Facesheet: 1. Request Information (1 of 2)

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

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

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

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

Idaho Medicaid Plus

C. Type of Request. This is an:

☒ **Amendment request for an existing waiver.**

The amendment modifies (Sect/Part):

Main, Section A, Part I (Program Overview, A-Additional Information, B-1.f, B-2, B-Additional Information, D-2, D-Additional Information, F-Additional Information), Section A: Part II (1, 4), Section A: Part IV (C-2.a-b, E-Additional Information), and Section D: Part I (A.b-d).

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

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

Draft ID:ID.015.01.01
Waiver Number:ID.0004.R01.01

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

Approved Effective Date of Base Waiver being Amended: 04/01/23

Proposed Effective Date: (mm/dd/yy)

07/01/25

Approved Effective Date: 07/01/25

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

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

Name:

Alexandria Scott

Phone: (208) 364-1928 **Ext:** ☐ **TTY**

Fax: (208) 332-7283

E-mail:

alexandria.childers-scott@dhw.idaho.gov

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

☒ **Idaho Medicaid Plus**

Name:

Jennifer Pinkerton

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

Fax: (208) 332-7283

E-mail:

Jennifer.Pinkerton@dhw.idaho.gov

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

Section A: Program Description

Part I: Program Overview

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

A. Ongoing Informal Tribal Communication.
The Idaho Department of Health and Welfare (IDHW) emailed tribal notifications on December 17, 2024 and February 5, 2025, to the federally recognized tribes in Idaho ((Coeur d'Alene, Kootenai, Nimiipuu, Northwestern Band of the Shoshone Nation, Shoshone-Bannock, and Shoshone-Paiute tribe) regarding these Idaho Medicaid Plus program changes related to plan options and expansion of mandatory counties.

B. Formal Tribal Notification.
IDHW emailed tribal notification on May 20, 2025 to the federally recognized tribes in Idaho (Coeur d'Alene, Kootenai, Nimiipuu, Northwestern Band of the Shoshone Nation, Shoshone-Bannock and Shoshone-Paiute tribes) regarding this Idaho Medicaid Plus waiver amendment. This tribal notification was also posted on May 20, 2025 to the Idaho Medicaid Program and Tribes of Idaho website located at https://healthandwelfare.idaho.gov/about-dhw/boards-councils-committees/idaho-medicaid-program-and-tribes-idaho.

The State provides monthly updates during meetings facilitated by the Northwest Portland Area Indian Health Board. The transition from Blue Cross to United Healthcare was discussed at meetings held on December 12, 2024; January 29, 2025; and March 19, 2025.

This proposed waiver amendment was discussed at the Department's Tribal Quarterly meetings on November 20, 2024, February 26, 2025, and is on the agenda for May 28, 2025. Notices sent to tribal representatives solicited feedback from the tribes on the proposed waiver amendment. Tribal members are exempt from mandatory enrollment into Idaho Medicaid Plus under this waiver.

C. Ongoing Formal Tribal Stakeholder Engagement.
The Department hosted town halls with tribal members statewide to discuss the duals program in Payette on February 26, 2025, in Twin Falls on March 11, 2025, and in Boise on April 22, 2025. Upcoming meetings are scheduled for the Coeur d?Alene Tribe on May 28, 2025; the Nimiipuu Tribe on May 29, 2025, and the Shoshone-Bannock Tribe on June 10, 2025. Meeting dates for the Shoshone-Paiute and Kootenai Tribes are currently being scheduled.

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).

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

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

The Department extended contracts with the existing Health Plans currently administering the voluntary MMCP to also administer the mandatory Idaho Medicaid Plus program implementation and expansion in Idaho. Medicaid used a phase-in implementation to expand mandatory enrollment under Idaho Medicaid Plus.

The Department launched Idaho Medicaid Plus as a pilot program in Twin Falls County in November 2018. After successful implementation of this pilot program, the Department verified performance benchmarks were met (including continuity of care indicators, claims payment requirements, and outreach activities) prior to expanding into additional counties. The Department has since continued a phased-in approach to successfully expand Idaho Medicaid Plus into additional counties over this timeline:

? 2019: Ada, Bannock, Bingham, Bonner, Bonneville, Canyon, Kootenai, and Nez Perce counties; and

? 2020: Boise, Boundary, Cassia, Elmore, Freemont, Gem, Jefferson, Madison, Minidoka, Owyhee, Payette, and Power counties.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

   a. ☒ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
   -- *Specify Program Instance(s) applicable to this authority*

   ☒ **ID Medicaid Plus**

   b. ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
   -- *Specify Program Instance(s) applicable to this authority*

   ☐ **ID Medicaid Plus**

   c. ☐ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
   -- *Specify Program Instance(s) applicable to this authority*

   ☐ **ID Medicaid Plus**

   d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with

access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

☒ **ID Medicaid Plus**

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

☒ **MCO**

☐ **PIHP**

☐ **PAHP**

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

☐ **FFS** Selective Contracting program

Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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

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

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

   ☒ **ID Medicaid Plus**

   b. ☒ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

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

   ☒ **ID Medicaid Plus**

   c. ☒ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

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

   ☒ **ID Medicaid Plus**

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

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

☐ **ID Medicaid Plus**

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

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

☐ **ID Medicaid Plus**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

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

Idaho Code §56-263 - ?Medicaid Managed Care Plan? directs Idaho Medicaid to develop a managed care plan for dual eligibles.

Idaho Administrative Rules (IDAPA) approved by the Idaho Legislature governing the Idaho Medicaid Plus waiver (effective through June 30, 2025) are found in the following IDAPA chapters:
? 16.03.17 ? ?Medicare-Medicaid Coordinated Plan Benefits,? and
? 16.03.10 ? ?Medicaid Enhanced Plan Benefits,? Sections 076-079, ?Managed Care For Duals?.

Rules pending approval by the 2026 Idaho Legislature governing the Idaho Medicaid Plus waiver (effective July 1, 2025) are found in IDAPA chapter 16.03.26, ?Medicaid Benefit Plans,? under Sections 960-979, ?Dual Eligibles?.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

a. ☒ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. ☐ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

- ○ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

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

- ○ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

d. ☐ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

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

Idaho Medicaid operates the Medicare-Medicaid Coordinated Plan (MMCP) for dual-eligible individuals who enroll with a participating Medicare Advantage plan. The MMCP is a voluntary program that permits a dual-eligible beneficiary to enroll in a single managed care organization (MCO) that delivers both Medicaid and Medicare services to the individual. MCOs receive capitation payments for delivering MMCP services.

Due to the success of the MMCP program, the Idaho legislative directed the State to expand the duals program to offer this mandatory managed care long-term services and supports (MLTSS) program, Idaho Medicaid Plus (IMPlus), for dual-eligible individuals who have not elected to enroll in the MMCP. IMPlus is a Medicare "wrap" program, meaning that it covers all services available under the Medicaid State Plan that are not fully reimbursable by Medicare for dual Medicare/Medicaid beneficiaries, including behavioral health and long-term services and supports to provide more efficient coordination of care than the FFS delivery system. The State contracts with the same Medicare Advantage plans as the MMCP program for IMPlus.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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

☒ **Procurement for MCO**

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

☐ **Procurement for PIHP**

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

☐ **Procurement for PAHP**

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

☐ **Procurement for PCCM**

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

☐ **Procurement for FFS**

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

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

Section A: Program Description

Part I: Program Overview

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

1. Assurances.

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

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

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

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

☒ **Two or more MCOs**

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

☐ **A PCCM or one or more MCOs**

☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☐ **Other:**
please describe

Section A: Program Description

Part I: Program Overview

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

3. Rural Exception.

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

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

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

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

Section A: Program Description

Part I: Program Overview

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

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

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- *Specify Program Instance(s) for Statewide*

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

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

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Region 1 counties: Benewah/Bonner/Boundary/Kootenai/Shoshone	MCO	Molina Healthcare of Idaho
Region 2 counties: Clearwater/Idaho/Latah/Nez Perce	MCO	Molina Healthcare of Idaho
Region 3 counties: Adams/Canyon/Gem/Owyhee/Payette/Washington	MCO	Molina Healthcare of Idaho
Region 4 counties: Ada/Boise/Elmore/Valley	MCO	Molina Healthcare of Idaho
Region 5 counties: Blaine/Cassia/Gooding/Jerome/Lincoln/Minidoka/Twin Falls	MCO	Molina Healthcare of Idaho
Region 6 counties: Bannock/Power	MCO	Molina Healthcare of Idaho
Region 7 counties: Bingham/Bonneville/Clark/Fremont/Jefferson/Madison	MCO	Molina Healthcare of Idaho
Region 1 counties: Benewah/Bonner/Boundary/Kootenai/Shoshone	MCO	United Healthcare
Region 2 counties: Clearwater/Idaho/Latah/Nez Perce	MCO	United Healthcare
Region 3 counties: Adams/Canyon/Gem/Owyhee/Payette/Washington	MCO	United Healthcare
Region 4 counties: Ada/Boise/Elmore/Valley	MCO	United Healthcare
Region 5 counties:	MCO	United Healthcare

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Blaine/Cassia/Gooding/Jerome/Lincoln/Minidoka/Twin Falls		
Region 6 counties: Bannock/Power	MCO	United Healthcare
Region 7 counties: Bingham/Bonneville/Clark/Fremont/Jefferson/Madison	MCO	United Healthcare

Section A: Program Description

Part I: Program Overview

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

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

The Department operates under contracts with the existing Health Plans currently operating the voluntary Medicare Medicaid Coordinated Plan (MMCP) and mandatory Idaho Medicaid Plus programs.

The Department successfully implemented Idaho Medicaid Plus as a pilot program in Twin Falls County in November, 2018. The Department continued a phased implementation for additional counties after verifying that performance benchmarks were met (including continuity of care indicators, claims payment requirements, and outreach activities). Successful implementation of Idaho Medicaid Plus expansion into additional counties occurred over this timeline:

? 2019: Ada, Bannock, Bingham, Bonner, Bonneville, Canyon, Kootenai, and Nez Perce counties.

? 2020: Boise, Boundary, Cassia, Elmore, Freemont, Gem, Jefferson, Madison, Minidoka, Owyhee, Payette, and Power counties.

? 2025: Adams, Benewah, Blaine, Clark, Clearwater, Gooding, Idaho, Jerome, Latah, Lincoln, Shoshone, Valley, and Washington counties.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the 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):

Individuals aged 21 and older who reside in an approved geographic service area may enroll in Idaho Medicaid Plus (IMPlus) when they are entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and eligible for the Medicaid Enhanced State Plan.

Aged and Disabled (A&D) waiver (ID.1076) members who meet all other IMPlus criteria are also required to enroll.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

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

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

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

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

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

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

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

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

☐ **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

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

All individuals under age 21 are excluded. This includes individuals aged 18 to 20 who are eligible for the Enhanced Plan, including those eligible under Katie Beckett and Youth Empowerment Services (YES) eligibility categories.

☒ **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):

Clarifications for the following excluded mandatory enrollment populations:
? Duals already enrolled in an MCO under a Medicare Medicaid Coordinated Plan (MMCP) or Idaho Medicaid Plus (IMPlus) plan are excluded from mandatory enrollment. Enrollment in the State?s Behavioral Health contractor or in Idaho Smiles is not an exclusion. Once enrolled in MMCP/IMPlus, participants are disenrolled from the behavioral health managed care plan and receive their benefits under this waiver through the plan under which they are enrolled.
? Participate in HCBS Waiver: Only individuals served under the Idaho Adult Developmental Disabilities 1915(c) HCBS Waiver (ID.0076) are excluded from IMPlus.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

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

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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

1. Assurances.

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

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

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

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

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

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

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

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

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

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

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

Emergency Services Category General Comments (optional):

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

☒ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.

☐ Other (please explain):

☐ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

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

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

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

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

FQHC Services Category General Comments (optional):

All members enrolled in Idaho Medicaid Plus have Medicare as a primary payer. Consequently, their access to FQHC services is not impacted by the Idaho Medicaid Plus MCO. Tribal FQHC services are carved out of the contracts and provided in accordance with Medicaid State Plan requirements.

5. EPSDT Requirements.

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

EPSDT Requirements Category General Comments (optional):

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

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

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

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

7. Self-referrals.

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

Self-referrals Requirements Category General Comments:

Self-referrals are also allowed for urgent care services.

8. Other.

☒ Other (Please describe)

Idaho?s 1115 Behavioral Health Transformation Waiver Services.
Idaho Medicaid Plus (IMPlus) includes inpatient behavioral health services in an Institution for Mental Diseases (IMD) for enrollees age 18-20 and over age 65. For enrollees age 21-64, IMPlus includes inpatient services in an IMD for mental health and substance use disorder (SUD) diagnoses.

1915c Aged & Disabled (A&D) Home & Community Based Services (HCBS) Waiver.
This 1915(b) waiver application operates concurrently with Idaho?s A&D waiver (ID.1076.R07.00).

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

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

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

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

Consequently, under 1915(a) authority, Idaho has offered a voluntary Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) under the Medicare/Medicaid Coordinated Plan (MMCP) since 2014. MMCP provides integrated, comprehensive, seamless coverage to dual eligibles. The expanded delivery system aligns the care delivery model and payment methodology to ensure high-quality, efficient care that leads to better health for Idaho?s dual eligible citizens. The established MMCP ensures that all necessary Medicaid and Medicare services (including primary and acute care, pharmacy, behavioral health, 1915(c) Aged and Disabled waiver services, and other LTSS) not otherwise carved out are provided, coordinated, and managed by the Health Plan.

Idaho Medicaid manages IMPlus under this waiver as an improved service delivery system for those dual eligibles who have not voluntarily enrolled into the more integrated MMCP or another IMPlus plan. IMPlus covers the same Medicaid services as MMCP, those not reimbursed by Medicare. However, enrollment is not required to align with Medicare. IMPlus ?wraps? the Medicare benefit.

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:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The 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:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

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

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

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

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

Please describe the enrollment limits and how each is determined:

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

Please describe the State?s standard:

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

Please describe the State?s standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

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

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

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal	
	0	0	0	

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

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

Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

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

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

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

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

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

Contract requirements related to Access are monitored by the Duals Contract Monitor.

The enrollee may choose from the available providers within a health plan's network.

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

For services in which Medicaid is the traditional primary payer (including LTSS and Community-Based Outpatient Behavioral Health Services), each Enrollee must have a choice of at least two (2) providers located within:
i. 30 miles or within 30 minutes of travel within Ada, Bannock, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls counties, and
ii. Within 45 miles or within 45 minutes in all other counties.

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

Section A: Program Description

Part II: Access

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

Section A: Program Description

Part II: Access

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

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

The following items are required.

a. ☐ The plan is a PIHP/PAHP, and the State has determined that based on the 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:

Enrollees that require institutional level of care are identified to the health plans via a standard 834 file transaction that provides enrollee eligibility/rate codes, as well as individual determination information provided by the Bureau of Long Term Care via the Department?s assessment tool.

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:

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

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

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

Please describe:

The MCOs develop an Individualized Care Plan (ICP) with enrollee, their Primary Care Provider, and any applicable specialists based on information obtained during the Wellness Assessment and using information provided by the Bureau of Long Term Care's assessment instrument. Treatment plans must be completed within 120 days of enrollment in the plan or within 30 calendar days of the completion of a Wellness Assessment, whichever occurs first.

MCOs must continuously monitor the ICP and ensure gaps in care are addressed in an integrated manner, including any necessary revisions to the ICP, and must ensure the ICP is updated on an ongoing basis as appointments occur, tests are completed, medications change, transitions made, goals are added or completed, etc.

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:

There are two (2) methods to by which the Managed Care Entity (MCE) and the State ensure enrollees have direct access to specialty medical providers:

1. For new enrollees who have an existing relationship with a specialist provider, all established enrollee-provider relationships are honored without additional referral or approval requirements to ensure the enrollee maintains direct access to their specialist(s).

2. For enrollees who have new special healthcare needs that require specialist care, these needs are outlined on the participant?s Individualized Care Plan (ICP) and/or a referral is made by their Primary Care Physician (PCP). Once this has occurred, ongoing or additional approvals are not required to ensure the participant maintains direct access to the specialist(s) once the need has been identified by the Health Plan or their PCP.

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:

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.

i. ☐ **Referrals.**

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

Section A: Program Description

Part II: Access

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

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

Health Plans shall use best efforts to work with each member?s primary carrier to effectively and comprehensively manage transitions of care between both physical and behavioral health settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes.

In order to assure continuity of care for medical, behavioral. LTSS, and pharmacy services, the Health Plans must offer a transition period of the first ninety (90) days of enrollment during which they must:

1. Honor existing enrollees? prior authorizations;
2. Allow enrollees to continue receiving services from providers with whom there was already a relationship;
3. Reimburse providers at no less than the current Medicaid Provider Rates; and
4. Ensure that during the Transition Period, a change to a new Provider only occurs in the following circumstances:
a. The Enrollee requests a change;
b. The Provider chooses to discontinue providing Services to an Enrollee as currently allowed by Medicare or Medicaid; or
c. The Health Plan or IDHW identify Provider performance issues that affect an Enrollee?s Health or Welfare.

The MCO receives a service determination file from the State for prospective enrollees so that the MCO may begin outreach to any providers not already in the MCO?s network to initiate provider enrollment activities. When the member enrolls, the Plan is required to continue covering services under existing participant-provider relationships even if the provider is out of network for up to ninety (90) days while the MCO attempts to establish a network provider contract. In the event that a provider cannot or will not enroll with the MCO, the state requires the Plan to engage in care coordination activities to support the member in identifying a new in-network provider and facilitate a transition.

Each enrollee receives a Care Specialist and an Individualized Care Plan (ICP) to ensure improved care coordination. The Plan receives prior authorization and assessment data (if available) from the State for prospective enrollees. The Plan is required to conduct a Wellness Assessment upon enrollment to identify whether the member has any additional unmet needs that could be addressed by the Plan through additional service referrals. The Care Specialist must communicate with other providers and health care facilities about any health issues that could affect an enrollee's care.

All members are required to have an ICP. Enrolled members fall into one of three (3) ?risk? categories for prioritization in conducting Wellness Assessments; this is based on their state-assigned aid code of community well, home and community-based services (HCBS) participant, or institutionalized participant.

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

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

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

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

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

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

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

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	EQRO	N/A	All mandatory activities as described in §438.358	N/A
PIHP				

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
2. ☐ Initiate telephone and/or mail inquiries and follow-up
3. ☐ Request 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:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

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

1. Provider Selection Process:
The State?s provider selection requirements are detailed in the Idaho Medicaid Plus Additional Terms to Medicaid Provider Agreement (Contract) with each health plan which includes the following topics related to selecting providers:
o Provider Network Requirements;
o Access Standards;
o Service Delivery Standards;
o Provider Subcontracting;
o Anti-gag;
o Clinical Laboratory Improvement Amendments (CLIA) of 1988;
o Pharmacies;
o Provider Directories
o LTSS Network Development Plans;
o Indian, Tribal Organization, or Urban Indian Organization (I/T/U) Requirements; and
o Credentialing and Other Certifications.

2. How the State assures quality of services:
a. The State utilizes a variety of methods to ensure quality of services. The State receives the following reports from the MCOs:
o Provider Network Report
- Timeliness of Services
- Provider Satisfaction with Utilization Management
- Geographical Access.

b. The State also monitors provider claim complaints and entries from the complaints database. Information from these complaints is monitored for trends for the MCO to address. Any deficiencies are identified in the monitor report for the MCO to address along with any monetary penalties. An External Quality Review Organization (EQRO) completes an annual quality review on each health plan. However, the State has had difficulty in obtaining an ERQO vendor but will be awarding a new contract shortly. The EQRO vendor will then conduct its review for the previous year and current year. The EQRO is not providing optional EQR protocols.

3. Quality and Performance Standards:
Quality and Performance Standards are also detailed in the Idaho Medicaid Plus Additional Terms to Medicaid Provider Agreement (Contract) with each health plan which includes a detailed table of standard items monitored, how they are weighted, and any resulting remedial actions (including invoice reductions) assessed when deficiencies are found. The State also provides a Health Plan Corrective Action Response and Dispute Process in the event the MCEs do not agree with the contract monitoring results.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

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

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

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for

compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. ☐ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2. ☒ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

Please list types of indirect marketing permitted:

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

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

Please list types of direct marketing permitted:

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the 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:

The State allows the dissemination of token gift items to potential enrollees including nominal gifts such as pens, key chains, magnets, etc. Any gift with a monetary value exceeding $10.00 per item or $50 total annually are prohibited. Reports of gifts or other incentives in violation of this policy will be investigated by the Department as needed.

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their

marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

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

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

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

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

The state collects language as part of the member?s demographic record that is sent to the Plan on the EDI file transmission. Primary language is loaded into the Plan systems to ensure system-generated documents are translated into the member?s language if they speak/read/write Spanish. The translation information for all required languages with respective phone numbers to call to request translated materials is included on all notices and documents.

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

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

Please describe the methodology for determining prevalent languages:

b. ☒ The languages comprise all languages in the service area spoken by approximately 5 percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

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

The Department limits direct marketing and outreach activities to potential Enrollees outside of open enrollment periods to minimize potential confusion or misinformation.

Section A: Program Description

Part IV: Program Operations

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

1. Assurances

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

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

2. Details

a. Non-English Languages

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

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

All enrollee/potential enrollee materials are translated into Spanish.

Health plans must also include a Spanish phrase in all materials presented in the English language that informs Spanish-speaking members how to obtain a copy of the materials in Spanish.

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

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

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

Please explain how the State defines ?significant.?:

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

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

c. ☐ Other

Please explain:

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

Network Providers have staff that can speak to all enrollees or provide access to free Translation Services.

Call Centers provide a translation system for callers whose primary language is not English.

Free oral translation services are available for all potential enrollees to review marketing materials.

All denial notices must include information for how to request Translation Services.

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

Please describe:

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

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

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☒ State
☒ Contractor

Please specify:

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

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

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

c. Enrollee Information

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

☒ the State

☐ State contractor

Please specify:

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

Section A: Program Description

Part IV: Program Operations

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

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

The Department distributes notices and materials to potential Enrollees advising them of the open enrollment period during which they can actively select a Health Plan to administer their Idaho Medicaid Plus program. Once the open enrollment period concludes, the Health Plans are responsible for distributing materials to members enrolled with the plan through active selection or auto-assignment by the Department.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

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

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

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

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the 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:

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

A. Direct Communication with Duals.
The State monitors dual status changes by county on a monthly basis. For newly eligible Medicaid participants residing in a mandatory enrollment county, Idaho Medicaid mails letters to dual-eligible participants in these counties who fail to select and enroll in an IMPlus health plan or enroll in the Medicare Medicaid Coordinated Plan (MMCP), to inform that the State will auto-enroll them in one of the two (2) available IMPlus health plans. Participant are provided the number for the Duals Beneficiary Support Specialist line at 1 (833) 814-8568 to receive assistance with selecting a plan. Participants may enroll in IMPlus by returning the enrollment form included with their letter or while talking to the Duals Beneficiary Support Specialist. Individuals residing in mandatory enrollment counties have at least ninety (90) days prior to enrollment to choose a health plan or enroll in the MMCP.

Town-hall style meetings with dual-eligible participants statewide are held in advance of any expansion of Idaho Medicaid Plus into new counties. The Department held over 40 visits across the state between February 2 and March 20 for members and providers related to this amendment.

B Idaho Rulemaking Engagement.
Idaho?s Rules of Administrative Procedure require that the State engage in various outreach during rulemaking (including public comment periods, negotiated rulemaking sessions with stakeholders, and public hearings). The State held numerous rulemaking activities with stakeholders for to various chapters of Idaho Code (IDAPA) related to this waiver throughout 2018, 2022, and 2025.

C. Department Public Communication.
The MedicAide newsletter, which is a monthly digital communication distributed to Medicaid providers and available to the public, regularly includes articles with updates and information about the MMCP and Idaho Medicaid Plus. Updates related to this amendment were published in November 2024, January 2025, and March 2025 accessible on the following website:
https://www.idmedicaid.com/MedicAide%20Newsletters/Forms/All.aspx.

Medicaid hosts a webpage dedicated to information and materials for Dual-Eligible stakeholders at https://healthandwelfare.idaho.gov/services-programs/medicaid-health/medicaidmedicare-participants that is regularly updated.

The State published Medicaid Information Release (IR) articles to further assist stakeholders with these duals program changes which are available in an Information Release library on the Department?s public website under the 2024 and 2025 folders at
https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=3211&dbid=0&repo=PUBLIC-DOCUMENTS. IRs related to this program change include:
? MA24-29 Duals BCI Termination (December 17, 2024)
? MA25-03 Duals Transition (February 5, 2025)

The State updates duals program materials (promotional event flyers, participant worksheets, FAQs, etc.) frequently to address participant needs on the public website under the Duals document library at https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=26631&dbid=0&repo=PUBLIC-DOCUMENTS.

Medicaid staff also routinely provide education and informational presentations upon request for a variety of stakeholder groups, including:
o Statewide Health Insurance Benefits Advisors (SHIBA)
o Justice Alliance for Vulnerable Adults (JAVA)
o State Independent Living Council (SILC)
o Medical Care Advisory Committee (MCAC), replaces the Personal Assistance Oversight Committee (PAOC) in 2025
o Family Caregiver Alliance
o Idaho Healthcare Association (Skilled Nursing Facilities, Residential Assisted Living Facilities, hospitals)

o Idaho Association of Home Care Providers (Personal Assistance Agencies)

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☒ State staff conducts the enrollment process.

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

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

Broker name:

Please list the functions that the contractor will perform:

☐ choice counseling

☐ enrollment

☐ other

Please describe:

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

Please describe the process:

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

The Department processes Enrollee requests for disenrollment due to cause and the enrollment into another participating Health Plan. Requests for disenrollment for cause are effective the first of the month following the month in which the request was made.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

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

☐ This is a **new** program.

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

phased in by population, etc.):

☒ 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.):

Future expansion of mandatory enrollment beyond the currently active counties is contingent upon the Health Plans meeting required performance benchmarks as specified in the contract. The Department plans to eventually expand to additional counties during the life of this waiver renewal. An appropriate amendment will be submitted once the Department determines the best time to expand.

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

i. ☒ Potential enrollees will have 90 ◉ **day(s)** / ○ **month(s)** to choose a plan.

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

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

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

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

☐ The State automatically enrolls beneficiaries.

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

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

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

Please specify geographic areas where this occurs:

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

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

Please describe the circumstances under which a beneficiary would be eligible for exemption from

enrollment. In addition, please describe the exemption process:

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

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

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

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

☒ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

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

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

(i) Enrollee moves from an available Idaho Medicaid Plus service area.
(ii) The plan does not, for moral/religious objections, cover a service the enrollee seeks.
(iii) Enrollee needs related services to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
(iv) For enrollees that use Managed Long Term Services and Supports (MLTSS), the enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider, would experience a disruption in their residence/employment.

Upon disenrollment from the current Health Plan, the Enrollee is assigned to another participating Health Plan. Participants who request disenrollment from their Health Plan may remain on Fee-for-Service if they have been disenrolled from the other available MCO only after Department approval.

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

first day of the second month following the request.

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

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

Please describe the reasons for which enrollees can request reassignment

The State does not have any additional for-cause reasons allowing enrollees to request reassignment.

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

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

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

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

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

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

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

   a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

   b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

   c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

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

   ☒ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

   Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to

which the waiver will apply, and what the State proposes as an alternative requirement, if any:

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

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

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

b. Timeframes

☒ The State?s timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 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:

Relating to b. Timeframes above, the Enrollee or the Enrollee?s Representative may file a Grievance at any time.

The Health Plan shall give Enrollees any reasonable assistance in completing Forms and taking other Procedural Steps including, but not limited to providing Interpreter Services and toll-free numbers that have adequate TTY/TDD and Interpreter Capability.

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:

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

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

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

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

☐ Has time frames for resolving requests for review.

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

☐ Establishes and maintains an expedited review process.

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

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

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

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

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

Participants may file a request for a State Fair Hearing up to one hundred and twenty (120) calendar days from the date of the Health Plan's notice of resolution upholding the adverse benefit determination. Administrative Hearings are conducted by the State?s Office of Administrative Hearings. Additional information on the State?s Fair Hearing Process and forms to request an appeal are available on the State?s Appeals and Fair Hearings website: https://healthandwelfare.idaho.gov/appeals-and-fair-hearings.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

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

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the 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 exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Program Impact

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

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Access

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

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

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

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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

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- **PCCM and FFS selective contracting** programs:
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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**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

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

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

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

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

Programs Authorized by this Waiver:

Program	Type of Program
ID Medicaid Plus	MCO;

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Idaho Medicaid Plus

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

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

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the 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:

Enrollee feedback is collected via a standardized Quality Survey used as part of the administration of the 1915(c) Aged and Disabled (A&D) Waiver, in addition to an Issue Log tracking database for all members enrolled in Idaho Medicaid Plus (IMPlus).

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

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

☐ **CAHPS**

Please identify which one(s):

☒ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

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

Personnel Responsible: Health Plan staff, Department Contract Monitor
Description of Activity: The Health Plans supply regular reports on a variety of functions. Reports include:
? Service denials by service type, including denial reason.
? Grievance and appeal logs.
? Critical Incident resolution.
? Systems availability and performance (claims and case management systems)
? Provider network data ? timeliness of services and geographical access
? Care coordination reports
? Quality Management/Quality Improvement (QM/QI reports)
Frequency of Use: Monthly, Quarterly
Information Obtained: Data pertaining to Health Plan performance of contract functions across multiple areas, in addition to trends in performance over time.

☒ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

☐ **From plan**

☐ **From PCP within plan**

☒ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☒ **Enrollee Hotlines**

Activity Details:

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

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

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

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

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

Activity Details:

The State will complete a comprehensive independent assessment that incorporates an evaluation of the access to, and quality of services provided under the waiver program with the next waiver renewal. The State will also incorporate the feedback CMS provided on the previous Independent Assessment.

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

Activity Details:

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

Activity Details:

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

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

k. ☐ **Ombudsman**

Activity Details:

l. ☒ **On-Site Review**

Activity Details:

The Department conducts on-site audits with the Health Plans as needed to address issues.

Personnel Responsible: Department Contract Monitor and Contract Manager, Health Plans
Description of Activity: Department staff conduct on-site audits with the Health Plans to validate data supplied by the Health Plan in prior reporting periods against the plan's records and to conduct additional targeted reviews of specific compliance areas. The Department notifies the Health Plan in advance of any targeted compliance areas that will be evaluated during the on-site audit and selects a sample (of Enrollees, Providers, service codes, etc.) prior to the on-site visit to validate. The Health Plan is issued a Contract Monitor Report summarizing the Department's findings.

Frequency of Use: As needed to address issues.
Information Obtained: Validation of data supplied by the Health Plans during routine monthly reporting, in addition to evaluation of targeted compliance areas to evaluate Health Plan performance of contract functions.

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

Activity Details:

The Department requires the Health Plans to utilize an ongoing performance improvement program for the services it furnishes to its Enrollees. The program must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. The performance improvement plan must account for performance measures required by the Department. The Department requires that participating Health Plans conduct PIPs that address both clinical and nonclinical areas. PIPs are negotiated between an individual MCO and the State and are unique to each MCO and the specific needs of the plan population.

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

☐ **Clinical**

☒ **Non-clinical**

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

Activity Details:

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

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

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

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

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

Health plan stability/financial cost of care
Personnel Responsible: Health Plan, Department Contract Monitor, Department Actuarial Firm
Description of Activity: The Health Plans are required to submit financial data on an annual basis to the Department?s actuarial firm for the purposes of calculating the Medical Loss

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

- ☒ **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:

1. The Department requires the Health Plans to submit an annual provider network report which includes measuring timely and geographical access, as well as any waiting lists (when applicable) for all providers of Medicaid services, including physical, behavioral health, and long-term care providers.

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

2. The State is working on operationalizing additional improvements for this measure that will go live in future contract years.

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

Activity Details:

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

Personnel Responsible: MPIU staff
Description of Activity: MPIU staff conduct targeted data reviews of provider utilization to detect patterns that may be indicative of potential program integrity concerns. MPIU has access to Health Plan claims paid in addition to FFS claims data for analysis.
Frequency of Use: Ongoing
Information Obtained: Program integrity compliance on behalf of Health Plan network providers, in addition to information about Health Plan monitoring of potential program integrity concerns.

q. ☒ **Provider Self-Report Data**

Activity Details:

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

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

☒ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

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

Activity Details:

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

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

t. ☒ **Other**

Activity Details:

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

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

Section C: Monitoring Results

Renewal Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the 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:

The state contracted with Telligen, Inc., an independent external quality review organization (EQRO), to complete the independent assessment for this 1915(b) Waiver renewal. The state also contracted with Milliman, Inc., an independent actuarial firm, to complete the assessment of the waiver?s cost-effectiveness. This summary includes Telligen's findings related to the access to and quality of care for this waiver population, and the results of Milliman?s cost-effectiveness assessment.

For all areas reviewed in this independent assessment, the state demonstrated clear expectations for implementation, monitoring, and oversight of Idaho Medicaid Plus, indicating positive results related to this Waiver renewal. While Telligen provided minor program improvement recommendations, no items were identified that would impede the state from continuing to deliver these health benefits for this Waiver population. Additionally, the review of the baseline expenditures to projected expenditures for this waiver indicate the program is cost-effective according to CMS established standards.

Telligen assessed the following assurances and determined that all references and data sources provided met the assurances in this waiver renewal:

1. Assessment Results for the Access to Care Assurance:
All areas reviewed met the assurances in this waiver renewal. These recommendations are noted as options to be considered for potential program improvement:

a. Compliance: All areas of compliance are proficient for both Managed Care Entities (MCE) operating Idaho Medicaid Plus: Blue Cross of Idaho (BCI) and Molina Healthcare (MOI). Telligen recommends continued observation to ensure continued compliance.

b. Communication: Telligen recommends an opportunity for improvement related to calls answered within thirty (30) seconds for specific impact to enrollees. The state and MCEs should identify a corrective action plan (CAP) and consider implementing strategies to ensure these standards are met moving forward.

c. Enrollment and Disenrollment: The state manages all enrollments and disenrollment requests for Idaho Medicaid Plus. The state distributes notices and materials to all eligible dual participants in the approved geographic service areas (GSA) advising of the open enrollment period to actively select a Health Plan. Once the open enrollment period ends, MCEs distribute materials to enrollees under each plan. MCEs must offer informational materials upon enrollment and ongoing; and access to customer service to explain and answer questions about this program. The state also operates a dedicated toll-free number for all dual eligible participants to request assistance with choice counseling and for support in understanding the dual managed care programs in Idaho. The state complies with the requirements of the waiver and the contract for this assurance.

d. Access to Information: Both MCEs provided adequate access to information for enrollees through their websites, monthly newsletters, enrollee handbooks and enrollee services hotlines. Information is distributed by both the state and the MCEs. All Enrollee and potential Enrollee materials require prior approval by the state.

e. Utilization Performance Measures: The state requires MCEs to report on all aspects of programming, network functioning, utilization management, service delivery, and operations and claims processing as well as all other areas of performance required by contract. MCEs are required to submit over-utilization and under-utilization reports to the state. Telligen found the utilization reports to be in compliance with contracts and the waiver renewal.

f. Network Adequacy and Capacity: In accordance with 42 CFR 438.207, the MCEs must maintain a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the approved GSA. The MCEs must also maintain a network of appropriate providers, supported by written agreements, sufficient to provide adequate access to all services covered under contract, and must comply with 42 CFR §422.112 regarding access to services. Telligen found the Network Adequacy and Capacity report results sufficient to meet the assurances in this waiver renewal.

g. Enrollee Satisfaction Survey: Telligen found Enrollee Satisfaction Survey processes and results sufficient to meet the assurances in this waiver renewal.

2. Quality of Care
All areas reviewed met assurances in this waiver renewal. These recommendations are noted as options to consider for program improvement:

a. Quality Assessment/Performance Improvement (QAPI) Annual Evaluations: Telligen found that both MCE?s QAPI programs met assurances for this waiver renewal; however, recommended that both MCEs add one (1) new Process Improvement Plan (PIP) each as those reviewed are now part of current day-to-day operations. Telligen is aware that both MCEs have other QI projects not submitted for review/validation.

b. Provider Quality: The MCEs must maintain a network of appropriate providers, supported by written agreements, sufficient to provide adequate access to all services covered under the contract, and must comply with 42 CFR §422.112 regarding access to services. Telligen found that both MCE?s network of providers appropriate and that written agreements existed with all service providers.

c. Enrollee Perception of Quality of Care and Services: The state complies with this assurance, and Telligen has no recommendations for this waiver renewal.

d. Grievance Systems: The state complies with this assurance, and Telligen has no recommendations for this waiver renewal.

e. Program Integrity/Fraud, Abuse and Waste: The state complies with this assurance, and Telligen has no recommendations for this waiver renewal.

3. Cost-Effectiveness - Milliman found the state to comply with this assurance and has no recommendations for this waiver renewal.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Full Dual Eligibles	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/2020	09/30/2021	10/01/2021	09/30/2022
Enrollment Projections for the Time Period*	04/01/2023	03/31/2024	04/01/2024	03/31/2025

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Emergency Hospital Services	☒	☐	☒	
Physician Services - Medical Services	☒	☐	☒	
Medical Equipment, Supplies and Devices; Prosthetic Devices	☒	☐	☒	
Other Practitioner Services	☒	☐	☒	
Non-Emergency Medical Transportation	☒	☐	☐	
Prevention Services	☒	☐	☒	
Prescribed Drugs	☒	☐	☒	
Essential Providers - Rural Health Clinic Services	☒	☐	☒	
Preventive Health Assistance	☒	☐	☒	
Mental Health Services - Community-Based Outpatient Behavioral Health Services	☒	☐	☒	
Essential Providers - Federally Qualified Health Center Services	☒	☐	☒	
Laboratory and Radiological Services	☒	☐	☒	
Home and Community-Based Services - Aged and Disabled 1915(c) waiver	☒	☐	☒	
Long-Term Care Services; Nursing	☒	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Facility Services				
Screening Services	☒	☐	☒	
Vision Services	☒	☐	☒	
State Plan Personal Care Services	☒	☐	☒	
Substance Abuse Treatment Services	☒	☐	☒	
Physician Services - Surgical Services	☒	☐	☒	
Therapy Services (Physical Therapy, Occupational Therapy, Speech Language Pathology)	☒	☐	☒	
Dental Services	☒	☐	☐	
Family Planning Services	☒	☐	☒	
Hospice Care	☒	☐	☒	
Mental Health Services - Inpatient Psychiatric Services	☒	☐	☒	
Audiology Services	☒	☐	☒	
Outpatient Hospital Services	☒	☐	☒	
Inpatient Hospital Services	☒	☐	☒	
Medical Equipment, Supplies and Devices; Medical Equipment and Supplies	☒	☐	☒	
Ambulatory Surgical Center Services	☒	☐	☒	
Case Management Services	☒	☐	☒	
Essential Providers - Indian Health Services Facility Services	☒	☐	☒	
Home Health Services	☒	☐	☒	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the 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:	Jennifer Pinkerton
	State Medicaid Director or Designee
Submission Date:	Jun 25, 2025

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

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

b. Name of Medicaid Financial Officer making these assurances:

Angela Toomey

c. Telephone Number:

(208) 364-1896

d. E-mail:

Angela.Toomey1@dhw.idaho.gov

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

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:

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

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

The payment rate to each Health Plan reflects the membership mix by geographic service areas currently active under Idaho Medicaid Plus. Material shifts in the membership mix result in updates to the plans? composite rate. In addition, the Scope of Work between the state and Health Plans outlines a process for medical loss ratio settlements.

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

- a. ☐ **Management fees are expected to be paid under this waiver.**
  The management fees were calculated as follows.
  1. ☐ **Year 1:$** _____ **per member per month fee.**
  2. ☐ **Year 2:$** _____ **per member per month fee.**
  3. ☐ **Year 3:$** _____ **per member per month fee.**
  4. ☐ **Year 4:$** _____ **per member per month fee.**
- b. ☐ **Enhanced fee for primary care services.**
  Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. ☐ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in

Appendix D3. Actual Waiver Cost.

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

$

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

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☒ [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:

Initial decrease in eligible participants due to end of the COVID-19 Public Health Emergency on 4/1/2023 causing an end to continuous Medicaid enrollment. Overall enrollment expected to continue to increase due to an increase in the Idaho population.

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

There is no additional variance in eligible member months.

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

FFY

Appendix D1 ? Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

For Conversion or Renewal Waivers:

- ☐ **[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:

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

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

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

Idaho?s 1115 Behavioral Health Transformation Waiver services are included as described in Section A: Part I. F. Costs for Inpatient Behavioral Services in an Institution for Mental Diseases (IMD) reimbursed through the Managed Care Organization (MCO) are included in the capitation rate and Cost-Effective workbook and not reflected in the 1115 cost reporting.

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
Emergency Hospital Services	☒	☐	☐	☐	☐	☐	☐
Physician Services - Medical Services	☒	☐	☐	☐	☐	☐	☐
Medical Equipment, Supplies and Devices; Prosthetic Devices	☒	☐	☐	☐	☐	☐	☐
Other Practitioner Services	☒	☐	☐	☐	☐	☐	☐
Non-Emergency Medical Transportation	☐	☐	☐	☐	☐	☒	☐
Prevention Services	☒	☐	☐	☐	☐	☐	☐
Prescribed Drugs	☒	☐	☐	☐	☐	☐	☐
Essential Providers - Rural Health Clinic Services	☒	☐	☐	☐	☐	☐	☐
Preventive Health Assistance	☒	☐	☐	☐	☐	☐	☐
Mental Health Services - Community-Based Outpatient Behavioral Health Services	☒	☐	☐	☐	☐	☐	☐
Essential Providers - Federally Qualified Health Center Services	☒	☐	☐	☐	☐	☐	☐
Laboratory and Radiological Services	☒	☐	☐	☐	☐	☐	☐
Home and Community-Based Services - Aged and Disabled 1915(c)	☒	☐	☐	☐	☐	☐	☐

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
waiver							
Long-Term Care Services; Nursing Facility Services	☒	☐	☐	☐	☐	☐	☐
Screening Services	☒	☐	☐	☐	☐	☐	☐
Vision Services	☒	☐	☐	☐	☐	☐	☐
State Plan Personal Care Services	☒	☐	☐	☐	☐	☐	☐
Substance Abuse Treatment Services	☒	☐	☐	☐	☐	☐	☐
Physician Services - Surgical Services	☒	☐	☐	☐	☐	☐	☐
Therapy Services (Physical Therapy, Occupational Therapy, Speech Language Pathology)	☒	☐	☐	☐	☐	☐	☐
Dental Services	☐	☐	☐	☐	☐	☒	☐
Family Planning Services	☒	☐	☐	☐	☐	☐	☐
Hospice Care	☒	☐	☐	☐	☐	☐	☐
Mental Health Services - Inpatient Psychiatric Services	☒	☐	☐	☐	☐	☐	☐
Audiology Services	☒	☐	☐	☐	☐	☐	☐
Outpatient Hospital Services	☒	☐	☐	☐	☐	☐	☐
Inpatient Hospital Services	☒	☐	☐	☐	☐	☐	☐
Medical Equipment, Supplies and Devices; Medical Equipment and Supplies	☒	☐	☐	☐	☐	☐	☐
Ambulatory Surgical Center Services	☒	☐	☐	☐	☐	☐	☐
Case Management Services	☒	☐	☐	☐	☐	☐	☐
Essential Providers - Indian	☒	☐	☐	☐	☐	☐	☐

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
Health Services Facility Services							
Home Health Services	☒	☐	☐	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

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

c. ☒ **Other**
Please explain:

State staff resource allocation associated with program administration and oversight (non-MMIS) are calculated using the approved Medicaid budgets for this program, administration cost of 0.09%.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

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

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

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

renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

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

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

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

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

   Document

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

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

   Document:

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

Appendix D3 ? Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

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

a. State Plan Services Trend Adjustment ? the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage

factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **. This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☒ **[Required, if the 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: 0.00

   Please document how that trend was calculated:

   P1 Data is actuals. There is no trend being 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.

   2021-2022

   Linear Regression

   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.

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:

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

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

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

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

D. ☒ Other
Please describe

Size of adjustment is based on historical and projected case mix differential between Idaho Medicaid Plus and Medicare Medicaid Coordinated Plan (MMCP). Case mix is designated by level of care under these categories: Institutional, Home and Community Based Services (HCBS), or Community Well.

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 isPMPM size of adjustment

0.00

Please describe:

D. ☒ Other

Please describe:

A -3.00% adjustment for increase in FFS administration costs was calculated using the approved Medicaid budgets for this program.

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:

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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

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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.

The State adjusted the dates of historical cost increase data used to base rates from 2015-2017 to 2021-2022.

Appendix D5 ? Waiver Cost Projection

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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.

Projections for this waiver amendment included only the counties where the mandatory Idaho Medicaid Plus program is expanding to operate in 2025.

Initial decrease in eligible participants due to end of the COVID-19 Public Health Emergency on 4/1/2023 causing an end to continuous Medicaid enrollment. Additional increases in trends are due to Idaho continuing to experience record population growth resulting in an increase of eligible participants in each of the counties in operation.

Appendix D6 ? RO Targets

Section D: Cost-Effectiveness

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M. Appendix D7 - Summary

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

Variances in overall percentage change in spending are due to the State projections for the initial application included the populations for all counties in Idaho, whether they were active or not.

Original projections included only counties with mandatory enrollment in the Idaho Medicaid Plus program as of the last waiver renewal. Projections were amended due to expansion of mandatory enrollment into additional counties submitted to CMS with waiver amendment ID.0004.R01.01. Additional variances are due to an initial slight decrease in eligible participants due to end of the COVID-19 Public Health Emergency on 4/1/2023 causing an end to continuous Medicaid enrollment and continuing unprecedented population growth across all populations in Idaho.

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:

Initial decrease in eligible participants due to end of the COVID-19 Public Health Emergency on 4/1/2023 causing an end to continuous Medicaid enrollment. Overall enrollment expected to continue to increase in eligible participants due to geographic expansion as well as continued unprecedented growth of Idaho?s population.

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:

State historical FFS cost increases using SFYs 2019-2020 for trend of 2.4% determined by linear regression.

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:

Changes in utilization of the waiver are due to an initial decrease in eligible participants due to end of the COVID-19 Public Health Emergency on 4/1/2023 causing an end to continuous Medicaid enrollment and Idaho continuing to experience record population growth resulting in an increase of eligible participants in each of the counties in operation.

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

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

Appendix D7 - Summary