

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

- A. The **State of Montana** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.
- B. **Name of Waiver Program(s):** Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program
PRGR121459		undefined
PRGR121460		undefined
Passport	Passport to Health, Health Improvement and Nurse First Programs.	PCCM; FFS;

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

**Passport to Health waiver renewal**

- C. **Type of Request.** This is an:

**Renewal request.**

**This is the first time the State is using this waiver format to renew an existing waiver.**

The renewal modifies (Sect/Part):  
Sections A,B,C and D.

**Migration Waiver** - this is an existing approved waiver

**Renewal of Waiver:**

Provide the information about the original waiver being renewed

**Base Waiver Number:**

0002

**Amendment Number** (if applicable):

MT02.R09

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

04/01/10

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

1 year  2 years  3 years  4 years  5 years

**Draft ID: MT.20.01.00**

**Waiver Number: MT.0002.R01.00**

- D. **Effective Dates:** This renewal is requested for a period of 2 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

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

04/01/12

**Proposed End Date: 03/31/14**

Calculated as "Proposed Effective Date" (above) plus two years minus one day.

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

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

**Name:**

Mary Noel

**Phone:**

(406) 444-4146

**Ext:**

**TTY**

**Fax:**

(406) 444-1861

**E-mail:**

manoel@mt.gov

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

**The State contact information is different for the following programs:**

**Passport to Health, Health Improvement and Nurse First Programs.**

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

## Section A: Program Description

### Part I: Program Overview

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#### **Tribal consultation.**

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

During this renewal process, the State of Montana sent a notice to each Tribe, Indian Health Service and Urban Indian Center in Montana to inform them of the renewal of the waiver. The State provided information on the programs and direction on how to make comments, suggestions or request more information regarding the waiver.

See Attachment A: Letters to Tribes, Indian Health Services and Urban Indian Centers

The State of Montana received one response back on our tribal consultation, a letter from the Confederated Salish and Kootenai Tribes that follows:

The Confederated Salish & Kootenai Tribes thank you for the opportunity to comment on the Medicaid passport to Health Waiver.

Since the elements of the program are not changing, and the services remain the same with no known changes, the Tribes have no comment or objections to the application.

S. Kevin Howlett, Department Head  
CSKT Tribal Health & Human Services

In addition, the State of Montana Passport and Team Care program officers visited each IHS facility in Montana to meet with IHS staff in October and November, 2011.

#### **Program History.**

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

Passport to Health Program

Passport to Health is Montana Medicaid's Primary Care Case Management (PCCM) and Medical Home Program. Passport has been in operation since January of 1993. Passport serves all Montana Counties.

Team Care is a sub-program of Passport to Health which began operating in 2004. Clients enrolled in Team Care are restricted from changing their primary care provider (PCP) without good cause and are restricted to one pharmacy. Enrollment in Team Care is based on utilization that is found to be excessive, inappropriate or fraudulent with respect to need. Medicaid clients can be referred to Team Care by Drug Utilization Review Clinical Case Managers, PCPs, or from claims data mining.

Health Improvement Program

In 2009, Montana designed a new statewide Health Improvement Program (HIP) as an enhancement to Passport to Health. This enhanced PCCM is operated through a network of Passport providers who receive an enhanced case management fee to work with Passport eligible clients who have been identified as high risk, high cost through predictive modeling, or have been referred by a primary care provider. See Attachment B: HIP Provider Agreement

#### Nurse First Program

Montana has operated the nurse advice line, Nurse First, since 2004. Through the competitive bidding process, the state contracted with Nurse Response.

Clients call Nurse First for free advice 24 hours a day. Nurse First provides triage and treatment recommendation, from registered nurses, for injuries and health conditions. It also provides general health information about diseases, treatments, and medications. After each call, Nurse First faxes a description of the client's concern to the client's primary care provider, if the client is enrolled in Passport.

## Section A: Program Description

### Part I: Program Overview

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#### 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*
    - PRGR121460**
    - PRGR121459**
    - Passport**
  - b.  **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.  
 -- *Specify Program Instance(s) applicable to this authority*
    - PRGR121460**
    - PRGR121459**
    - Passport**
  - c.  **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.  
 -- *Specify Program Instance(s) applicable to this authority*
    - PRGR121460**
    - PRGR121459**
    - Passport**
  - d.  **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).  
 -- *Specify Program Instance(s) applicable to this authority*

PRGR121460 PRGR121459 Passport

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

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

Please describe:

Nurse Advice Line

The State of Montana pays Nurse Response set fees per client phone call, one fee for informational calls and a higher fee for triaged calls.

See Attachment C:Nurse First Contract

## Section A: Program Description

### Part I: Program Overview

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#### 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
- PRGR121460
- PRGR121459
- Passport
- b.  **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.  
-- Specify Program Instance(s) applicable to this statute
- PRGR121460
- PRGR121459
- Passport
- c.  **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.  
-- Specify Program Instance(s) applicable to this statute
- PRGR121460
- PRGR121459
- Passport

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

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

**PRGR121460**

**PRGR121459**

**Passport**

- e.  **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

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

**PRGR121460**

**PRGR121459**

**Passport**

## Section A: Program Description

### Part I: Program Overview

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#### 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

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#### 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

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#### B. Delivery Systems (3 of 3)

**Additional Information.** Please enter any additional information not included in previous pages:  
Narrative description of our delivery system model, including PCCM and FFS:

##### Passport to Health

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

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

##### Health Improvement Program

Montana operates a statewide Health Improvement Program (HIP) as an enhancement to Passport to Health. This enhanced PCCM is operated through a network of Passport providers who receive an enhanced case management fee to work with Passport eligible clients identified as high risk, high cost through predictive modeling. Primary care providers may also refer

at-risk clients. In addition to location, coordination and monitoring of primary health care services, enhanced services include the following:

- Conduct patient health assessment within 30 days of State referral of patient to Provider, using an approved Health Survey. Patients who cannot be reached or who prefer not to participate in an assessment initially are placed in “on demand” status and additional contact attempts are made at least twice during the following 12 months.
- Provide initial and ongoing clinical assessment at pre-determined intervals such as 30, 60, 90 days and one year, depending on diseases and risks.
- Tailor a holistic treatment/action plan for each enrolled patient in consultation with patient’s primary care provider.
- Manage patients as indicated—in person, telephonically, or other means suited to the individual.
- Provide group appointments for education and prevention when appropriate.
- Monitor and remind patients about routine testing; provide follow-up education regarding tests.
- Coordinate services with existing partners and form new partnerships (examples—hospitals, community primary care providers, specialists, social service and non-profit programs).
- Participate in multi-disciplinary hospital pre-discharge planning and counseling.
- Provide post hospital discharge visits, in-person and/or telephonic.
- Educate and support patients in self-management of health conditions.
- Be familiar with and refer patients to available local resources that can help patients with social services, housing, and other life problems that could prevent patients from paying attention to medical conditions.
- Track patient data—enrollment status, diseases, risks, interventions, and outcomes—and report to the State.
- In conjunction with the State, incorporate new methods such as remote disease monitoring or virtual video visits as technology is available and appropriate.
- Monitor patient progress and determine criteria for completion/graduation.

See Attachment B: HIP Provider Agreement

#### Nurse First Program

Montana has provided clients a nurse advice line (NAL), Nurse First, since 2004. Nurse Response took over operation of Nurse First on May 1, 2009.

Clients may call Nurse First for free advice 24 hours a day. Nurse First provides triage and treatment recommendation, from registered nurses, for injuries and health conditions. It also provides general health information about diseases, treatments, and medications. After each call, Nurse First faxes a description of the client's concern to the client's primary care provider, if the client is enrolled in Passport.

## 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: ". "

- 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

There is one provider fro the Nurse Advice Line.

*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

*Program: " Passport to Health, Health Improvement and Nurse First Programs.. "* **Two or more MCOs** **Two or more primary care providers within one PCCM system.** **A PCCM or one or more MCOs** **Two or more PIHPs.** **Two or more PAHPs.** **Other:**

please describe

The Health Improvement and Nurse First programs are voluntary.

**Nurse First**

Montana Medicaid's Nurse Advice Line is a valuable medical benefit which all eligible clients can access, however it is not mandatory. The potential for improved health outcomes and cost savings exists when clients are better informed about their symptoms, how to treat them, they understand their health condition(s) and only utilize services when medically necessary. This service is provided by one contractor through a 24-hour, seven day a week, statewide toll-free telephone number that all Medicaid eligible clients may access.

**Health Improvement Program**

Enhanced Primary Care Case Management provides additional services including health assessment, care planning, self management education, health coaching, health status monitoring and hospital pre-discharge planning for Passport eligible clients who are identified as high cost/high risk. Passport eligible clients will be enrolled, but will have the ability to opt out. The goal of the program is to improve health outcomes for clients and reduce costs due to unnecessary medical service utilization.

## 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.
- The Nurse First advice line provides services statewide.
- 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:  
Beneficiaries will be limited to a single provider in their service area for:  
Nurse Advice Line, statewide coverage  
EPCCM Health Improvement Program, statewide coverage  
See Attachment D: HIP Coverage Map and Provider County Listing

Beneficiaries will be given a choice of providers in their service area for:  
The PCCM program

**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*
    - PRGR121460
    - PRGR121459
    - Passport
  - **Less than Statewide**  
-- *Specify Program Instance(s) for Less than Statewide*
    - PRGR121460
    - PRGR121459
    - Passport
- 2. Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	PCCM/EPCCM	
Statewide	FFS NAL	

**Section A: Program Description**

## Part I: Program Overview

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### 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

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### E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's 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 Children's Health Insurance Program (SCHIP) through the Medicaid program.

**Mandatory enrollment**

**Voluntary enrollment**

**Other** (Please define):

## 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/MR** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).
- Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program
- Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
- Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
- Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.
- SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.
- Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

**Other** (Please define):

Medically needy clients with a spend down. These clients are included in the Nurse First program but are excluded from Passport and HIP unless they are part of Team Care. The system has a separate program indicator for the Passport and Team Care programs. A medically needy client with a Team Care indicator will ensure the client's participation in the Team Care program. A client's medically needy status will be transferred to the contractor through the eligibility file received from CHIMES (state Medicaid eligibility system)

Clients in a Medicaid eligibility subgroup of Subsidized Adoption

Clients who cannot find a PCP who is willing to provide case management. These clients are included in the Nurse First program but are excluded from Passport unless they are part of Team Care.

**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:

Medicaid beneficiaries with less than three months of Medicaid eligibility remaining upon enrollment in the program are excluded from the Passport program but included in the Nurse First program.

Medicaid beneficiaries who participate in a Home and Community-Based Waiver (HCBS, also referred to as a 1915(c) waiver) are excluded from the Passport program but included in the Nurse First program.

**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

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#### F. Services (2 of 5)

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

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

Emergency Services Category General Comments (optional):

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

- The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.
- The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.
- The State will pay for all family planning services, whether provided by network or out-of-network providers.
- Other (please explain):  
The State will pay for covered family planning services furnished by enrolled Medicaid providers.
- Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

## Section A: Program Description

### Part I: Program Overview

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

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

- The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
- The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:  
Enrollees can choose any FQHC in the state of Montana as their Passport provider. All 14 FQHCs are participating Passport providers.
- The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

**5. EPSDT Requirements.**

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

EPSDT Requirements Category General Comments (optional):

## Section A: Program Description

### Part I: Program Overview

#### F. Services (4 of 5)

**6. 1915(b)(3) Services.**

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

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

**7. Self-referrals.**

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

Self-referrals Requirements Category General Comments:

Passport Clients can self-refer to any Montana Medicaid provider for the following services:

- Ambulance

- Anesthesiology
- Audiology
- Blood lead testing
- Christian science nurses & sanatoriums (EPSDT)
- Dental (except orthodontia & dental surgery)
- Dialysis
- Dialysis Attendant
- Drug/Alcohol outpatient treatment (EPSDT)
- Durable medical equipment
- Emergency Services
  - Emergency room screening
  - Emergency room services for emergent conditions
- Eye exams
- Eyeglasses
- Family planning
- Hearing aids
- Hearing exams
- Home & Community Based Waiver services
- Home care
- Home infusion therapy
- Hospice
- Hospital-nursing home care beds
- Immunizations
- Intermediate care facilities for the mentally retarded
- Indian Health Service Clinic
- Lab
- Licensed clinical counseling
- Mental health services
  - Community mental health centers
  - Inpatient & outpatient with specific diagnosis
  - Inpatient hospital psych
  - Licensed professional counselors
  - Licensed social worker services
  - Other psych practitioner
- Nursing home and ICFMR services
- Obstetrical services
- Optometry services
- Personal care attendant services
- Podiatry
- Pregnancy-related services
- Prescription drugs
- Prosthetic devices
- Psychologists
- Residential treatment centers
- Skilled & intermediate nursing services in nursing facilities
  - ICF-MR services
  - Swing bed services
- STD (Sexually Transmitted Diseases)
  - Testing & treatment
  - Department designated sites
- Substance Abuse services
- Targeted Case Management
- Therapeutic family care
- Transportation
- X-ray services

**8. Other.**

Other (Please describe)

## Section A: Program Description

### Part I: Program Overview

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

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

## 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 State's 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:*

Montana does not use a single distance and/or travel time to gauge access. We determine through a variety of means, like client surveys and network adequacy reports, whether Passport primary care providers are available in the normal service delivery area for each town or region.

2.  Specialists

*Please describe:*

Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

3.  Ancillary providers

*Please describe:*

Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

4.  Dental

*Please describe:*

Passport clients can go to any Montana Medicaid provider without a referral.

5.  Hospitals

*Please describe:*

Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

6.  Mental Health

*Please describe:*

Mental Health services do not require a referral from a client's primary care provider. Passport clients can self refer to Montana Medicaid mental health providers.

7.  Pharmacies

*Please describe:*

Passport clients, except for Team Care, can go to any Montana Medicaid pharmacy provider. Team Care clients are locked into one pharmacy. The pharmacy restriction can be lifted temporarily by State staff or the enrollment broker if need be.

8.  Substance Abuse Treatment Providers

*Please describe:*

Substance Abuse Treatment services do not require a referral from a client's primary care provider. Passport clients can self refer to Montana Medicaid mental health or substance abuse providers.

9.  Other providers

*Please describe:*

Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

**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 State’s PCCM Program includes established standards for appointment scheduling for waiver enrollee’s access to the following providers.

**1.**  PCPs

*Please describe:*

For PCPs and other providers, Passport adopted the state standards for HMOs.

1. Emergency services must be available and accessible at all times.
2. Appointments for urgent care services must be available within 24 hours.
3. Appointments for non-urgent care with symptoms must be available within 10 calendar days.
4. Appointments for routine care must be available within 45 calendar days.

**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

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

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

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

1.  PCPs

*Please describe:*

We have not established standards for in-office wait times for our PCCM program; however, we do monitor this for any problems through the Client Help Line and client surveys.

2.  Specialists

*Please describe:*

3.  Ancillary providers

*Please describe:*

4.  Dental

*Please describe:*

5.  Mental Health

*Please describe:*

6.  Substance Abuse Treatment Providers

*Please describe:*

7.  Other providers

*Please describe:*

## Section A: Program Description

### Part II: Access

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

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

- d.  **Other Access Standards**

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

## Section A: Program Description

### Part II: Access

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#### A. Timely Access Standards (6 of 7)

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

Nurse First

The Nurse Advice Line vendor's staff schedule is dictated by their call volume. Nurse Response utilizes a work force management (WFM) system called Blue Pumpkin. Nurse Response has a dedicated WFM department, their primary responsibility is to; forecast call volumes, complete scheduling, report, monitor real time metrics and service levels, and assist with any type of outage. The WFM system allows you to forecast with appropriate service levels and populate a schedule based on the requirements.

In order to ensure enough customer service representatives (CSRs) and RNs are available to handle the inbound and outbound call queues, the WFM team creates a forecast based on historical call trends and adjusts for any new clients, current trends, etc. Once the forecast has been created the WFM department breaks the time down to 30 minute intervals and runs the call volumes through an Erlang C calculator to see how many RNs are required per 30 minute interval in order to reach performance goals. The WFM department verifies requirements versus schedule to ensure adequate coverage. The WFM department continually monitors their coverage requirements 24/7/365 on a real time basis with the WFM team and frontline management team.

The WFM Department and Telecom group work together to review call trunk space (available inbound/outbound lines) to ensure ample trunk space is available to allow all calls without experiencing any type of blockage (blockage indicates that you need to review trunk spacing). The vendor reviews this monthly as well as quarterly and looks

ahead to any additional services they may be offering. Should they come near to capacity, Nurse Response has a plan in place that includes a disaster recovery overflow switch which can be utilized until new circuits have been installed to increase current trunk space. This tool has never been needed but it is available should the situation occur.

During September, 2011, the NAL received 669 calls. The average hold time was 77 seconds. The average length of call was seven minutes 47 seconds, with an average talk time of six minutes 28 seconds. Abandoned calls numbered 30, or 4.5%.

## Section A: Program Description

### Part II: Access

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

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

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

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

## Section A: Program Description

### Part II: Access

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

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

- The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

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

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

## Section A: Program Description

### Part II: Access

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#### 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:*

The State allows a limit of 1000 clients per PCP. Each provider can select his/her own limit not to exceed 1000 clients. The enrollment system has a lock in place to disallow the enrollment for any provider to exceed his/her preselected limit. If it is noted that a provider has reached his/her limit and has clients requesting him/her as PCP, we ask the provider to increase the selected limit.

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

*Please describe the State's standard:*

The State monitors potential provider access issues every six months with our network adequacy report. There have been no issues with access to PCPs in the State. The State reviews limited provider's pending lists semi-annually to ensure that requesting clients are being notified of decisions regarding their choice of providers.

- 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 State's standard for adequate PCP capacity:*

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

## Section A: Program Description

### Part II: Access

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

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

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

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal
FQHCs and RHCs		154	154
Family Practitioners		339	339
General Practitioners		88	88
Indian Health Service Clinics		7	7
Internists		159	159
OB/GYN		25	25
Other		19	19
Pediatrician		92	92

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

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

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

*Please describe the State's standard:*

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

## Section A: Program Description

### Part II: Access

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

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

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

Area/(City/County/Region)	PCCM-to-Enrollee Ratio
Beaverhead County	1:42
Big Horn County	1:1041
Blaine County	1:281
Broadwater County	1:131
Carbon County	1:80
Carter County	1:55
Cascade County	1:121
Choteau County	1:43
Custer County	1:47
Daniels County	1:31
Dawson County	1:111
Deer Lodge County	1:64
Fallon County	1:38
Fergus County	1:81
Flathead County	1:106
Gallatin County	1:49
Garfield County	1:87
Glacier County	1:193
Golden Valley County	1:102
Granite County	1:67
Hill County	1:82
Jefferson County	1:28
Judith Basin County	0:143
Lake County	1:159
Lewis and Clark County	1:81
Liberty County	1:36
Lincoln County	1:115
Madison County	1:52
McCone County	1:81
Meagher County	1:90
Mineral County	1:82
Missoula County	1:110
Musselshell County	1:38
Park County	1:50
Petroleum County	0:24
Phillips County	1:528

Pondera County	1:188
Powder River County	1:73
Powell County	1:83
Prairie County	1:84
Ravalli County	1:137
Richland County	1:66
Roosevelt County	1:217
Rosebud County	1:142
Sanders County	1:107
Sheridan County	1:37
Silver Bow County	1:113
Statewide Average	1:92
Stillwater County	1:169
Sweetgrass County	1:56
Teton County	1:73
Toole County	1:55
Treasure County	1:54
Valley County	1:68
Wheatland County	1:91
Wibaux County	0:55
Yellowstone County	1:64

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

- g.  **Other capacity standards.**

*Please describe:*

Total number of practitioners is higher since FQHCs and and IHSs are not required to list linked providers. No IHSs list providers; FQHCs sometimes list providers. Big Horn County exceeds 1:1000 ratio because linked IHS providers are not included.

## 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.
- Nurse First

The Nurse Advice Line vendor's staff schedule is dictated by their call volume. Nurse Response utilizes a work force management (WFM) system called Blue Pumpkin. Nurse Response has a dedicated WFM department, their primary responsibility is to; forecast call volumes, complete scheduling, report, monitor real time metrics and service levels, and assist with any type of outage. The WFM system allows you to forecast with appropriate service levels and populate a schedule based on the requirements.

In order to ensure enough customer service representatives (CSRs) and RNs are available to handle the inbound and outbound call queues, the WFM team creates a forecast based on historical call trends and adjusts for any new clients, current trends, etc. Once the forecast has been created the WFM department breaks the time down to 30 minute intervals and runs the call volumes through an Erlang C calculator to see how many RNs are required per 30 minute interval in order to reach performance goals. The WFM department verifies requirements versus schedule to ensure adequate coverage. The WFM department continually monitors their coverage requirements 24/7/365 on a real time basis with the WFM team and frontline management team.

The WFM Department and Telecom group work together to review call trunk space (available inbound/outbound lines) to ensure ample trunk space is available to allow all calls without experiencing any type of blockage (blockage indicates that you need to review trunk spacing). The vendor reviews this monthly as well as quarterly and looks ahead to any additional services they may be offering. Should they come near to capacity, Nurse Response has a plan in place that includes a disaster recovery overflow switch which can be utilized until new circuits have been installed to increase current trunk space. This tool has never been needed but it is available should the situation occur.

During September, 2011, the NAL received 669 calls. The average hold time was 77 seconds. The average length of call was seven minutes 47 seconds, with an average talk time of six minutes 28 seconds. Abandoned calls numbered 30, or 4.5%.

## Section A: Program Description

### Part II: Access

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

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

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

The State allows a limit of 1000 clients per PCP. Each provider can select his/her own limit not to exceed 1000 clients. The enrollment system has a lock in place to disallow the enrollment for any provider to exceed his/her preselected limit. Once that limit has been reached clients can be enrolled with a provider on a pending basis. This pending status allows the provider to choose whether to accept the client. If the client calls in to select the provider and the provider has reached the selected limit the client is informed of the "pending" status. If the provider does not choose to accept the increased caseload the client is sent a letter telling him/her to select another provider. If the limit has been reached, no one can be auto-assigned to that provider.

A client not currently enrolled who chooses a "pending" or "limited" provider is not required to get a referral for services until the client is actively enrolled with a provider. Therefore, the client is able to access all Medicaid covered services while on the "pending list".

If a client currently enrolled with a provider in the Passport program and decides to change to a provider who is "limited", the client remains with the current provider through the end of the current month. At the beginning of the following month, the client would not be actively enrolled with a provider, therefore, would not be required to get a referral for Medicaid covered services. The client would have access to all Medicaid covered services until they are actively enrolled again with another provider. There are no clients who do not have access to a provider.

Caseload limits are monitored periodically by running a report of providers, their limits and the number of clients on their caseload. Providers are sent letters or called to ask about increasing the selected limits. If it is noted that a provider has reached his/her limit and is having several clients requesting him/her as PCP, a letter or phone call is made asking the provider to increase the selected limit.

## Section A: Program Description

### Part II: Access

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#### 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 plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

*Please provide justification for this determination:*

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

*Please describe:*

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

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

- d.  **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
1.  Developed by enrollees' primary care provider with enrollee participation, and in consultation

- with any specialists' care for the enrollee.
2.  Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
  3.  In accord with any applicable State quality assurance and utilization review standards.

*Please describe:*

- e.  **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's 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 enrollee's needs.
  - b.  Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
  - c.  Each enrollee is receives **health education/promotion** information.

*Please explain:*

#### Passport to Health

Clients receive health education/promotion information about the Passport Program from the Medicaid Helpline, the Welcome to Passport mailing and an online tutorial. In the month preceding a child's birthday, parents are sent a letter reminding them that Medicaid covers well-child visits and dental visits. They are also sent an age-appropriate immunization schedule magnet.

Passport clients are encouraged to use Nurse First. They learn about Nurse First through mailings and and telephone outreach. Nurse First offers online tools including self-care information and a decision support tool.

See Attachment E: Health Education/ Promotion Information

#### Health Improvement Program

Enrollees in the EPCCM receive education and healthcare information from their Nurse Case Manager, Health Coach or PCP that is specific to their health status, current medical condition and/or identified need in their treatment plan. The information is given to the client by a variety of methods: direct contact with health center staff, direct mailings, care support pages, access to the Nurse Advice Line's Audio Health Library, and viewing the Healthwise website.

- 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 manager's files.*

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

The Passport EPCCM program provides additional services by care managers including patient assessment, development of a care plan, health monitoring, coordinating care, pre- and post-hospital stay planning and health education.

- i.  **Referrals.**

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

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

## Section A: Program Description

### Part II: Access

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

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program. The Nurse Advice Line faxes the client's primary care provider a triage/disposition report. This fax allows the PCP to know when their client called the NAL, what symptoms they presented, the Nurse's recommendations, e.g., seek ER immediately, call PCP and make appointment, or self care, and can become a part of their client's medical record. This service allows for care coordination and continuity of services.

## Section A: Program Description

### Part II: Access

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#### 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

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

- The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

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

- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.  
The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

(mm/dd/yy)

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

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

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

**Section A: Program Description**

**Part III: Quality**

**2. Assurances For PAHP program**

- The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

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

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

## Section A: Program Description

### Part III: Quality

- 3. Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.
- a.  The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

*Please describe:*

- Access and Adequacy – Network Adequacy Report, Provider Type Listing Report, Client Survey, Complaints, Fair Hearing Requests, 24-Hour Call Log Report, Provider Change Report, Change Enrollment Report. For details on the results of this monitoring see Section B.

- In the previous waiver period, the state measured Client Satisfaction -This is monitored indirectly through the Provider Change Report and Change Enrollment Report. It is monitored directly through the following means:

- o Client mail survey –The state will conduct a statistically valid survey at an 85% confidence level with a margin of error of 5%.

- o Complaint and Grievance – Clients are made aware of the complaint and grievance process and their right to a fair hearing in the Medicaid Client Handbook. For provider or program specific complaints, clients are directed to call the client helpline operated by the enrollment broker.

- o Comprehensive Overview Report of QA Activity - This comprehensive report will be provided quarterly and looks at all QA activity. To date, the state has not found population-wide issues, region-wide issues, quality of care issues or issues specific to one provider.

## 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 PCCM's response to identified problems
  4.  Refer to program staff for further investigation
  5.  Send warning letters to PCCMs
  6.  Refer to State's medical staff for investigation
  7.  Institute corrective action plans and follow-up
  8.  Change an enrollee's PCCM

9.  Institute a restriction on the types of enrollees
10.  Further limit the number of assignments
11.  Ban new assignments
12.  Transfer some or all assignments to different PCCMs
13.  Suspend or terminate PCCM agreement
14.  Suspend or terminate as Medicaid providers
15.  Other

*Please explain:*

## Section A: Program Description

### Part III: Quality

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

- c.  **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
- Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):
1.  Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
  2.  Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
  3.  Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
    - A.  Initial credentialing
    - B.  Performance measures, including those obtained through the following (check all that apply):
      - The utilization management system.
      - The complaint and appeals system.
      - Enrollee surveys.
      - Other.

*Please describe:*

4.  Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5.  Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6.  Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7.  Other

*Please explain:*

Our enrollment broker, ACS, performs outreach to potential Passport Providers and helps them to complete paperwork necessary for enrollment.

Montana Medicaid providers are eligible to be Passport Providers if they are a physician, mid-level, nurse practitioner, physician's assistant or a specialist who provides primary care to Passport clients and additionally agrees to:

- Offer suitable coverage during normal office hours.
- Give direction to clients for emergent care 24/7.
- Offer comprehensive medical services including preventative care.
- Follow protocol for enrollment and disenrollment of clients
- Agree to provisions in the Passport Agreement and the Passport Provider Handbook.
- Provide case management services in accordance with the agreement.
- Maintain a unified patient record for each Passport client.
- Document clients' referrals.

See Attachment F: Passport Provider Handbook

## Section A: Program Description

### Part III: Quality

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

##### d. Other quality standards (please describe):

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

o Client mail survey – Passport will conduct a statistically valid survey at an 85% confidence level with a margin of error of 5%. While one of the goals is to have a consistent survey to compare from year to year, Passport continues to make modifications to the survey to ensure the questions are formatted appropriately so they do not confuse the clients, and to ensure that questions are beneficial to monitoring the program.

o Complaint and Grievance – Clients are made aware of the complaint and grievance process and their right to a fair hearing in the Medicaid Client Handbook. For provider or program specific complaints, clients are directed to call the client helpline operated by the enrollment broker. The enrollment broker records the complaint and explains the process to the client. The client is sent a letter describing the details of the complaint as it was received by the helpline. The client is asked to sign the letter and send it back to the helpline to confirm the information is correct. If it is incorrect, the client is asked to correct the information or call the helpline to relay the correct information. When a signed, correct complaint is received by the enrollment broker, it is forwarded to a state program officer who is designated to receive all complaints. The program officer records the complaint in a shared, password protected spreadsheet. The complaint is then forwarded to the appropriate program officer who investigates the matter. Investigation may include contacting the client, contacting a provider, researching the ARM or MCA, looking at claims, etc. A letter is sent to the client and sometimes the provider explaining the results of the investigation, any action taken by the state and any action required on the part of the client and or provider. Copies of letters and investigatory materials are forwarded to the program officer who is responsible for receiving all complaints and the spreadsheet is updated with findings. The client and provider are encouraged to follow-up if they have questions or concerns about the findings. If the findings are not in favor of the provider or client and they wish to pursue the matter further, they are informed about the fair hearings process.

## Section A: Program Description

### Part III: Quality

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- 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:

The State of Montana released an RFP for nurse advice line services on October 24, 2008. Through the competitive bidding process, the state contracted with a new vendor, Nurse Response. Nurse Response took over operation of Nurse First on May 1, 2009.

The nurse advice line is an important component of the PCCM and EPCCM programs. Nurse Response provides free advice line services 24/7. When clients receive triage direction Nurse Response sends the client's PCP a faxed account of the encounter in order to facilitate coordination of care.

Nurse Advice Line activities are monitored on a monthly basis via the ACD report detailing number of calls received, number of calls abandoned, abandonment rate, call length and average talk time to assure clients access to the service. Nurse Response has consistently met the URAC Health Call Center standards listed below:

- o Average abandonment rate of less than 5% for calls holding 30 seconds or more.
- o Average nurse call back time of 30 minutes or less.
- o Average service level of 85% or higher.
- o Blockage rate of 5% or less.
- o Average speed of answer - 30 seconds or less.

The program officer and analyst monitor monthly reports including the Post Intent Report, callers are asked whether or not they agree with recommendations received from the Nurse Advice Line.

The state conducts annual on-site performance reviews of Nurse Response. Performance reviews identify commendable practices, recommendations and findings to guide and require meeting contractual obligations.

Client satisfaction with the nurse advice line is measured by a client survey. See Attachment G for a summary of client survey results.

## Section A: Program Description

### Part IV: Program Operations

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#### A. Marketing (1 of 4)

##### 1. Assurances

- The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

## Section A: Program Description

**Part IV: Program Operations****A. Marketing (2 of 4)****2. Details****a. Scope of Marketing**

1.  The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2.  The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

*Please list types of indirect marketing permitted:*

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

*Please list types of direct marketing permitted:*

**Section A: Program Description****Part IV: Program Operations****A. Marketing (3 of 4)****2. Details (Continued)**

- b. Description.** Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

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

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

2.  The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

*Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:*

3.  The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

*Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):*

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

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

*Please describe the methodology for determining prevalent languages:*

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

- c.  Other

*Please explain:*

## Section A: Program Description

### Part IV: Program Operations

#### A. Marketing (4 of 4)

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

## Section A: Program Description

### Part IV: Program Operations

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

##### 1. Assurances

- The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

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

- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

## Section A: Program Description

### Part IV: Program Operations

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

##### 2. Details

###### a. Non-English Languages

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

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

The State has no need to translate materials because we have no prevalent languages other than English. Montana has very few non-English speaking groups, none of which comprise 10 percent of the population. We are prepared to translate materials if there is a need. To date we have emailed one blind client the Medicaid General Handbook so he could listen to the handbook through his computer.

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

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

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

*Please explain how the State defines "significant.":*

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

*Please explain:*

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

Translators are available at no charge to clients who need translator services during the eligibility

- determination process or during the receipt of medical services.
3.  The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

*Please describe:*

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

## Section A: Program Description

### Part IV: Program Operations

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

##### 2. Details (Continued)

###### b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- State  
 Contractor

*Please specify:*

Information on Passport to Health, Health Improvement Program and the Nurse First programs is distributed by the state, the enrollment broker and community health centers. Potential enrollees access information at local Offices of Public Assistance and through program handbooks, direct mailings and outreach telephone calls.

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

## Section A: Program Description

### Part IV: Program Operations

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

##### 2. Details (Continued)

###### c. Enrollee Information

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

- the State  
 State contractor

*Please specify:*

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

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

## Section A: Program Description

### Part IV: Program Operations

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

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

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

Enrollees or potential enrollees can access translators (including sign-language) to assist them in communicating in order to understand the program. Providers, eligibility specialists and the enrollment broker and state staff can access translator services in order to explain the program to non-English speaking clients. Because Montana has no prevalent languages other than English, and staff has had no requests to date, written materials have not been translated. Providing translator services is an efficient mechanism to address the limited prevalence of non-English languages.

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

##### Passport to Health

The enrollment process for Passport starts with Medicaid eligibility conducted at the local County Offices of Public Assistance (OPA). Medicaid information and basic Passport information is given to all potentially eligible clients. The information is given verbally by the Eligibility Case Manager and in the form of the General Medicaid Handbook.

Clients receive a letter from the OPA when Medicaid eligibility is determined. The data for Medicaid eligible clients who have also been determined Passport eligible is then sent to the enrollment broker.

##### Health Improvement Program

For the EPCCM, all eligible clients are notified of enrollment at the same time as they are notified of their Passport to Health enrollment. The health centers make direct contact with those members selected through predictive modeling for case management. They contact clients initially by letter followed by up to three telephone attempts. If they are not able to reach by telephone, a follow-up letter is sent. Patients are given all of the information about the program both in writing and by telephone when contacted by the health centers.

##### Nurse First

Nurse First clients are notified of their eligibility for the program through the OPA office, the general Medicaid Handbook, Passport handbook and the Passport outreach calls.

## Section A: Program Description

### Part IV: Program Operations

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#### 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 State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

##### a. Outreach

- The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

*Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:*

##### Passport to Health

The enrollment broker markets the program with outreach materials and calls. When a client is deemed Passport eligible, the enrollment broker sends a Welcome to Passport packet. This packet includes: a letter explaining the Passport Program; information on how to enroll with a provider by phone, post or on the web. The packet also includes a list of ten PCPs clients can choose from (clients are told they can choose a PCP who is not on the list as long as the PCP is a Passport Provider). The first provider on the list is the provider the client will be assigned to if they do not choose a provider. This provider is system generated using an algorithm which looks at, in the order listed, the client's previous Passport enrollment, family enrollment, claims history, Tribal enrollment (if tribally enrolled the provider will be IHS) and geographic area. The other nine providers on the list are the closest within a fifty mile radius of the client address. After a client has received outreach materials by mail, over 80% will receive an outreach call. During the call, program is explained in detail and the client is given an opportunity to ask questions and choose a provider over the phone. If a client has not enrolled with a PCP 45 days after they were sent the initial outreach materials, they will receive a final letter encouraging them to voluntarily enroll with a provider, or have one chosen for them.

The outreach performance standard for the enrollment broker is to successfully outreach 80 percent of those clients new to Passport with telephones. This goal is always met and most months exceeded. Please see the Client Outreach Enrollment Process chart at the end of this narrative.

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

Passport Program staff participate in bi-annual provider trainings throughout the state in conjunction with ACS. Staff also coordinate trainings for specific providers or groups as necessary. Program staff regularly writes articles with Passport updates for the Claim Jumper, the provider newsletter. Staff regularly update print and web-based client and provider information.

See Attachment E: Health Education/ Promotional Materials

Attachment H: Passport Outreach Materials

#### Team Care

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

See Attachment I: Team Care Outreach Materials

#### Health Improvement Program

Clients are auto-enrolled to a community health center or tribe based on geographic area. This network of Passport providers who provide EPCCM services will make a minimum of five attempts (2 in writing and three via telephone) to engage members recommended by the State. They will also follow-up with any clients they are not able to reach at six-month intervals.

#### Nurse First

The Nurse First program is explained in the client handbooks, and all Passport brochures.

#### Client Outreach/Enrollment Process:

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

\*Note: In order to ensure that persons have sufficient time to choose a provider and voluntarily enroll with that provider, ACS allows a minimum of 30 days from the time a person is deemed eligible for managed care before assignment. The monthly "cut-off date" occurs around the 23rd of every month. If a client has been on managed care two months in the past, the individual is reinstated with their previous PCP.

## Section A: Program Description

### Part IV: Program Operations

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

##### 2. Details (Continued)

##### b. Administration of Enrollment Process

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

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

Broker name:

Please list the functions that the contractor will perform:

- choice counseling
- enrollment
- other

*Please describe:*

The contractor’s duties include maintaining the Medicaid Help Line. Clients may call the Medicaid Help Line for questions unrelated to Passport. The contractor’s duties include providing general Medicaid information and phone referrals to other entities when necessary. Also included in the enrollment function is exemption processing.

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

*Please describe the process:*

The enrollment broker enrolls clients into the Passport program. Medicaid clients may choose a provider from a list provided by the enrollment broker or pick another provider. Clients have 45 days to choose a provider. Clients that do not choose are auto-enrolled based on an auto-assignment algorithm described in the next section.

## Section A: Program Description

### Part IV: Program Operations

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

##### 2. Details (Continued)

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

- This is a **new** program.

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

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

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

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

- i.  Potential enrollees will have   **day(s)** /  **month(s)** to choose a plan.

- ii.  There is an auto-assignment process or algorithm.

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

Passport to Health auto-assigns clients to a provider if they have not chosen one, sixty days or more after the first outreach attempt. The auto assignment algorithm is intended to choose the best suited PCP for a client. The system assigns by the following criteria, in this order:

1. Previous Passport enrollment
2. Most recent claims history
3. Case (family) Passport assignment(s)
4. Native Americans will be assigned to IHS if one is within fifty miles of their home
5. Geographic area (within a fifty mile radius)

The Health Improvement Program auto-enrolls clients to a community center or tribe based on geographic area. This Enhanced Primary Care Case Management provides additional services including health assessment, care planning, self management education, health coaching, health status monitoring and hospital pre-discharge planning for Passport eligible clients who are identified as high cost/high risk. Passport eligible clients will be enrolled, but will have the ability to opt out. The goal of the program is to improve health outcomes for clients and reduce costs due to unnecessary medical service utilization.

- The State automatically enrolls beneficiaries.
- on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
  - on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
  - on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

*Please specify geographic areas where this occurs:*

- The State provides **guaranteed eligibility** of \_\_\_\_\_ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.
- The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

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

1. Third Party Liability (TPL): When a client requests a TPL exemption the TPL unit at the enrollment broker contacts the insurance company to determine whether participation in Passport would create a hardship.
2. Out of state foster care/treatment center-auto-exemption written into MMIS.
3. Error correction/incorrect enrollment exemptions.
4. Provider leaves without 30 day notice.
5. Doctor refuses to see patient or give referrals.
6. Enrollment broker staff is able to exempt clients from Passport if enrollment in the program would cause hardship due to certain medical circumstances. For neonatal care or ICU cases, the enrollment broker can grant a medical exemption without elevating it to the state. For all other medical hardship exemptions, the enrollment broker sends a request form to the client which is sent on to the state.
7. State granted medical hardship. This exemption process consists of the client or his/her agent,

requesting an exemption in writing to the state. The Department reviews the exemption request.

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

The Nurse First program and EPCCM are voluntary.

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

## Section A: Program Description

### Part IV: Program Operations

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

#### 2. Details (Continued)

##### d. Disenrollment

- The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.
- i.  Enrollee submits request to State.
- ii.  Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- iii.  Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.
- The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.
- The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of \_\_\_\_\_ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

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

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

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

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

A provider can disenroll a Passport or Team Care client for the following reasons:  
 The provider-patient relationship is mutually unacceptable.  
 The client fails to follow prescribed treatment.  
 The client is abusive.

The client could be better treated by a different type of provider, and a referral process is not feasible.

A provider cannot disenroll a Passport or Team Care client for the following reasons:

Because of an adverse change in the enrollee's health status.

Client's utilization of medical services.

Client's diminished mental capacity.

Disruptive behavior as a result of the client's special needs. The exception is if enrollment seriously impairs the PCP's ability to furnish care to the client or other clients. If this is the case,

disenrollment must be approved by the Passport Program officer.

Any reason that may be considered discrimination

- 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 PCCM's 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:

Description of circumstances under which a beneficiary would be eligible for exemption from enrollment and a description of the exemption process including additional information:

1. Third Party Liability (TPL): (Covers most medical needs and requires the client to choose a PCP.) When a client requests a TPL exemption the TPL unit at the enrollment broker contacts the insurance company to determine whether participation in Passport would create a hardship for the client. This may be if the other insurance requires that the client stay in a network or participates in another managed care program.
2. Out of state foster care/treatment center - auto-exemption written into the MMIS system
3. Error correction/incorrect enrollment exemptions.
4. Provider leaves without 30 day notice.
5. Doctor refuses to see patient or give referrals.
6. Other enrollment broker granted exemptions. Enrollment broker staff is able to exempt clients from Passport if enrollment in the program would cause hardship due to certain medical circumstances. Clients are directed in the general Medicaid Handbook to call the client help line if they would like an exemption due to medical need. In the cases of neonatal care or ICU, the enrollment broker can grant a medical exemption without elevating it to the state. For all other medical hardship exemptions, the enrollment broker sends a request form to the client which is sent to the state. The enrollment broker provides the State with a monthly exemption report and regularly revisits exemptions they have granted to ensure they are still required. (E.g. calls on neonatal every 60 days to determine if baby is still inpatient).
7. State granted medical hardship. This exemption process consists of the client or his/her agent, requesting an exemption in writing to the state. The Department reviews the exemption request. Reviews may consist of the following: review of claims, review of managed care history, phone conversations with medical providers, review of patient charts, phone conversation with client, etc. When a determination is made the client is notified via letter of the decision and notified of his or her right to appeal if the decision is negative. An exemption is granted for a period of time that accommodates the individual client and will usually be a period from 3 months to six months. A monitoring system is in place to review exemptions with the goal of ending the exemption when appropriate and enrolling the client with a PCP.

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

Additional information on the process of enrollee disenrollment after a PCCM submits request to the state:

Providers can request that a client be disenrolled for cause. The request from the provider must be in writing and should

allow 30 days for the change to take place.

If a provider requests that a client be removed from his or her caseload after the 6th working day from the end of the month, they must give care or referrals to the client through the end of the month. If the provider is unwilling the client gets an "emergency" exemption, which means the client can see any Medicaid provider that month without referral. The client's provider change information is entered into the call tracking software. The client is sent a letter instructing him or her to choose a new provider if the PCP initiated the change. A list of providers is enclosed with the letter. When a Passport provider leaves the Passport Program, all of his or her clients are disenrolled using the above procedure. ACS updates the provider information in the Passport database.

Additional information on the process of enrollee disenrollment after enrollee submits request to the state:

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

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

Clients are enrolled in Team Care for a minimum of 24 months. Cases are assessed on an individual basis after they have met the minimum time requirement. Part of the assessment includes contacting the client's Team Care Provider. If a provider validates that a client has shown adequate improvement regarding previous misuse of the Medicaid program, the client may be graduated from the Team Care program. Most clients, however, are enrolled for a period of longer than 24 months and many have been on the Team Care program since its inception.

The Nurse First program and EPCCM program are voluntary.

## Section A: Program Description

### Part IV: Program Operations

#### D. Enrollee Rights (1 of 2)

##### 1. Assurances

- The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

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

- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

## Section A: Program Description

### Part IV: Program Operations

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#### D. Enrollee Rights (2 of 2)

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

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

The Montana Department of Public Health and Human Services employs a HIPAA privacy officer. All DPHHS and ACS employees are required to attend HIPAA training and be evaluated on the training. The state has reviewed and will comply with the new HIPAA regulations set forth in the American Recovery and Reinvestment Act.

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

- PHI or identifying information is only transferred electronically through secure email or secure file transfer.
- Clients and providers are required to give at least three pieces of identifying information when they call the help line or state staff in order to discuss PHI or any client identifying information.
- PHI or identifying information is not given unless it is required.

## Section A: Program Description

### Part IV: Program Operations

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#### 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

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#### 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 State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is \_\_\_\_\_ days (between 20 and 90).
- The State's 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 enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's 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 State's 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:*

Quality of Care (QOC) Complaints and General Complaints: Informal, verbal communication by a client or authorized representative.

Formal Complaint: Written communication that is a follow-up to a verbal complaint.

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

Appeal

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

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

The complaints typically come into the help line that is staffed by the enrollment broker. The help line staff initially review the complaint. If the complaint cannot be resolved immediately it is referred to the appropriate State of Montana staff.

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

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

Enrollee has 90 days to request a review of fair hearing decisions.

- Has time frames for resolving requests for review.

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

The state has 20 calendar days from date of receiving a complaint.

- Establishes and maintains an expedited review process.

*Please explain the reasons for the process and specify the time frame set by the State for this process:*

- Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.
- Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.
- Other.

*Please explain:*

## Section A: Program Description

### Part IV: Program Operations

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#### E. Grievance System (5 of 5)

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

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

**Quality of Care (QOC) Complaint:** Informal, verbal communication by a client or their authorized representative indicating that s/he wants the opportunity to present her/his case to a reviewing authority regarding what the client or her/his authorized representative perceives to be inappropriate or lack of appropriate care or services received from the state, or any of its agents or providers under the Medicaid program. QOC reasons are listed below:

- Had to wait too long for an appointment.
- Provider or staff did not explain things clearly.
- Provider or staff was rude.
- Not getting good medical care.

**General Complaint:** Informal, verbal or email (sent through our client website) communication by a client or their authorized representative indicating that s/he wants the opportunity to present her/his case to a reviewing authority regarding what the client or her/his authorized representative perceives to be inappropriate or lack of appropriate service related to issues regarding eligibility, satisfaction with county or state agencies, or other similar matters not related to QOC concerns.

**Formal Complaint:** Written communication from a client or her/his authorized representative is a follow-up to a verbal complaint. This written communication is sent by the state to the client to confirm a complaint that was given verbally.

**Grievance:** Written communication which a client or her/his authorized representative presents indicating s/he wants the opportunity to present her/his case to a reviewing authority regarding what the client or her/his authorized representative perceives to be an inappropriate action by the state or any of its agents or providers. This can be a QOC concern or a general concern.

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

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

We will assist in filling out paperwork and have a TDD system for people with hearing deficiencies. We work with our clients on an individual basis and assist as needed whenever we can. If a client has a special need that cannot be met by us we may refer to the county office or to an advocacy group. In either case we will work closely with the client and the other party to assist.

## Section A: Program Description

### Part IV: Program Operations

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#### 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 MCO's, PCCM's, PIHP's, or PAHP's 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 MCO's, PCCM's, PIHP's, or PAHP's 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 excluded 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	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Accreditation for Participation	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Consumer Self-Report data	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
Data Analysis (non-claims)	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
Enrollee Hotlines	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP

	<input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS	<input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Focused Studies</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Geographic mapping</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Independent Assessment</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Measure any Disparities by Racial or Ethnic Groups</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Network Adequacy Assurance by Plan</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Ombudsman</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>On-Site Review</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Performance Improvement Projects</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Performance Measures</b>						

	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Periodic Comparison of # of Providers</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Profile Utilization by Provider Caseload</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Provider Self-Report Data</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Test 24/7 PCP Availability</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Utilization Review</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Other</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> 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	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Accreditation for Participation	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Consumer Self-Report data	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
Data Analysis (non-claims)	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Enrollee Hotlines	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
Focused Studies	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Geographic mapping	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM

	<input type="checkbox"/> FFS	<input type="checkbox"/> FFS	<input type="checkbox"/> FFS
<b>Independent Assessment</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Measure any Disparities by Racial or Ethnic Groups</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Network Adequacy Assurance by Plan</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Ombudsman</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>On-Site Review</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Performance Improvement Projects</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Performance Measures</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Periodic Comparison of # of Providers</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Profile Utilization by Provider Caseload</b>	<input type="checkbox"/> MCO	<input type="checkbox"/> MCO	<input type="checkbox"/> MCO

	<input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Provider Self-Report Data</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Test 24/7 PCP Availability</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Utilization Review</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Other</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> 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.

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  - 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	<input type="checkbox"/> MCO	<input type="checkbox"/> MCO	<input type="checkbox"/> MCO

	<input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Accreditation for Participation</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Consumer Self-Report data</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS
<b>Data Analysis (non-claims)</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS
<b>Enrollee Hotlines</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Focused Studies</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Geographic mapping</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Independent Assessment</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Measure any Disparities by Racial or Ethnic Groups</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM

	<input type="checkbox"/> FFS	<input type="checkbox"/> FFS	<input type="checkbox"/> FFS
<b>Network Adequacy Assurance by Plan</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Ombudsman</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>On-Site Review</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input checked="" type="checkbox"/> FFS
<b>Performance Improvement Projects</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Performance Measures</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Periodic Comparison of # of Providers</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Profile Utilization by Provider Caseload</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Provider Self-Report Data</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Test 24/7 PCP Availability</b>	<input type="checkbox"/> MCO	<input type="checkbox"/> MCO	<input type="checkbox"/> MCO

	<input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Utilization Review</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input checked="" type="checkbox"/> PCCM <input type="checkbox"/> FFS
<b>Other</b>	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> 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
PRGR121459	undefined
PRGR121460	undefined
Passport	PCCM; FFS;

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:**

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 organization’s 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:

- CAHPS
- State-developed survey
- Disenrollment survey
- Consumer/beneficiary focus group

Please identify which one(s):



d.  **Data Analysis (non-claims)**

Activity Details:

- Denials of referral requests
- Disenrollment requests by enrollee
  - From plan
  - From PCP within plan
- Grievances and appeals data
- Other

Please describe:



e.  **Enrollee Hotlines**

Activity Details:



f.  **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)  
**Activity Details:**

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g.  **Geographic mapping**  
**Activity Details:**

---

h.  **Independent Assessment** (Required for first two waiver periods)  
**Activity Details:**

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i.  **Measure any Disparities by Racial or Ethnic Groups**  
**Activity Details:**

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

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k.  **Ombudsman**  
**Activity Details:**

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l.  **On-Site Review**  
**Activity Details:**

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

---

- Clinical**
- Non-clinical**

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

---

- Process**
- Health status/ outcomes**
- Access/ availability of care**
- Use of services/ utilization**

- Health plan stability/ financial/ cost of care
- Health plan/ provider characteristics
- Beneficiary characteristics

**o.**  **Periodic Comparison of # of Providers**

Activity Details:



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

Activity Details:



**q.**  **Provider Self-Report Data**

Activity Details:

- Survey of providers
- Focus groups



**r.**  **Test 24/7 PCP Availability**

Activity Details:



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

Activity Details:



**t.**  **Other**

Activity Details:



**Section B: Monitoring Plan**

**Part II: Details of Monitoring Activities**

**Program Instance:**

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 organization's 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:**

- CAHPS

Please identify which one(s):

- State-developed survey
- Disenrollment survey
- Consumer/beneficiary focus group

d.  **Data Analysis (non-claims)**

**Activity Details:**

- Denials of referral requests
- Disenrollment requests by enrollee
  - From plan
  - From PCP within plan
- Grievances and appeals data
- Other

Please describe:

e.  **Enrollee Hotlines**

**Activity Details:**

---

f.  **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

**Activity Details:**

---

g.  **Geographic mapping**

**Activity Details:**

---

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

**Activity Details:**

---

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

**Activity Details:**

---

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

**Activity Details:**

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k.  **Ombudsman**

**Activity Details:**

---

l.  **On-Site Review**

**Activity Details:**

---

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

**Activity Details:**

---

**Clinical**

**Non-clinical**

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

**Activity Details:**

---

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

**o.**  Periodic Comparison of # of Providers

Activity Details:

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

Activity Details:

**q.**  Provider Self-Report Data

Activity Details:

- Survey of providers
- Focus groups

**r.**  Test 24/7 PCP Availability

Activity Details:

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

Activity Details:

**t.**  Other

Activity Details:

## Section B: Monitoring Plan

### Part II: Details of Monitoring Activities

**Program Instance: Passport to Health, Health Improvement and Nurse First Programs.**

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 organization's 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:**

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

- The State will conduct a confidential client survey by mail, using a computerized client survey tool. Clients will be selected at random to participate in the survey. Clients will be sent paper surveys and asked to rate services (satisfaction with Passport Provider's services, NAL, HIP, Client Helpline, etc.) on a relative scale.
- Surveys will be conducted on an annual basis
- Clients will be asked to rate Passport services they have received. This will enable the state to measure levels of satisfaction in the program and identify areas that clients are not happy with. On the survey, clients will be given an opportunity to make any additional comments regarding Medicaid services.

CAHPS

Please identify which one(s):

- State-developed survey
- Disenrollment survey
- Consumer/beneficiary focus group

d.  **Data Analysis (non-claims)**

**Activity Details:**

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

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

Denials of referral requests

Disenrollment requests by enrollee

From plan

From PCP within plan

Grievances and appeals data

Other

Please describe:

PCP terminations

e.  **Enrollee Hotlines**

**Activity Details:**

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

- Enrollment Broker and State operate and review client helpline.
- Operation of the client helpline is a part of the Enrollment Broker contract. The State has set forth performance measures in the EB contract amendment to ensure the helpline is being operated efficiently and effectively. The EB prepares the monthly High Level Report and the EB Report Card which include details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate. The report data is collected from the helpline call software. State staff also routinely listens to calls and perform a yearly audit of the helpline functionality.
- Monitored monthly
- Details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate are analyzed to determine whether performance measures are being met.

f.  **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer

defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

**Activity Details:**

g.  **Geographic mapping**

**Activity Details:**

Geographic mapping performed for the Passport to Health program:

- Enrollment Broker and State operate and review.
- Enrollment Broker prepares a quarterly Network Adequacy Report which details the number of Passport providers and clients in each county.
- Report prepared quarterly.
- State analyzes data to ensure adequate, statewide provider coverage.

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

**Activity Details:**

Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State that an Independent Assessment is needed in the waiver approval letter.

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

**Activity Details:**

Disparities measured for the Passport to Health program:

- Enrollment Broker and State prepare and review report.
- Enrollment Broker monthly High Level Report details enrollment into Passport by race.
- monthly
- State analyzes data for any disparities between choice enrollment and auto-assignment depending on race.

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

**Activity Details:**

Network adequacy report for the Passport to Health program:

- Enrollment Broker and State perform and review report.
- Enrollment Broker prepares a quarterly Network Adequacy Report which details provider to enrollee ratios by county, PCP caseload and limits by county, measurement of enrollee requests for disenrollment from a PCP due to capacity issues, open PCCM slots by county and provider type, tracking of complaints and grievances related to capacity.
- quarterly
- State analyzes data to ensure adequate, statewide provider coverage.

- k.  **Ombudsman**

**Activity Details:**

- l.  **On-Site Review**

**Activity Details:**

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

**Activity Details:**

- Clinical**
- Non-clinical**

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

**Activity Details:**

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

- o.  **Periodic Comparison of # of Providers**

**Activity Details:**

Comparison performed for Passport to Health program:

- Enrollment Broker and State prepare and review report.
- Enrollment Broker prepares a quarterly Network Adequacy Report which details provider to enrollee ratios by county, and types of providers.
- Report prepared quarterly.
- State analyzes data to ensure an adequate number and range of providers are available statewide.

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

**Activity Details:**

- q.  **Provider Self-Report Data**

**Activity Details:**

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

- State staff conduct and analyze data.
- The State will conduct a provider survey by mail, using a computerized survey tool. Providers will be sent paper surveys and asked to rate their experience with Passport and to offer any suggestions for improving the program.
- Survey's will be conducted on an annual basis
- This will enable the state to measure levels of satisfaction in our program, identify areas that providers are not happy with and perhaps, give the state suggestions for improvements.

**Survey of providers**

**Focus groups**

- r.  **Test 24/7 PCP Availability**

**Activity Details:**

PCP availability tested for the Passport to Health program:

- Enrollment Broker performs tests.
- Enrollment Broker makes calls to providers after hours to ensure they have a message that directs clients to care 24/7.
- Testing occurs weekly
- Enrollment Broker ensures necessary coverage is available to clients by testing provider's phone lines after hours.

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

**Activity Details:**

Utilization review performed for the Passport to Health program:

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

- t.  **Other**

**Activity Details:**

## Section C: Monitoring Results

### Renewal Waiver Request

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

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

#### This is a renewal request.

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

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

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

#### The Monitoring Activities were conducted as described:

**Yes**  **No**

If No, please explain:

#### Provide the results of the monitoring activities:

Consumer self-report data:

Strategy: Use client data survey tool to survey client satisfaction with the Passport program and Passport providers.

Survey was conducted in SFY 2011.

See Attachment J: Summary of client survey results.

Consumer self-report data for Nurse Advice Line:

Strategy: Use Nurse First client survey tool to survey client satisfaction with the Nurse First Advice Line. Survey was conducted SFY 2011.

See Attachment G: Summary of NAL client survey results.

Data analysis (non-claims):

Strategy: To monitor client disenrollment, grievances and appeals and termination of PCPs from the Passport program.

See Attachment K: Enrollment Broker High Level Report.

**Summary of results:**

The High Level Report provided by the enrollment broker reflects client and provider disenrollment. The state looks for trends or areas of concern such as frequent, mass disenrollment of clients by a single provider. Since the enrollment broker has been fully functional we have not had any areas of major concern.

All grievances and appeals come directly to the State, which monitors grievances and appeals for trends and follow-up if necessary. There have been no major concerns or fluctuations in grievances during this waiver period.

**Enrollee hotlines operated by State:**

Strategy: Ensure that the Medicaid Client Help Line (operated by the enrollment broker, ACS) is effectively reaching performance standards set forth in the contract. The monthly High Level Report and EB Report Card include call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate. The report data is collected from the helpline call software. State staff also routinely listens to calls and perform a yearly audit of the helpline functionality.

See Attachment K: Enrollment Broker High Level Report

Attachment L: Enrollment Broker Report Card

Attachment M: 2011 State Enrollment Broker Audit Report

Summary of results: EB(ACS) was not performing Quality Assurance on the EB Project Manager's inbound or outbound calls. Enrollment Broker Manager's EB call center calls are now recorded and subject to the QA process.

**Geographic mapping of provider network:**

Strategy: Ensure adequacy of provider network. Network Adequacy Report (NAR) attached- includes a client/provider ratio for each county.

See Attachment N: Network Adequacy Report

Summary of results: There have been no major issues with the network adequacy during this waiver period.

**Measurement of any disparities by racial or ethnic groups:**

Strategy: Monitor for disparities between racial or ethnic groups and program enrollment and auto assignment versus voluntary program enrollment. Disparities are monitored through the Enrollment Broker High Level Report .

See Attachments K: Enrollment Broker High Level Report

Summary of results: No racial or ethnic disparities have been identified in the managed care programs or enrollment.

**Network adequacy assurance submitted by plan:**

Strategy: Monitor provider network adequacy, specifically: provider to enrollee ratios, PCP caseload and limits by practice, open PCCM slots by provider, tracking of complaints and grievances related to capacity. This data is monitored through the Network Adequacy Report.

See Attachment N: Network Adequacy Report

Summary of results: No major issues have been identified.

**On-site audits of contractors:**

Strategy: The managed care bureau's data analyst conducts annual on-site audits of program contractors that provide services under the 1915(b)waiver to ensure that contractual responsibilities are being met . ACS provides enrollment broker functions and predictive modeling services; and Nurse Response operates the Nurse Advice Line.

See Attachment M: 2011 State Enrollment Broker Audit Report

See Attachment O: 2011 Nurse Advice Line Audit Report

Summary of results: Audits identified commendable practices, recommendations and findings to guide and require meeting contractual obligations.

**Periodic comparison of number and types of Medicaid providers before and after waiver:**

Strategy: Ensure availability of a range of providers to populations covered under this waiver. The NAR tracks the ratio of providers to clients by county. The state closely monitors complaints about access to providers.

See Attachment N: Network Adequacy Report

Summary of results: No major issues have been identified regarding availability of providers.

**Provider self-report data:**

Strategy: Use state provider survey tool to survey provider satisfaction with the Passport program.

See Attachment P for a summary of Provider Survey results.

Summary of results: Survey was conducted in SFY 2011.

Test 24 hours/7 day week PCP availability:

Strategy: Identify where Passport referral numbers have been used but not authorized. The state randomly audits Passport referrals by looking at claims and contacting referring providers to confirm they have given the referral.

See Attachment K: Enrollment Broker High Level Report - Passport Referral Audit

Summary of results: Some providers are not keeping adequate records of referrals making it impossible to audit the use of their numbers. In several cases, misuse of Passport numbers results in claims being paid that were not properly referred.

Problems identified: Lack of record keeping; misuse of Passport referral numbers

Funds have been recouped in several cases and providers educated about the requirement that they keep documentation of every time they refer a Passport client.

Corrective action (plan/provider level) Providers who have not kept adequate records will be asked to provide lists of referrals 6 months after they have been educated about this requirement.

Program change: (system-wide level)

### Section D: Cost-Effectiveness

#### Medical Eligibility Groups

Title
PASSPORT TANF (PRIMARY CARE CASE MANAGEMENT - TANF ONLY)
PASSPORT SSI (PRIMARY CARE CASE MANAGEMENT - SSI ONLY)
PASSPORT HK (PASSPORT -CHIP EXPANSION GROUP)
EPCCM (TANF & SSI) (ENHANCED PRIMARY CARE CASE MANAGEMENT - TANF AND SSI POPULATIONS)
EPCCM - HK (ENHANCED PRIMARY CARE CASE MANAGEMENT - CHIP EXPANSION GROUP)
NAL (NURSE ADVICE LINE)
NAL - HK (NURSE ADVICE LINE -CHIP EXPANSION GROUP)

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	04/01/2010	03/31/2011	04/01/2011	09/30/2011
Enrollment Projections for the Time Period*	04/01/2012	03/31/2013	04/01/2013	03/31/2014
**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
Chiropractic Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detoxification	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis - Free Standing Centers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis - Home Dialysis AHD	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs Prescription	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Durable Medical Equipment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education Agency Services School Based Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPCCM - Case Management Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPSDT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Planning Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Federally Qualified Health Center Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aids & Exams	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home & Community Based Waiver Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Infusion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospice	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Hospital - Other	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Hospital - Psych	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lab and x-ray	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NAL - Nurse Advice Line Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse Midwife	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse Practitioner	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrical Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Psych Practitioner	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Hospital - All other	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Hospital - Lab and X-ray	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partial Hospitalization	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCCM Case Management Fees	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Assistant Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Podiatry	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Duty Nursing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Professional & Clinic and Other Lab and X-ray	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Care Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rural Health Clinic	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Worker Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Treatment Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing for Sexually Transmitted Diseases (STDs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic Group and Family Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transplants	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation - Emergency	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation - Non- Emergency	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Exams and Glasses	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Well Child Check Ups	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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 State’s 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 State’s submitted CMS-64 forms.

**Signature:** Jo Thompson  
 State Medicaid Director or Designee

**Submission Date:** Dec 29, 2011

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

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

Mary LeMieux

**c. Telephone Number:**

(406) 444-1921

**d. E-mail:**

MleMieux2@mt.gov

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

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

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

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

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

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

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

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

**Section D: Cost-Effectiveness****Part I: State Completion Section****C. Capitated portion of the waiver only: Type of Capitated Contract**

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

- a.**  **MCO**

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

Please describe:

## Section D: Cost-Effectiveness

### Part I: State Completion Section

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

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

- a.  **Management fees are expected to be paid under this waiver.**  
 The management fees were calculated as follows.
- |    |  |      |                           |
|----|--|------|---------------------------|
| 1. | <input checked="" type="checkbox"/> Year 1: \$ | 3.00 | per member per month fee. |
| 2. | <input checked="" type="checkbox"/> Year 2: \$ | 3.00 | per member per month fee. |
| 3. | <input checked="" type="checkbox"/> Year 3: \$ | 3.00 | per member per month fee. |
| 4. | <input checked="" type="checkbox"/> Year 4: \$ | 3.00 | 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.

Explanation for above letter b. Enhanced fee for primary care services.

- 1.X First Year: \$3.75 per member per month fee  
 2.X Second Year: \$3.75 per member per month fee  
 3.X Third Year: \$3.75 per member per month fee  
 4.X Fourth Year: \$3.75 per member per month fee

Case management fee for enhanced PCCM was determined through consultation with PCCM Provider Network and with consideration of the expenses incurred under the former disease management program. Additional services include:

- Conduct patient health assessment within 30 days of Department referral of patient to Provider, using an approved Health Survey. Patients who cannot be reached or who prefer not to participate in an assessment initially are placed in "on demand" status and additional contact attempts are made at least twice during the following 12 months.

- Provide initial and ongoing clinical assessment at pre-determined intervals such as 30, 60, 90 days and one year, depending on diseases and risks.
- Tailor a holistic treatment/action plan for each enrolled patient in consultation with patient's primary care provider.
- Manage patients as indicated—in person, telephonically, or other means suited to the individual.
- Provide group appointments for education and prevention when appropriate.
- Monitor and remind patients about routine testing; provide follow-up education regarding tests.
- Coordinate services with existing partners and form new partnerships (examples—hospitals, community primary care providers, social service and non-profit programs).
- Participate in multi-disciplinary hospital pre-discharge planning and counseling.
- Provide post hospital discharge visits, in-person and/or telephonic.
- Educate and support patients in self-management of health conditions.
- Be familiar with and refer patients to available local resources that can help patients with social services, housing, and other life problems that could prevent patients from paying attention to medical conditions.
- Track patient data—enrollment status, diseases, risks, interventions, and outcomes—and report to the Department.
- In conjunction with the Department, incorporate new methods such as remote disease monitoring or virtual video visits as technology is available and appropriate.
- Monitor patient progress and determine criteria for completion/graduation.

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

- 1.X First Year: \$6.00 per member per month fee
- 2.X Second Year: \$6.00 per member per month fee
- 3.X Third Year: \$6.00 per member per month fee
- 4.X Fourth Year: \$6.00 per member per month fee

## Section D: Cost-Effectiveness

### Part I: State Completion Section

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#### E. Member Months

Please mark all that apply.

- a.  [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b.  For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c.  [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:  
The change in member months is based on experience in R1 and R2 factoring natural growth within demographics.
- d.  [Required] Explain any other variance in eligible member months from BY/R1 to P2:  
There are none.
- e.  [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:  
R1/ R2 are neither state nor fiscal year. The dates are based on the previous waiver period. R1 runs from April 1, 2010 to March 31, 2011. R2 runs from April 1, 2011 through September 30, 2011.

#### Appendix D1 – Member Months

## Section D: Cost-Effectiveness

### Part I: State Completion Section

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

**For Conversion or Renewal Waivers:**

- a.  **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**  
Explain the differences here and how the adjustments were made on Appendix D5:

There are no changes to services included in the Actual Waiver Cost from the previous period.

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

There were no excluded services

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

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Chiropractic Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detoxification	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis - Free Standing Centers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis - Home Dialysis AHD	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs Prescription	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Durable Medical Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education Agency Services School Based Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPCCM - Case Management Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPSDT	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Planning Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Federally Qualified Health Center Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aids & Exams	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home & Community							

Based Waiver Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Health	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospice	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Hospital - Other	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Hospital - Psych	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lab and x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NAL - Nurse Advice Line Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse Midwife	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Psych Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Hospital - All other	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Hospital - Lab and X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partial Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCCM Case Management Fees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Assistant Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Podiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Duty Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional &							

Clinic and Other Lab and X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Care Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rural Health Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Worker Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Treatment Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing for Sexually Transmitted Diseases (STDs)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic Group and Family Services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transplants	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation - Emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation - Non-Emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Exams and Glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Well Child Check Ups	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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:

- 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.*
- 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.*
- Other

Please explain:

In Montana, we have seven Medical Eligibility Groups (MEGs). Three of our MEGs are PCCM, two are EPCCM, and the final two are NAL. The actual administrative expenditures for R1 and R2 were separated into PCCM (SSI/TANF), EPCCM (SSI/TANF), and NAL costs. Per CMS, the administrative costs for the Medicaid/CHIP expansion groups (PPHK/EPCCMHK/NALHK) are not included in the CMS 64.

Projected administrative costs for P1 and P2 were calculated by applying the enrollment broker amount to the PCCM and EPCCM MEGs (PPSSI/PPTANF/EPCCM). The remaining administrative costs were applied to each MEG on a PMPM basis. (Excluding the Medicaid/CHIP expansion groups)

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

### Section D: Cost-Effectiveness

#### Part I: State Completion Section

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

- 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.
- 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:

- 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:

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

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

**Document**

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

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

**Document:**

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

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

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

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

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

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

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

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

**This section is only applicable to Initial waivers****Section D: Cost-Effectiveness****Part I: State Completion Section**

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**I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)****This section is only applicable to Initial waivers****Section D: Cost-Effectiveness****Part I: State Completion Section**

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**I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)****This section is only applicable to Initial waivers****Section D: Cost-Effectiveness****Part I: State Completion Section**

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**I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)****This section is only applicable to Initial waivers****Section D: Cost-Effectiveness****Part I: State Completion Section**

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**I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)****This section is only applicable to Initial waivers****Section D: Cost-Effectiveness****Part I: State Completion Section**

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**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 State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).**  
**The actual trend rate used is:**  
Please document how that trend was calculated:
  
2.  **[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (i.e., trending from present into the future).**
  - i.  **State historical cost increases.**  
Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.  
  
Base years April 1, 2010 to March 31, 2011 and April 1, 2011 to September 30, 2011  
  
The adjustment was due to a trend analysis that was completed based on prior years for the State of Montana.  
A health care trend analysis is completed at the end of each year. This analysis is based on the prior three years. The inflation rate is calculated for each year and then average for the three years. This average inflation rate is the rate used in the calculation for this waiver.  
  
This adjustment was not applied to the EPCCM or NAL MEGS as service costs for these population groups will not be affected by trending increases.
  - ii.  **National or regional factors that are predictive of this waiver's future costs.**  
Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's 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.**

Montana does not expect to have a legislative rate increase for the next waiver period. Increase was based on trending analysis as described in 2.i. above.

#### 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:  
\_\_\_\_\_
- D.  Other  
Please describe:  
Adjustments were needed to account for the salary and benefits of a new position,

addition of a data base for the Health Improvement Program, and new materials for outreach campaigns.

- 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 State's 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 State's 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 State's 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 State's 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 State's 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 contractor's providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles.**
3.  Other

*Please describe:*

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

## Section D: Cost-Effectiveness

### Part I: State Completion Section

#### K. Appendix D5 – Waiver Cost Projection

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

#### Appendix D5 – Waiver Cost Projection

## Section D: Cost-Effectiveness

### Part I: State Completion Section

#### L. Appendix D6 – RO Targets

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

#### Appendix D6 – RO Targets

## Section D: Cost-Effectiveness

### Part I: State Completion Section

#### M. Appendix D7 - Summary

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

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

The change in member months for these population groups are based on experience in R1 and R2 factoring

natural growth within demographics.

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 State's explanation of cost increase given in Section D.I.I and D.I.J:

The adjustment was due to a trend analysis that was completed based on prior years for the State of Montana. A health care trend analysis is completed at the end of each year. This analysis is based on the prior three years. The inflation rate is calculated for each year and then average for the three years. This average inflation rate is the rate used in the calculation for this waiver.

This adjustment was not applied to the EPCCM or NAL MEGS as service costs for these population groups will not be affected by trending increases.

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 State's explanation of utilization given in Section D.I.I and D.I.J:

Montana will not have a legislative rate increase for the next waiver period. Increase was based on trending analysis as described in 2. above.

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

Unable to account for in online application. - Payments outside of the MMIS were made. Those payments include (please describe): Services for clients included on the NAL and NAL HK MEGs are paid outside of the MMIS system. These payments are processed through the state's AWACS payment system.

#### **Appendix D7 - Summary**