

Facesheet: 1. Request Information (1 of 2)

A. The **State of Louisiana** 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
DBP	Dental Benefit Program	PAHP;

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

Dental Benefit Program

C. Type of Request. This is an:

Amendment request for an existing waiver.

The amendment modifies (Sect/Part):

- Section A: Part I.E.Population - Update to "Other" box to reference adults enrolled in an OCDD 1915(c) waiver
- Section A: Part I.F.Services - Update to "Other" box to references dental services authorized through the OCDD 1915(c) waivers (NOW, ROW, Supports)
- Updates to Appendix D Cost Effectiveness

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

1 year

2 years

3 years

4 years

5 years

Draft ID:LA.040.02.01

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

Approved Effective Date of Base Waiver being Amended: 07/01/21

Proposed Effective Date: (mm/dd/yy)

07/01/22

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

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

Name:

Brian Bennett

Phone:

(225) 342-9846

Ext:

TTY

Fax:

E-mail:

Brian.Bennett@la.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:

Dental Benefit Program

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

Section A: Program Description

Part I: Program Overview

Tribal consultation.

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

The State provided notification of its intent to amend the waiver on November 24, 2021 to all federally recognized tribes in the State . A copy of the notification letter was uploaded into the Waiver Management System portal. No comments were received as a result of the letter.

Program History.

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

In June 2012, Louisiana moved to a statewide managed care model statewide to provide coordinated care for enrollees. Currently, five managed care organizations provide a comprehensive array of services in a coordinated fashion. Dental services are carved out.

On January 8, 2014, DHH released a Request for Proposal to transition the provision of Medicaid and CHIP State Plan dental services for 1.2 million enrollees to a statewide Prepaid Ambulatory Health Plan (PAHP) in order to improve access and outcomes through appropriate care and network management.

DHH used a consensus scoring process to extensively evaluate all proposals to select a qualified DBP on March 21, 2014. The DBP underwent a thorough readiness review before their network began providing services to Medicaid recipients. To ensure network adequacy, the DBP had to demonstrate it had a robust network of providers in place to treat patients, sufficient support staff to handle administrative processes and provider relations, and the ability to meet all the deliverables specified in the proposal. DHH obtained CMS approval on June 23, 2014 to operate the DBP as a PAHP utilizing the authority obtained through 1915(b) waiver approval. DHH's original timeline called for implementation to begin May 1, 2014, but after revisiting the timeline to ensure adequate time existed for readiness reviews and provider and recipient education, DHH decided to launch the DBP on July 1, 2014 launch.

Contracting with a DBP has enabled Louisiana to improve coordination of access to care and improve dental health outcomes. The contractor has provided a network of dentists that provide quality, cost-effective care in addition to member outreach services. In addition, the DBP is required to provide education and outreach to dentists, dental hygienists and the state dental association.

The most significant change in this waiver will be the addition of the proposed Medicaid expansion population during the renewal period. Effective July 1, 2016 Louisiana will implement Medicaid expansion under the provisions of the Affordable Care Act (ACA), expanding Medicaid to cover working citizens aged 19 to 64 and earning up to 138 percent of the federal poverty level. Expansion will make Medicaid available to more than 300,000 Louisianans statewide who do not currently qualify for full Medicaid coverage and cannot afford to buy private health insurance. Expansion benefits will be the same as current benefits enrollees receive with full Medicaid coverage, including dental services. By receiving Medicaid coverage, these Louisianans, many of them working adults in important industries like food service and construction, will finally be able to get the regular, preventative and primary health care that best promotes overall health and wellness.

Medicaid enrollees benefit from numerous member outreach efforts, including gap alerts for members who are in danger of falling behind on preventative treatment. Network adequacy requirements and a real-time provider network online search facilitate ease of access to providers within certain time and mileage restrictions to avoid extensive appointment wait times. Dedicated call centers for both members and providers offer a knowledgeable staff focused on the coordination of dental benefits.

As a result of contracting with a DBP, the renovation of the pre-payment clinical review process has helped to identify and correct improper payments through the efficient detection and prevention of inappropriate payments made on claims for dental services provided to Medicaid enrollees. The DBP has also allowed the State to provide enrollees with dental specific member education in various media forms, including but not limited to, emails, social networking sites, blogs and apps.

DHH anticipates that continuing to provide services through a single DBP will achieve:

- Improved coordination of care;
- Better dental health outcomes;
- Increased quality of dental care;
- Improved access to essential specialty dental services;
- Outreach and education to promote dental health;
- Increased personal responsibility and self-management;
- A more financially sustainable system; and
- Net savings to the state compared to the existing FFS Medicaid delivery system.

The DBP will serve Medicaid beneficiaries eligible for dental services including children, including SCHIP Medicaid expansion children eligible, adults, and the proposed expansion population, excluding those that reside in Intermediate Care Facilities. As a result, the State is seeking a renewal of the 1915(b) waiver to obtain the necessary authority to continue to operate the program as a Prepaid Ambulatory Health Plan (PAHP) statewide.

In February 2020, the Louisiana Department of Health (LDH) announced its intent to contract with two dental benefit plans

following a state bid process that began in June 2019 when the Department issued a request for proposals. The selected organizations will be responsible for providing Medicaid dental benefits and services to eligible children and adults in Louisiana, effective 01/01/2021. Medicaid beneficiaries will have the opportunity to select a plan during the next open enrollment period which will be October 15, 2020 through November 30, 2020. The DBPMs will also begin administering dental services to Medicaid beneficiaries who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) effective January 1, 2021. This action is being taken to improve access to essential and specialty dental services, improve coordination of care, increase quality of dental care, and achieve better health outcomes.

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*

DBP

- 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*

DBP

- 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*

DBP

- 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*

DBP

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

MCO

PIHP

PAHP

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

FFS Selective Contracting program

Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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

- a. **Section 1902(a)(1)** - Statewide--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

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

DBP

- 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

DBP

- 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

DBP

- 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

DBP

- 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

DBP

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

- a. **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
- b. **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

The PIHP is paid on a risk basis

The PIHP is paid on a non-risk basis

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

The PAHP is paid on a risk basis

The PAHP is paid on a non-risk basis

- d. **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.
- e. **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

the same as stipulated in the state plan

different than stipulated in the state plan

Please describe:

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

Section A: Program Description

Part I: Program Overview**B. Delivery Systems (2 of 3)**

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

Procurement for MCO

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PIHP

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PAHP

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PCCM

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for FFS

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

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

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: " **Dental Benefit Program.** "

Two or more MCOs

Two or more primary care providers within one PCCM system.

A PCCM or one or more MCOs

Two or more PIHPs.

Two or more PAHPs.

Other:

please describe

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*

DBP

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

DBP

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	PAHP	Dental Benefit Plan

Section A: Program Description

Part I: Program Overview

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

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

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

Other (Please define):

Individuals eligible under the newly created former foster care children under age 26 years eligibility category will be included in the program as a mandatory population.

Individuals residing in a nursing facility will also be included in the program as a mandatory population.

Medicaid Expansion Individuals:

1. Individuals without dependent child in home who are age 19-64 with gross income using MAGI methodology less than 138% FPL and who are not eligible for Medicare or already getting Medicaid as of 7/1/16.

2. Individuals with dependent child in home who are age 19-64 with gross income using MAGI methodology of 25% or more but less than 138% FPL, who are not eligible for Medicare, and not already getting Medicaid as of 7/1/16 or eligible for Medicaid using MAGI methodology (income below 25% FPL; Pregnant Woman with income below 200% FPL)

Adults enrolled in one of the three OCDD 1915(c) waivers including New Opportunities (LA.0401), Residential Options (LA.0472), and Supports (LA.0453) are currently enrolled under the 1915(b) waiver and receive State Plan services. These individuals will also receive enhanced dental services authorized under the 1915(c) authority.

Section A: Program Description**Part I: Program Overview****E. Populations Included in Waiver (2 of 3)**

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

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

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

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

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

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

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

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

American Indian/Alaskan Native --Medicaid beneficiaries who are American Indians or Alaskan Natives and

members of federally recognized tribes.

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

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

Retroactive Eligibility Medicaid beneficiaries for the period of retroactive eligibility.

Other (Please define):

Individuals who are residing in out-of-state facilities are excluded from the DBP.

Individuals who are residing in a Psychiatric Residential Treatment Facility (PRTF).

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

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

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):

The DBP will be responsible for emergency services related to dental care consistent with coverage under the State plan.

- 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 DBP must offer a contract to all FQHCs and RHCs appropriately licensed to provide dental services under State law and meet the provider qualifications outlined in the State Plan for applicable services. Enrollees will have a choice of available providers in the plan's network.

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

FQHC Services Category General Comments (optional):

- 5. EPSDT Requirements.**

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

EPSDT Requirements Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

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

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

7. Self-referrals.

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

Self-referrals Requirements Category General Comments:

Enrollees may self-refer (without prior approval) for dental emergency services and EPSDT dental screening services.

8. Other.

Other (Please describe)

Adults enrolled in one of the three OCDD 1915(c) waivers including New Opportunities (LA.0401), Residential Options (LA.0472), and Supports (LA.0453) will have access to dental services outside of the State Plan benefit. These services are authorized by each 1915(c) waiver and provide an enhanced dental benefit to these populations.

Section A: Program Description**Part I: Program Overview****F. Services (5 of 5)**

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

Section A: Program Description**Part II: Access****A. Timely Access Standards (1 of 7)**

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

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

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

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Hospitals

Please describe:

6. Mental Health

Please describe:

7. Pharmacies

Please describe:

8. Substance Abuse Treatment Providers

Please describe:

9. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Mental Health

Please describe:

6. Substance Abuse Treatment Providers

Please describe:

7. Urgent care

Please describe:

8. Other providers

Please describe:

Section A: Program Description

Part II: Access**A. Timely Access Standards (4 of 7)**

2. Details for PCCM program. (Continued)

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

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Mental Health

Please describe:

6. Substance Abuse Treatment Providers

Please describe:

7. Other providers

Please describe:

Section A: Program Description**Part II: Access**

A. Timely Access Standards (5 of 7)**2. Details for PCCM program.** (Continued)**d. Other Access Standards****Section A: Program Description****Part II: Access**

A. Timely Access Standards (6 of 7)**3. Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.**Section A: Program Description****Part II: Access**

A. Timely Access Standards (7 of 7)

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

Section A: Program Description**Part II: Access**

B. Capacity Standards (1 of 6)**1. Assurances for MCO, PIHP, or PAHP programs**

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

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

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

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

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

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

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

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

Please describe the enrollment limits and how each is determined:

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

Please describe the States standard:

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

Please describe the States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

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

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

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

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

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

Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

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

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

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

- g. **Other capacity standards.**

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

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

Section A: Program Description

Part II: Access

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

Section A: Program Description

Part II: Access

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

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

The following items are required.

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

Please provide justification for this determination:

The waiver covers dental services only. In accordance with 42 CFR 438.208(a)(2), the State has determined that the implementation of a mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of 438.208 is not applicable given the limited scope of the program.

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

Please describe:

- c. **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care

professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

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

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

Please describe:

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

Please describe:

Section A: Program Description

Part II: Access

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

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

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

Please explain:

- d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. There is appropriate and confidential **exchange of information** among providers.
- f. Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are

given training in self-care.

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

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

- i. Referrals.**

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

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

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

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

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

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

Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

 (mm/dd/yy)

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

Please provide the information below (modify chart as necessary):

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

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

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

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

- c. **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of

qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

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

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

Please describe:

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

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

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

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:

Marketing only Event, Mass Media, Marketing Material Restock, Presentation, Community Meeting, Interview, Exhibit Booth, Informational Table. Both marketing and member education events are submitted as part of the marketing plan, including goal/strategy references, planned events and materials. All proposed sponsorships, media events, and media activities must be submitted to LDH for review. LDH will approve, deny, or require necessary changes.

3. The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

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

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

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

Patient Steering is defined in Title 50 of the Louisiana Administrative Code as unsolicited advice or mass-marketing directed at Medicaid recipients by health plans, including any of the entity's employees, affiliated providers, agents, or contractors, that is intended to influence or can reasonably be concluded to influence the Medicaid recipient to enroll in, not enroll in, or disenroll from a particular health plan(s).

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

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

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

Please describe the methodology for determining prevalent languages:

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

- c. Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

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

Section A: Program Description

Part IV: Program Operations

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

1. Assurances

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

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

2. Details**a. Non-English Languages**

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

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

Materials will be translated 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.:

- 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 contracted DBPs will be required to provide oral translation services regardless of language spoken. This is achieved by having staff available to communicate with the member in his/her spoken language and/or access to a phone-based translation service so that someone is readily available to communicate orally with the member in his/her spoken language.

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

Please describe:

The DBPs is required to provide all covered services and provide information to enrollees. All enrollees will receive information in a welcome packet about the DBP when first eligible for the program. This explanation, which includes a description of the PAHP program, is also available on the website 24/7 for all enrollees.

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:

A contracted Enrollment Broker will mail letters with information about the dental plans and instructions for how to select a plan during Open Enrollment. The Enrollment Broker will provide a customer service call center to assist enrollees and potential enrollees with any questions regarding selection of a DBP. A website and mobile app are also available with educational information on the DBP.

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 state contractor for enrollment broker services is MAXIMUS.

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:

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:

A contracted Enrollment Broker will mail letters with information about the dental plans and instructions for how to select a plan during Open Enrollment. The Enrollment Broker will provide a customer service call center to assist enrollees and potential enrollees with any questions regarding selection of a DBP. A website and mobile app are also available with educational information on the DBP.

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: MAXIMUS

Please list the functions that the contractor will perform:

choice counseling

enrollment

other

Please describe:

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

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

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

This is a **new** program.

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

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

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

Amendment will introduce ICF/IID population as a mandatory population for the DBP, statewide, effective 01/01/2021.

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:

If the enrollee has household enrollees enrolled in a DBPM, the enrollee shall be enrolled in that DBPM. If multiple DBPM linkages exist within the household, the enrollee shall be enrolled to the DBPM of the youngest household enrollee. If DBPM assignment cannot be made based on the beneficiary's household enrollment, the enrollment broker shall seek to preserve existing provider-beneficiary relationships. If the enrollee has had a relationship with a Medicaid PDP within the past twelve (12) months, the enrollee will be assigned to a DBPM in which the PDP participates, using a round robin method.

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):

The Contractor does not, because of moral or religious objections, cover the service the enrollee seeks;
 The enrollee needs related services to be performed at the same time; not all related services are available within the DBPM and the enrollee's Primary Dental Provider (PDP) or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;
 The Contract between the Contractor and LDH is terminated;
 Poor quality of care rendered by the Contractor as determined by LDH;
 Lack of access to DBPM covered services as determined by LDH; or
 Any other reason deemed to be valid by LDH and/or its agent.

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

The DBP may request involuntary disenrollment of an enrollee if the enrollee's utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee's ID card to another person to obtain services. In such case the Contractor shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).

- 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 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:

Enrollee may request a grievance or an appeal. Grievances are defined as an expression of dissatisfaction about matters other than an action. Examples of grievances include, but are not limited to, the quality of care or services provided & aspects of interpersonal relationships such as rudeness of staff, etc. An appeal is defined as request for a review of an action pursuant to 42CFR 438.400(b).

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:

An enrollee, or authorized representative acting on the enrollee's behalf, may file a grievance orally or in writing at any time. An enrollee, authorized representative, or legal representative of the estate may file an appeal orally or in writing within sixty (60) calendar days from the date on the notice of adverse benefit determination.

Has time frames for resolving requests for review.

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

90 days for grievances and an appeal shall be heard and notice of appeal resolution shall be sent to the enrollee no later than thirty (30) calendar days from the date the DBP receives the appeal.

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:

Enrollees may request an expedited review in accordance with 438.410. Resolutions is not to exceed seventy-two (72) hours after the DBP receives the appeal request, whether the appeal was made orally or in writing.

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

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

Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

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

The DBP must establish Member grievance and appeals process and state fair hearing procedures and time frames, as described in 42 CFR §438.400 through §438.424.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

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

The prohibited relationships are:

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

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

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain

crimes described in section 1128(b)(8)(B) of the Act;

3. Employs or contracts directly or indirectly with an individual or entity that is
 - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
 - b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

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

Please note:

- **MCO, PIHP, and PAHP** programs:
 - There must be at least one checkmark in each column.

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

Summary of Monitoring Activities: Evaluation of Program Impact

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

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
Independent Assessment	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Measure any Disparities by Racial or Ethnic Groups	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Network Adequacy Assurance by Plan	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Ombudsman	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
On-Site Review	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Performance Improvement Projects	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Performance Measures	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
Periodic Comparison of # of Providers	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Accreditation for Non-duplication	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Accreditation for Participation	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Consumer Self-Report data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Data Analysis (non-claims)	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Enrollee Hotlines	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Focused Studies	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Geographic mapping	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Independent Assessment	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	FFS	FFS	FFS
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Ombudsman	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
On-Site Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Periodic Comparison of # of Providers	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Profile Utilization by Provider Caseload	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Quality

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

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS
Accreditation for Participation	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Consumer Self-Report data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Data Analysis (non-claims)	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Enrollee Hotlines	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Focused Studies	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Geographic mapping	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Independent Assessment	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Ombudsman	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
On-Site Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Periodic Comparison of # of Providers	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Profile Utilization by Provider Caseload	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

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

Programs Authorized by this Waiver:

Program	Type of Program
DBP	PAHP;

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Dental Benefit Program

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

For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity

- Frequency of use
- How it yields information about the area(s) being monitored

a.

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

Activity Details:

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:

Annual Enrollee Satisfaction Survey

The DBPM shall conduct annual LDH-approved enrollee satisfaction surveys comparable to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to enrollees each calendar year. Survey results and a description of the survey process shall be reported to LDH.

The survey shall be administered to a statistically valid random sample of enrollees who are enrolled in the DBPM at the time of the survey.

Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.

Enrollee Satisfaction Survey Reports are due one-hundred twenty (120) calendar days after the end of each calendar year.

CAHPS

Please identify which one(s):

State-developed survey

Disenrollment survey

Consumer/beneficiary focus group

d.

Data Analysis (non-claims)

Activity Details:

Strategy 1: Grievance, Appeals and Fair Hearing Data : Review and Analysis of Reports

Personnel responsible: State staff

Description of strategy: LDH requires the DBP to collect data monthly, quarterly and annually on a calendar year basis using a standardized reporting format. The grievance, appeals, and fair hearing reports summarize the numbers of grievances, appeals and expedited appeals by the subject matter of the grievance or appeal as established by LDH (e.g., access, denial of services, interpersonal skills, quality of care, timeliness , etc.) and its disposition(e.g. referred out, resolved, still pending). Reports are to be submitted to the contract monitor by the 15th of the month following the activity for monthly reports and the 30th of the month for quarterly and annual reports.

The grievance and appeals data will be used to identify issues that should be addressed with the DBP and/or that indicate statewide trends that require technical assistance or policy clarification. The contract monitor will review the grievances and appeals reports and identify deficiencies or trends in order to address these deficiencies through the DBPs quality improvement processes which may include analyzing data to measure against goals, identifying opportunities for improvement, designing and implementing interventions for improving performance, and measuring effectiveness of interventions. LDH will share its significant findings with the DBP based on deficiencies identified.

Frequency of use: Monthly, quarterly, and annual data is reported with quarterly review and annually, at a minimum.

How it yields information about the area(s) being monitored: The grievance and appeal report from the DBP provides data on the types, excessive reversals, process, and disposition of concerns affecting the beneficiaries being served, particularly in the area of access to and quality of care. The DBP Quality Committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes.

Denials of referral requests

Disenrollment requests by enrollee

From plan

From PCP within plan

Grievances and appeals data

Other

Please describe:

Strategy 2: Form CMS 416 Report Analysis; Personnel responsible: DBP

Detailed description of strategy: During the initial waiver period, DHH required the DBP to collect data quarterly and annually, on a calendar year basis using the standardized CMS 416 reporting format provided by CMS. Review of the data is taking place in the context of the CMS Oral Health Initiative.

Beginning in waiver period 3, the DBP will begin collecting data on a federal fiscal year.

The CMS 416 data is used by the DBP to identify access issues and to provide context about overall performance. By analyzing data, the DBP can identify gaps, identify drivers that may contribute to these gaps or variations in dental service utilization and choose targeted interventions to improve the delivery of oral health care. The focus of this data is on oral health objectives such as increasing the utilization of preventive dental service (sealants, prophylaxis, and fluoride) and access to the oral health system based on DHH's performance standards or national standards developed by the Centers of Medicare and Medicaid Services (CMS).

The DBP will then utilize key performance indicators (KPIs) and performance improvement projects (PIPs) to measure, analyze, and improve performance. Indicators are selected and defined by developing standards for performance, which take into account contractual requirements that are to be met. The indicators are monitored through standard reporting requirements of descriptions and outcomes on an annual basis. Reporting allows for structured communication with the DBP's Quality Improvement department. The KPIs are a standing agenda item for the QIC.

In waiver period 3, DHH will require the DBP to collect CMS 416 data on a federal fiscal year basis, to allow measures to reflect standardize reporting.

Frequency of Use: Quarterly and Annually

How it yields information about the area(s) being monitored: The analysis of the CMS 416 data provides the state with information regarding the utilization of oral health services to allow for the tracking of progress on the CMS Oral Health Initiative. The data will also identify gaps in oral health utilization, monitor progress towards goals, and assist the DBP in the development and implement quality improvement strategies.

Beginning 01/01/21, CMS-416 data, specifically, to Increase the percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), age 1-20, receiving at least 1 preventative dental service, will be used as a contractual clinical performance measure.

Additionally, HEDIS ADV, Increase the percentage of EPSDT enrollees (enrolled for at least 45 consecutive days), age 2-20, receiving at least 1 dental visit, will be a clinical performance measure.

e.

Enrollee Hotlines**Activity Details:**

Personnel responsible: DBP and State staff

The DBP shall develop performance standards and monitor enrollee help line performance by recording calls and employing other monitoring activities. Such standards shall be submitted to and approved by LDH before use, and comply with monetary penalties outlined in the Contract. The DBP shall report its performance on these standards. These standards shall be measured on a monthly basis and, at a minimum, require that:

1. The average speed to answer shall not exceed thirty (30) seconds.
2. The call blockage rate for direct calls shall not exceed one-half of one percent (.05%).
3. The average call abandonment rate shall not exceed three percent (3%). A system which places calls in a queue may be used, but the average wait time in the queue shall not exceed sixty (60) seconds.

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:

Strategy 4: Network Adequacy Review

Personnel responsible: DBP and State staff

Detailed description of strategy: The DBP submits documentation verifying that it offers an appropriate range of services that are adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees. Documents are reviewed for contractual compliance with accessibility of benefits/services, including geographic access, appointments, wait times, and timely access. GEO mapping and coding of all network providers for each provider type are also reviewed to geographically demonstrate network capacity. The DBP provide updated GEO coding to DHH quarterly or upon request.

Frequency of Use: Network adequacy documentation is submitted quarterly.

How it yields information about the area(s) being monitored:

Network reports provide information on timely access and provider capacity. Network adequacy will be addressed through performance measures that focus on specific time measures. The data is used to: 1) develop a quantitative, regional appraisal of the service delivery system; 2) identify needs for further data collection; and 3) identify processes and areas for detailed study. The result of the analysis becomes a part of the DBPs Quality Improvement Committee work plan and is reported to DHH. The committee members discuss the results of the analysis to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes.

h.

Independent Assessment (Required for first two waiver periods)

Activity Details:

Strategy 3: Independent Assessment of DBP Program Impact, Access, Quality, and Cost-Effectiveness

Personnel responsible: An independent third party will be contracted to perform this activity

Detailed description of strategy: The State will hire an independent assessor to assess quality of care, access to services and cost-effectiveness of the DBP as required by the waiver. Louisiana will rely upon the CMS independent assessment guide to meet this requirement

Frequency of Use: In year two (2) of the initial waiver period and year four (4) of the renewal wavier period, and submitted to CMS prior to each of the first two waiver renewals.

How it yields information about the area(s) being monitored: The independent assessment will be used to monitor:

- access
- quality of care
- cost effectiveness

The data collected is used to: 1) analyze the effectiveness of the programs 2) develop a quantitative, regional appraisal of access to the dental benefit plan's delivery system; 3) identify sources of cost savings in the program; and/or 4) identify processes and areas of quality of care for detailed study through on-going performance measures and quality improvement strategies. The analysis will become a part of the DBP Quality Improvement Committee work plan and is reported to the DHH annually for review. The DBP Quality Improvement Committee members discuss the findings to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes.

i.

Measure any Disparities by Racial or Ethnic Groups

Activity Details:

j.

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

Activity Details:

Same as Activity details of Geographic Mapping

Strategy 4: Network Adequacy Review

Personnel responsible: DBP and State staff

Detailed description of strategy: The DBP submits documentation verifying that it offers an appropriate range of services that are adequate for the anticipated number of enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees. Documents are reviewed for contractual compliance with accessibility of benefits/services, including geographic access, appointments, wait times, and timely access. GEO mapping and coding of all network providers for each provider type are also reviewed to geographically demonstrate network capacity. The DBP provide updated GEO coding to LDH quarterly or upon request.

Frequency of Use: Network adequacy documentation is submitted quarterly.

How it yields information about the area(s) being monitored:

Network reports provide information on timely access and provider capacity. Network adequacy will be addressed through performance measures that focus on specific time measures. The data is used to: 1) develop a quantitative, regional appraisal of the service delivery system; 2) identify needs for further data collection; and 3) identify processes and areas for detailed study. The result of the analysis becomes a part of the DBPs Quality Improvement Committee work plan and is reported to DHH. The committee members discuss the results of the analysis to identify opportunities for improvement. In addition, this information aids in the assessment of the effectiveness of the quality improvement processes.

k.

Ombudsman

Activity Details:

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l.

On-Site Review

Activity Details:

Strategy 5: Onsite Readiness Review: DBP Policies/Procedures

Personnel responsible: State staff, develop policies and procedures and monitor for compliance

Detailed description of activity: The purpose of this review is to determine the organization's readiness to administer the dental program with an adequate network to provide services to eligible beneficiaries. LDH will include a set of criteria established by contractual requirements, in addition to state and federal laws. The review will focus on a wide variety of areas, including evidence of the site's policies and procedures to evaluate member grievances, appeals, fair hearings, access, network adequacy, timeliness, coordination of care, information systems, claims management and emergency preparedness. The DBP must undergo a review before any network can begin providing services to Medicaid beneficiaries.

During the onsite readiness reviews, state staff review policies and procedures that demonstrate the DBP has a system in place that adhere to contractual requirements that are in accordance with all applicable state and federal laws. The DBP agrees to provide all materials required to complete the review by the dates established by LDH and must have successfully met all Readiness Review requirements established by LDH no later than the date of implementation. The onsite readiness review allows a review of automated systems and communication with the Contractor staff that perform each of the above processes.

If the DBP does not meet all of the established criteria, LDH will develop an initial compliance plan to bring the DBP into compliance. This plan will outline both the unmet criteria and any corrective actions necessary.

Frequency of Use: The Readiness Review is done once per contract period, prior to contract implementation.

How it yields information about the area(s) being monitored:

The Readiness Review process provides the State with information regarding whether DBP has a system in place, including policies and procedures, adhere to contractual requirements that are in accordance with all applicable state and federal laws.

m.

Performance Improvement Projects [Required for MCO/PIHP]**Activity Details:**

The DBPM shall conduct performance improvement projects (PIPs) that focus on both clinical and nonclinical areas, as identified by LDH. Each PIP must be designed to achieve significant improvement, sustained over time, in dental outcomes and enrollee satisfaction, and must include the following elements:

- 1.Measurement of performance using objective quality indicators;
- 2.Implementation of interventions to achieve improvement in the access to and quality of care;
- 3.Evaluation of the effectiveness of the interventions based on approved performance measures; and
- 4.Planning and initiation of activities for increasing or sustaining improvement.

The DBPM must report the status and results of each PIP conducted to LDH as requested, but not less than annually.

As approved by LDH, the DBPM may develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement project.

Clinical

Non-clinical

n.

Performance Measures [Required for MCO/PIHP]**Activity Details:**

LDH will establish benchmarks for clinical performance measures utilizing statewide data of the Medicaid population from the previous calendar year(s) with the expectation that performance improves by a certain percentage toward the benchmarks. Clinical performance measures shall be reported at least annually twelve (12) months after services begin.

Clinical performance measures include:

- 1 Healthcare Effectiveness and Information Set (HEDIS) Annual Dental Visits (ADV); and
- 2 Total Eligibles Receiving Preventive Dental Services based on data reported on the CMS 416.

Process

Health status/ outcomes

Access/ availability of care

Use of services/ utilization

Health plan stability/ financial/ cost of care

Health plan/ provider characteristics

Beneficiary characteristics

o.

Periodic Comparison of # of Providers

Activity Details:

--

p.

Profile Utilization by Provider Caseload (looking for outliers)

Activity Details:

--

q.

Provider Self-Report Data

Activity Details:

Strategy 6: Provider Satisfaction Survey Report

Personnel responsible: DBP

Detailed description of strategy: The DBP conducts an annual provider survey to assess satisfaction of their primary care dentist network with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes. The provider must have at least ten (10) assigned members and have been contracted with the DBP for at least six (6) months. The survey is conducted through an outbound call campaign during the fourth quarter of each year. The survey is also posted on the DBP's provider portal where the selected providers are prompted to complete the survey prior to submitting prior authorizations.

The results are analyzed by the DBP's Quality Improvement Director. All survey results that rate below the satisfaction goal of at least 80% are presented to the Quality Improvement Committee where plan-wide activities are developed and implemented to improve provider satisfaction. The DBP reports a summary of the survey methods and findings as well as an analysis of opportunities for improvement and interventions implemented to improve provider satisfaction to DHH no later than one hundred and twenty (120) days after the end of the calendar year.

Frequency of Use: Data is reviewed annually by the state for contractual compliance.

How it yields information about the area(s) being monitored: Monitoring the results of the survey provides information that assists in the measurement and monitoring of provider satisfaction and support implementation of interventions as warranted.

Survey of providers

Focus groups

r.

Test 24/7 PCP Availability

Activity Details:

s.

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

Activity Details:

t.

Other

Activity Details:

Strategy 7: External Quality Review

Personnel responsible: External independent External Quality Review Organization (EQRO) identified by State

Detailed description of strategy: External Quality Review is a process by which an EQRO, through a specific agreement with the State, assess the DBP's compliance with contractual, federal and state regulations regarding access to care, structure and operations, grievance policies, provider network relations and network, quality measurement and utilization management. External Quality Reviews include extensive review of DBP documentation and interviews with DBP staff. Interviews with stakeholders and confirmation of data may also be initiated.

The audit will be comprised of a desk review, which included a comprehensive evaluation of the DBP's policies, procedures and materials corresponding to the nine (9) domains that were subject to review:

1. Eligibility, Enrollment & Disenrollment
2. Marketing/Member Education
3. Member Grievances & Appeals
4. Provider Network
5. Provider Relations
6. Quality Management
7. Utilization Management
8. Reporting
9. Fraud and Abuse

Frequency of Use: External Quality Review is done annually.

How it yields information about the area(s) being monitored: External Quality Review provides monitoring information related to information to beneficiaries, grievances and appeals, coordination/continuity, coverage/authorization and quality of care. The review obtains additional information that was not provided through conference calls, meetings, documentation requests or quarterly reports. The data from all sources is analyzed for compliance.

If indicated, the contractor is required to implement corrective action. The DBP discuss the results of the analysis to identify opportunities for improvement.

Section C: Monitoring Results

Renewal Waiver Request

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

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

This is a renewal request.

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

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

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

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

The Monitoring Activities were conducted as described:

Yes No

If No, please explain:

Provide the results of the monitoring activities:

LDH monitors routine reports on call center metrics, marketing and member education materials, grievance and appeals, PCD profile reports and linkages, and network adequacy. If deficiencies are identified, action is taken that can include corrective action plans and monetary penalties. LDH contracted with IPRO to conduct its Independent Assessment (IA) and External Quality Review of the Dental Benefit Program. Additional details of the state's monitoring efforts can be found in the IA and EQRO reports. The IA report was submitted to CMS with the waiver renewal application and the EQRO report or any additional information or results is available upon request.

As part of the external quality review activity, 534 elements were reviewed for compliance. Of the 534, 525 were determined to fully meet the regulations, while 3 substantially met the regulations, and none were determined to be non-compliant. Six elements were "not applicable." The overall compliance score for the PAHP was 99% elements in full compliance. Additionally, as part of its contract, the PAHP is required to submit a quarterly report to LDH containing administrative performance measures which include data on claims, call center statistics, grievances and appeals, and service authorizations. The PAHP met or exceeded performance standards for these measures with the exception of the following:

- during calendar year 2016: percent of member state fair hearing requests received and resolved within 90 days (91%)
- during calendar year 2020: percent of standard service authorizations processed within 72 hours (99.99%), percent of expedited service authorizations processed within 72 hours (99.99%), and percent of call center calls answered by a live person within 30 seconds of selection (85.6%).

The PAHP met the provider network distance requirements for the following provider types:

- General dentists: 99.8% of urban and 100% of rural members had access to providers within the distance requirements.
- Oral surgeons: 100% of members had access to providers within the distance requirements.
- Orthodontist: 100% of members had access to providers within the distance requirements.

The PAHP conducted a PIP to improve member receipt of oral health services. The baseline measurement period covered 1/1/15-12/31/15, with 3 re-measurement periods that included an extension year from 1/1/18-12/31/18.

The indicators, baseline rates and corresponding target rates for performance improvement from baseline to final measurement are as follows:

- Any Dental Service, Ages 1-20: Baseline rate=51.24%; Target rate at baseline=53.24%; Target rate at re-measurement 1=53.24%; Target rate at re-measurement 2=55.24%; Target rate at re-measurement 3=57.24%.
- Preventive Dental Services, Ages 1-20: Baseline rate=48.80%; Target rate at baseline=50.80%; Target rate at re-measurement 1=50.80%; Target rate at re-measurement 2=52.80%; Target rate at re-measurement 3=54.80%.
- Dental Sealants, Ages 6-9: Baseline rate=15.45%; Target rate at baseline=17.45%; Target rate at re-measurement 1=17.45%; Target rate at re-measurement 2=19.45%; Target rate at re-measurement 3=21.45%.

Results:

- Any Dental Service, Ages 1-20: The rate increased from 51.24% at baseline to 53.27% at re-measurement 3 and exceeded the target rate of 53.24% at re-measurement 1; however, the target rate of 57.24% was not met at re-measurement 3.
- Preventive Dental Services, Ages 1-20: The rate increased from 48.80% at baseline to 50.53% at re-measurement 3; however, the target rate was not met for any of the re-measurement years.
- Dental Sealants, Ages 6-9: The rate increased from 15.45% at baseline to 17.8% at re-measurement 3 and exceeded the target rate of 17.45% at re-measurement 1; however, the target rates were not met for the subsequent two years.

A notice of action was issued on February 14, 2020 Regarding three substantially met regulations. A substantial determination indicates the PAHP is compliant with most of the requirements of the standard but has minor deficiencies. These included: Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230

- Distance to Primary Dental Services – travel distance from member's place of residence shall not exceed forty (40) miles for rural areas and twenty (20) miles for urban areas.
- Distance to Specialty Dental Services - travel distance shall not exceed sixty (60) miles from the member's place of residence for at least 75% of members and shall not exceed ninety (90) miles from the member's place of residence for all members.

The PAHP did not meet the provider network distance requirements for the following provider types:

- Endodontist: 76.3% of members had access to providers within the distance requirements.
- Periodontist: 65.5% of members had access to providers within the distance requirements.
- Prosthodontist: 84.5% members had access to providers within the distance requirements.

Federal Regulation: 438.214, 438.240

- The DBPM is encouraged to include a member advocate representative on the QAPI Committee.

The PAHP was required to meet the following performance measurement goals for Federal Fiscal years 2015, 2016, and 2017. The two measures were:

- Increase the percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), ages 1-20, receiving one annual dental preventive service

- Increase the percentage of EPSDT enrollees (enrolled for at least 90 consecutive days), age 6-9 years, receiving one or more sealants on permanent molar teeth.

Although the PAHP improved over the baseline for both measures, it failed to meet the performance goals for all three measurement years. Consequently, LDH assessed monetary penalties in accordance with the contract.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
MEG 1 - Medicaid Children (ages 0 through 20)	
MEG 2 - Medicaid Adults (duals and non-duals)	
MEG 3 - CHIP	
MEG 5 -Medicaid Expansion Adults (ages 21+)	
MEG 4 _Medicaid Expansion Children (ages 19-20)	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	01/01/2019	12/31/2019	01/01/2020	12/31/2020
Enrollment Projections for the Time Period*	07/01/2021	06/30/2022	07/01/2022	06/30/2023
**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	
Orthodontic Services				
Preventive Dental Services				
Diagnostic Dental Services				
Fixed Prosthodontics Dental Services				
Oral and Maxillofacial Surgery Services				
Periodontal Dental Services				
Restorative Dental Services				
Removable Prosthodontics Dental Services				
Endodontic Dental Services				
Adjunctive General Dental Services				
Maxillofacial Prosthetics Dental Services				

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

Signature:

State Medicaid Director or Designee

**Submission
Date:**

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

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

b. Name of Medicaid Financial Officer making these assurances:**c. Telephone Number:****d. E-mail:****e. The State is choosing to report waiver expenditures based on**

date of payment.

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

Section D: Cost-Effectiveness**Part I: State Completion Section****B. Expedited or Comprehensive Test**

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

- b.** The State provides additional services under 1915(b)(3) authority.
- c.** The State makes enhanced payments to contractors or providers.
- d.** The State uses a sole-source procurement process to procure State Plan services under this waiver.
- e.** The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has*

overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

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

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

The management fees were calculated as follows.

1. Year 1: \$ per member per month fee.
2. Year 2: \$ per member per month fee.
3. Year 3: \$ per member per month fee.
4. Year 4: \$ per member per month fee.

- b. **Enhanced fee for primary care services.**

Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

- c. **Bonus payments from savings generated under the program are paid to case managers who control**

beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. Other reimbursement method/amount.

\$

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

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

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

Member months are projected to increase from the base period through the first two quarters of P1 due to ceased disenrollment as a result of Maintenance of Effort restrictions during the COVID-19 Public Health Emergency. Currently, LDH expects that disenrollment processes will commence by the third quarter of P1 and be completed by the end of P1.

For P2 and subsequent years in this waiver, the enrollment is projected to grow at normal growth rates experienced in the previous waiver period of 0.4% per quarter. The projection of member months was based on current trends and overall growth in the Medicaid program.

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

There is a six month lag between the end of R2 and the beginning of P1. Enrollment projections were increased to account for the difference in timeframes and continued membership increases expected during that time.

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

The State's R1 and R2 are on a calendar year basis.
 - R1 = January 1, 2019 through December 31, 2019
 - R2 = January 1, 2020 through December 31, 2020

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost**For Conversion or Renewal Waivers:**

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

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

There are no changes in services between the previous period and the upcoming waiver period. All State Plan dental services identified under Section A, Part I, subsection F of this preprint for Medicaid/CHIP have been included.

- b. **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**

For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

No State Plan dental services are excluded from the cost-effectiveness projections. Related services, such as pharmacy and physician services, are included in the Healthy Louisiana program and not part of this waiver.

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
Orthodontic Services							
Preventive Dental Services							
Diagnostic Dental Services							
Fixed Prosthodontics Dental Services							
Oral and Maxillofacial Surgery Services							
Periodontal Dental Services							
Restorative Dental Services							
Removable Prosthodontics Dental Services							
Endodontic Dental Services							
Adjunctive General Dental Services							
Maxillofacial Prosthetics Dental Services							

Section D: Cost-Effectiveness**Part I: State Completion Section**

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

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

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

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

Appendix D2.A: Administration in Actual Waiver Cost**Section D: Cost-Effectiveness****Part I: State Completion Section****H. Appendix D3 - Actual Waiver Cost**

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

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

Basis and Method:

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

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

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

Document

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

--

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

Document:

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

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Appendix D3 Actual Waiver Cost**Section D: Cost-Effectiveness****Part I: State Completion Section****I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)**

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness**Part I: State Completion Section****I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)**

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness**Part I: State Completion Section****I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)**

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness**Part I: State Completion Section****I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)**

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness**Part I: State Completion Section****I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)**

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness**Part I: State Completion Section****I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)**

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness**Part I: State Completion Section****I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)**

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness**Part I: State Completion Section****I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)**

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness**Part I: State Completion Section****J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)**

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

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

The actual trend rate used is:

Please document how that trend was calculated:

The rate range effective 7/1/21 for the DBP included an aggregate annual trend of 3.0%. This trend assumption was developed using a regression methodology and general industry trends. This assumption was subsequently applied to the waiver populations.

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

i. **State historical cost increases.**

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

R2 rates effective 1/1/20 are based on MBES data from FFY20 (October 1, 2019 – September 30, 2020) and FFY21 (October 1, 2020 – September 30, 2021).

Trend projections were based on analysis of historical dental encounters and review of dental trend benchmarks in other state Medicaid programs and commercial dental managed care programs. The State considered historical year over year trends in developing trend estimates, consistent with the development of capitation rates.

For the prospective time periods (P1 through P5), the State assumed an overall 3.0% annual trend for each of the MEGs.

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

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

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

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

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

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

Appendix D4 Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

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

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any

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

Others:

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

1. The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. An adjustment was necessary. The adjustment(s) is(are) listed and described below:
 - i. The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.

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

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment
- B. The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment
- C. Determine adjustment based on currently approved SPA.
PMPM size of adjustment
- D. Determine adjustment for Medicare Part D dual eligibles.
- E. Other:
Please describe

- ii. The State has projected no externally driven managed care rate increases/decreases in the

managed care rates.

- iii.** Changes brought about by legal action:
Please list the changes.

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

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

PMPM size of adjustment

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

Approximate PMPM size of adjustment

- C.** Determine adjustment based on currently approved SPA.

PMPM size of adjustment

- D.** Other

Please describe

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

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

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

PMPM size of adjustment

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

Approximate PMPM size of adjustment

- C.** Determine adjustment based on currently approved SPA

PMPM size of adjustment

- D.** Other

Please describe

- v.** Other
Please describe:

--	--

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

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

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

D. Other
Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

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

c. Administrative Cost Adjustment: This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. No adjustment was necessary and no change is anticipated.
2. An administrative adjustment was made.
 - i. Administrative functions will change in the period between the beginning of P1 and the end of P2.
Please describe:

--

- ii. Cost increases were accounted for.
 - A.** Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B.** Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C.** State Historical State Administrative Inflation. The actual trend rate used is PMPM size of adjustment

Please describe:

See attachment "1915b REN Waiv Cost Eff App_5yr_2021-2026"

- D.** Other
Please describe:

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

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

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

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

The actual documented trend is:

Please provide documentation.

- 2.** [Required, when the States BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are

unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

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

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

2. Please provide documentation.

B. State Plan Service trend

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

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

1. List the State Plan trend rate by MEG from Section D.I.I.a

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

3. Explain any differences:

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

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

Please describe:

1. No adjustment was made.
2. This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 Waiver Cost Projection

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

There were no adjustments applied

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 RO Targets

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

See attachment"1915b REN Waiv Cost Eff App_5yr_2021-2026"

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.

The projection of member months was based on current trends and overall growth in the Medicaid program since the base year period. The membership projections assume disenrollment between January 1, 2022 through June 30, 2022 as a result of Maintenance of Effort restrictions in effect during the Public Health Emergency. It is assumed enrollment growth will resume to normal trends of approximately 0.4% per quarter following P2. For the prospective time periods (P1 through P5), the State assumed an overall 3.0% annual trend for each of the MEGs.

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

The projection of member months was based on current trends and overall growth in the Medicaid program since the base year period. The membership projections assume disenrollment between January 1, 2021 through June 30, 2022 as a result of Maintenance of Effort restrictions in effect during the Public Health Emergency. An adjustment was made to the projected member months in P1 reflecting the anticipated disenrollment due to the end of PHE and MOE. It is assumed enrollment growth will resume to normal trends of approximately 0.4% per quarter following P2.

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:

The historical dental encounter data was the primary source used by the actuary for determining trend for the prospective periods for this waiver request. The State considered historical year over year trends in developing trend estimates, consistent with the development of capitation rates.

For the prospective time periods (P1 through P5), the State assumed an overall 3.0% annual trend for each of the MEGs.

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:

There are no program changes included in the projections.

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

Appendix D7 - Summary