Facesheet: 1. Request Information (1 of 2)

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

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

Short title (nickname)	Long title	Type of Program	
ID Medicaid Plus	Idaho Medicaid Plus	MCO;	

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

Idaho Medicaid Plus

C. Type of Request. This is an:

☒ **Amendment request for an existing waiver.**
The amendment modifies (Sect/Part):

Section A: Part 1.D - Geographic Areas Served by the Waiver - Both of our health care providers will be expanding to new service areas.

Minor Edits throughout to update current status of ID Medicaid Plus Implementation.

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

- ○ **1 year**
- ○ **2 years**
- ○ **3 years**
- ◉ **4 years**
- ○ **5 years**

Draft ID:ID.015.00.01
Waiver Number:ID.0004.R00.01

D. Effective Dates: This amendment is requested for a period of 4 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)
Approved Effective Date of Base Waiver being Amended: 11/01/18
Proposed Effective Date: (mm/dd/yy)

01/01/20

Approved Effective Date: 01/01/20

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

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

Name:

Alexandra Fernandez

Phone: (208) 287-1179 **Ext:** ☐ **TTY**

Fax: (208) 332-7283

E-mail:

Alexandra.Fernandez@dhw.idaho.gov

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

☒ **Idaho Medicaid Plus**

Name:

Jennifer Pinkerton

Phone: (208) 287-1171 **Ext:** ☐ **TTY**

Fax: (208) 332-7283

E-mail:

Jennifer.Pinkerton@dhw.idaho.gov

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

Section A: Program Description

Part I: Program Overview

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

The Idaho Department of Health and Welfare (hereafter referred to as the "Department") sent tribal notifications on August 28, 2019 to the federally recognized tribes in Idaho (Coeur d'Alene, Kootenai, Nez Perce, Northwestern Band of the Shoshone Nation, Shoshone-Bannock and Shoshone-Paiute tribes) regarding the Idaho Medicaid Plus program for duals that are not enrolled in the Idaho Medicare Medicaid Coordinated Plan (MMCP). This tribal notification was also posted on August 28, 2019 to the Idaho Medicaid Program & Tribes of Idaho Teamsite located at https://healthandwelfare.idaho.gov/meditribe/Home/tabid/1331/Default.aspx.

These notices list the regions in which each of the participating health plans will be expanding their service area for Idaho Medicaid Plus. These proposed changes and updates were discussed at the Tribal Quarterly meeting on August 14, 2019. Notices sent to tribal representatives solicited feedback from the tribes on the proposed changes. Tribal members are exempt from mandatory enrollment into Idaho Medicaid Plus under this waiver.

The Department did not receive comments from tribal representatives on the draft waiver amendment.

Program History required for renewal waivers only.

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*

☒ **ID Medicaid Plus**

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*

☐ **ID Medicaid Plus**

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*

☐ **ID Medicaid Plus**

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*

☒ **ID Medicaid Plus**

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*

☒ **ID Medicaid Plus**

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*

☒ **ID Medicaid Plus**

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*

☒ **ID Medicaid Plus**

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

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

☐ **ID Medicaid Plus**

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*

☐ **ID Medicaid Plus**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

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

Idaho Code §56-263 provides direction to Idaho Medicaid to develop a plan for managed care for dual eligibles.

Idaho Medicaid will concurrently promulgate changes to Idaho Administrative Rules (IDAPA) to align with the program changes described in this waiver amendment. Temporary rules will go before the 2020 Idaho legislature for final approval; contingent upon securing approval from CMS to continue to operate this 1915(b) waiver.

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.)

Idaho Medicaid has a Medicare-Medicaid Coordinated Plan (MMCP) for dual-eligible individuals who enroll with a participating Medicare Advantage plan. This model is a voluntary program that permits a dual-eligible beneficiary to enroll in a single managed care organization (MCO) that receives capitation payments to deliver both Medicaid and Medicare services to the individual.

As a result of Idaho legislative direction in House Bill 260 in 2011, the Department also developed a managed long-term services and supports (MLTSS) program, Idaho Medicaid Plus, for dual-eligible individuals who have not elected to enroll in the MMCP. Idaho Medicaid Plus integrates behavioral health and long term services and supports and provide more efficient coordination of care than the FFS delivery system.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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

☒ **Procurement for MCO**

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

☐ **Procurement for PIHP**

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

☐ **Procurement for PAHP**

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

☐ **Procurement for PCCM**

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

☐ **Procurement for FFS**

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

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

The Department has developed a new contract with the existing Health Plans that currently operate the MMCP to administer the Idaho Medicaid Plus program to expand ID Medicaid Plus coverage to additional counties in Idaho. Medicaid seeks to phase-in implementation of mandatory enrollment in these additional counties. The Department successfully implemented Idaho Medicaid Plus as a pilot program in Twin Falls County in November, 2018. After the Department verified that performance benchmarks were met (including continuity of care indicators, claims payment requirements, and outreach activities), Idaho Medicaid Plus expanded to Bannock, Bingham, and Bonneville counties in April 2019, followed by Bonner, Kootenai, and Nez Perce in June 2019. The most recent expansion of Idaho Medicaid Plus occurred in Ada and Canyon Counties in August 2019. Expansion of mandatory enrollment beyond the currently active counties will be contingent upon the Health Plans meeting required performance benchmarks as specified in the contract.

Section A: Program Description

Part I: Program Overview

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

1. Assurances.

☒ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

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

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

Program: " **Idaho Medicaid Plus.** *"*

☒ **Two or more MCOs**

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

☐ **A PCCM or one or more MCOs**

☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☐ **Other:**

please describe

Section A: Program Description

Part I: Program Overview

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

3. Rural Exception.

☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the

following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

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

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

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

Section A: Program Description

Part I: Program Overview

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

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

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*

     ☐ **ID Medicaid Plus**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*

     ☒ **ID Medicaid Plus**
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)
Twin Falls/Bannock/Bingham/Bonneville/Ada/Canyon/Bonner	MCO	Blue Cross of Idaho
Twin Falls/Bannock/Bingham/Bonneville/Ada/Canyon/Bonner/Kootenai/Nez Perce	MCO	Molina HealthCare

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
		of Idaho
Kootenai/Nez Perce/Benewah/Shoshone/Latah/Washington/Valley/Adams/Gooding/Jerome	MCO	Blue Cross of Idaho
Boise/Boundary/Cassia/Elmore/Fremont/Gem	MCO	Molina Healthcare of Idaho
Jefferson/Madison/Minidoka/Owyhee/Payette/Power	MCO	Molina Healthcare of Idaho

Section A: Program Description

Part I: Program Overview

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

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

Twin Falls county was selected as the pilot county for Idaho Medicaid Plus, with the intention of expanding to all counties in which there are two or more participating Health Plans that administer Idaho Medicaid Plus. The Department successfully implemented ID Medicaid Plus in Twin Falls in November, 2018. Expansion into additional counties was contingent upon successful implementation in Twin Falls county and upon the participating Health Plans meeting the performance expectations established in the Provider Agreement for ID Medicaid Plus. After the Department verified that performance benchmarks were met (including continuity of care indicators, claims payment requirements, and outreach activities), ID Medicaid Plus expanded to Bannock, Bingham, and Bonneville counties in April 2019, followed by Bonner, Kootenai, and Nez Perce in June 2019. The most recent expansion of ID Medicaid Plus occurred in Ada and Canyon Counties in August 2019.

The Department has developed a new contract with the Health Plans that currently operate the MMCP and the ID Medicaid Plus program to expand ID Medicaid Plus coverage to additional counties in Idaho. Medicaid seeks to phase-in implementation of mandatory enrollment in these additional counties. Expansion of mandatory enrollment beyond the currently active counties will be contingent upon the Health Plans meeting required performance benchmarks as specified in the contract.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

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

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

☐ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level

pregnant women and optional group of caretaker relatives.

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

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

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

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

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

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

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

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

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

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

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

☒ **Other** (Please define):

ID Medicaid Plus is available to individuals residing in an approved geographic service area who meet all of the following criteria:

- Age 21 and older at the time of enrollment
- Entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and receive full Medicaid state plan benefits.
- Aged and Disabled waiver (ID.1076) members who meet all other ID Medicaid Plus criteria are also required to enroll.

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.

All individuals under age 21 are excluded.

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

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

☒ **Other** (Please define):

The following populations will be excluded from enrollment in ID Medicaid Plus:
• Individuals under the age of 21
• Pregnant women
• Individuals served under the Idaho Adult Developmental Disabilities 1915(c) Waiver (ID.0076)
• Dual eligible participants already enrolled in the Medicare Medicaid Coordinated Plan (MMCP)

Tribal members are not required to mandatorily enroll into ID Medicaid Plus but may elect to do so voluntarily. Tribal members may opt out of ID Medicaid Plus at any time.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

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

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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

1. Assurances.

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

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

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

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

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

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

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

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

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. Emergency Services. In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if

the emergency services provider does not have a contract with the entity.

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

Emergency Services Category General Comments (optional):

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

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):

All members enrolled in ID Medicaid Plus have Medicare as a primary payer. Consequently, their access to FQHC services is not impacted by the ID Medicaid Plus MCO.

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):

Not applicable. All members served under ID Medicaid Plus are over age 21.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

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

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

7. Self-referrals.

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

Self-referrals Requirements Category General Comments:

Self-referrals are allowed for the following services:

1) Emergency services
2) Urgent care services
3) Family planning services

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

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

The goal of this initiative is to improve coordination of care for all full-benefit Medicare-Medicaid enrollees ("dual eligibles") to improve beneficiary health and quality of life and enhance the quality and cost-effectiveness of long-term services and supports for this vulnerable population.

Dual eligibles often have difficulty navigating the complex Medicare and Medicaid systems to properly address their extensive medical needs, frequent care transitions, and interactions with multiple providers and provider types in various settings. Many complications arise because Medicare and Medicaid were not designed with an intention to serve people in both programs in a coordinated manner. As a result, there are different Medicare and Medicaid rules and processes for enrollment, benefits, appeals, administration, marketing, financing, and more. This current state of misalignment means that dual eligibles can greatly benefit from an approach under which one entity coordinates their full range of interactions with the health care system.

Consequently, Idaho has offered a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) under the MMCP since 2014 which provides integrated, comprehensive, seamless coverage to dual eligibles. The expanded delivery system has aligned the care delivery model and payment methodology to ensure high-quality, efficient care that leads to better health for Idaho's dual eligible citizens. The established MMCP ensures that all necessary Medicaid and Medicare services (including primary and acute care, pharmacy, behavioral health, and long-term supports and services) not otherwise carved out are provided, coordinated, and managed by the Health Plan. 1915(c) Developmental Disability Waiver services, 1915(i) Developmental Disabilities services, dental benefits, and non-emergency medical transportation will be carved out of the program and will continue to be covered through the Medicaid fee-for-service system.

Due to the limitations on passive or mandatory enrollment into Medicare Advantage plans, Idaho Medicaid intends to manage ID Medicaid Plus as an improved service delivery system for those dual eligibles who have not elected to enroll into the more integrated MMCP.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

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

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The States PCCM Program includes established standards for in-office waiting

times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

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

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

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

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

   Please describe the enrollment limits and how each is determined:

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

   Please describe the States standard:

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

   Please describe the States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

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

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

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

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

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

   Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

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

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

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

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

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

Section A: Program Description

Part II: Access

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

Section A: Program Description

Part II: Access

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

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

The following items are required.

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

Please provide justification for this determination:

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:

Enrollees that require institutional level of care will be identified to the health plan in accordance with 42 CFR 438.208. This information is available to the Health Plans via a standard 834 file transaction.

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:

Enrollees will receive a Wellness Assessment of medical, behavioral health, substance use, LTSS and social needs. Assessment domains may include: social, functional, medical, behavioral, wellness and prevention, and Enrollees' preferences, strengths and goals. Each Health Plan must submit their assessment template to the Department for review and approval. Relevant and comprehensive sources, including the Enrollee, providers, family/caregivers/service providers, etc., will be used. Results are used to confirm the risk stratification level and the basis for developing the Individualized Care Plan. All Enrollees receive an assessment within 90 days of enrollment and at least annually thereafter. A reassessment must be completed when there is a change in the Enrollee's health and/or functional status that results in an increased need for services and supports, a significant health care event, or as requested by the Enrollee. Assessments will be conducted by health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials, and are appropriate for responding to or managing the Enrollee's needs. There are no enrollment limits.

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:

The Health Plans must have a process in place ensuring that enrollees are permitted to directly access specialists, under appropriate circumstances. This provision is included as part of the contract with the Health Plans.

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.

In accordance with 42 CFR 438.207, the Health Plans must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

The Health Plans must maintain a network of appropriate providers, supported by written agreements, sufficient to provide adequate access to all services covered under the contract, and the Health Plan must comply with federal requirements in 42 CFR §422.112 regarding access to services. The enrollee may choose from the available providers within a health plan's network.

1. Medical and pharmacy network adequacy requirements will be based on Medicare requirements.
2. The State's network adequacy requirements will be used for Medicaid-only services.

For services for which Medicaid is the traditional primary payer (including LTSS and Community-Based Outpatient Behavioral Health Services), each Enrollee must have a choice of at least two providers located within:
i. 30 miles or within 30 minutes of travel within Ada, Bannock, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls counties, and
ii. Within 45 miles or within 45 minutes in all other counties.

For LTSS provider types that travel to the Enrollee to deliver services, the Health Plans shall ensure that the provider-to-Enrollee ratio is comparable to the provider-to-participant ratio in FFS Medicaid.

Additionally, the Health Plans must offer a transition period of the first ninety (90) days of enrollment during which the enrollee may continue to receive services from providers with whom there was already a relationship.

Each enrollee will have a care specialist and an Individualized Care Plan to ensure improved care coordination. The care specialist must communicate with other providers and health care facilities about any health issues that could affect an enrollee's care.

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

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

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

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

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

☒ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:
06/01/18 (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	Telligen		All mandatory activities as described in §438.358	N/A
PIHP				

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

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

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

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

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

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

   Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

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

1. Provider Selection Process:
• The Department will contract with managed care entities that are D-SNP providers that are willing and qualified to execute the functions described in the contract.
• The Health Plans must demonstrate they are ready to implement the program by successfully passing a Readiness Review prior to go-live of the program.

2. How the State assures quality in the services:
• The Department requires the Health Plans to report on all aspects of programming, network functioning, utilization management, service delivery, and operations and claims processing as well as all other areas of performance required by the contract.
• The Department will monitor the contract on a monthly basis.
• The Department will draw conclusions from the data provided by the Health Plans in combination with the data the State directly collects and will report level of compliance with performance requirements back to the Health Plans via routine Contract Monitor Reports.
• In the event the deficiencies are detected, the Health Plans are required to submit to the Department their corrective action and ameliorative processes to ensure improved quality.
• The Department will continue in an iterative process of obtaining data and working with the Health Plans to ensure continuous quality improvement.
• In accordance with 42 CFR 438.350, an External Quality Review Organization (EQRO) will complete an annual quality review on each health plan.

3. Quality and Performance Standards:
The Health Plans must:
• Engage in ongoing quality assurance work that includes reporting on quality of care concerns and submitting plans for how the deficits in quality will be addressed.
• Conduct enrollee and provider satisfaction surveys and must incorporate such feedback into its policies, procedures and operations.
• Report performance quarterly and annually to the State using measures provided by the State.
• Use industry recognized methodologies to analyze quality assurance data.
• Monitor performance of its provider network and have a plan for improving the network’s performance.
• Conduct utilization management activities and respond to over and under-utilization.
• Establish a compliance program and conduct surveillance activities for fraud and abuse issues and must report on these findings.
• Develop a Disaster Recovery Plan that describes how they will ensure continuity of service administration in the event of a disaster.

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:

Mailings, radio, and television advertising are permitted within sixty (60) days prior to member enrollment in a new county into ID Medicaid Plus. The Health Plan may also post written outreach and promotional materials at sites statewide upon approval from the Department.

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:

Direct mail is permitted. However, in accordance with 42 CFR 438.104, the Health Plan must not, either directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

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:

The State allows the dissemination of token gift items to potential enrollees including nominal gifts such as pens, key chains, magnets, etc. Any gift with a monetary value exceeding $25.00 is prohibited. Reports of gifts or other incentives in violation of this policy will be investigated by the Department as needed.

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):

Spanish and each Limited English Proficiency group that constitutes five percent (5%) or more of Enrollees or one thousand (1,000) or more Enrollees in the Health Plan's statewide service area, whichever is less.

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 5 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:

The Department will limit direct marketing and outreach activities to potential Enrollees outside of open enrollment periods to minimize potential misinformation.

Section A: Program Description

Part IV: Program Operations

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

1. Assurances

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

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

2. Details

a. Non-English Languages

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

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

Spanish. Health plans will include a Spanish phrase in materials to inform Spanish-speaking members how to obtain a copy of the material in Spanish.

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

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

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

Please explain how the State defines significant.:

Any Limited English Proficiency group that constitutes five percent (5%) or more of Enrollees or one thousand (1,000) or more Enrollees in the Health Plan's statewide service area, whichever is less.

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

c. ☐ Other

Please explain:

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

The contract issued by the Department requires the Health Plans to establish policies to ensure Enrollees have access to oral interpretive services, at no cost to Enrollees, that are available statewide.

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

Please describe:

Health Plans must offer informational materials to enrollees upon enrollment and ongoing; and access to customer service staff who can explain and answer questions about the program.

The Department has a dedicated toll-free contact number for Enrollees and Potential Enrollees to access assistance in choice counseling and for support in understanding the managed care programs available to them.

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☒ State
☒ Contractor

Please specify:

Information is distributed by both the State and the Health Plans. All Enrollee and potential Enrollee materials require prior approval by the Department.

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

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

c. Enrollee Information

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

☒ the State

☐ State contractor

Please specify:

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

Section A: Program Description

Part IV: Program Operations

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

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

The Department will distribute notices and materials to potential Enrollees to advise them of the open enrollment period during which they can make an active selection of a Health Plan to administer their ID Medicaid Plus program. Once the open enrollment period has concluded, the Health Plans are responsible for distributing materials to members enrolled with the plan through active selection or auto-assignment by the Department.

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:

The Department continues to engage in extensive outreach efforts to inform stakeholders of the continued implementation of ID Medicaid Plus. Outreach activities include:

• Town-hall style meetings with dual-eligible participants statewide. All dual eligible Medicaid beneficiaries received invitations to meetings hosted throughout the month of May 2018. Thirty-one (31) meetings were hosted in various locations throughout the state and at varying times of day to maximize opportunities for duals to attend.

• The Department presented at the Idaho Healthcare Conference in Post Falls, Sandpoint, and Boise in May 2018. The annual Healthcare Conference is a well-attended provider conference and includes a broad audience of stakeholders.

• Changes to Idaho Code (IDAPA) to align with the ID Medicaid Plus program required outreach as part of the rule promulgation process. A Negotiated Rulemaking meeting was hosted on May 16, 2018, in Twin Falls, Idaho, with a WebEx and toll-free conference call option for those unable to attend in-person to share information about the proposed rules and solicit feedback. Public hearings to solicit additional testimony about the implementation of Idaho Medicaid Plus were held August 14, 15, and 16 in Boise, Idaho Falls, and Lewiston, respectively.

• Medicaid hosts quarterly Dual-Eligible Stakeholder meetings via WebEx to provide regular updates on the MMCP and will include updates on the progress of implementing Idaho Medicaid Plus.

• The MedicAide newsletter, which is a monthly digital communication distributed to Medicaid providers, has included articles with updates and information about the MMCP and included information about the implementation of Idaho Medicaid Plus.

• Medicaid hosts a webpage dedicated to information and materials for Dual-Eligible stakeholders at http://mmcp.dhw.idaho.gov that is regularly updated.

• Medicaid staff also routinely provide education and informational presentations upon request for a variety of stakeholder groups, including
o SHIBA
o Justice Alliance for Vulnerable Adults (JAVA)
o State Independent Living Council (SILC)
o Medicaid Personal Assistance Oversight Committee (subcommittee of the MCAC)
o Family Caregiver Alliance
o Idaho Healthcare Association (Skilled Nursing Facilities, Residential Assisted Living Facilities, hospitals)
o Idaho Association of Home Care Providers (Personal Assistance Agencies)

• The Department published notice in the newspapers of widest circulation in the state, the Idaho Press Tribune, the Idaho Statesman, the Idaho State Journal, the Post Register, and the Coeur D'Alene Press, notifying stakeholders of the opportunities for comment on this 1915(b) waiver amendment on August 28, 2019.

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:

During the open enrollment period, potential Enrollees may contact the Department to identify their Health Plan of choice. Department staff will complete the enrollment. Potential Enrollees may also contact their Health Plan of choice, in which case the Health Plan will complete a warm transfer to the Department to complete the enrollment.

The Department will complete Enrollee requests for disenrollment for cause and the enrollment into another participating Health Plan. Requests for disenrollment for cause will be effective the first of the month following the month in which the request was made.

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.):

ID Medicaid Plus was implemented in Twin Falls county effective November 1, 2018 with an open enrollment period occurring from July 1, 2018 through September 30, 2018.

The Department phased in additional counties in which there are two or more participating Health Plans after successful implementation in Twin Falls county and upon meeting the quality and performance standards as outlined in the contract with the Health Plans. The phase-in of each of the additional 8 counties (Bonneville, Bingham, Bannock, Bonner, Kootenai, Nez Perce, Ada, and Canyon) was completed in August 2019.

The Department plans to expand to the following additional 20 counties during the 2020 Contract Year: Adams, Benewah, Boise, Boundary, Cassia, Elmore, Fremont, Gem, Gooding, Jefferson, Jerome, Latah, Madison, Minidoka, Owyhee, Payette, Power, Shoshone, Valley, and Washington.

☐ 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 90 ◉ **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:

Auto-assignment will be stratified by population to ensure equitable assignment of case mix between the Health Plans. Populations include: individuals residing in institutional settings, individuals receiving Home and Community-Based Services (HCBS), and individuals who do not receive or reside in institutional settings.

Individuals who voluntarily elect to disenroll from the more integrated MMCP are auto-assigned to the same Health Plan to administer their ID Medicaid Plus benefits to ensure a smooth transition.

☐ 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 12 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):

Enrollees may request disenrollment from their current Health Plan for the following reasons:

(i) The enrollee moves out of the ID Medicaid Plus service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) For enrollees that use MLTSS, the enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider, would experience a disruption in their residence or employment.

(v) Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs.

Upon disenrollment from the current Health Plan, the Enrollee will be assigned to another participating Health Plan.

☐ 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

An Enrollee may be subject to an optional involuntary disenrollment if the Enrollee's continued enrollment seriously impairs the Health Plan's ability to furnish services to either the individual or other Enrollees, provided the Enrollee's behavior is determined to be unrelated to an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

Upon disenrollment from the current Health Plan, the Enrollee will be assigned to another participating Health Plan.

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

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

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

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

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

PAHP, or PCCM.

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

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

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

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 120 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:

Participants are required to exhaust the Health Plan appeal system before filing for a State Fair Hearing. In accordance with 42 CFR §438.408(f)(2), participants may file a request for a State Fair Hearing up to 120 calendar days from the date of the Health Plan's notice of resolution upholding the adverse benefit determination.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

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

The prohibited relationships are:

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

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP	☒ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☒ MCO ☐ PIHP	☒ MCO ☐ 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
Data Analysis (non-claims)	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO	☐ 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
On-Site Review	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Access

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

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

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Quality

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

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

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

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

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

Programs Authorized by this Waiver:

Program	Type of Program
ID Medicaid Plus	MCO;

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Idaho Medicaid Plus

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

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

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

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

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

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

Enrollee feedback is collected via a standardized Quality Survey used as part of the administration of the 1915(c) Aged and Disabled Waiver, in addition to an Issue Log tracking database.

Quality Survey.
Personnel Responsible: Bureau of Long Term Care (BLTC) Nurse Reviewers, Department Contract Monitor, Health Plan staff
Description of Activity: BLTC Nurse Reviewers conduct level-of-care assessments for Enrollees that access services under the 1915(c) Aged and Disabled Waiver. As part of the assessment process, Enrollees are asked questions pertaining to the quality of and access to HCBS.
Frequency of Use: Quarterly
Information Obtained: Data regarding quality of and access to HCBS by Enrollees, as well as data on Health Plan remediation of issues detected.

Issue Log
Personnel Responsible: Department Staff, Department Contract Monitor
Description of Activity: Regional Department staff who receive complaints from Enrollees or reports of potential issues with the administration of Idaho Medicaid Plus and MMCP log the report in a SharePoint Issue Log. The Issue Log is configured with automated notifications to route items appropriately to the correct Department staff for investigation and follow-up. The Department Contract monitor is responsible for overseeing the investigation and remediation of items on the Issue Log, in addition to aggregating data to identify potential trends or compliance issues on behalf of the Health Plans.
Frequency of Use: Ongoing
Information Obtained: Summary data regarding complaints or potential issues with the administration of the program.

☐ **CAHPS**

Please identify which one(s):

☒ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

The Health Plans supply routine monthly, quarterly, and annual reports that are validated during quarterly on-site audits.

Personnel Responsible: Health Plan staff, Department Contract Monitor
Description of Activity: The Health Plans supply regular reports on a variety of functions. Reports include:

- Service denials by service type, including denial reason.
- Grievance and appeal logs.
- Critical Incident resolution.
- Systems availability and performance (claims and case management systems)
- Provider network data – timeliness of services and geographical access
- Care coordination reports
- Quality Management/Quality Improvement (QM/QI reports)

Frequency of Use: Monthly, Quarterly
Information Obtained: Data pertaining to Health Plan performance of contract functions across multiple areas, in addition to trends in performance over time.

☒ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

☐ **From plan**

☐ **From PCP within plan**

☒ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☒ **Enrollee Hotlines**

Activity Details:

The Health Plans must offer customer service to participants via phone during normal business hours, at least 40 hours per week, by trained representatives knowledgeable about contracted services. If the Health Plans elect to operate a Nurse Advice Line separately from the customer service line, it must be staffed by a Registered Nurse (or a healthcare professional with more advanced qualifications) and available twenty four (24) hours per day, seven (7) days per week.

Personnel Responsible: Health Plan staff, Department Contract Monitor
Description of Activity: The health plan will provide written documentation of the availability of these phone lines, along with the phone numbers and hours of operation.
Frequency of Use: Quarterly
Information Obtained: Written verification of the customer service phone number and hours of operation. The health plan will submit quarterly reports including call data (total number of calls, caller wait times, types of requests made by caller, etc.). In addition, the Department may request call logs or audio files of specific calls to investigate complaints or issues.

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:

In accordance with CFR 42.438.350, a qualified External Quality Review Organization (EQRO) will perform an annual external quality review for each contracting Health Plan.

Personnel Responsible: Department Contract Monitor
Description of Activity: An EQRO will perform an external quality review for each contracting Health Plan and report results to the Department.
Frequency of Use: Annual
Information Obtained: Health plan performance via the required EQR protocols.

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

Activity Details:

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

Activity Details:

In accordance with 42 CFR 438.207, the Department requires the Health Plans to develop and maintain networks of providers that are sufficient in number, mix, and geographic distribution to meet the needs of participants in each service area.

Personnel Responsible: Department Contract Monitor
Description of Activity: The Department will monitor provider network development, including enrollment, selection, and maintenance of the network to specifically identify the capacity to deliver the required services.
Frequency of Use: Annual
Information Obtained: The reports supplied by the health plans must identify the enrollment of network providers in relation their location in the state and ability to meet participants' needs. A provider network file in addition to a geographic access report is supplied on a semi-annual basis for evaluation by the Department.

k. ☐ **Ombudsman**

Activity Details:

l. ☒ **On-Site Review**

Activity Details:

The Department conducts quarterly on-site audits with the Health Plans.

Personnel Responsible: Department Contract Monitor and Contract Manager, Health Plans
Description of Activity: Department staff conduct quarterly on-site audits with the Health Plans to validate data supplied by the Health Plan in prior reporting periods and to conduct targeted reviews of specific compliance areas. The Department notifies the Health Plan in advance of any targeted compliance areas that will be evaluated during the on-site audit and selects a sample (of Enrollees, Providers, service codes, etc.) prior to the on-site visit to validate. The Health Plan is issued a Contract Monitor Report summarizing the Department's findings.
Frequency of Use: Quarterly
Information Obtained: Validation of data supplied by the Health Plans during routine reporting, in addition to evaluation of targeted compliance areas to evaluate Health Plan performance of contract functions.

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

Activity Details:

The Department will require the Health Plans to, in accordance with 42 CFR 438.240, utilize an ongoing performance improvement program for the services it furnishes to its Enrollees. The program must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. The performance improvement plan must take into account performance measures required by the Department. The Department requires that participating Health Plans conduct PIPs that address both clinical and nonclinical areas.

Personnel Responsible: Department Contract Monitor
Description of Activity: The Health Plans will send the Department a copy of their performance improvement plan and their evaluation of its effectiveness.
Frequency of Use: Annually and upon request.
Information Obtained: Planned measurements and interventions to improve performance, and effectiveness of performance improvement plans.

☐ **Clinical**

☒ **Non-clinical**

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

Activity Details:

The Department requires the Health Plans to meet all minimum performance thresholds established in the contract.

Process
Personnel Responsible: Health Plan staff, Department Contract Monitor
Description of Activity: The Department maintains oversight of a variety of Health Plan processes, including: timely service authorization decisions, timely and accurate appeal and grievance resolutions, care coordination outreach to new Enrollees, and wellness assessment completion, among other contractually required processes. The Department Contract Monitor maintains oversight of these activities via routine reports delivered by the Health Plan, in addition to requesting ad hoc reports or conducting targeted reviews during quarterly on-site visits when potential issues are detected. Performance thresholds are established in the contract with the Health Plans. Failure to meet performance thresholds results in a request for corrective action.
Frequency of Use: Monthly, Quarterly, and Annual
Information Obtained: Health Plan compliance with process requirements outlined in the contract.

Health status/outcomes
Personnel Responsible: Health Plan, Department Contract Monitor
Description of Activity: The Health Plan is required to complete a wellness assessment for all new Enrollees and at least annually thereafter. The required timelines for completing wellness assessments are dependent upon the individual Enrollee's risk stratification level. The risk stratification level is assigned based on the Enrollee's current needs. This is monitored via the Care Coordination Assessment report, which is due from the Health Plan on a monthly basis. Data is validated during the quarterly on-site audit.
Frequency of Use: Monthly, Quarterly
Information Obtained: Health Plan compliance with risk stratification and care coordination outreach requirements.

Access/availability of care
Personnel Responsible: Health Plan, Department Contract Monitor
Description of Activity: The Health Plan is required to ensure its provider network is robust enough to ensure compliance with the access standards outlined in the contract. This data is supplied to the Department via routine reporting and validated during quarterly on-site audits.
Frequency of Use: Quarterly and Ongoing
Information Obtained: Health Plan compliance with access standards established in the contract.

Use of services/utilization
Personnel Responsible: Health Plan, Department Contract Monitor
Description of Activity: The Health Plan is required to identify Enrollees who are authorized to receive HCBS under the Aged and Disabled 1915(c) waiver who have not utilized a waiver service in over 30 days to conduct outreach to the Enrollee. In addition, the Health Plan is required to have procedures in place to detect both over-utilization and under-utilization of services.
Frequency of Use: Quarterly
Information Obtained: Health Plan compliance with contract requirements pertaining to utilization management and 1915(c) waiver assurances.

Health plan stability/financial cost of care
Personnel Responsible: Health Plan, Department Contract Monitor, Department Actuarial Firm
Description of Activity: The Health Plan is required to submit financial data on an annual basis to the Department's actuarial firm for the purposes of calculating the Medical Loss Ratio for the contract year. The Health Plan is required to maintain a Medical Loss Ratio corridor as specified in the contract.

Frequency of Use: Annual
Information Obtained: Validation that Health Plan expenses incurred meet the minimum required Medical Loss Ratio of 85%, and a determination of whether the capitation rate for the upcoming contract year must be adjusted.

- [x] **Process**
- [x] **Health status/ outcomes**
- [x] **Access/ availability of care**
- [x] **Use of services/ utilization**
- [x] **Health plan stability/ financial/ cost of care**
- [ ] **Health plan/ provider characteristics**
- [ ] **Beneficiary characteristics**

o. [x] **Periodic Comparison of # of Providers**

Activity Details:

The Department requires the Health Plans to submit a provider network report which includes information on all providers of Medicaid services, including physical, behavioral health, and long-term care providers.

Personnel Responsible: Department contract monitor
Description of Activity: The Department will review reports submitted by the Health Plans to ensure they meet contractual requirements regarding the number of providers for Medicaid services. The Health Plans are expected to ensure that there is a sufficient number and mix of providers to meet the needs of the Enrollees in the geographic service area.
Frequency of Use: Quarterly
Information Obtained: The Department will obtain information regarding whether network adequacy requirements are being met and whether the number of providers is increasing or decreasing.

p. [x] **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

The Department's Medicaid Program Integrity Unit (MPIU) will have access to encounter data submitted by the Health Plans for analysis.

Personnel Responsible: MPIU staff
Description of Activity: MPIU staff conduct targeted data reviews of provider utilization to detect patterns that may be indicative of potential program integrity concerns. Once encounter data submission has been established between the Health Plans and the state's MMIS, MPIU will have access to Health Plan claims paid in addition to FFS claims data for analysis.
Frequency of Use: Ongoing
Information Obtained: Program integrity compliance on behalf of Health Plan network providers, in addition to information about Health Plan monitoring of potential program integrity concerns.

q. [x] **Provider Self-Report Data**

Activity Details:

The Department requires the Health Plans to report data from provider surveys.

Personnel Responsible: Health Plan staff, Department Contract Monitor
Description of Activity: Health Plans are required to conduct a provider survey at least annually that captures provider satisfaction with utilization management as well as provider compliance with access standards. In the event that a Health Plan identifies deficiencies in either area, a plan that details the correct action taken to remediate the issue must accompany the report furnished to the Department.
Frequency of Use: Annual
Information Obtained: The Department will obtain information about provider satisfaction with Health Plan utilization management policies and procedures, and provider compliance with access standards.

☒ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

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

Activity Details:

The Department requires the Health Plans to adopt and implement utilization management practices sufficient to meet the needs of participants. Health Plans are required to submit policies and procedures associated with utilization management practices to the Department for approval prior to implementation and at least annually thereafter. The Department will be able to validate aspects of utilization review via encounter claims submission and on-site reviews.

Personnel Responsible: Department Contract Monitor
Description of Activity: The Department will monitor utilization of services derived from analyses of encounter claims data.
Frequency of Use: Annual
Information Obtained: The Department will obtain administrative claims data from the encounter claims submitted by the health plan, including information on high-cost claimants, emergency department visits, and Aged and Disabled Waiver service utilization.

t. ☒ **Other**

Activity Details:

The Department monitors Health Plan marketing and outreach to ensure compliance with applicable contract requirements and state and federal regulations.

Personnel Responsible: Department Contract Monitor
Description of Activity: All Health Plan marketing and outreach materials, including direct mailers, call center scripts, and public-facing materials pertaining to Idaho Medicaid Plus must be prior approved by the Department. The Department utilizes a SharePoint for Health Plans to submit materials for review. The Department validates that Health Plans are only using approved materials during quarterly on-site audits and upon request in the event that potential issues are reported to the Department.
Frequency of Activity: Quarterly and Ongoing
Information Obtained: Health Plan compliance with marketing and outreach contract, state, and federal requirements.

Section C: Monitoring Results

Initial Waiver Request

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

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

This is an Initial waiver request.

☒ **The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.**

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Full Dual Eligibles	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**				
Enrollment Projections for the Time Period*	11/01/2018	09/30/2019	10/01/2019	09/30/2020

**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	
Inpatient Hospital Services	☒	☐	☒	
Outpatient Hospital Services	☒	☐	☒	
Emergency Hospital Services	☒	☐	☒	
Ambulatory Surgical Center Services	☒	☐	☒	
Physician Services - Medical Services	☒	☐	☒	
Physician Services - Surgical Services	☒	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Other Practitioner Services	☒	☐	☒	
Prevention Services	☒	☐	☒	
Screening Services	☒	☐	☒	
Laboratory and Radiological Services	☒	☐	☒	
Prescribed Drugs	☒	☐	☒	
Family Planning Services	☒	☐	☒	
Mental Health Services - Inpatient Psychiatric Services	☒	☐	☒	
Mental Health Services - Community-Based Outpatient Behavioral Health Services	☒	☐	☒	
Case Management Services	☒	☐	☒	
Home Health Services	☒	☐	☒	
Therapy Services (Physical Therapy, Occupational Therapy, Speech Language Pathology)	☒	☐	☒	
Audiology Services	☒	☐	☒	
Medical Equipment, Supplies and Devices; Medical Equipment and Supplies	☒	☐	☒	
Medical Equipment, Supplies and Devices; Prosthetic Devices	☒	☐	☒	
Vision Services	☒	☐	☒	
Essential Providers - Rural Health Clinic Services	☒	☐	☒	
Essential Providers - Federally Qualified Health Center Services	☒	☐	☒	
Essential Providers - Indian Health Services Facility Services	☒	☐	☒	
Long-Term Care Services; Nursing Facility Services	☒	☐	☒	
State Plan Personal Care Services	☒	☐	☒	
Home and Community-Based Services - Aged and Disabled 1915(c) waiver	☒	☐	☒	
Hospice Care	☒	☐	☒	
Substance Abuse Treatment Services	☒	☐	☒	
Dental Services	☒	☐	☐	
Non-Emergency Medical Transportation	☒	☐	☐	
Preventive Health Assistance	☒	☐	☒	

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: Robin Butrick

State Medicaid Director or Designee

Submission Date: Sep 30, 2019

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

b. Name of Medicaid Financial Officer making these assurances:

Aaron Howard

c. Telephone Number:

(208) 287-1141

d. E-mail:

Aaron.Howard@dhw.idaho.gov

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

This section is only applicable to Renewals

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:

Idaho Medicaid will enter into a Medicaid Managed Long Term Services and Supports (MLTSS) agreement with participating Health Plans that also administer the Medicare Medicaid Coordinated Plan (MMCP) in the state of Idaho.

Payments to health plans will be blended capitation payments based on an actuarial analysis of historical costs and projected costs for duals' Medicaid services.

The payment rate to each Health Plan will reflect the membership mix by geographic service area at the implementation of Idaho Medicaid Plus. Material shifts in the membership mix will result in an update to the plans' composite rate. In addition, the Scope of Work between Department and Health Plans outlines a process for medical loss ratio settlements.

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. ☒ Population in the base year data

1. ☒ Base year data is from the same population as to be included in the waiver.

2. ☐ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b. ☐ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

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

Increase in eligible participants.

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

There is no additional variance in eligible member months.

e. ☒ [Required] List the year(s) being used by the State as a base year:

2018

If multiple years are being used, please explain:

f. ☒ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

FFY

g. ☒ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

N/A

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

For Conversion or Renewal Waivers:

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

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

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

Beneficiaries served under Idaho Medicaid Plus will access dental and non-emergency medical transportation under different approved 1915(b) waivers.

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
Inpatient Hospital Services	☒	☐	☐	☐	☐	☐	☐
Outpatient Hospital Services	☒	☐	☐	☐	☐	☐	☐
Emergency Hospital Services	☒	☐	☐	☐	☐	☐	☐
Ambulatory Surgical Center Services	☒	☐	☐	☐	☐	☐	☐
Physician Services - Medical Services	☒	☐	☐	☐	☐	☐	☐
Physician Services - Surgical Services	☒	☐	☐	☐	☐	☐	☐
Other Practitioner Services	☒	☐	☐	☐	☐	☐	☐
Prevention Services	☒	☐	☐	☐	☐	☐	☐
Screening Services	☒	☐	☐	☐	☐	☐	☐
Laboratory and Radiological Services	☒	☐	☐	☐	☐	☐	☐
Prescribed Drugs	☒	☐	☐	☐	☐	☐	☐
Family Planning Services	☒	☐	☐	☐	☐	☐	☐
Mental Health Services - Inpatient Psychiatric Services	☒	☐	☐	☐	☐	☐	☐
Mental Health Services - Community-Based Outpatient Behavioral Health	☒	☐	☐	☐	☐	☐	☐

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
Services							
Case Management Services	☒	☐	☐	☐	☐	☐	☐
Home Health Services	☒	☐	☐	☐	☐	☐	☐
Therapy Services (Physical Therapy, Occupational Therapy, Speech Language Pathology)	☒	☐	☐	☐	☐	☐	☐
Audiology Services	☒	☐	☐	☐	☐	☐	☐
Medical Equipment, Supplies and Devices; Medical Equipment and Supplies	☒	☐	☐	☐	☐	☐	☐
Medical Equipment, Supplies and Devices; Prosthetic Devices	☒	☐	☐	☐	☐	☐	☐
Vision Services	☒	☐	☐	☐	☐	☐	☐
Essential Providers - Rural Health Clinic Services	☒	☐	☐	☐	☐	☐	☐
Essential Providers - Federally Qualified Health Center Services	☒	☐	☐	☐	☐	☐	☐
Essential Providers - Indian Health Services Facility Services	☒	☐	☐	☐	☐	☐	☐
Long-Term Care Services; Nursing Facility Services	☒	☐	☐	☐	☐	☐	☐
State Plan Personal Care Services	☒	☐	☐	☐	☐	☐	☐
Home and Community-Based Services - Aged and Disabled 1915(c) waiver	☒	☐	☐	☐	☐	☐	☐
Hospice Care	☒	☐	☐	☐	☐	☐	☐
Substance Abuse	☒	☐	☐	☐	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Treatment Services							
Dental Services	☐	☐	☐	☐	☐	☒	☐
Non-Emergency Medical Transportation	☐	☐	☐	☐	☐	☒	☐
Preventive Health Assistance	☒	☐	☐	☐	☐	☐	☐

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:

State staff resource allocation associated with program administration and oversight (non-MMIS) - calculated from appropriation bill on the Coordinated Plan, administration cost of 0.09%.

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)

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. State Plan Services Trend Adjustment the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. 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 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present)
The actual trend rate used is:

Please document how that trend was calculated:

2. ☒ [Required, to trend BY 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

2015-2017

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

Linear regression

ii. ☐ National or regional factors that are predictive of this waivers future costs.
Please indicate the services and indicators used.

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

3. ☐ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost

increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the 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.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. 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.*

Others:

- **Additional State Plan Services (+)**
- **Reductions in State Plan Services (-)**
- **Legislative or Court Mandated Changes to the Program Structure or fee**

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:

The population enrolled into IMPlus may shift in case mix after implementation. Institutional members may remain in Idaho Medicaid Plus while the HCBS and Community Well populations transition to the MMCP. There is only one MEG for all duals rather than ILOC versus HCBS versus community well - since this can't be reflected in one MEG it was reflected as a risk factor.

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

Size of adjustment was based on projected case mix differential between IMPlus and MMCP.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

c. Administrative Cost Adjustment*: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *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. ☐ FFS administrative functions will change in the period between the beginning of P1 and the end of P2.
Please describe

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)
Please describe

C. ☐ Other
Please describe

ii. ☒ FFS 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. ☒ Other
Please describe

A 0.09% adjustment for increase in FFS administration costs was calculated from the appropriation bill on the Coordinated Plan.

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.I.a. above

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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 States trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from Section D.I.I.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:

f. Graduate Medical Education (GME) Adjustment: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. ☐ We assure CMS that GME payments are included from base year data.

2. ☐ We assure CMS that GME payments are included from the base year data using an adjustment.
Please describe adjustment.

3. ☐ Other
Please describe

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5.**

1. ☐ GME adjustment was made.
   i. ☐ GME rates or payment method changed in the period between the end of the BY and the beginning of P1.
   Please describe

   ii. ☐ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2.
   Please describe

2. ☐ No adjustment was necessary and no change is anticipated.

Method:

1. ☐ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2. ☐ Determine GME adjustment based on a pending SPA.
3. ☐ Determine GME adjustment based on currently approved GME SPA.
4. ☐ Other
Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

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

g. ***Payments / Recoupments not Processed through MMIS Adjustment:*** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in ***Appendix D5.***

1. ☐ Payments outside of the MMIS were made.

Those payments include (please describe):

2. ☐ Recoupments outside of the MMIS were made.
Those recoupments include (please describe):

3. ☒ The State had no recoupments/payments outside of the MMIS.

h. ***Copayments Adjustment:*** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. ☒ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. ☐ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ☐ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. ☐ Other
Please describe

If the States FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.
2. ☐ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

***Method*:**

1. ☐ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. ☐ Determine copayment adjustment based on pending SPA.
3. ☐ Determine copayment adjustment based on currently approved copayment SPA.
4. ☐ Other
Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

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

i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. ☒ No adjustment was necessary
2. ☐ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. ☐ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. ☐ The State made this adjustment:*
   i. ☐ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in Appendix D5.
   ii. ☐ Other
   Please describe

j. **Pharmacy Rebate Factor Adjustment:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or 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.
   Please describe
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. ☒ Ohter
   Please describe

   Only non-part D drugs are included in capitation rate.

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under Other including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1. ☒ We assure CMS that DSH payments are excluded from base year data.
2. ☐ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3. ☐ Other

Please describe

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. ☒ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. ☐ This adjustment was made:
   i. ☐ Potential Selection bias was measured.
   Please describe

   ii. ☐ The base year costs were adjusted.
   Please describe

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1. ☒ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs.
   Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2. ☐ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. ☐ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
4. ☐ Other
   Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

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

Special Note Section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a. ☐ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b. ☒ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain capitated-only adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program	

Section D: Cost-Effectiveness

Part I: State Completion Section

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

n. ***Incomplete Data Adjustment (DOS within DOP only)*** The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including lag factors, incurred but not reported (IBNR) factors, or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.

Documentation of assumptions and estimates is required for this adjustment.:

1. ☐ Using the special DOS spreadsheets, the State is estimating DOS within DOP.
Incomplete data adjustments are reflected in the following manner on Appendix D5 for services to be complete and on Appendix D7 to create a 12-month DOS within DOP projection:

2. ☒ The State is using Date of Payment only for cost-effectiveness no adjustment is necessary.

3. ☐ Other
Please describe

o. ***PCCM Case Management Fees (Initial PCCM waivers only)*** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset

these fees. The new PCCM case management fees will be accounted for with an adjustment on ***Appendix D5.***

1. ☐ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2. ☐ Other
   Please describe

p. ***Other adjustments:*** Federal law, regulation, or policy change: 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.

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

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 Waiver Cost Projection

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

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 RO Targets

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

Appendix D6 RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

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

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

   Increase in eligible participants.

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:

State historical FFS cost increases using SFYs 2014-2016 for trend of 3.04%

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

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

The adjustments applied for State Plan Programmatic changes (risk adjustment for case mix due to one MEG for duals) and the Quality Improvement costs (Administration Costs - Improvement) contribute to the overall annualized rate of change.

Appendix D7 - Summary