1 counties (urban). Idaho is expanding monitoring in this area. The Contractor measures access through the geo-mapping application, which relies on a radius measure between locations rather than a true measure of navigable distance via public access streets and roads. The State continues to recognize access gaps in frontier counties and continues to work in collaboration with the Contractor for innovative solutions to serve these counties.

Utilization Review: Idaho required the Contractor to have a system to conduct utilization management, program integrity, and compliance reporting activities. The Contractor complied with monthly reporting for most areas identified in the contract. Encounter data has been submitted on a monthly basis by the Contractor.

The contractor has standards in place to prevent a conflict of interest when reviews are being conducted. They have policy and procedures in place to direct the ongoing quality and monitoring of providers. Their Provider Quality Specialist who conducts reviews is a different person than the Provider Network Specialist who works with the providers. The state reviews contractor reports on all services and works with provider organizations and other stakeholders on contract and service issues. The state also reviews the contractor's criteria and complaint reports for all services.

Other:

1. CHOICE: Freedom of choice waiver was requested in the initial waiver application as the State has established a single statewide PAHP. Members are allowed to choose from network-enrolled service providers.
2. MARKETING: The IBHP contract does not permit the Contractor to conduct direct or indirect marketing.
3. ENROLL/DISENROLL: The State automatically enrolls Medicaid beneficiaries into the PAHP on a mandatory basis upon eligibility determination and does not allow disenrollment.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Duals	
Expansion	
Non-duals	
MCHIP Non-Duals 64.21U Waiver	

	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	
Treatment Planning				
Screening, Evaluation and Diagnostic Assessments (includes Occupational Therapy assessments)				
Partial Care Treatment				
Psychotherapy (Individual, Group and Family)				
Drug Screening				
Behavioral Health Nursing				
Pharmacologic Management				
Psychological and Neuropsychological Testing				
Community-based Rehabilitation Services				
Occupational Therapy				
Case Management				
Community Crisis Intervention				
Respite				
Intensive Outpatient Program				
Peer Support				
Psychoeducation				
Partial Hospitalization				

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:

State Medicaid Director or Designee

Submission Date:

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:

c. Telephone Number:

d. E-mail:

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:

IBHP is a risk-based single-statewide PAHP established through a competitive procurement process to administer outpatient behavioral health services by establishing and managing a statewide network of behavioral health service providers.

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 State of Idaho forecasts caseload by month for several program components. The member month projections reflect these anticipated changes in total beneficiary enrollment. We assume that the comparable populations continue as the same proportion to the projected totals.

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

There is no additional variance in eligible member months. There is a current decrease projected in P1, which is accounting for the MOE as a result of the Public Health Emergency. After P1 there are no additional variances.

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

Other: R1 = 10/01/2018 - 9/30/2019
R2 = 10/01/2019 - 9/30/2020
This is based on the Federal Fiscal Year.

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:

There are no changes to the Outpatient Behavioral Health Services.

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.

There are no members receiving outpatient behavioral health services through any other waiver program in Idaho. SSA 1915(i) SED services (respite) are included in D2.S, and are calculated into the CE projections similar to all other services.

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
Treatment Planning							
Screening, Evaluation and Diagnostic Assessments (includes Occupational Therapy assessments)							
Partial Care Treatment							
Psychotherapy (Individual, Group and Family)							
Drug Screening							
Behavioral Health Nursing							
Pharmacologic Management							
Psychological and Neuropsychological Testing							
Community-based Rehabilitation Services							
Occupational Therapy							
Case Management							
Community Crisis Intervention							
Respite							
Intensive Outpatient Program							
Peer Support							
Psychoeducation							
Partial Hospitalization							

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:

Idaho reports actual personnel and personnel benefits costs.

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.**

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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:

Please document how that trend was calculated:

The trend was calculated using estimates for overall Idaho Department of Health and Welfare aggregate benefit expenditures for all fee for service programs. We aligned the aggregate benefit expenditures by month with the enrollment forecast to develop aggregate per member per month (PMPM) amounts of benefit expense. The percentage of 3.9% in the PMPM was used to determine the trend for all program expenditures which is assumed to be a reasonable proxy for the services included in the waiver. We do show a negative enrollment percentage in P1, as it correlates with the end of the PHE. After P1 we show a consistent trend line that is reasonable when reviewing our enrollment data and forecast.

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.

Projected costs for P1 through P5 were based on a linear forecast trend as it relates to Medicaid-eligible members. That forecast methodology was applied to the eligible member counts of R2 and projected forward.

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:

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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:

Administrative costs decrease year over year in the cost-effectiveness workbook; however, the administrative costs included in the PMPM in the aggregate will go up as the utilization increases.

- 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

Trend rate of 0% for three MEGs.

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.

See attached spreadsheet

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.

See attached spreadsheet

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