Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Montana** 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	
Passport	Passport to Health	PCCM;	
Team Care	Team Care	PCCM;	
THIP	Tribal Health Improvement Program	PCCM;	

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

Passport to Health waiver renewal

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):

Sections A,B,C and D. Nurse First is removed per SPA 22-0005 due to loss of current contractor and increasing availability of telehealth services. Montana has revised the waiver application to reflect the appropriate component programs of Passport to Health, Team Care, and the Tribal Health Improvement Program. Revised cost effectiveness prospective and retrospective data and accompanying Section D narrative to reflect Nurse First ending on 4/1/22, drug rebate reporting, and changes to expenditures and member months due to removing non-waiver programs, Patient Centered Medical Home (PCMH) and Comprehensive Primary Care Plus (CPC+).

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:MT.020.05.00

Waiver Number:MT.0002.R05.00

D. Effective Dates: This renewal is requested for a period of 2 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)

07/01/22

Proposed End Date:06/30/24

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:

Mary Eve Kulawik

Phone: (406) 444-2584 **Ext:** ☐ **TTY**

Fax: (406) 444-1970

E-mail:

mkulawik@mt.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:

☐ **Passport to Health**

☐ **Team Care**

☐ **Tribal Health Improvement Program**

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

Section A: Program Description

Part I: Program Overview

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

The State of Montana sent a Tribal Consultation notice to each Tribe on 05/26/2021, Indian Health Service, Tribal Health, and Urban Indian Center in Montana to invite comment on the waiver renewal. The State provided information on the programs and direction on how to make comments, suggestions, or request more information regarding the waiver. In addition, the Passport Waiver was discussed at the virtual tribal consultation meeting held May 18-19th, 2021. The Fort Peck tribe commented in a letter of support that it would be nice if the state would tie the T-HIP fixed fees to the inflation factor for the Indian Health Service prospective payment fee, thus allowing an increase in the T-HIP fees.

See Attachment A: Tribal Consultation Letter and Attachment B: Letter of Support

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).

Passport to Health Program
Passport to Health (Passport) is Montana Medicaid's Primary Care Case Management (PCCM) program. Members enrolled in Passport have a designated primary care provider (PCP) that coordinates the member's care and provides referrals to other providers when necessary. Passport has been in operation since January of 1993. In 2009, Passport added the Children's Health Insurance Program (CHIP) expansion population. In 2018, Passport added the Health and Economic Livelihood Partnership (HELP) Act new Medicaid state plan adult population. Passport serves all Montana Counties. In the 2018 waiver amendment pregnancy Medicaid and the Breast Cervical Cancer populations where removed from the Passport, and Team Care, care management programs. Revised the per member per month (PMPM) for all the Passport eligible populations except those determined categorically eligible for Aged, Blind, Disabled, and Medically Frail Medicaid from $3 to $1. The Health Improvement Program (HIP) was removed from the 1915(b) waiver. The 2019 renewal updated the member survey name.
See Attachment B: Passport to Health Provider Agreement

Team Care is a sub-program of Passport, which has been in operation since 2004. Members enrolled in Team Care are restricted from changing their PCP without good cause and are restricted to one pharmacy. Enrollment in Team Care is based on utilization that is found to be excessive, inappropriate or fraudulent with respect to need. Passport members can be referred to Team Care by Drug Utilization Review Clinical Case Managers, claims data mining, Tribal Health Improvement Program (THIP) Care Managers, or by PCPs. In the 2018 waiver amendment pregnancy Medicaid and the Breast Cervical Cancer populations were removed for the Passport, and Team Care, care management programs.

The Tribal HIP program was created in April 2017 as a partnership between the Tribal, State and Federal government to address factors that contribute to health disparities in American Indians eligible for Medicaid residing on a reservation. The Tribal HIP program is operated through federally recognized tribes in Montana who receive an enhanced care management fee. The 2018 amendment included updates (tagged) to the THIP language to include all American Indians eligible for Medicaid and residing on a reservation in the THIP program.

See Attachment Q: Tribal HIP Task Order

Nurse First Program
Montana operated the Nurse Advice Line (NAL), Nurse First, since 2004. Members call Nurse First for free advice 24 hours a day. Nurse First is available to all eligible Medicaid and CHIP members. Registered Nurses, licensed in the State of Montana, provide triage and treatment recommendations for injuries and health conditions. Nurse First also provides general health information about diseases, treatments, and medications. After each call, Nurse First faxes a description of the member's concern to the member's primary care provider, if the member is enrolled in Passport. This program ended 4/1/2022.

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*
      - ☒ **THIP**
      - ☒ **Team Care**
      - ☒ **Passport**
    - **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*
      - ☒ **THIP**

☒ **Team Care**

☒ **Passport**

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*

☐ **THIP**

☐ **Team Care**

☐ **Passport**

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*

☒ **THIP**

☒ **Team Care**

☒ **Passport**

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

☐ **MCO**

☐ **PIHP**

☐ **PAHP**

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

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

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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

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

☒ **THIP**

☐ **Team Care**

☐ **Passport**

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*

☒ **THIP**

☒ **Team Care**

☒ **Passport**

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*

☒ **THIP**

☒ **Team Care**

☒ **Passport**

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*

☐ **THIP**

☐ **Team Care**

☐ **Passport**

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*

☐ **THIP**

☐ **Team Care**

☐ **Passport**

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:

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:

Narrative description of our delivery system model, PCCM:

Passport to Health
Passport is Montana Medicaid's PCCM program. With Passport, Medicaid members who are eligible for Passport choose a PCP to see when they are sick, hurt, or need preventative, and primary care. Passport establishes a Medical Home that encourages a strong and continuous patient-provider relationship that promotes accessible, comprehensive, coordinated, and culturally-sensitive care. Providers sign a Passport agreement in which they consent to: provide primary care, treatment of illness or injury and preventative care services; educate members about self-referrals and appropriate use of emergency services; provide direction for emergency care 24/7; maintain a unified patient record; and provide medically necessary referrals for services they cannot provide. For these additional services to Passport members, providers receive a PMPM fee for each member on their Passport caseload. Members also receive outreach materials from the State, which include information about health care, well-child exams,immunization schedules, transportation opportunities, and billing rules.

With Passport, most specialty services require a referral from the PCP. Passport providers are assigned a unique referral number. When a provider refers a member who is on their Passport caseload for a specialty service, they relay their Passport number to the specialty provider. The Passport referral number must be present on the claim or the claim will deny. This ensures referrals are made by PCPs and they are aware of the services their Passport members are receiving.
See Attachment B: Passport to Health Provider Agreement

Team Care
Team Care is a companion program of Passport designed to educate members how to appropriately and effectively access medical care. Enrollment in Team Care is based on utilization of services. Members can be referred by Drug Utilization Review Clinical Case Managers, PCPs, pharmacists, hospitals, THIP Care Managers, or from claims data mining. Team Care follows the same Passport rules and guidelines for referrals and enrollment/disenrollment. However, members enrolled in Team Care are restricted from changing their PCP without good cause and are restricted to one pharmacy.

Tribal HIP is a three-tiered program. Tribes may choose the level in which they wish to participate. Tier 1 of Tribal HIP focuses on the services listed below. Tiers 2 and 3 address specific health focus areas that contribute to health disparities. Tier 2 and 3 activities focus on improving the health of a population rather than focusing on an individual member. Health focus areas for tiers 2 and 3 of Tribal HIP must be agreed upon by both the Tribe and the Department.

Tribal HIP services may include:
• Conducting member outreach to 10% of eligible members with the highest risk scores;
• Working with eligible members to develop care plans that address the member’s high risk and/or high cost health care needs;
• Educating members in self-management of their high risk and/or high cost condition;
• Providing pre-admission and post-discharge care coordination for out of state hospital referrals;
• Utilizing the Department's predictive modeling software to identify members needing preventive/screening services and medical visits;
• Developing community partnerships with health care providers and other community resources; and
• Referring members to available local resources that can assist with social services, housing, and other needs.

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.

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

Program: " **Tribal Health Improvement Program.** *"*

☐ **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

The Tribal HIP program is voluntary.

Tribal HIP Program
Enhanced PCCM (EPCCM) provides additional services using care managers including health assessments, care planning, care coordination, self-management education, health coaching, health status monitoring, and pre- and post-discharge planning for Passport eligible members. Passport eligible members are enrolled, but have the ability to not participate and be in an on demand status or opt out of the program entirely. The goal of the program is to address factors that contribute to health disparities in the American Indian population eligible for Medicaid and residing on a reservation.

Program: " **Team Care.** *"*

☐ **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

Program: " **Passport to Health.** *"*

☐ **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)):

The State will apply the rural exception in all areas statewide except for the counties of Missoula, Cascade, Golden Valley, Yellowstone, and Carbon.

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:

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*

  ☐ **THIP**

  ☒ **Team Care**

  ☒ **Passport**

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

☒ **THIP**

☐ **Team Care**

☐ **Passport**

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	PCCM/EPCCM	
Blackfeet Reservation located in Glacier and Pondera counties	EPCCM	T-HIP
Confederated Salish and Kootenai Reservation in Lake and Sanders counties	EPCCM	T-HIP
Fort Belknap Reservation in Blaine and Phillips counties	EPCCM	T-HIP
Fort Peck Reservation located in Roosevelt, Daniels and Valley Counties	EPCCM	T-HIP
Northern Cheyenne Reservation located in Big Horn and Rosebud counties	EPCCM	T-HIP
Chippewa Cree Reservation located in Hill and Chouteau counties	EPCCM	T-HIP

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):

Individuals ages 19 through 64 who are eligible in the new adult group under the state plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, and 42 CFR 435.119.

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):

Medically needy members with a spend down, members who are unable to find a PCP who is willing to provide case management, eligible for a non-Medicaid plan with a non-Medicaid participating primary care provider in their primary plan, receiving Medicaid under presumptive eligibility, members participating the the Family Planning Waiver, members eligible for the Breast and Cervical Cancer program, and members residing out of state or in a PRTF.

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:

Members eligible for the PCCM program are also eligible for EPCCM program. The PCCM (Passport) program is the basis of our attribution model and how members are determined eligible for our EPCCM programs.

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):

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):

The State will pay for covered family planning services furnished by enrolled Medicaid providers through the state plan.

☐ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

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:

Enrollees can choose any FQHC in the state of Montana as their Passport provider. All FQHCs are participating Passport providers.

☐ 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):

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:

Passport members can self-refer without Passport referral to any Montana Medicaid provider for the following services:

- Ambulance
- Anesthesiology
- Audiology
- Blood lead testing
- Dental
- Dialysis
- Dialysis Attendant
- Drug/Alcohol outpatient treatment
- Durable medical equipment
- Emergency Services
- Eye exams
- Eyeglasses
- Family planning
- Hearing aids
- Hearing exams
- Home & Community Based Waiver services
- Home infusion therapy
- Home support services and therapeutic foster care
- Hospice
- Hospital swing bed
- Immunizations
- Indian Health Service clinic
- Inpatient lab and x-ray
- Inpatient professional services
- Intermediate care facilities
- Institution for mental disease
- Laboratory/pathology tests
- Licensed social workers
- Licensed professional counselors
- Mental health centers
- Nursing facilities
- Obstetrical services (inpatient and outpatient)
- Optometry or ophthalmologist services
- Personal assistance
- Pharmacy (excluding Team Care members)
- Psychiatric residential treatment facility
- Psychiatrists
- Psychologists
- School-based
- STD (Sexually Transmitted Diseases) testing & treatment
- Substance Abuse services
- Targeted case management
- Transportation (commercial and specialized non-emergency)

Services listed above are subject to prior authorization requirements.

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

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

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. ☒ PCPs

Please describe:

PCCM providers must provide or arrange for suitable coverage for needed services, consultation, and approval or denial of referrals during posted normal business hours. PCCM providers must also provide direction to members in need of emergency care 24 hours a day.

The State monitors provider availability through the Member Help Line and member surveys.

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:

The State has not established standards for in-office wait times for our PCCM program; however, we do monitor for any problems through the Member Help Line and CAHPS surveys.

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**

Passport providers provide 24/7 direction to members on how to access the care they need. After hours direction is provided by an answering service, call forwarding, provider-on-call coverage, or answering machine message. The State performs audits of providers' 24/7 direction.

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:

Full explanation of Availability Standards from A. Timely Access Standards (2 of 7)

Montana is a rural, frontier state characterized in the east by sparsely populated plains and in the west by small clusters of populations separated by mountain ranges. Given the diversity in geography and population density, Montana does not use a single distance and/or travel time to gauge access. Instead, a variety of means, like member surveys and network adequacy reports determine whether Passport primary care providers are available in the normal service delivery area for each town or region. In a frontier state like Montana, this case-by-case approach is more meaningful to members who are accustomed to living, and often choose to live, extended distances from services.

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:

Each provider can select their own limit. The enrollment system has a mechanism to disallow the voluntary enrollment with any provider that has exceeded their limit. If it is noted that a provider has reached their limit and has members requesting them as a PCP, the provider is asked to increase their selected limit.

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

Please describe the States standard:

The State monitors potential provider access issues monthly with our network adequacy report. To date there have been no issues with access to PCPs in the State.

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:

The State reviews the network adequacy report monthly to ensure all participating counties have an adequate number of PCPs to ensure access to Medicaid members. To date there have been no issues concerning access in the state.

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	
FQHCs and RHCs	**0**	**119**	**124**	
Family Practitioners	**0**	**441**	**428**	
General Practitioners	**0**	**126**	**116**	
Indian Health Service Clinics		**7**	**8**	
Internists	**0**	**151**	**152**	
OB/GYN	**0**	**26**	**22**	
Other	**0**	**478**	**492**	
Pediatrician	**0**	**117**	**116**	

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

This listing is for the entire state. "Other" category is for specialists and sub-specialists. Montana's rural/frontier nature results in a limited number of specialists and sub-specialists throughout the state. The total number of practitioners is higher than listed above since FQHCs and IHSs are not required to list linked providers. No IHSs list providers; FQHCs sometimes list providers.

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

Please describe the States standard:

The State attempts to outreach and bring on all potential Passport providers, focusing efforts in areas where we see the greatest need. The monthly Network Adequacy Report lists all counties and the ratios of providers to members. Montana is a frontier state with limited providers. This limitation is not unique to Passport/Medicaid members.

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	
Beaverhead County	**1:79**	
Big Horn County	**1:302**	
Blaine County	**1:296**	
Broadwater County	**1:124**	
Carbon County	**1:162**	
Carter County	**1:46**	
Cascade County	**1:181**	
Choteau County	**1:81**	
Custer County	**1:65**	
Daniels County	**1:59**	
Dawson County	**1:146**	
Deer Lodge County	**1:103**	
Fallon County	**1:83**	
Fergus County	**1:90**	
Flathead County	**1:153**	
Gallatin County	**1:111**	
Garfield County	**1:90**	
Glacier County	**1:570**	
Golden Valley County	**0:245**	
Granite County	**1:225**	
Hill County	**1:369**	
Jefferson County	**1:193**	
Judith Basin County	**0:381**	
Lake County	**1:232**	
Lewis and Clark County	**1:149**	
Liberty County	**1:127**	
Lincoln County	**1:222**	
Madison County	**1:70**	
McCone County	**1:100**	
Meagher County	**1:107**	
Mineral County	**1:185**	
Missoula County	**1:169**	
Musselshell County	**1:227**	
Park County	**1:121**	
Petroleum County	**0:79**	
Phillips County	**1:368**	
Pondera County	**1:295**	
Powder River County	**1:63**	
Powell County	**1:231**	
Prairie County	**1:92**	
Ravalli County	**1:215**	
Richland County	**1:99**	
Roosevelt County	**1:404**	
Rosebud County	**1:239**	

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	
Sanders County	1:243	
Sheridan County	1:58	
Silver Bow County	1:214	
Statewide Average	1:164	
Stillwater County	1:143	
Sweetgrass County	1:507	
Teton County	1:171	
Toole County	1:210	
Treasure County	1:150	
Valley County	1:145	
Wheatland County	1:158	
Wibaux County	1:107	
Yellowstone County	1:175	

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

g. ☒ **Other capacity standards**.

Please describe:

Total number of practitioners is higher since FQHCs and IHSs are not required to list linked providers. No IHSs list providers; FQHCs sometimes list providers.

The large change in the number of FQHCs and RHCs from the previous waiver number of 151 and 328 is due to FQHCs transitioning to the PCMH program. The growth expected is attributed to group clinics transitioning to an RHC.

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:

Full explanation of description of enrollment limits and how each is determined from B. Capacity Standards (2 of 6):

Each provider can select their own limit. The enrollment system has a mechanism in place to disallow the voluntary enrollment for any provider to exceed their preselected limit. Providers who have reached their limit will be provided the opportunity to increase their limit.

Caseload limits are monitored monthly through the network adequacy report. Providers are sent letters or called to ask about increasing the selected limits. If it is noted that a provider has reached their limit and is having several members requesting him/her as PCP, a letter or phone call is made asking the provider to increase the selected limit.

Section A: Program Description

Part II: Access

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

Section A: Program Description

Part II: Access

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

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

The following items are required.

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

Please provide justification for this determination:

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

Please describe:

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:

Passport members receive information about the Passport program from the Member Help Line, Passport mailings, and an online tutorial. In the month preceding a child's birthday, parents are sent a letter, which includes an age-appropriate immunization magnet reminding them that Medicaid covers well-child visits and dental visits.

Members in the Tribal EPCCM program receive education and health care information from their Nurse Care Manager, Health Coach, or PCP that is specific to their health status, current medical condition, and/or identified need in their treatment/care plan. The information is given to the member by a variety of methods: direct contact with health center staff, mailings, and care support pages.

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.

Passport providers agree to provide case management of their members' care within a Medical Home. Members are referred by their PCPs for medical services that the primary care provider determines are necessary but cannot provide directly. The primary care provider is required to document all referrals in the member's record or in a log book. The referral to the specialist or treating provider can be verbal or written.

The Tribal EPCCM program provides additional services by care managers including patient assessments, care planning, care coordination, self-management education, health coaching, health status monitoring, and pre- and post-discharge planning and health education.

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.

Referrals are either verbal or written. Passport does not require that the primary care provider complete a written referral form. The primary care provider, must however, document the referral into the member's medical record or a log book. The provider receiving the referral is also required to document the referral. It is expected, as standard healthcare practices, that the referred to provider will notify the PCP of the results of any referral.

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.

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

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

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

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

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

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

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

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

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

• Access and Adequacy: Monitored on an ongoing basis via the Network Adequacy Report, Provider Type Report, Member Survey, Complaints, Fair Hearing Requests, 24-Hour Call Log Report, Provider and Member Enrollment Change Reports. For details on the results of this monitoring see Section B.

• Member Satisfaction: In the previous waiver period, the State measured Member Satisfaction. This is monitored indirectly through the Provider and Member Enrollment Change Reports. It is monitored directly through the following means:

• CAHPS Surveys: The State contracts with a certified contractor to conduct a CAHPS 5.0 survey for Medicaid adults and a CAHPS 5.0 children's survey for Medicaid enrolled children. For details on the results of this monitoring see Section B.

• Complaint and Grievance: Members are made aware of the complaint and grievance process and their right to a fair hearing in the Montana Medicaid/Health Montana Kids Plus Member Guide. For provider or program specific complaints, members are directed to call the Member Help Line operated by the enrollment broker.

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:

Our enrollment broker performs outreach to potential Passport providers and helps them complete the necessary enrollment paperwork.

Enrolled Montana Medicaid physicians, nurse practitioners, physician assistant; FQHCs, RHCs, or IHS providers who provide primary care are eligible to enroll in Passport and additionally agree to offer suitable coverage during posted office hours, give direction to members for emergent care 24/7, offer comprehensive medical services including preventative care, follow policies for facilitation of enrollment/disenrollment of members, agree to provisions in the Passport Agreement and the Passport to Health Provider Manual, provide case management services in accordance with the Passport agreement, maintain a unified patient record for each Passport member, and document member referrals.

See Attachment G: Passport to Health Provider Manual

The EPCCM program contracts with 6 Tribal governments. THIP providers agree to conduct health assessments, care planning, care coordination, self-management and health education, health status monitoring, and provide pre and post hospital discharge planning.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Added detail on two methods (member mail survey and complaint and grievance procedures) of monitoring member satisfaction:

• Member mail surveys: Montana Medicaid contracts with a National Committee for Quality Assurance certified contractor to conduct annual CAHPS 5.0 surveys for Medicaid-enrolled adults and children. This allows the Montana Medicaid program to monitor patient experience of care.

• Complaint and Grievance: Members are made aware of the complaint and grievance process and their right to a fair hearing in the Montana Medicaid/Healthy Montana Kids Plus Member Guide. For provider or program specific complaints, members are directed to call the Medicaid Member Help Line operated by the enrollment broker. The enrollment broker fills out the complaint form while on the phone with the member. Once completed the staff review it with the member to make sure the information is accurate. The complaint is forwarded to administrative staff at the State and recorded in a shared, password protected spreadsheet. The complaint is then forwarded to the appropriate program officer who investigates the matter. Investigation may include contacting the member, contacting a provider, researching the Administrative Rules of Montana or Montana Code Annotated, looking at claims, etc. A letter is sent to the member and sometimes the provider explaining the results of the investigation, any action taken by the State and any action required on the part of the member and/or provider. Copies of letters and investigatory materials are forwarded to administrative staff who are responsible for receiving all complaints and the spreadsheet is updated with findings. The member and/or provider are encouraged to follow-up if they have questions or concerns about the findings. If the findings are not in favor of the provider or member and they wish to pursue the matter further, they are informed about the fair hearings process.

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:

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):

The State has no prevalent languages other than English. Montana has very few non-English speaking groups, none of which comprise 10% of the population. We are prepared to translate materials if there is a need. To date, we have provided one blind member a voice recorded copy of the Medicaid/Health Montana Kids Plus Member Guide to listen to through their computer.

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 10.00 percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

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

Translators are available at no charge to members who need translator services during the eligibility determination process or during the receipt of medical services.

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

Please describe:

Enrollees or potential enrollees can access translators (including sign-language) to assist them in communicating in order to understand the program. Providers, eligibility specialists, and our enrollment broker and State staff can access translator services in order to explain the program to non-English speaking and hearing impaired members.

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:

Information on the Passport and Team Care are distributed by the State, medical providers, the enrollment broker, and Tribal Health Improvement Program providers. Potential enrollees access information through the Office of Public Assistance (OPA) and through program guides, direct mailings, and outreach telephone calls.

☐ 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 enrollment broker mails program materials and performs outreach calls to enrollees. The State provides materials as requested or needed based on escalated correspondences with enrollees.

☒ 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:

Description of mechanism in place to help enrollees and potential enrollees understand the managed care program including additional information:

Enrollees or potential enrollees can access translators (including sign-language) to assist them in communicating in order to understand the program. Providers, eligibility specialists, the enrollment broker, and State staff can access translator services in order to explain the program to non-English speaking members. Montana has no prevalent languages other than English. Providing translator services is an efficient mechanism to address the limited prevalence of non-English languages.

How information is distributed to potential enrollees and enrollees including additional information:

Passport to Health
The enrollment process for Passport starts with Medicaid eligibility conducted at the Office of Public Assistance (OPA).

Members receive a letter from the OPA when Medicaid eligibility is determined. The data for Medicaid eligible members is then sent to the enrollment broker who determines Passport eligibility. Passport eligible members are sent a welcome packet with enrollment information and receive an outreach call that provides Medicaid and Passport information. Members are directed to locate additional information on the web through program mailings, or request hard copies of the information through the enrollment broker.

Team Care Program
Members are notified of enrollment in the Team Care program through a welcome letter that includes an explanation of the program and the members appeal rights. Members also receive a Team Care Handbook.

Tribal Health Improvement Program
The Tribal government makes direct contact with American Indian members residing on a reservation selected as high risk, high cost through predictive modeling for care management. They contact members initially by letter followed by up a telephone attempt. Members are given all of the information about THIP, both in writing and by telephone when contacted by the Tribal governments.

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 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:

Passport to Health
The enrollment broker promotes the program with outreach materials and calls. When a member is deemed Passport eligible, the enrollment broker sends a Welcome to Passport packet. This packet includes: a letter explaining the Passport Program; information on how to enroll with a provider by phone, mail or on the web. The packet also includes a list of ten PCPs members can choose from (members are told they can choose a PCP who is not on the list as long as the PCP is a Passport provider). The first provider on the list is the provider the member will be assigned to if they do not choose a provider. This provider is system generated using an algorithm which looks at, in the order listed: the member's previous Passport enrollment, claims history, family enrollment, tribal enrollment (if tribally enrolled the provider will be IHS) and random assignment based on geographic area. The other nine providers on the list are the closest within a fifty mile radius of the members address. After a member has received outreach materials by mail, the enrollment broker attempts to contact the member by phone. During the call, the Passport program is explained in detail and the member is given an opportunity to ask questions and choose a provider over the phone. If a member has not enrolled with a PCP 30 days after they were sent the initial outreach materials, they will receive a final letter encouraging them to voluntarily enroll with a provider, or have one chosen for them.

Children enrolled in Passport receive a letter from the enrollment broker the month preceding their birthday reminding their parents that Medicaid pays for Well-Child check-ups, and explaining what the exams may entail. Each family also receives an immunization schedule magnet.

Passport program staff participate in provider trainings in conjunction with Conduent. Staff also coordinate trainings for specific providers or groups as necessary. Staff participate in quarterly WebEx member trainings. Program staff regularly write articles with Passport updates for the Claim Jumper, the monthly Medicaid provider newsletter, the Montana Medicaid and Health Montana Kids Plus Messenger, the quarterly Medicaid member newsletter. Staff regularly update print and web-based member and provider information.
See Attachment F: Health Education Materials
Attachment I: Passport Outreach Materials

Team Care
Members enrolled in Team Care receive a letter of explanation, Team Care handbook, and a 345-page self-care guide. Drug Utilization Review (DUR) case managers in the Medicaid Pharmacy Program speak with PCPs and pharmacies about individual members who may be appropriate for Team Care.

See Attachment J: Team Care Outreach Materials

Tribal HIP Program
Members are auto-enrolled to a Tribal government based on geographic area. This network of Tribal governments who provide enhanced PCCM services will make two attempts for to engage members recommended by the State.

Member Outreach/Enrollment Process:

Day 1 Receive member file from member eligibility system (CHIMES) and identify Passport eligible members.
Day 1-2 Send Member Welcome Letter and Enrollment Packet.
Day 5-10 1st Outreach/Enrollment Call or Attempt.
Day 10-15 2nd Outreach/Enrollment Call or Attempt.
Day 15 Send Member Reminder Letter if not yet enrolled.
Day 16-30 3rd Outreach/Enrollment Call or Attempt.
Day 30 Mail the Intent to Default or Automatic Assign Letter (This event occurs once per month on the 11th or next business day of the month).
Day 30-40 Outreach/Enrollment Call or Attempt to members that have been assigned.
Day 40 Enrollments uploaded to MMIS (Cutoff Day).
Day 47-48 Beginning of next month - Enrollments take effect on the 1st of the new month.

*Note: In order to ensure that members have sufficient time to choose a provider and voluntarily enroll with

that provider, the enrollment broker allows a minimum of 45 days from the time a person is deemed eligible for managed care before assignment. The monthly "cut-off date" occurs the sixth to the last business day of every month. If a member has been on managed care within the past two months, the individual is reinstated with their previous PCP.

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: Conduent

Please list the functions that the contractor will perform:

☒ choice counseling

☒ enrollment

☒ other

Please describe:

The enrollment broker enrolls members into the Passport program. Medicaid members may choose a provider from a list provided by the enrollment broker or pick another Passport provider of their choice. Members have 45 days to choose a provider. Members that do not choose are auto-enrolled based on an auto-assignment algorithm described in the next section. The contractor's duties also include maintaining the Medicaid Member Help Line. Members may call the Medicaid Member Help Line for questions unrelated to Passport. The contractor's duties include providing general Medicaid information and phone referrals to other entities as necessary. Also included in the enrollment function is exemption processing.

☐ 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 45 days ◉ **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:

Passport auto-assigns members to a provider if they have not chosen one, 60 days or more after the first outreach attempt. The auto-assignment algorithm is intended to choose the best suited PCP for a member. The system assigns by the following criteria (in this order), previous Passport enrollment, most recent claims history, case (family) Passport assignment(s); Native Americans will be assigned to an IHS if one is within 50 miles; and random based on geographic area.

The Tribal HIP program auto-enrolls members to a Tribal government based on geographic area. This EPCCM provides additional services including health assessments, care planning, care coordination, self-management education, health coaching, health status monitoring, and hospital pre/post-discharge planning for Passport eligible members. Passport eligible members are enrolled, with the ability to not participate and be in an on demand status or opt out of the programs entirely. The goal of the program is to address factors that contribute to health disparities in the Medicaid American Indian population.

☐ 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:

1. Third Party Liability (TPL): Members must submit documentation showing they are enrolled in a comparable managed care program;
2. Treatment center: Auto-exemption written into MMIS;
3. Provider choice errors;
4. Provider leaves without 30 day notice;
5. Provider refuses to see patient or give referrals;
6. NICU or ICU cases: The enrollment broker can grant a medical exemption without elevating to the State;
7. Unable to find a PCP willing to provide case management;
8. Residing in a county in which there are not enough PCPs to serve the Passport population; and
9. State granted medical hardship. The exemption process consists of the member/agent, requesting a written exemption. The State reviews the exemption request on a case-by-case basis. An exemption is granted for a period of time that accommodates the individual member. Exemptions are typically granted for 3 months to 6 months.

☒ 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

Per clarification from CMS and Thompson-Reuters, the request should read" Please describe the reasons for which an entity (PCCM) can disenroll an enrollee".

A provider can disenroll a Passport or Team Care enrollee for the following reasons:
The provider-patient relationship is mutually unacceptable;
Member has not established care;
The member fails to follow prescribed treatment;
The member is abusive;
The member could be better treated by a different type of provider, and a referral process is not feasible; and
Member consistently fails to show up for appointments.

A provider cannot disenroll a Passport or Team Care member for the following reasons:
Because of an adverse change in the enrollees health status;
Member's utilization of medical services;
Member's diminished mental capacity;
Disruptive behavior as a result of the member's special needs. The exception is if enrollment seriously impairs the PCP's ability to furnish care to the member or other members. If this is the case,
disenrollment must be approved by the Passport program officer;
Any reason that may be considered discrimination; and
Failure of member to pay copayment or other bills.

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:

A monitoring system is in place to review member exemptions with the goal of ending the exemption when appropriate and enrolling the member with a PCP. The enrollment broker provides the State with a monthly Passport exemption report and regularly reviews member exemptions to ensure they are still required.

Team Care members cannot be exempt from the program but can request a fair hearing.

Additional information on the process of member disenrollment initiated by the PCP is provided below:

Providers can request that a Passport or Team Care member be disenrolled for cause. A written disenrollment notification must be sent to the member and the enrollment broker, and should allow 30 days for the change to take place. Team Care provider changes may take effective prior to the 30 days.

If a provider requests that a member be removed from his or her caseload the provider is responsible for care or referrals for 30 days. The 30 day care obligation does not start until the letter is received by the enrollment broker. If the provider is unwilling, the member gets an "emergency" exemption, which means the member can see any Medicaid provider that month without referral. The member is sent a letter instructing him or her to choose a new provider. A list of providers is enclosed with the letter. When a Passport provider leaves the Passport program, their members are disenrolled using the above procedure. Conduent updates the provider information in the Passport database.

Additional information on the process disenrollments initiated by the member is provided below:

Passport members not in Team Care may change providers up to once per month without cause.

Team Care members must petition the State or the enrollment broker to make a provider or pharmacy change. The enrollment broker and/or the Team Care program officer reviews the circumstance of the request and determine if a change is warranted. Provider/pharmacy changes take effect the first day of the next month after cut off unless extenuating circumstances require the pharmacy change to be immediate.

Members are enrolled in Team Care for a minimum of 12 months. Cases are assessed on an individual basis after they have met the minimum time requirement. Part of the assessment may include contacting the member's Team Care Provider. If a provider validates that a member has shown adequate improvement regarding previous misuse of the Medicaid program, the member may be graduated from the Team Care program. Most members, however, are enrolled for a period of longer than 12 months and many have been on the Team Care program since its inception. The State reviews Team Care enrollment annually to identify members eligible for graduation from the Team Care program.

The EPCCM programs is voluntary.

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:

Description of how state will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164:

The Montana Department of Public Health and Human Services (DPHHS) employs a HIPAA privacy officer. All DPHHS and the Contractor's employees are required to attend HIPAA training and be evaluated on the training. The State has reviewed and will comply with all HIPAA regulations including those put forth in the American Recovery and Reinvestment Act.

The HIPAA privacy officer is consulted when questions arise regarding HIPAA. The steps taken by the Medicaid Member Help Line and State staff to ensure HIPAA compliance have been approved by the HIPAA officer. The rules that affect our everyday work are:

PHI or identifying information is only transferred electronically through secure email or secure file transfer;

Members and providers are required to give identifying information when they call the Medicaid Member or Provider Help Line or State staff in order to discuss PHI or any member identifying information; and

PHI or identifying information is not given unless it is required.

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: Conduent
- ☐ the PCCM
- ☐ the PAHP

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

Please describe:

Quality of Care Complaints and General Complaints: Informal, verbal or written communication by a member or authorized representative.

Grievance: Written communication in which a member or authorized representative indicates the desire to present his/her case to a reviewing authority.

Appeal to Fair Hearing Order

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

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

The complaints typically come into the Medicaid Member Help Line that is staffed by the enrollment broker. The Medicaid Member Help Line staff initially review the complaint. If the complaint cannot be resolved immediately

it is referred to the appropriate State of Montana staff.

☒ 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:

Enrollees must file a request for a formal complaint, administrative review or fair hearing within 90 days from the date of the adverse action.

Enrollees are initially given 20 days to respond to State's decision on administrative review. However, case is open for 90 days and enrollee is provided additional opportunities to respond.

Enrollees have 15 days to appeal fair hearing decision.

☒ Has time frames for resolving requests for review.

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

The State has 14 working days from date of receiving an formal complaint to respond.

The State has 20 calendar days from date of receiving an administrative review or fair hearing request to respond.

☐ 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:

☒ 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:

Description of the types of requests for review that can be made in the PCCM grievance system including additional information:

Quality of Care (QOC) Complaint: Informal, verbal, or written communication by a member or their authorized representative indicating that he/she wants the opportunity to present his/her case to a reviewing authority regarding what the member or his/her authorized representative perceives to be inappropriate or lack of appropriate care or services received from the state, or any of its agents or providers under the Medicaid program. Quality of care complaints are referred to the appropriate State licensing agency.

Complaint: Informal, verbal, or written communication by a member or their authorized representative indicating that he/she wants the opportunity to present his/her case to a reviewing authority regarding what the member or her/his authorized representative perceives to be inappropriate or lack of appropriate service related to issues regarding health care bills, Medicaid providers, eligibility, satisfaction with county or state agencies, or other similar matters not related to QOC concerns. The enrollment broker fills out the complaint form while on the phone with the member. Once completed the Medicaid Member Help Line staff review it with the member to make sure it is accurate. The complaint is then forwarded to administrative staff at the State and recorded in a shared, password protected spreadsheet. The complaint is then forwarded to the appropriate program officer who investigates the matter.

Grievance: Written communication which a member or her/his authorized representative presents indicating he/she wants the opportunity to present his/her case to a reviewing authority regarding what the member or his/her authorized representative perceives to be an inappropriate action by the State or any of its agents or providers.

Appeal: A request on behalf of a member for a review of an action taken on a complaint or grievance.

Description of any special process that the State has for persons with special needs:

The State will assist in filling out paperwork and have a Telecommunication Device for the Deaf (TDD) system for people with hearing deficiencies. The State works with our members on an individual basis and assist as needed whenever we can. If a member has a special need that cannot be met the State may refer to the county office or to an advocacy group. In either case the State will work closely with the member and the other party to assist.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

2. A person with beneficial ownership of five percent or more of the MCOs, PCCMs, PIHPs, or PAHPs equity;

3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCOs, PCCMs, PIHPs, or PAHPs obligations under its contract with the State.

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

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;

3. Employs or contracts directly or indirectly with an individual or entity that is

a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or

b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

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

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

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

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

☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the

provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Program Impact

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

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

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

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Access

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

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

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
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 ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☒ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☒ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☒ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☒ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☒ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☒ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☒ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

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

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

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

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

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

Programs Authorized by this Waiver:

Program	Type of Program
Passport	PCCM;
Team Care	PCCM;
THIP	PCCM;

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: Tribal Health Improvement Program

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:

The Tribe is required to have Tribal Health Improvement Program (T-HIP) services as a part of their 638 agreement.

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☒ **Other**

Please describe:

With the exception of registered nurses, all tribal Care Coordinators must complete a Chronic Care Management Training program within 210 days of employment. Once certified the Care Coordinators are responsible to keep their certification current.

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

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

Each tribe's T-HIP program must report Tier 1 month and six-month member surveys. Tribes who participate in Tier 2 and Tier 3 must complete reporting requirements that are mutually agreed upon by the State and Tribe.

☐ **CAHPS**

Please identify which one(s):

☒ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

State receives and monitors disenrollment requests (signed opt-outs) from enrollees.

☐ **Denials of referral requests**

☒ **Disenrollment requests by enrollee**

- ☐ **From plan**
- ☐ **From PCP within plan**

☐ **Grievances and appeals data**

☒ **Other**

Please describe:

The state uses data reported by tribes and Tableau software to monitor adherence to required reporting.

e. ☒ **Enrollee Hotlines**

Activity Details:

Enrollee hotline for the Passport to Health, Team Care, and Tribal Health Improvement programs:

Enrollment broker and State operate and review the Medicaid Member Help Line;
Operation of the Medicaid Member Help Line is a part of the enrollment broker contract. The State has set forth performance measures in the enrollment broker contract amendment to ensure the Medicaid Member Help Line is being operated efficiently and effectively. The enrollment broker prepares the monthly High Level Report and the enrollment broker report card which include details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate. The report data is collected from the Medicaid Member Help Line call software. State staff also routinely listens to calls and performs periodic audits of the Medicaid Member Help Line functionality;
Monitored monthly; and
Details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate are analyzed to determine whether performance measures are being met.

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:

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

Activity Details:

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

Activity Details:

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:

Tribal HIP collects the following monthly quality measures on all active members: BMI (height and weight), blood pressures, and HbA1c's.

Tribal HIP also collects social determinants of health on all active members every six months.

☐ **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:

t. ☐ **Other**

Activity Details:

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Team Care

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

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

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

Activity Details:

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

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

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

The CAHPS 5.0 is conducted annually one survey each for children and adults, the State adopted the survey for reporting purposes in 2018. The adult Medicaid 5.0 CAHPS survey conducted for Montana Medicaid. The survey is usually conducted by mail and telephone during the period third and fourth quarter of each calendar year. The survey was conducted by mail only in 2020 due to the public health emergency. The survey procedure and questionnaire were developed jointly by the Agency for Healthcare Research and Quality and the National Committee for Quality Assurance (NCQA). A copy of the summary results are attached.

☒ **CAHPS**

Please identify which one(s):

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☐ **Data Analysis (non-claims)**

Activity Details:

Data analysis performed for Passport to Health and Team Care programs:

Enrollment broker and State perform and review data reports;
Enrollment broker prepares a monthly High Level Report which details member disenrollments, grievances and PCP terminations. In addition, enrollment broker forwards all written
complaints/grievances to the State to be handled by program staff. State staff reviews the High Level Report and analyzes the data for trends which must be addressed; and
High Level Report details the frequency of disenrollments, grievances and PCP terminations, which are closely monitored by the State.

☐ **Denials of referral requests**

☒ **Disenrollment requests by enrollee**

☐ **From plan**

☒ **From PCP within plan**

☐ **Grievances and appeals data**

☒ **Other**

Please describe:

PCP terminations and disenrollments, network adequacy, member exemptions, and provider 24-hour coverage audits.

e. ☒ **Enrollee Hotlines**

Activity Details:

Enrollee hotline for the Passport to Health, Team Care, and Tribal Health Improvement programs:

Enrollment broker and State operate and review the Medicaid Member Help Line;
Operation of the Medicaid Member Help Line is a part of the enrollment broker contract. The State has set forth performance measures in the enrollment broker contract amendment to ensure the Medicaid Member Help Line is being operated efficiently and effectively. The enrollment broker prepares the monthly High Level Report and the enrollment broker report card which include details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate. The report data is collected from the Medicaid Member Help Line call software. State staff also routinely listens to calls and performs periodic audits of the Medicaid Member Help Line functionality;
Monitored monthly; and
Details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate are analyzed to determine whether performance measures are being met.

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:

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

Activity Details:

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

Activity Details:

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:

Provider surveys for the Passport to Health and Montana Medicaid programs:

State staff conduct and analyze data;
The State will conduct a provider survey by mail. Providers will be sent paper surveys and asked to rate their experience with Passport and to offer any suggestions for improving the program;
Surveys will be conducted once during each waiver period; and
This will enable the State to measure levels of satisfaction in our program, identify areas that providers are not happy with, and give the State suggestions for improvements. On the survey, providers will be given an opportunity to make any additional comments regarding the Passport program.

☒ **Survey of providers**

☐ **Focus groups**

r. ☒ **Test 24/7 PCP Availability**

Activity Details:

PCP availability tested for the Passport to Health program:

Enrollment broker performs tests;
Enrollment broker makes calls to providers after hours to ensure they provide direction to members in need of emergency care 24/7;
Testing occurs monthly; and
Enrollment broker ensures necessary coverage is available to members by testing provider's phone lines after hours.

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

Activity Details:

Utilization review performed for the Passport to Health program:

Enrollment broker conducts review;
Enrollment broker randomly audits provider referrals by looking at billed claims with referral numbers, contacting referring providers and determining whether the referral was authorized by the Passport provider;
Referral auditing is an ongoing process, and is conducted monthly; and
Contacting providers to determine whether they authorized referrals enables EB to determine which providers are storing Passport numbers and using them for unauthorized referrals.

t. ☐ **Other**

Activity Details:

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Passport to Health

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

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

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

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

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

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

The CAHPS 5.0 is conducted annually one survey each for children and adults, the State adopted the survey for reporting purposes in 2018. The adult Medicaid 5.0 CAHPS survey conducted for Montana Medicaid. The survey is usually conducted by mail and telephone during the period third and fourth quarter of each calendar year. The survey was conducted by mail only in 2020 due to the public health emergency. The survey procedure and questionnaire were developed jointly by the Agency for Healthcare Research and Quality and the National Committee for Quality Assurance (NCQA). A copy of the summary results are attached.

☒ **CAHPS**

Please identify which one(s):

CAHPS 5.0

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

Data analysis performed for Passport to Health and Team Care programs:

Enrollment broker and State perform and review data reports;
Enrollment broker prepares a monthly High Level Report which details member disenrollments, grievances and PCP terminations. In addition, enrollment broker forwards all written complaints/grievances to the State to be handled by program staff. State staff reviews the High Level Report and analyzes the data for trends which must be addressed; and
High Level Report details the frequency of disenrollments, grievances and PCP terminations, which are closely monitored by the State.

☐ **Denials of referral requests**

☒ **Disenrollment requests by enrollee**

☐ **From plan**

☒ **From PCP within plan**

☒ **Grievances and appeals data**

☒ **Other**

Please describe:

PCP terminations and disenrollments, network adequacy, member exemptions, and provider 24-hour coverage audits.

e. ☒ **Enrollee Hotlines**

Activity Details:

Enrollee hotline for the Passport to Health, Team Care, and Tribal Health Improvement programs:

Enrollment broker and State operate and review the Medicaid Member Help Line;
Operation of the Medicaid Member Help Line is a part of the enrollment broker contract. The State has set forth performance measures in the enrollment broker contract amendment to ensure the Medicaid Member Help Line is being operated efficiently and effectively. The enrollment broker prepares the monthly High Level Report and the enrollment broker report card which include details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate. The report data is collected from the Medicaid Member Help Line call software. State staff also routinely listens to calls and performs periodic audits of the Medicaid Member Help Line functionality;
Monitored monthly; and
Details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate are analyzed to determine whether performance measures are being met.

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:

Geographic mapping performed for the Passport program:

Enrollment broker and State operate and review;
Enrollment broker prepares a monthly Network Adequacy Report which details the number of Passport providers and members in each county;
Report is prepared monthly; and
State analyzes data to ensure adequate, statewide provider coverage.

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

Activity Details:

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

Activity Details:

Disparities measured for the Passport to Health program:

Enrollment broker and State prepare and review report;
Enrollment broker monthly High Level Report details enrollment into Passport by race;
Report is prepared monthly; and
State analyzes data for any disparities between choice enrollment and auto-assignment by race.

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

Activity Details:

Network Adequacy Report for the Passport to Health program:

Enrollment broker and State perform and review report;
Enrollment broker prepares a monthly network adequacy report which, details provider to enrollee ratios by county, PCP caseloads and limits by county, PCP provider network changes, measurement of enrollee requests for disenrollment from a PCP due to capacity issues, open PCCM slots by county and provider type, and tracking of complaints and grievances related to capacity;
Report is prepared monthly; and
State analyzes data to ensure adequate, statewide provider coverage.

k. ☐ **Ombudsman**

Activity Details:

l. ☒ **On-Site Review**

Activity Details:

On-site audits of Enrollment Broker:

The state conducts periodic on-site audits of the Enrollment Broker to ensure that contractual responsibilities are being met.

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:

Comparison performed for Passport to Health program:

Enrollment broker and State prepare and review report;
Enrollment broker prepares a monthly network adequacy report, which details provider to enrollee ratios by county, types of providers, caseload limits and provider restrictions;
Report is prepared monthly; and
State analyzes data to ensure an adequate number and range of providers are available statewide.

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

Activity Details:

q. ☒ **Provider Self-Report Data**

Activity Details:

Provider surveys for the Passport to Health and Montana Medicaid programs:

State staff conduct and analyze data;
The State will conduct a provider survey by mail. Providers will be sent paper surveys and asked to rate their experience with Passport and to offer any suggestions for improving the program;
Surveys will be conducted once during each waiver period; and
This will enable the State to measure levels of satisfaction in our program, identify areas that providers are not happy with, and give the State suggestions for improvements. On the survey, providers will be given an opportunity to make any additional comments regarding the Passport program.

☒ **Survey of providers**

☐ **Focus groups**

r. ☒ **Test 24/7 PCP Availability**

Activity Details:

PCP availability tested for the Passport to Health program:

Enrollment broker performs tests;
Enrollment broker makes calls to providers after hours to ensure they provide direction to members in need of emergency care 24/7;
Testing occurs monthly; and
Enrollment broker ensures necessary coverage is available to members by testing provider's phone lines after hours.

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

Activity Details:

Utilization review performed for the Passport to Health program:

Enrollment broker conducts review;
Enrollment broker randomly audits provider referrals by looking at billed claims with referral numbers, contacting referring providers and determining whether the referral was authorized by the Passport provider;
Referral auditing is an ongoing process, and is conducted monthly; and
Contacting providers to determine whether they authorized referrals enables EB to determine which providers are storing Passport numbers and using them for unauthorized referrals.

t. ☐ **Other**

Activity Details:

Section C: Monitoring Results

Renewal Waiver Request

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

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

This is a renewal request.

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

◉ **The State has used this format previously**The State provides below the results of the monitoring activities conducted during the previous waiver period.

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

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

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

Consumer self-report data:
Strategy: Survey members experience of care for the Passport program and Passport providers.
Survey is conducted annually starting in SFY 2018
See Attachment K: CAHPS 5.0 Survey

Data analysis (non-claims):
Strategy: To monitor member disenrollment, grievances, and appeals and termination of PCPs from the Passport program.
See Attachment L: Enrollment Broker High Level/Network Adequacy Report
Summary of results: The High Level Report provided by the enrollment broker reflects member and provider disenrollment. The State looks for trends or areas of concern such as frequent, mass disenrollment of members by a single provider. There have been no areas of of major concern with member disenrollment of providers during this waiver period.
All grievances and appeals come directly to the State, which monitors grievances and appeals for trends and follow-up if necessary. There have been no major concerns or fluctuations in grievances during this waiver period.

Enrollee hotlines operated by State:
Strategy: Ensure that the Medicaid Member Help Line (operated by the enrollment broker) is effectively reaching performance standards set forth in the contract. The monthly High Level Report and the Report Card include call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate. The report data is collected from the Help Line call software. State staff also routinely listens to calls and perform periodic audits of the Medicaid Member Help Line functionality.
See Attachment L: Enrollment Broker High Level/Network Adequacy Report
Attachment M: Enrollment Broker Report Card
Summary of results: The performance of the enrollment broker hotline has been sufficient meeting all contract State Level Agreements (SLA) during this waiver period.

Geographic mapping of provider network:
Strategy: Ensure adequacy of provider network. The Network Adequacy Report (NAR) includes a member/provider ratio for each county.
Attachment L: Enrollment Broker High Level/Network Adequacy Report
Summary of results: No major issues have been identified.

Measurement of any disparities by racial or ethnic groups:
Strategy: Monitor for disparities between racial or ethnic groups and program enrollment/auto assignment versus voluntary program enrollment. Disparities are monitored through the Enrollment Broker High Level Report .
See Attachment L: Enrollment Broker High Level/Network Adequacy Report
Summary of results: No racial or ethnic disparities have been identified.

Network adequacy assurance submitted by plan:
Strategy: Monitor provider network adequacy, specifically: provider to enrollee ratios, PCP caseload and limits by practice, open PCCM slots by provider, tracking of complaints and grievances related to capacity. Data is monitored through the Network Adequacy Report.
See Attachment L: Enrollment Broker High Level/Network Adequacy Report
Summary of results: No major issues have been identified.

On-site audits of contractors:
Strategy: The Member Health Management Bureau conducts periodic on-site and desk audits of program contractors that provide services under the 1915(b) waiver to ensure that contractual responsibilities are being met. Conduent provides enrollment broker functions and predictive modeling services.
Summary of results: The State plans performed a virtual audit of the enrollment broker operation in February of 2021. A copy of the audit report is attached as Attachment .
Periodic comparison of number and types of Medicaid providers before and after waiver:
Strategy: Ensure availability of a range of providers to populations covered under this waiver. The NAR tracks the ratio of providers to members by county. The State closely monitors complaints about access to providers.
See Attachment L: Enrollment Broker High Level/Network Adequacy Report
Summary of results: No major issues have been identified regarding availability of providers.

Provider self-report data:
Strategy: Survey provider satisfaction with the Passport program.
Summary of results: Survey was conducted in SFY 2019/2020. A copy of the summary report is attached as Attachment .

Test 24 hours/7 day week PCP availability:
Strategy: Identify Passport providers that are not providing directions to emergency services to the members on their caseload.
See Attachment L: Enrollment Broker High Level/Network Adequacy Report- 24 Hour Audit
Summary of results: Some providers are not providing directions to emergency care 24/7.
Corrective action: Providers who fail the audit are provided 30 days to correct emergency directions to members.

Utilization Review:
Strategy: Identify where Passport referral numbers have been used but not authorized. The State randomly audits Passport referrals by looking at claims and contacting referring providers to confirm they have given the referral.
See Attachment L: Enrollment Broker High Level/Network Adequacy Report- Passport Referral Audit
Summary of results: Some providers are not keeping adequate records of referrals making it impossible to audit the use of their numbers. In several cases, misuse of Passport numbers results in claims being paid that were not properly referred.
Funds have been recouped in those cases and providers educated about the requirement to keep documentation of every time they refer a Passport member.
Corrective action (plan/provider level): Providers who have not kept adequate records will be asked to provide lists of referrals 6 months after they have been educated about this requirement.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
PASSPORT HK (PASSPORT -CHIP EXPANSION GROUP)	
PASSPORT TANF (PRIMARY CARE CASE MANAGEMENT - TANF ONLY)	
Passport HELP	
Tribal EPCCM TANF & SSI & HK	
Tribal EPCCM HELP	
PASSPORT SSI (PRIMARY CARE CASE MANAGEMENT - SSI ONLY)	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	07/01/2020	06/30/2021	07/01/2021	12/31/2021
Enrollment Projections for the Time Period*	07/01/2022	06/30/2023	07/01/2023	06/30/2024

**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	
Home Health	☒	☐	☒	
Immunizations	☒	☐	☒	
Therapeutic Group and Family Services	☒	☐	☒	
Other Psych Practitioner	☒	☐	☒	
Transportation - Emergency	☒	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Private Duty Nursing	☒	☐	☒	
EPCCM - Case Management Services	☒	☐	☒	
Nurse Practitioner	☒	☐	☒	
Obstetrical Services	☒	☐	☒	
Dialysis - Home Dialysis AHD	☒	☐	☒	
Drugs Prescription	☒	☐	☒	
Durable Medical Equipment	☒	☐	☒	
Inpatient Hospital - Psych	☒	☐	☒	
Emergency Services	☒	☐	☒	
Personal Assistant Services	☒	☐	☒	
Family Planning Services	☒	☐	☒	
Hospice	☒	☐	☒	
Podiatry	☒	☐	☒	
Transportation - Non- Emergency	☒	☐	☒	
Transplants	☒	☐	☒	
NAL - Nurse Advice Line Services	☐	☐	☐	
Nurse Midwife	☒	☐	☒	
Physician	☒	☐	☒	
Education Agency Services School Based Services	☒	☐	☒	
Speech Therapy	☒	☐	☒	
Hearing Aids & Exams	☒	☐	☒	
EPSDT	☒	☐	☒	
Home Infusion	☒	☐	☒	
Occupational Therapy	☒	☐	☒	
Well Child Check Ups	☒	☐	☒	
Detoxification	☒	☐	☒	
Dental	☒	☐	☒	
Testing for Sexually Transmitted Diseases (STDs)	☒	☐	☒	
Dialysis - Free Standing Centers	☒	☐	☒	
Home & Community Based Waiver Services	☒	☐	☒	
Outpatient Hospital - All other	☒	☐	☒	
Substance Abuse Treatment Services	☒	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Mental Health Services	☒	☐	☒	
Outpatient Hospital - Lab and X-ray	☒	☐	☒	
Psychologist	☒	☐	☒	
Nutrition	☒	☐	☒	
Partial Hospitalization	☒	☐	☒	
Vision Exams and Glasses	☒	☐	☒	
Professional & Clinic and Other Lab and X-ray	☒	☐	☒	
PCCM Case Management Fees	☒	☐	☒	
Nursing Facility	☒	☐	☒	
Social Worker Services	☒	☐	☒	
Respiratory Care Therapy	☒	☐	☒	
Inpatient Hospital - Other	☒	☐	☒	
Rural Health Clinic	☒	☐	☒	
Physical Therapy	☒	☐	☒	
Lab and x-ray	☒	☐	☒	
Federally Qualified Health Center Services	☒	☐	☒	
Chiropractic Services	☒	☐	☒	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the States waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the States submitted CMS-64 forms.

Signature: Mary Eve

State Medicaid Director or Designee

Submission Date: Jun 23, 2022

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

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

b. Name of Medicaid Financial Officer making these assurances:

Darci Wiebe

c. Telephone Number:

(406) 444-4158

d. E-mail:

dwiebe@mt.gov

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

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

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

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

e. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete ***Appendix D3***
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☐ **MCO**
b. ☐ **PIHP**
c. ☐ **PAHP**
d. ☐ **PCCM**
e. ☐ **Other**

Please describe:

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: $** 1.00 **per member per month fee.**
2. ☒ **Year 2: $** 1.00 **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.**
$ 0.00
Please explain the State's rationale for determining this method or amount.

Explanation for above letter a. Management fee for the Passport providers.
1. First Year: Aged, Blind, Disabled and Medically Frail Medicaid populations $3.00 PMPM, all other Passport populations $1.00 PMPM.
2. Second Year: Aged, Blind, Disabled and Medically Frail Medicaid populations $3.00 PMPM, all other Passport populations $1.00 PMPM.

Explanation for above letter b. Enhanced fee for primary care services for the Tribal HIP providers.

1. First Year: THIP fee tier 1 $75 PMPM, tier 2 $150 PMPM and tier 3 $213.96 PMPM
2. Second Year: THIP fee tier 1 $75 PMPM, tier 2 $150 PMPM and tier 3 $213.96 PMPM

Provider Network and with consideration of the expenses incurred under the former disease management program. Additional services include services listed in Section A, Part I.B.

The Tribal HIP fee was calculated based on the services listed in Section A, Part I.B. The average life span for the AI population in MT is 20 years shorter on average than non-AI populations. The AI population is significantly more likely to suffer from cardiovascular disease, cancer, respiratory illness, and diabetes and therefore has a need for increased care management.

Additionally, Management fees for Team Care were calculated as follows.

1.X First Year: $6.00 per member per month fee
2.X Second Year: $6.00 per member per month fee

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 change in member months is based on experience in R1 and R2 factoring natural growth within demographics.

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

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

R1/R2 are based in the waiver period but do not align with the state fiscal year. R1 runs from July 1, 2020 to June 30, 2021. R2 runs from July 1, 2021, through June 30, 2022.

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:

The HCBS and DDI services marked are not part of any 1915c authority and are state plan services only.

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.

The HCBS and DDI services marked are not part of any 1915c authority and are state plan services only.

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
Home Health	☐	☐	☒	☐	☐	☐	☐
Immunizations	☐	☐	☒	☐	☐	☐	☐
Therapeutic Group and Family Services	☐	☐	☒	☐	☐	☐	☐
Other Psych Practitioner	☐	☐	☒	☐	☐	☐	☐
Transportation - Emergency	☐	☐	☒	☐	☐	☐	☐
Private Duty Nursing	☐	☐	☒	☐	☐	☐	☐
EPCCM - Case Management Services	☐	☐	☒	☐	☐	☐	☐
Nurse Practitioner	☐	☐	☒	☐	☐	☐	☐
Obstetrical Services	☐	☐	☒	☐	☐	☐	☐
Dialysis - Home Dialysis AHD	☐	☐	☒	☐	☐	☐	☐
Drugs Prescription	☐	☐	☒	☐	☐	☐	☐
Durable Medical Equipment	☐	☐	☒	☐	☐	☐	☐
Inpatient Hospital - Psych	☐	☐	☒	☐	☐	☐	☐
Emergency Services	☐	☐	☒	☐	☐	☐	☐
Personal Assistant Services	☐	☐	☒	☐	☐	☐	☐
Family Planning Services	☐	☐	☒	☐	☐	☐	☐

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
Hospice	☐	☐	☒	☐	☐	☐	☐
Podiatry	☐	☐	☒	☐	☐	☐	☐
Transportation - Non- Emergency	☐	☐	☒	☐	☐	☐	☐
Transplants	☐	☐	☒	☐	☐	☐	☐
NAL - Nurse Advice Line Services	☐	☐	☐	☐	☐	☐	☐
Nurse Midwife	☐	☐	☒	☐	☐	☐	☐
Physician	☐	☐	☒	☐	☐	☐	☐
Education Agency Services School Based Services	☐	☐	☒	☐	☐	☐	☐
Speech Therapy	☐	☐	☒	☐	☐	☐	☐
Hearing Aids & Exams	☐	☐	☒	☐	☐	☐	☐
EPSDT	☐	☐	☒	☐	☐	☐	☐
Home Infusion	☐	☐	☒	☐	☐	☐	☐
Occupational Therapy	☐	☐	☒	☐	☐	☐	☐
Well Child Check Ups	☐	☐	☒	☐	☐	☐	☐
Detoxification	☐	☐	☒	☐	☐	☐	☐
Dental	☐	☐	☒	☐	☐	☐	☐
Testing for Sexually Transmitted Diseases (STDs)	☐	☐	☒	☐	☐	☐	☐
Dialysis - Free Standing Centers	☐	☐	☒	☐	☐	☐	☐
Home & Community Based Waiver Services	☐	☐	☒	☐	☐	☐	☐
Outpatient Hospital - All other	☐	☐	☒	☐	☐	☐	☐
Substance Abuse Treatment Services	☐	☐	☒	☐	☐	☐	☐
Mental Health Services	☐	☐	☒	☐	☐	☐	☐
Outpatient Hospital - Lab and X-ray	☐	☐	☒	☐	☐	☐	☐
Psychologist	☐	☐	☒	☐	☐	☐	☐

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
Nutrition	☐	☐	☒	☐	☐	☐	☐
Partial Hospitalization	☐	☐	☒	☐	☐	☐	☐
Vision Exams and Glasses	☐	☐	☒	☐	☐	☐	☐
Professional & Clinic and Other Lab and X-ray	☐	☐	☒	☐	☐	☐	☐
PCCM Case Management Fees	☐	☐	☒	☐	☐	☐	☐
Nursing Facility	☐	☐	☒	☐	☐	☐	☐
Social Worker Services	☐	☐	☒	☐	☐	☐	☐
Respiratory Care Therapy	☐	☐	☒	☐	☐	☐	☐
Inpatient Hospital - Other	☐	☐	☒	☐	☐	☐	☐
Rural Health Clinic	☐	☐	☒	☐	☐	☐	☐
Physical Therapy	☐	☐	☒	☐	☐	☐	☐
Lab and x-ray	☐	☐	☒	☐	☐	☐	☐
Federally Qualified Health Center Services	☐	☐	☒	☐	☐	☐	☐
Chiropractic Services	☐	☐	☒	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*
The allocation method for either initial or renewal waivers is explained below:

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

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

c. ☒ **Other**
Please explain:

In Montana, we have eight existing Medicaid Eligibility Groups (MEGs) for restrospective periods and six MEGS for the prospective periods. Two of them are Tribal EPCCM, two are NAL (Nurse Advice Line) only for the retrospective period, and the remaining four are Passport. The actual administrative expenditures for R1 and R2 were separated on a per member basis into the following three MEGS: PCCM Passport TANF, PCCM Passport SSI, and NAL. Per CMS, the administrative costs for the Medicaid/CHIP expansion groups (PPHK/Tribal EPCCMHK/NALHK) are not included in the CMS 64 but are included on the CMS 21. The administrative costs for the Medicaid/CHIP expansion groups are minimal, therefore, the time/effort it would take to break out FTE, travel, supplies, etc would not be beneficial to report.

Projected administrative costs for P1 and P2 were calculated by applying the administrative percentage of change to the MEGs equally. (Excluding the Medicaid\CHIP expansion groups, HELP groups, and Tribal EPCCM groups).

Additional Administrative costs explanation for Medicaid expansion group MEGs:

Medicaid administrative costs are reimbursed at a 50/50 match and CHIP/Medicaid expansion administrative costs are reimbursed at a higher rate of 24.57/75.43 match. Montana reports administrative costs for the expansion group on the CMS 21 because a separate unit oversees all eligibility determination and other similar administrative costs.

The Montana 1915(b) waiver administrative costs include staff salary, travel, materials, enrollment broker operations, predictive modeling operations, medical advisor contract, etc. Montana does not currently have the ability to track 1915 (b) administrative costs separately for Medicaid (50/50 FMAP) and CHIP/Medicaid expansion (24.57/75.43 FMAP), therefore, administrative costs are not reported on the CMS 64.21U for the expansion group MEGs. (Medicaid/CHIP expansion group MEGs include – Passport HK, and NAL HK (Nurse Advice Line)). The reference to NAL HK MEG is only for retrospective administrative costs and the MEG is not included in projections for the renewal period.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

a. ☐ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

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

c. ☐ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.
Basis and Method:

1. ☐ **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. ☐ **The State provides stop/loss protection**

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

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

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

   Document

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

2. ☐ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

   Document:

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

Appendix D3 Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

1. ☐ **[Required, if the States BY or R2 is more than 3 months prior to the beginning of P1] The State is using**

actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).

The actual trend rate used is:

Please document how that trend was calculated:

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.

Base years are July 1, 2020 through June 30, 2021, July 1, 2021 through June 30, 2022.

The growth rate is based on the average annual growth for the Medicaid projections from State Fiscal Year (SFY) 21 to SFY 22. The projections for SFY 23 through SFY 27 are based on models that are produced monthly to track and project Medicaid expenditures. The models use provider expenditure trends, both current and historical, to forecast expenditures. The models use basic statistical trends and correlation analysis that are controlled for provider rate changes and new or deleted services. The basic focus of the modeling is utilizing patterns during normal periods of growth, modeling this pattern to project future growth, then adjusting the projection based on anticipated changes to services and provider rates. The increase that is applied between R2 and P1 of 5.4% is a cost increase and falls under 2i. The rate increase of 6% between P1 and P2 in column J - State Plan increase is the Unadjusted 12-month Medical Care Services CPI for all Urban Consumers: US City Average increase as of June 2020. The 2.0% increase in column L between R2 and P1 and also between P1 and P2 is an estimated Legislative impact increase.
Now that drug rebates are reported as a Line #7 adjustment in the CMS 64 and allocated back to the respective quarter, MT needed to include a drug rebate adjustment for P1 in the Legislative or Other Program Adjustment column. The percentages for each component are listed below along with the final percentages reported in column L, rows 13 – 16.
Other Program Adjustments P1 Column L:

Legislative Increase:
PASSPORT TANF = 2.0%
PASSPORT SSI = 2.0%
PASSPORT HK = 2.0%
PASSPORT HELP = 2.0%

Drug Rebate Adjustment:
PASSPORT TANF = -3.8%
PASSPORT SSI = -3.8%
PASSPORT HK = -4.8%
PASSPORT HELP = -3.8%

Final Adjustment:
PASSPORT TANF = -1.9%
PASSPORT SSI = -1.9%
PASSPORT HK = -2.9%
PASSPORT HELP = -1.9%

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:

Adjustments to TRIBAL EPCCM (TANF & SSI & HK) and TRIBAL EPCCM HELP for P1, and P2 Other adjustments are due to movement amongst the tiers.

P1 = 20% increase
P2 = 20% increase

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

0.00

Please describe:

D. ☒ Other

Please describe:

Admin adjustment of 1.0% for P1 and P2 was applied due to Historical State Administrative changes.

iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

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

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
Please indicate the State Plan Service trend rate from Section D.I.J.a. above

Section D: Cost-Effectiveness

Part I: State Completion Section

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

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide

additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☐ [Required, if the States BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
   The actual documented trend is:

   Please provide documentation.

2. ☐ [Required, when the States BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

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

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

   B. State Plan Service trend

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

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)** *: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

  Basis and Method:

  1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5.**
  2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
  3. ☐ Other

     Please describe:

1. ☒ No adjustment was made.

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

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 Waiver Cost Projection

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

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 RO Targets

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

Appendix D6 RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

   The change in member months for the population groups are based on experience in R1 and R2 factoring natural growth within demographics. The PHE has caused unexpected increases in the populations. Because the official PHE end is not currently known, we did not adjust for the unraveling of the PHE changes.

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:

   Base years are July 1, 2020 through June 30, 2021, July 1, 2021 through June 30, 2022.

   This growth rate is based on the average annual growth for the Medicaid projections from State Fiscal Year (SFY) 21 through SFY 22. The projections for SFY 23 through SFY 24 are based on models that are produced monthly to track and project Medicaid expenditures. The models use provider expenditure trends, both current and historical, to forecast expenditures. The models use basic statistical trends and correlation analysis that are controlled for provider rate changes and new or deleted services. The basic focus of the modeling is utilizing patterns during normal periods of growth, modeling this pattern to project future growth, then adjusting the projection based on anticipated changes to services and provider rates.

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:

   This adjustment reflects the changes in utilization between R2 and P1 and years P1 and P2.

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

Appendix D7 - Summary