

**Facesheet: 1. Request Information (1 of 2)**

- A. The **State of Arkansas** 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
NET Waiver	Arkansas Non-Emergency Transportation 1915(b)(4) Waiver	PAHP;

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

Arkansas Non-Emergency Transportation 1915(b)(4) Waiver Renewal (04/01/2023-03/31/2028)

- 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):

'Beneficiary' changed to 'client' throughout the waiver.

Section A: Program Description, Part I Program Overview : Updated sections D. E. F.  
 Part II: Access - A. timely access standards - 3 additions; B. Information added

III Quality : Details for PCCM program deleted.

IV Program Operations: B. Information to potential enrollees: updates to 1.a, 2, 3.  
 C. updates to Enrollment and Disenrollment

IV - E. Additional information added to Grievance System ; Section C. monitoring results updated

Appendix D updated in various places to align with cost effectiveness.

**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:AR.052.03.00**

**Waiver Number:AR.0003.R03.00**

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

**Proposed Effective Date:** (mm/dd/yy)

04/01/23

**Proposed End Date:03/31/28**

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:**

Elizabeth Pitman

**Phone:**

(501) 244-3944

**Ext:**

**TTY**

**Fax:**

(501) 682-1197

**E-mail:**

elizabeth.pitman@dhs.arkansas.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:**

**Arkansas Non-Emergency Transportation 1915(b)(4) Waiver**

*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**

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**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.

There are no Federally recognized Native American tribes in the State of Arkansas.

**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).

Under the State's Title XIX State Plan fee-for-service Medicaid non-emergency transportation program, a client was allowed to arrange his/her own transportation to/from Medicaid covered services with any Medicaid enrolled non-emergency transportation provider. Medicaid enrolled non-emergency transportation providers included taxicabs, wheelchair vans and buses. Volunteer non-emergency transportation providers did not enroll, but they were required to register with the Division of Medical Services (DMS).

Under the State's Section 1915(b)(4) waiver for Medicaid non-emergency transportation (NET), Medicaid clients must arrange non-emergency medical transportation through the single Prepaid Ambulatory Health Plan (PAHP) that is contracted to broker non-emergency transportation services for the region in which the client resides.

On 8/26/1998, CMS approved Arkansas' request for a waiver of the freedom-of-choice requirement in Section 1902(a)(23) of the Social Security Act. The waiver allows the State to selectively contract with regional PAHPs. Medicaid clients whose coverage includes transportation are automatically enrolled with their single regional PAHP. The State Medicaid Agency (SMA) pays each PAHP a monthly capitated rate that is based on the number of Medicaid eligible clients residing in the PAHP's region.

The initial approval period of the NET 1915(b)(4) waiver was 8/26/1998 - 8/25/2000. This initial approval period was extended by CMS for an additional 12 months (through 8/25/2001). The first 2-year renewal of the NET waiver was for the period 8/26/2001 - 8/25/2003 that was extended by CMS for an additional 2 months and 27 days (through 11/21/2003) while the review/approval process was being completed. Since the initial approval in August 1998, the NET 1915(b)(4) waiver has been renewed a total of nine 2-year renewals. This renewal application will be the tenth 2-year renewal.

Some important milestones in the 22 year program include:

- 1.) For state fiscal year 2001, an administrative decision was made to pay, retroactively, a full month's capitation for clients who were eligible for 14 or more days during the month. This capitation policy continues. Previously, a month's rate was paid for each client eligible on the last day of the month, regardless of the total number of days of eligibility.
- 2.) In the first 2-year waiver period, DMS Contracted with a vendor to operate a consumer helpline, conduct consumer satisfaction surveys, and provide outreach. DMS's vendor also prints and distributes Medicaid Non-Emergency Transportation (NET) bumper stickers to its NET brokers and brokers' sub-contractors that must be prominently displayed providing a toll-free telephone number to report any complaints or to make comments or ask questions. Clients can call this toll-free number to obtain information regarding the NET program and how to utilize NET services. They can also call and report positive/negative feedback regarding the services they've received, including unsafe or improper driving.
- 3.) In 2018, DMS restructured the regions of services, decreasing from eleven (11) regions to seven (7). No eligibility change of services occurred in this restructure. The Broker's monthly payment rate calculation also changed to utilize a capitated rate multiplied by clients months. Additional safeguards were added to the contract, including a gatekeeper function and heightened vehicle safety requirements.
- 4.) In 2021, DMS began allowing the use of Transportation Network Companies (TNC). TNC is the utilization of taxis, Uber, Lyft, etc. to assist brokers in fulfilling their obligation(s) of transporting clients to their medical appointments. Currently, TNC is only being utilized by one of the three brokers and that is Verida (formerly Southeastrans). Verida verifies that the client is qualified to utilize a TNC by asking client qualification questions. Qualification questions per Verida policy are: 1) Do you suffer from Alzheimer's or Dementia? 2) If the driver needs assistance, can you provide directions? 3) Are you able to walk to/from the vehicle with no assistance? If client qualifies to ride with a TNC, a TNC spreadsheet is sent to AFMC with a column showing the type of TNC service or company being utilized, the region client is located, clients name, Medicaid number, date of appointment, pickup time, pick up address, drop off address, and if client is a minor, the name of the person that will be accompanying the minor. Once the TNC spreadsheet is submitted to AFMC, AFMC will submit the TNC spreadsheet to DMS for approval. Verida will reach out to each client after the use of an approved TNC to see how the transportation went on the day of their appointment and notate the comments on the TNC spreadsheet.

## 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*

**NET Waiver**

- 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*

**NET Waiver**

- 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*

**NET Waiver**

- 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*

**NET Waiver**

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*

**NET Waiver**

- 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*

**NET Waiver**

- 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*

**NET Waiver**

- 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).

Eligible clients must receive NET services from the NET Broker contracted in a certain specified region, based on the client's address.

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

**NET Waiver**

- 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*

**NET Waiver**

**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:

NO ADDITIONAL INFORMATION

**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:

DMS does one procurement for the NET Waiver. The procurement results in a broker contract to cover each of the seven identified regions.

**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.

Each Medicaid client is automatically enrolled with the PAHP (non-emergency medical transportation broker) responsible for non-emergency medical transportation in the region/county in which the client resides. The lack of choice is not detrimental to Medicaid clients' ability to access services because the non-emergency medical transportation broker has a contractual obligation to ensure safe, courteous and punctual pick-up and to transport and deliver in accordance with the standards in the contract. DMS works with its contracted vendor to ensure adequate monitoring is in place and closely monitors Broker performance.

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

*Program: " Arkansas Non-Emergency Transportation 1915(b)(4) Waiver. "*

**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

Each Medicaid client is automatically enrolled with the PAHP (non-emergency medical transportation broker) responsible for non-emergency medical transportation in the region/county in which the client resides.

**Section A: Program Description**

**Part I: Program Overview**

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

**3. Rural Exception.**

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

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

**Beneficiaries will be limited to a single provider in their service area**

Please define service area.

Each Medicaid client is automatically enrolled with the PAHP (non-emergency medical transportation broker) responsible for non-emergency medical transportation in the region/county in which the client resides.

**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:

NO ADDITIONAL INFORMATION

**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*

NET Waiver

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

NET Waiver

**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)
Region D	PAHP	Verida, Inc.
Region B	PAHP	Verida, Inc.
Region C	PAHP	Verida, Inc.
Region E	PAHP	Central Arkansas Development Council
Region F	PAHP	Area Agency on Aging of Southeast Arkansas
Region A	PAHP	Verida, Inc.
Region G	PAHP	Verida, Inc.

**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:

NO ADDITIONAL INFORMATION
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## Section A: Program Description

### Part I: Program Overview

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#### 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):

Other eligible groups include:

HCBS (Living Choices (Assisted Living Facility)), AR Choices, CES Waiver (DDS Waiver), PACE is HCBS, but can also be a PACE and the individual is in a nursing facility. If they are in a nursing facility, they are excluded for NET.

- State aid category 56 U-18 (under age 18 no grant) clients;
- State aid category 61 PW-PL (Pregnant Women, Infants and Children Poverty Level (SOBRA)) and State aid category 61 PW "Unborn Child" (Pregnant Women PW Unborn Child);
- Medically Needy aid categories clients are covered for eligibility periods that are not retroactive;
- TEFRA-like 1115(a) demonstration waiver clients;
- Former foster children described in 1902(a)(10)(A)(i)(IX) of the Social Security Act;
- ARHome demonstration waiver beneficiaries receive a limited benefit.

## 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):

With the exception of State aid category 61 PW-PL (Pregnant Women, Infants and Children Poverty Level (SOBRA) and State aid category 61 "Unborn Child" (Pregnant Women Unborn Child, individuals eligible in aid categories that do not receive the full range of Medicaid services also do not receive non-emergency medical transportation. There groups are:

- 1) Qualified Medicare Beneficiaries (QMBs) for whom Medicare premium and/or Medicare co-insurance and deductible are not eligible for NET services. True Medicare/Medicaid dual eligibles are not excluded; and
- 2) Special Low Income Beneficiaries (SMBs)
- 3) Qualified Individual -1 (QI-1)
- 4) Qualified Disabled Working Individual (QDWI)

**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:

NO ADDITIONAL INFORMATION

**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):

Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

## Section A: Program Description

### Part I: Program Overview

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#### F. Services (3 of 5)

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

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

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

The 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:

[Empty text box for 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:

[Empty text box for Self-referrals Requirements Category General Comments]

8. Other.

Other (Please describe)

[Empty text box for 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:

Because this a NET PAHP - FQHC, ER Family Planning and EPSDT services are not covered. Clients access these services through FFS, ARHOME, or other MCO programs. If needed, brokers have the option of utilizing Transportation Network Companies (TNC) such as taxis, Uber, Lyft, etc. to assist them in transporting clients to their medical appointments. Additionally, brokers may offer gas cards and gas reimbursement to clients at their discretion.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

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

**1. Assurances for MCO, PIHP, or PAHP programs**

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

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

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

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

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

**Section A: Program Description**

**Part II: Access**

**A. Timely Access Standards (2 of 7)**

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

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

**1. PCPs**

*Please describe:*

**2. Specialists**

*Please describe:*

**3. Ancillary providers**

*Please describe:*

4. Dental

*Please describe:*

5. Hospitals

*Please describe:*

6. Mental Health

*Please describe:*

7. Pharmacies

*Please describe:*

8. Substance Abuse Treatment Providers

*Please describe:*

9. Other providers

*Please describe:*

**Section A: Program Description**

**Part II: Access**

**A. Timely Access Standards (3 of 7)**

**2. Details for PCCM program. (Continued)**

**b. Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her

provider for both urgent and routine visits. The States PCCM Program includes established standards for appointment scheduling for waiver enrollees access to the following providers.

1. PCPs

*Please describe:*

2. Specialists

*Please describe:*

3. Ancillary providers

*Please describe:*

4. Dental

*Please describe:*

5. Mental Health

*Please describe:*

6. Substance Abuse Treatment Providers

*Please describe:*

7. Urgent care

*Please describe:*

8. Other providers

*Please describe:*

## Section A: Program Description

### Part II: Access

#### A. Timely Access Standards (4 of 7)

---

##### 2. Details for PCCM program. (Continued)

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

1. PCPs

*Please describe:*

2. Specialists

*Please describe:*

3. Ancillary providers

*Please describe:*

4. Dental

*Please describe:*

5. Mental Health

*Please describe:*

6. Substance Abuse Treatment Providers

*Please describe:*

- 7. Other providers

*Please describe:*

**Section A: Program Description**

**Part II: Access**

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**A. Timely Access Standards (5 of 7)**

**2. Details for PCCM program. (Continued)**

**d. Other Access Standards**

**Section A: Program Description**

**Part II: Access**

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**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.

DMS, through its contracted vendor, ensures access to services by monitoring the number of vans and drivers in each region. Additionally, the contracted vendor operates and maintains a toll-free NET Helpline where clients may register complaints; for example, missed appointments due to transportation, service issues, voice concerns and receive information. The issues and complaints are investigated and reported to DMS daily, monthly, and quarterly. DMS reviews for needed corrective action.

**Section A: Program Description**

**Part II: Access**

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**A. Timely Access Standards (7 of 7)**

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

No Additional Information.

**Section A: Program Description**

**Part II: Access**

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**B. Capacity Standards (1 of 6)**

**1. Assurances for MCO, PIHP, or PAHP programs**

The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of

adequate capacity and services, in so far as these requirements are applicable.

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

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

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

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

## Section A: Program Description

### Part II: Access

#### B. Capacity Standards (2 of 6)

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

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

*Please describe the enrollment limits and how each is determined:*

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

*Please describe the States standard:*

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

*Please describe the States standard for adequate PCP capacity:*

## Section A: Program Description

### Part II: Access

#### B. Capacity Standards (3 of 6)

**2. Details for PCCM program.** (Continued)

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

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

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

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

Please describe the States standard:

### Section A: Program Description

#### Part II: Access

#### B. Capacity Standards (4 of 6)

##### 2. Details for PCCM program. (Continued)

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

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

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

- g. **Other capacity standards.**

Please describe:

### Section A: Program Description

#### Part II: Access

#### B. Capacity Standards (5 of 6)

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

DMS, through its contracted vendor, ensures provider capacity by monitoring the number of vans and drivers in each region. Additionally, the contracted vendor operates and maintains a toll-free NET Helpline where clients may register complaints; for example, missed appointments due to transportation, service issues, voice concerns and receive information. The issues and complaints are investigated and reported to DMS daily, monthly, and quarterly. DMS reviews for needed corrective action.

**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:

No Additional Information.

**Section A: Program Description**

**Part II: Access**

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

**1. Assurances for MCO, PIHP, or PAHP programs**

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

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

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

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

**Section A: Program Description**

**Part II: Access**

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

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

The following items are required.

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

*Please provide justification for this determination:*

The purpose of the waiver is to allow PAHP brokers, through contracts with DMS, to broker only for transportation services to/from non-emergency medical services. Consequently, PAHPs need not meet the requirements for additional services for enrollees with special health care needs in 42 CFR 438.208.

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

*Please describe:*

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

*Please describe the enrollment limits and how each is determined:*

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

1. Developed by enrollees primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee.
2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. In accord with any applicable State quality assurance and utilization review standards.

*Please describe:*

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

*Please describe:*

## Section A: Program Description

### Part II: Access

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

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

- a. Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.
- b. Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees overall health care.

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

*Please explain:*

- d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. There is appropriate and confidential **exchange of information** among providers.
- f. Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- h. **Additional case management** is provided.

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

- i. **Referrals.**

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

### Section A: Program Description

#### Part II: Access

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

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

NOT APPLICABLE

### 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:

No additional information.

### 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**

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

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

*Please describe:*

**Section A: Program Description**

**Part III: Quality**

---

**3. Details for PCCM program.** (Continued)

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

*Please explain:*

**Section A: Program Description**

**Part III: Quality**

---

**3. Details for PCCM program.** (Continued)

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

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

1. Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
  - A. Initial credentialing
  - B. Performance measures, including those obtained through the following (check all that apply):
    - The utilization management system.
    - The complaint and appeals system.
    - Enrollee surveys.
    - Other.

*Please describe:*

4. Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. Other

*Please explain:*

**Section A: Program Description**

**Part III: Quality**

---

**3. Details for PCCM program.** (Continued)

d. Other quality standards (please describe):

**Section A: Program Description**

**Part III: Quality**

---

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

NOT APPLICABLE

**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):

Potential enrollee and enrollee materials will be provided in English, Spanish and Marshallese.

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.:

Spanish is spoken by at least 5% of the population. There is a large population of Marshallese in the state who are eligible to receive Medicaid benefits.

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

- c. Other

Please explain:

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

DMS's oversight vendor operates a toll-free NET Help-Line. The DMS oversight vendor employs bilingual staff for callers requiring interpretation service in Spanish and utilizes an interpreter service for other languages when needed. Additionally, DMS has an arrangement with a local service that can furnish interpretive services in virtually any language.

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

Please describe:

DMS's oversight vendor, through mailings and the NET Helpline, provides required information to enrollees. A postcard is mailed to all new enrollees that contains information on the NET Helpline and how to file a grievance against a NET Broker.

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:

[Empty text box for specifying distribution methods]

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:

DMS's oversight vendor, thru mailings and the NET Helpline, provide required information to enrollees. A Beneficiary Grievance/NET Helpline postcard is mailed out to all new enrollees. PAHPs are limited to explaining who they can and cannot transport.

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:

[Empty text box for additional information]

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:*

**Section A: Program Description**

**Part IV: Program Operations**

**C. Enrollment and Disenrollment (3 of 6)**

**2. Details (Continued)**

**b. Administration of Enrollment Process**

State staff conducts the enrollment process.

The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

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

Broker name:

Please list the functions that the contractor will perform:

choice counseling

enrollment

other

*Please describe:*

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

*Please describe the process:*

### Section A: Program Description

#### Part IV: Program Operations

#### C. Enrollment and Disenrollment (4 of 6)

##### 2. Details (Continued)

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

This is a **new** program.

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

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

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

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

- i.** Potential enrollees will have  **day(s) / month(s)** to choose a plan.
- ii.** There is an auto-assignment process or algorithm.

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

The State automatically enrolls beneficiaries.

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

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

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

*Please specify geographic areas where this occurs:*

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

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

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

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

## Section A: Program Description

### Part IV: Program Operations

#### C. Enrollment and Disenrollment (5 of 6)

##### 2. Details (Continued)

##### d. Disenrollment

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

- i. Enrollee submits request to State.
- ii. Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- iii. Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

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

The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of

months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

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

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

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

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

*Please describe the reasons for which enrollees can request reassignment*

- ii. The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- iii. If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCMs caseload.
- iv. The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

## Section A: Program Description

### Part IV: Program Operations

#### C. Enrollment and Disenrollment (6 of 6)

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

State staff conduct the enrollment process only to the extent that State staff determine Medicaid eligibility. Assignment into the regional NET PAHP is an automated process within the Medicaid Enterprise System, and is based on the client address on record.

## 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:

**Section A: Program Description**

**Part IV: Program Operations**

**E. Grievance System (1 of 5)**

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

- a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

**Section A: Program Description**

**Part IV: Program Operations**

**E. Grievance System (2 of 5)**

**2. Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance

System, in so far as these regulations are applicable.

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

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

**Section A: Program Description**

**Part IV: Program Operations**

**E. Grievance System (3 of 5)**

**3. Details for MCO or PIHP programs**

**a. Direct Access to Fair Hearing**

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

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

**b. Timeframes**

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

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

**c. Special Needs**

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

*Please describe:*

**Section A: Program Description**

**Part IV: Program Operations**

**E. Grievance System (4 of 5)**

**4. Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollees freedom to make a request for a fair hearing or a PCCM or PAHP enrollees direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

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

the State

the States contractor.

Please identify:

the PCCM

the PAHP

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

*Please describe:*

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

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

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

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

Has time frames for resolving requests for review.

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

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:

Complaints are received and investigated by AFMC who reports to DMS. DMS reviews and follows up as needed with the Broker on individual complaints. Additionally, clients contact State staff directly and complaints are addressed by the staff and broker. The DMS oversight vendor also maintains a website where clients may voice a complaint, issue, or concern via email, educational materials regarding the NET program, how to make an appointment for transportation, NET Broker map, the NET Helpline, and other educational material is available on the website.

## 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 A: Program Description, Part IV: Program Operations, (F. Program Integrity (2 of 3)) (2. assurances for MCO or PIHP programs) are NOT APPLICABLE

**Section B: Monitoring Plan**

**Part I: Summary Chart of Monitoring Activities**

**Summary of Monitoring Activities (1 of 3)**

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

Please note:

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

**Summary of Monitoring Activities: Evaluation of Program Impact**

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
Accreditation for Non-duplication	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP

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

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS
<b>Network Adequacy Assurance by Plan</b>	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
<b>Ombudsman</b>	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
<b>On-Site Review</b>	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
<b>Performance Improvement Projects</b>	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
<b>Performance Measures</b>	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
<b>Periodic Comparison of # of Providers</b>	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
<b>Profile Utilization by Provider Caseload</b>	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
Provider Self-Report Data	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Test 24/7 PCP Availability	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Utilization Review	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Other	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS

**Section B: Monitoring Plan**

**Part I: Summary Chart of Monitoring Activities**

**Summary of Monitoring Activities (2 of 3)**

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

Please note:

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

**Summary of Monitoring Activities: Evaluation of Access**

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Accreditation for Non-duplication	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM

<b>Evaluation of Access</b>			
<b>Monitoring Activity</b>	<b>Timely Access</b>	<b>PCP / Specialist Capacity</b>	<b>Coordination / Continuity</b>
	FFS	FFS	FFS
<b>Accreditation for Participation</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Consumer Self-Report data</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Data Analysis (non-claims)</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Enrollee Hotlines</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Focused Studies</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Geographic mapping</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Independent Assessment</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Measure any Disparities by Racial or Ethnic Groups</b>	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	PCCM FFS	PCCM FFS	PCCM FFS
<b>Network Adequacy Assurance by Plan</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Ombudsman</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>On-Site Review</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Improvement Projects</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Measures</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Periodic Comparison of # of Providers</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Profile Utilization by Provider Caseload</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Provider Self-Report Data</b>	MCO PIHP	MCO PIHP	MCO PIHP

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	PAHP PCCM FFS	PAHP PCCM FFS	PAHP PCCM FFS
Test 24/7 PCP Availability	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Utilization Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Other	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

**Section B: Monitoring Plan**

**Part I: Summary Chart of Monitoring Activities**

**Summary of Monitoring Activities (3 of 3)**

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

Please note:

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

**Summary of Monitoring Activities: Evaluation of Quality**

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

<b>Evaluation of Quality</b>			
<b>Monitoring Activity</b>	<b>Coverage / Authorization</b>	<b>Provider Selection</b>	<b>Quality of Care</b>
<b>Accreditation for Participation</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Consumer Self-Report data</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Data Analysis (non-claims)</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Enrollee Hotlines</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Focused Studies</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Geographic mapping</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Independent Assessment</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Measure any Disparities by Racial or Ethnic Groups</b>	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	FFS	FFS	FFS
<b>Network Adequacy Assurance by Plan</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Ombudsman</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>On-Site Review</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Improvement Projects</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Measures</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Periodic Comparison of # of Providers</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Profile Utilization by Provider Caseload</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Provider Self-Report Data</b>	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Test 24/7 PCP Availability	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Utilization Review	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Other	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS

**Section B: Monitoring Plan**

**Part II: Details of Monitoring Activities**

**Details of Monitoring Activities by Authorized Programs**

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

**Programs Authorized by this Waiver:**

Program	Type of Program
NET Waiver	PAHP;

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

**Section B: Monitoring Plan**

**Part II: Details of Monitoring Activities**

**Program Instance: Arkansas Non-Emergency Transportation 1915(b)(4) Waiver**

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:

[Empty text box]

NCQA

JCAHO

AAAHHC

Other

Please describe:

[Empty text box]

b.

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

Activity Details:

[Empty text box]

NCQA

JCAHO

AAAHHC

Other

Please describe:

[Empty text box]

c.

Consumer Self-Report data

Activity Details:

DMS's oversight vendor conducts a biannual satisfaction survey of clients utilizing non-emergency transportation (NET) services by mailing a satisfaction survey form to a sampling of clients.  
  
The results of the survey proceed to the Division of Medical Services (DMS) and are made available on the vendor's website. The survey allows DMS to review the performance of all its NET vendors in different regions of the state and take oversight action as necessary.

CAHPS

Please identify which one(s):

[Empty text box]

State-developed survey

Disenrollment survey

Consumer/beneficiary focus group

d.

Data Analysis (non-claims)

Activity Details:

DMS's oversight vendor analyzes encounter data received on a quarterly basis to determine utilization of services. The data is used to create the Provider Profile which is sent to DMS for analysis and posted to the vendor's website. The Provider Profile shows utilization of NET services.

**Denials of referral requests**

**Disenrollment requests by enrollee**

**From plan**

**From PCP within plan**

**Grievances and appeals data**

**Other**

Please describe:

Encounter data submitted by the NET brokers is provided to DMS's vendor.

e.

**Enrollee Hotlines**

**Activity Details:**

DMS's oversight vendor operates a toll-free NET Helpline on behalf of DMS. The Helpline is operational during State business hours. The NET Helpline receives and responds to any type of inquiry, problem or complaint regarding NET services. Every month, the DMS contractor reports to DMS on the complaints and issues received by the NET hotline.

All complaints/grievances received through the NET Helpline are investigated and resolved to the satisfaction of the client and/or DMS. The data collected by the NET Helpline assists DMS to evaluate program access and effectiveness and to identify ways to improve service quality, as well as to ensure the NET brokers are meeting the contract performance measures.

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:**

NET brokers must maintain, update & submit to DMS the names, locations & other identifying information of the its sub-contracted transportation providers. DMS has a contractor that monitors broker compliance with all contract requirements including Network adequacy. DMS's vendor maintains and updates all employee and vehicle documentations and a complete listing of sub-contractors who operate in each broker region on a daily basis.

Through this oversight, DMS ensures the number of providers under the Non-Emergency Transportation (NET) waiver is adequate for all eligible clients to access all needed non-emergency transportation.

k. **Ombudsman**

**Activity Details:**

[Empty text box]

l. **On-Site Review**

**Activity Details:**

DMS's oversight vendor monitors the transporting of NET clients during pick-up and drop-off processes at the original point of destination (residence), the facilities & medical appointments. The vendor conducts vehicle inspections, where safety factors are observed, such as proper utilization of child safety buzzers, proper placement and installation of rear-facing infant seats, child safety seats, as well as loading and unloading of wheelchairs and wheelchair securement. These inspections are both scheduled and non-scheduled Sub-contracted NET transportation providers must submit a copy of their inspections to DMS's vendor. The information is entered into a database for tracking. The vendor makes announced and unannounced visits to brokers' and sub-contracted transportation providers' business locations to review records, written policies and other required documentation and procedures.

The broker's central business office housing the call center is monitored by the vendor listening to reservations taken by customer service representatives, providing answers to questions & feedback to the brokers.

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

**Activity Details:**

[Empty text box]

**Clinical**

**Non-clinical**

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

**Activity Details:**

DMS monitors NET Brokers' compliance with the contract performance indicators through its oversight vendor. The DMS vendor conducts vehicle and driver inspections, collects data from the NET brokers, and compiles information collected from the NET Hotline to put together a monthly NET Report that is provided to DMS. DMS uses this data to assess NET broker compliance with the contract. If needed, DMS places the NET Brokers under a corrective action plan (CAP) or imposes sanctions under the contract.

**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:**

DMS's oversight vendor works with DMS to oversee Non-Emergency Transportation (NET) brokers' contractual requirements. DMS and its contractor review all written materials developed by the NET brokers before they can be utilized with clients. DMS oversees the activities of its vendor. DMS's vendor submits to DMS monthly and annually reports regarding monitoring activities for the NET program.

## Section C: Monitoring Results

### Renewal Waiver Request

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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:**

ACTIVITY - Consumer Self-Report Data (this is Item c. in Section B): The most recent period the NET client survey covers is January 1, 2021, through June 30, 2021. Survey results can be found at <https://afmc.org/health-care-professionals/arkansas-medicaid-providers/surveys-and-reporting/>.

PROBLEMS IDENTIFIED: DMS's oversight vendor conducts a biannual satisfaction survey of clients. DMS has been reviewing the latest survey, for Calendar Year 2021. While some sub-measures note improvement or no change when compared with prior years, a few of the more salient concerns from the survey include:

- “total satisfaction” composite
- “ease of getting a ride” composite
- “need of doctor’s approval to schedule ride” component of this composite
- “timeliness and reliability” composite
- “arrived at home” component
- “waited more than 30 minutes for pick-up” component
- “courtesy” composite
- “courtesy when calling for ride” component

CORRECTIVE ACTION: DMS is incorporating the Survey information into our approach to managing our relationships, and contracts, with the oversight vendor and brokers to and will work with them to address the most pressing concerns identified.

PROGRAM CHANGE: Being determined.

ACTIVITY - Data Analysis (non-claims)(this is Item d. in Section B): Information on results of monitoring data analysis and activities is available at <https://afmc.org/health-care-professionals/arkansas-medicaid-providers/net/>

PROBLEMS IDENTIFIED: Missed rides

CORRECTIVE ACTION: Current corrective action plan to address missed rides. PROGRAM CHANGE: None

ACTIVITY - Enrollee Hotlines (this is Item e. in Section B): DMS oversight vendor manages a NET Helpline. Periodic reporting is provided to DMS on a monthly basis. The data collected by the Helpline helps DMS evaluate program access and effectiveness and to identify ways to improve service quality. In the calendar year 2021, NET Helpline averaged 3,839 calls per quarter in 2021 96.6% of the calls were inquiries; the other 3.3 percent were complaints and issues.

PROBLEMS IDENTIFIED: Two top complaints were 1) No Provider/Driver Available & 2) No pick-up at residence.

CORRECTIVE ACTION: Current corrective action plan to address missed rides, and education provided for NET clients and PAHP brokers/sub-contracted NET transportation providers.

PROGRAM CHANGE: None

ACTIVITY - Network Adequacy Assurance by Plan [Required for MCO/PIHP/PAHP] (this is Item j. in Section B): State monitors encounter data and denial information to evaluate the utilization of transportation services in the NET program. The denials and complaints received by the Helpline are reviewed routinely by DMS to ensure clients are not being denied by the PAHP broker in order to manipulate the capitation system. DMS oversight vendor's monthly, quarterly and annual reports, based on the Helpline documentation, provides DMS with regular status updates to support DMS staff's role in the processes of evaluating access and effectiveness to aid in identifying quality improvement strategies. DMS oversight vendor distributes the reports to PAHP brokers and sub-contracted NET transportation providers regarding performance. NET Performance Profiles are posted online.

PROBLEMS IDENTIFIED: Based on the NET denial and complaint, no issue was left unresolved.

CORRECTIVE ACTION (plan/provider level): For most issues, corrective action involved the education of PAHP brokers, sub-contracted NET transportation providers and/or clients. Most issues were resolved immediately after the identification of the issue/problem.

PROGRAM CHANGE: None

ACTIVITY - On-site Review (this is Item I. in Section B: DMS oversight vendor monitors transporting of NET clients during pick-up and drop-off process at the original point of destination (residence), the facilities and medical appointments. Safety factors are observed, such as proper utilization of child safety buzzers, proper placement and installation of rear-facing infant seats, child safety seats and booster seats, as well as loading and unloading of wheelchairs and wheelchair securement. Periodic scheduled and non-scheduled onsite inspections take place by the NET vehicle monitor of the sub-contracted transportation providers' vehicles. NET transportation providers must submit a copy of their inspections to DMS oversight vendor. The information is entered into a database for tracking. DMS oversight vendor makes announced and unannounced visits to NET brokers' and transportation providers' business locations to review records, written policies, other required documentation and procedures and listen to call center representatives answer questions and take reservations for quality of service. DMS oversight vendor's last NET client satisfaction survey for the period 01/01/2021 - 06/30/2021 indicated 76% of clients were satisfied with the NET program; 88% were satisfied with the timeliness and reliability of the NET transportation drivers; 92% were satisfied with the courtesy of drivers and staff and 93% were satisfied w/ the safety of transport/riders.

PROBLEMS IDENTIFIED: Various vehicle infractions that were noted were corrected under the guidance of the DMS oversight vendor vehicle monitor. Statutory review of Federal and State laws regarding vehicle-operating condition with required safety equipment to reinforce importance of passenger safety were shared with NET brokers to increase compliance. Isolated improper utilization of wheelchair lift operations were noted with re-training for drivers & attendants to correct the issue. Safety factors are our highest priority.

CORRECTIVE ACTION: Validation of trip logs, review of policies and procedures, review of performance profiles and improvement recommendations and validation of training of NET transportation providers' new employees at time of hire and continued training thereafter are reviewed.

PROGRAM CHANGE: None

**Section D: Cost-Effectiveness**

**Medical Eligibility Groups**

Title				
	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	01/01/2020	12/31/2020	01/01/2021	12/31/2021
Enrollment Projections for the Time Period*	04/01/2023	03/31/2024	04/01/2024	03/31/2025
**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
Non-Emergency Transportation 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:**

State Medicaid Director or Designee

**Submission Date:**

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

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

**b. Name of Medicaid Financial Officer making these assurances:**

**c. Telephone Number:**

**d. E-mail:**

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

**date of payment.**

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

## Section D: Cost-Effectiveness

### Part I: State Completion Section

#### B. Expedited or Comprehensive Test

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

- b.** The State provides additional services under 1915(b)(3) authority.
- c.** The State makes enhanced payments to contractors or providers.
- d.** The State uses a sole-source procurement process to procure State Plan services under this waiver.
- e.** The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services,*

enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

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

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

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

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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

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

- a. MCO
- b. PIHP
- c. PAHP
- d. PCCM
- e. Other

Please describe:

This waiver functions to restrict client choice of Non-Emergency Medical Transportation providers to specific brokers operating within specified regions.

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

**D. PCCM portion of the waiver only: Reimbursement of PCCM Providers**

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

- a. **Management fees are expected to be paid under this waiver.**  
 The management fees were calculated as follows.
  - 1. Year 1: \$  per member per month fee.
  - 2. Year 2: \$  per member per month fee.
  - 3. Year 3: \$  per member per month fee.
  - 4. Year 4: \$  per member per month fee.
- b. **Enhanced fee for primary care services.**  
 Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under D.I.H.d., please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to

ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

**d. Other reimbursement method/amount.**

\$

Please explain the State's rationale for determining this method or amount.

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

**E. Member Months**

Please mark all that apply.

- a. [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

We assume that membership remains elevated due to the COVID-19 public health emergency (PHE) through June 2023, after which we assume that membership decreases consistent with internal DHS budget projections.

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

None

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

Calendar year

**Appendix D1 Member Months**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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

**For Conversion or Renewal Waivers:**

- a. [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.

Explain the differences here and how the adjustments were made on Appendix D5:

No difference in services.

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

No services were excluded from the cost effectiveness analysis.

**Appendix D2.S: Services in Waiver Cost**

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Non-Emergency Transportation Services							

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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

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

**The allocation method for either initial or renewal waivers is explained below:**

- a. **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees.***Note: this is appropriate for MCO/PCCM programs.*
- b. **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. **Other**  
Please explain:

**Appendix D2.A: Administration in Actual Waiver Cost**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

**H. Appendix D3 - Actual Waiver Cost**

- a. The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.
- b. **The State is including voluntary populations in the waiver.**  
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

- c. **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be

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

**Basis and Method:**

- 1. **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
- 2. **The State provides stop/loss protection**  
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

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

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

**Document**

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

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

**Document:**

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

**Appendix D3 Actual Waiver Cost**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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

**This section is only applicable to Initial waivers**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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**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**

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**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**

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**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**

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**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**

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**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**

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**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**

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

**This section is only applicable to Initial waivers**

**Section D: Cost-Effectiveness**

Part I: State Completion Section

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

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

- 1. [Required, if the States BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).

The actual trend rate used is:

Please document how that trend was calculated:

The waiver BYs are CY 2020 and CY 2021. Future years are projected using a 6.2% annual trend, which is consistent with recent cost increases. This 6.2% trend reflects a 0.0% utilization trend and 6.2% unit cost trend, consistent with recently observed changes in labor, vehicle operation, and fuel prices.

- 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.

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.

The waiver BYs are CY 2020 and CY 2021. Future years are projected using a 6.2% annual trend, which is consistent with recent cost increases. This 6.2% trend reflects a 0.0% utilization trend and 6.2% unit cost trend, consistent with recently observed changes in labor, vehicle operation, and fuel prices.

- 3. The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.

Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

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

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

**Appendix D4 Adjustments in Projection**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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

**b. State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
  - Reductions in State Plan Services (-)
  - Legislative or Court Mandated Changes to the Program Structure or fee
  - Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
  - Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.
1. The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
  2. An adjustment was necessary. The adjustment(s) is(are) listed and described below:
    - i. The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.  
Please list the changes.

For the list of changes above, please report the following:

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).  
PMPM size of adjustment
- B. The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment

- C. Determine adjustment based on currently approved SPA.  
PMPM size of adjustment

- D. Determine adjustment for Medicare Part D dual eligibles.

- E. Other:  
Please describe

- ii. The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii. Changes brought about by legal action:  
Please list the changes.

For the list of changes above, please report the following:

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

- B. The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment

- C. Determine adjustment based on currently approved SPA.  
PMPM size of adjustment

- D. Other  
Please describe

- iv. Changes in legislation.  
Please list the changes.

For the list of changes above, please report the following:

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

- B. The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment

- C. Determine adjustment based on currently approved SPA  
PMPM size of adjustment

- D. Other  
Please describe

- v. Other  
Please describe:

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

- B. The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment

- C. Determine adjustment based on currently approved SPA.  
PMPM size of adjustment

- D. Other  
Please describe

We used actual CY 2022 capitation rates, estimated CY 2023 rates, estimated enrollment by rate cell to calculate the est. P1 costs. Of the resulting R2 to P1 change, we assigned 6.2% to state plan services trend and the remainder to the programmatic/policy/pricing adjustment. Two primary drivers of this adjustment: updated experience data influencing capitation rates and impact of continued PHE.

### 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:

DHS' administrative expenses are trended to P1 and P2 at the same annual trend rate as the state plan service costs.

- 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.

[Empty rectangular box]

**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.

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**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.

[Empty rectangular box]

- 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:

Please see the discussion of enrollment changes in Section E.

- 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:

Please see the discussion of trends in section J.

- 3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of utilization given in Section D.I.I and D.I.J:

Please see the discussion of trends in section J.

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

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**Appendix D7 - Summary**