Section 1915(b) Waiver
Proposal For
MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs

MMA Amendment Version
July 18, 2005

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Proposal

Proposal for a Section 1915(b) Waiver

MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

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

The **name of the waiver program** is Dental Benefits Administrator (DBA). (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

X initial request for new waiver. All sections are filled.

__ amendment request for existing waiver, which modifies Section/Part ____

- __ Replacement pages are attached for specific Section/Part being amended (note: The State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
- __ Document is replaced in full, with changes highlighted renewal request
- __ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
- __ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is
- ___ replaced in full.
- ___ carried over from previous waiver period. The State:
  - ___ assures there are no changes in the Program. Description from the previous waiver period.
  - ___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is
- ___ replaced in full.
- ___ carried over from previous waiver period. The State:
  - ___ assures there are no changes in the Monitoring Plan from the previous waiver period.
  - ___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of two years; effective 07/01/2017 and ending 06/30/2019. (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)

State Contact: The State contact person for this waiver is Chuck Damon and can be reached by telephone at (775) 684-3771, or fax at (775) 684-3762, or e-mail at chuck.damon@dhcfp.nv.gov. (Please list for each program).

Section A: Program Description

Part I: Program Overview

Tribal consultation

A Tribal Letter was sent to the 27 Tribes in Nevada on November 16, 2016, describing the proposed application of this waiver and the implementation of a single source Dental Benefits Administrator (DBA) for Urban Clark and Urban Washoe Counties. The tribes did not request a consultation.

However, the Division of Health Care Financing and Policy placed the DBA presentation on the agenda for the January 10, 2017 quarterly Tribal Consultation. This meeting was cancelled due to inclement weather and was rescheduled for January 25, 2017 and the materials were presented at that time.

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).

A Dental Services Program designed to administer and provide dental care under the supervision of a licensed provider. Dental services provided will maintain a high standard of quality and will be provided within the coverage and limitation guidelines outlined in the Title XIX and Title XXI, State Plan and amendments and the Medicaid Service Manual Chapter 1000. The proposed start date is July 1, 2017.

The DBA is intended to strengthen the Dental program in terms of enhanced network access to quality dental and specialty providers, monitoring and encouraging appropriate dental utilization and effective program integrity activities, by establishing and expanding the provider network access; maintain high provider satisfaction ratings; target recruitment of providers and specialists based upon program need; effectively credentialing for participation of quality service providers; and assist with the development of a quality improvement strategy.

The vendor will be responsible for monitoring and encouraging appropriate dental utilization through dental disease prevention, outreach, and education activities.

The populations that will be enrolled in the DBA are in urban Clark and urban Washoe counties. The Medicaid Managed Care Organization (MCO) populations for those counties as of October 2016 are 62,765 and 396,804 respectively. All enrolled MCO recipients will be mandatorily enrolled into the DBA. Eligible Indians are exempt from mandatory enrollment in the DBA. In situations where Indians voluntarily enroll in the DBA, dental services from Indian Health Programs may be accessed without restriction.

A. Statutory Authority

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. **X 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.

   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.

   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.

   d. **X 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).

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

      __ MCO
      __ PIHP
      X 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).

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. **X Section 1902(a)(1)** – State wideness – 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.

b. **X 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.

c. **X 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.

d. **X 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).

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.

B. Delivery Systems

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. X **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.

X 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:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

___ the same as stipulated in the state plan.
___ is different than stipulated in the state plan (please describe).

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

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.):

   X **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience). This was accomplished under Request for Proposals (RFP) at the State of Nevada Purchasing Division, and Approved by the State Board of Examiners.

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

   ___ **Sole source** procurement.

   ___ **Other** (please describe).

C. Choice of MCOs, PIHPs, PAHPs and PCCMs

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.

X The State seeks a waiver of section 1902(a)(4) 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. Recipients enrolled in the DBA, PHAP will be offered the choice of providers under the DBA. Additionally, the RFP does describe the population ratio to providers and specialty providers and will monitor network adequacy.

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

___ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
X Other: (please describe) The DBA is designed as a single PHAP provider for the urban Clark and Washoe counties, recipients will still have a choice of providers within the DBA, additionally recipients will be able to self refer to specialists.

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.

D. Geographic Areas Served by the Waiver

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.

X **Less than Statewide** Limited to the Urban Clark and Washoe counties by zip codes.

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)
Washoe County (Urban)	PAHP	TBD
Clark County (Urban)	PAHP	TBD

E. Populations Included in Waiver

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:

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

X Mandatory enrollment
___ Voluntary enrollment

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

X 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
X Voluntary enrollment

X **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.

X Mandatory enrollment
___ Voluntary enrollment

X **Other:** Eligible Indians who are eligible as Nevada Medicaid or Nevada Check Up recipients may choose to be opt out of enrollment in the DBA.

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:

X **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.

X **Reside in Nursing Facility or ICF/MR –** Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

___ **Enrolled in Another Managed Care Program –** Medicaid beneficiaries who are enrolled in another Medicaid managed care program.

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

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

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

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

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

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

X **Other** (Please define):

1. Qualified Medicare Beneficiaries (QMB) who are not covered under full Medicaid benefits.
2. Special Low Income Medicare Beneficiaries (SLMB).
3. Qualified Individual (QISLMB2) special Low Income Medicare Beneficiaries.
4. Qualified Disabled Working Individuals (QDWI).
5. Undocumented aliens including non-qualified, undocumented and qualified aliens, who have not met the five-year bar, are eligible for care and services related to the treatment of an approved emergency medical condition.

F. Services

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

1. **Assurances.**

X 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).

X 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.

X 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.

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

Recipients are informed of the extent to which, and how, after hours and urgent dental care is provided, including how to contact a network dental provider twenty-four hours per day, seven days per week for urgent dental care. The vendor shall make arrangements with any out-of-network provider with respect to payment, and ensure there is no cost to the recipient.

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):

X Family planning services are not included under the waiver.

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.

X 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 vendor must pay for services provided by a Federally Qualified Health Center (FQHC). Vendors may enter into contracts with FQHCs provided that payments are at least equal to the amount paid to other providers for similar services. If the vendor does not have a contract with an FQHC, the vendor must pay at a rate equivalent to the FFS rate. This does not apply to out of network providers of emergency services. The vendor must demonstrate a good faith effort to negotiate a contract with FQHCs and include all licensed and qualified FQHC providers in the vendor's network. Contracting with just one provider at each FQHC does not constitute a good faith effort to include the FQHC in the vendor's network. The vendor must report to the DHCFP payments and visits made to FQHCs. The DHCFP is responsible for FQHC wrap payments; DBAs will be responsible for quarterly reporting on FQHC activity.

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

5. **EPSDT Requirements.**

X 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.

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.

7. **Self-referrals.**

X 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:

If the vendor's provider network is unable to provide medically necessary services covered under the plan to a particular recipient, the vendor must adequately and timely cover these services out of network for the recipient for as long as the vendor is unable to provide them. The vendor benefit package includes covered medically necessary dental services for which the vendor must reimburse certain types of providers with whom formal contracts may not be in place. The vendor must also coordinate these services with other services in the vendor benefit package.

When it is necessary for enrolled recipients to obtain services from out-of-network providers (i.e. the recipient needs to see a specialist for which the vendor has no such specialist in its network), the vendor must:

A. Coordinate the care with out-of-network providers;

B. Offer the opportunity to the out-of-network provider to become part of the network; and

C. Negotiate a contract to determine the rate prior to services being rendered or pay no more than the Medicaid FFS rate.

When it is necessary for recipients to obtain services from an out-of-state (OOS) provider, the vendor must negotiate a contract to determine the rate prior to services being rendered. The vendor must inform the provider to accept vendor reimbursement as payment in full. The only exception is for Third Party Liability (TPL). The OOS provider must not bill, accept or retain payments from Medicaid or Nevada Check Up recipients.

Section A: Program Description

Part II: Access

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.

A. Timely Access Standards

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

X 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.

X 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.

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):

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):

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):

d.___ **Other Access Standards** (please describe):

B. **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.

B. Capacity Standards

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

X 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 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.

X 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.

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.

d.___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

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

e.___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f.___ **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	*PCCM-to-Enrollee Ratio*
Statewide Average: (e.g. 1:500 and 1:1,000)	

g.___ **Other capacity standards** (please describe):

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.

C. Coordination and Continuity of Care Standards

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

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, 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.

X 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 438.208 Coordination and Continuity of Care. 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.

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

The following items are required.

a. **X** 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. This PAHP covers dental services only. In accordance with 42 CFR 438.208(a)(20), the State has determined that the implementation of a mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of 438.208 is not applicable given the limited scope of the program.

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

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

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.

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.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

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 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.

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

Section A: Program Description

Part 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 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 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 _____.

___ 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	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP				

2. **Assurances for PAHP program.**

X 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 a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above 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.

X 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.

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 attach.

b.___ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

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; and

15.___ Other (explain):

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 describe).

d.___ **Other quality standards** (please describe):

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. **Assurances**

X 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 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.

X 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.

2. **Details**

a. **Scope of Marketing**

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

2.___ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS

providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

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

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

1.___ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs /selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3.___ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

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

i.___ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
ii.___ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.
iii.___ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

X 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.

X 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.

2. **Details.**

a. **Non-English Languages**

X Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

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

1.___ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2.___ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.

3. X Other (please explain): The vendor must participate in State and federal efforts to promote the delivery of services in a culturally competent manner to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds pursuant to MSM Chapter 100. The State has identified the prevalent non-English language

in Nevada to be Spanish. The BBA Regulations: Title 42 of the Code of Federal Regulations (42 C.F.R.) 438.206(c) (2), and the DHCFP requires that vendors offer accessible and high quality services in a culturally competent manner.

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

The contract requires the vendor to establish policies to ensure recipients have access to oral interpretive services that are available through the provider network. The vendor must notify enrollees that interpretation is available for any language and that written language is available in prevalent languages at no expense to them and how to access those services.

X The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

Provision of informational materials is sent to enrollees within 10 business days and periodically thereafter. Enrollees have access to customer service staff who can answer questions about the program materials via face-to-face and by telephone in a language they can understand. Written notice of any changes in procedures at least 30 days before the effective date of the change

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

___ State
___ contractor (please specify) _____

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

c. Enrollee Information

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

(i) ___ the State
(ii)___ State contractor (please specify): _____
(iii) **X** the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. **Assurances.**

X 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 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. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

X 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.

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:

b. **Administration of Enrollment Process**.

X 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.

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

X 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.): The DBA will be implemented in Urban Clark and Washoe counties on July 1, 2017.

___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

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

i. ___ Potential enrollees will have____days/month(s) to choose a plan.
ii. ___ Please describe the auto-assignment process and/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.

X 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)
X 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 six months permitted) for MCO/PCCM enrollees under the State plan.

X 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: Medicaid recipients who have been determined Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) have the option of disenrolling from managed care. However, the Nevada Medicaid expansion population, defined as childless adults ages 19-64, and the expanded parent and caretakers ages 19-64, who are made eligible as part of the Patient Protection and Affordable Care Act expansion population, cannot opt out of managed care, where available, based on a determination of SMI.

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

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.

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

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

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

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

X The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

X MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

The vendor may request disenrollment of a recipient if the continued enrollment of the recipient seriously impairs the vendor's ability to furnish services to either the particular recipient or other recipients. In addition, the vendor must confirm the recipient has been referred to the vendor's Recipient Services Department and has either refused to comply with the referral or refused to act in good faith to attempt to resolve the problem. Prior approval by the DHCFP of a vendor's request for the recipient's disenrollment is required.

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

ii.___ 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.

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

D. Enrollee rights.

1. **Assurances.**

X 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 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.

X 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.

X 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.

E. Grievance System

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.

X The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

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.

   ___ 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 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(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.

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

   a. **Direct access to fair hearing**.

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

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

b. **Timeframes**

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

___ The State's timeframe within which an enrollee must file a **grievance** is __ days.

c. **Special Needs**

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

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.

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

X The grievance procedures is operated by:
___ the State.
___ the State's contractor. Please identify: _____.
___ the PCCM.
X the PAHP.

X Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

Any oral or written communications made by a recipient, or a provider acting on behalf of the recipient with the recipient's written consent, to any vendor employee or its providers expressing dissatisfaction with any aspect of the Medicaid DBA plan or

provider's operations, activities or behavior, regardless of whether the communication requests any remedial actions.

___ 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.

X Specifies a time frame from the date of action for the enrollee to file a request for review, which is: 20 days (please specify for each type of request for review)

An appeal is a specific request for review of one of the following actions:

A. The denial or limited authorization of a requested service, including the type or level of service;
B. The reduction, suspension or termination of a previously authorized service;
C. The denial, in whole or in part, of payment for a service;
D. The failure to provide services in a timely manner; or
E. The failure of a vendor to process grievances, appeals or expedited appeals within required timeframes including resolution and notification.

X Has time frames for resolving requests for review. Specify the time period set: (please specify for each type of request for review)

The vendor shall review and resolve complaints received within ten business days and ensure the DHCFP receives complaints that may need resolution at that level. For grievances, the vendor shall make a decision within 30 days of receipt and notify the recipient in writing.

X Establishes and maintains an expedited review process for the following reasons: Specify the time frame set by the State for this process____.

For cases in which a provider indicates or the vendor determines that following the standard timeframe could seriously jeopardize the recipient's life or health or ability to attain, maintain or regain maximum function, the vendor must make an expedited authorization decision and provide a Notice of Action as expeditiously as the recipient's health condition warrants and no later than 72 hours after receipt of the request for service. The vendor may extend the 72 hours' time period by up to 14 calendar days if the recipient requests an extension or if the vendor justifies (to the DHCFP upon request) a need for additional information and how the extension is in the recipient's best interest. The vendor must provide written notice of the reason for the extension and inform the recipient of their right to file

a grievance.

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

X 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):

F. Program Integrity

1. **Assurances.**

X 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.

X 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.

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 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 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 B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to 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 on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data					X		X	X	X	X	X	X
Data Analysis (non-claims)			X			X	X	X	X		X	X
Enrollee Hotlines						X						
Focused Studies				X	X					X		
Geographic mapping	X		X									
Independent Assessment		X			X	X	X		X			X
Measure any Disparities by Racial or Ethnic Groups	X											
Network Adequacy Assurance by	X		X		X	X	X	X	X		X	X

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Plan												
Ombudsman						X						
On-Site Review	X		X		X	X						
Performance Improvement Projects						X	X	X	X			
Performance Measures	X		X		X	X				X	X	X
Periodic Comparison of # of Providers	X	X	X				X					
Profile Utilization by Provider Caseload				X			X	X	X	X	X	X
Provider Self-Report Data				X	X	X				X	X	X
Test 24/7 PCP Availability				X		X						
Utilization Review				X						X		
Other: (describe)												

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care

II. Details of Monitoring Activities

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:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- 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. **X** 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)

___ NCQA
___ JCAHO
___ AAAHC
X Other (please describe)

The DHCFP intends to contract with highly qualified and experienced vendors, which will administer a DBA program to assist the DHCFP in reaching its goal to provide quality dental care to the targeted populations.

Authorization to operate as a certified vendor in the State of Nevada with the projected number of Medicaid and Nevada Check Up recipients by the United States Secretary of Health and Human Services and the Insurance Commissioner of the State of Nevada are conditions precedent to the contract and shall continue as conditions during the term of any contract. The vendor must hold a current certificate of authority from the Nevada State Insurance Commissioner for the applicable contract period and throughout the contract period, or have a written opinion from the Insurance Commissioner that such a certificate is not required. The awarded vendor must provide proof of a valid certificate of authority prior to the contract readiness review.

The vendor must adhere to all authorities including the Title XIX, Title XXI state plans and amendments, Code of Federal Regulations and the Medicaid Services Manual.

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

___ NCQA
___ JCAHO
___ AAAHC
X Other (please describe)

The vendor will have written policies and procedures that include a uniform documented process for credentialing, which include the vendor's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners. The vendor will comply with NAC 679B.0405 which requires the use of Form NDOI-901 for use in credentialing providers.

The DHCFP reserves the right to request and inspect the credentialing process and supporting documentation. The vendor agrees to allow the DHCFP and/or its contracted EQRO to inspect its credentialing process and supporting documentation.

Oversight by Governing Body
The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, will review and approve the credentialing policies and procedures.

Credentialing Entity
The vendor will designate a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.

Scope
The vendor will identify those practitioners who fall under its scope of authority and action. This must include, at a minimum, all dentists and other licensed independent practitioners included in the vendor's provider network.

Process
The initial credentialing process obtains and reviews primary source verification of the following information, at a minimum:

A. The practitioner holds a current valid license to practice in Nevada or a current valid license to practice in the state where the practitioner practices.
B. A Valid Drug Enforcement Administration (DEA) certificate for all practitioners authorized by the scope of their license to prescribe drugs.
C. Graduation from Dental school and completion of a residency, or other post-graduate training, as applicable.
D. Work history.

E. Professional liability claims history.
F. The practitioner holds current, adequate malpractice insurance according to the vendor's policy.
G. Any revocation or suspension of a State license or DEA number.
H. Any curtailment or suspension of medical staff privileges (other than for incomplete Dental records).
I. Any sanctions imposed by the OIG or the DHCFP.
J. Any censure by any state or county Dental Association or any other applicable licensing or credentialing entity.
K. The vendor obtains information from the National Practitioner Data Bank, the Nevada State Board of Dental Examiners, any equivalent licensing boards for out-of-state providers, and any other applicable licensing entities for all other practitioners in the plan.
L. The application process includes a statement by the applicant regarding:
    1. Any physical or mental health problems that may affect current ability to provide dental care;
    2. Any history of chemical dependency/ substance abuse;
    3. History of loss of license and/or felony convictions;
    4. History of loss or limitation of privileges or disciplinary activity; and
    5. An attestation to correctness/ completeness of the application.

This information should be used to evaluate the practitioner's current ability to practice.

M. There is an initial visit to each potential primary dental care practitioner's office, including documentation of a structured review of the site and Dental record keeping practices to ensure conformance with the vendor's standards.
N. If the vendor has denied credentialing or enrollment to a provider where the denial is due to vendor concerns about provider fraud, integrity, or quality the vendor is required to report this to the DHCFP Provider Enrollment Unit within 15 calendar days.

c. **X** Consumer Self-Report data

X CAHPS (please identify which one(s))
___ State-developed survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid

Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid and Nevada Check Up populations. The DBA will use a pre-approved enhanced mixed-mode methodology for data collection (i.e. mailed surveys followed by telephone interviews of non-respondents).

The populations to be surveyed will be adult Medicaid, child Medicaid and Nevada Check Up. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The DBA will be responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf.

d. X Data Analysis (non-claims)

- X Denials of referral requests
- ___ Disenrollment requests by enrollee
  - ___ From plan
  - ___ From PCP within plan
- X Grievances and appeals data
- X PCP termination rates and reasons
- ___ Other (please describe)

The vendor must designate a Dental Director to be responsible for the oversight of development, implementation and review of the vendor's Internal Quality Assurance Program, including implementation of and adherence to any Plan of Correction. The Dental Director need not serve full time or be a salaried employee of the vendor, but the vendor must be prepared to demonstrate it is capable of meeting all requirements using a part-time or contracted non-employee director. The vendor may also use assistant or associate Dental Directors to help perform the functions of this office. The Dental Director and the vendor's Utilization Management and Internal Quality Assurance Plan Committee are accountable to the vendor's governing body. The Dental Director must be licensed to practice dentistry in the State of Nevada.

The responsibilities of the Dental Director include the following:

Serves as co-chairman of the vendor's Utilization Management and Quality Assurance Plan committee;

Directs the development and implementation of the vendor's Internal Quality Assurance Plan (IQAP) and utilization management activities and monitoring the quality of care that vendor' recipients receive;

Oversees the development and revision of the vendor's clinical care standards and practice guidelines and protocols;

Reviews all potential quality of care problems, and oversees the development, and implementation of, as well as the adherence to, Plans of Correction;

Oversees the vendor's referral process for specialty and out-of-network services. All services prescribed by a PDP or requested by a recipient which are denied by the vendor must be reviewed by a dentist with the reason for the denial being documented and logged;

Oversees the vendor's provider recruitment and credentialing activities;

Serves as a liaison between the vendor and its providers, communicating regularly with the vendor's providers, including oversight of provider education, in-service training and orientation;

Serves as the vendor's consultant to dental staff with regard to referrals, denials, grievances and problems;

Ensures coordination of out-of-network services; and

The vendor must also identify a liaison, which can be the Dental Director, to work with DHCFP regarding utilization review and quality assurance issues.

e. **X** Enrollee Hotlines

The vendor shall maintain a Recipient Services Department (that also includes a Concierge Service) that personally assists recipients to find a service provider. This department must be adequately staffed with qualified individuals who shall also assist recipient, recipients' family members or other interested parties (consistent with laws on confidentiality and privacy) in obtaining information and services under the vendor's plan.

The Recipient Services Department is to be operated at a minimum, traditional business hours of Monday through Friday, 8:00 a.m. through 5:00 p.m., and not less than what is provided to the vendor's commercial clients, if applicable.

Ensure that a toll-free hotline telephone number is operated at a minimum, traditional business hours of Monday through Friday, 8:00 a.m. through 5:00 p.m for recipient access.

f. **X** 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).

The DHCFP reserves the right to require the vendor to conduct special focus studies and report on additional quality measures when requested.

g. **X** Geographic mapping of provider network

The vendor shall:

On a quarterly basis, use geo-access mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards.

h. **X** Independent Assessment of program impact, access, quality and cost-effectiveness (**Required** for first two waiver periods)

The role of vendor is to ensure accessibility and availability to appropriate dental care, provide for continuity of care, and provide quality care to enrolled recipients. Recipients benefit from preventive dental care services, the quality and availability of which are monitored and evaluated by the DHCFP in conjunction with the DHCFP's EQRO contractor. The vendor is required to work collaboratively with the DHCFP and the EQRO in these quality monitoring and evaluation activities. The vendor will designate a lead person to work with the DHCFP on quality management. By virtue of the DHCFP's contract with the EQRO and the federal regulations which set forth the State's mandates for an EQRO, the vendor will be required to provide reporting data beyond that stipulated in this section and will participate in those additional EQRO activities as assigned and required by the DHCFP.

The DHCFP will update Nevada's Quality Strategy to indicate the set of dental quality measures to be reported. The DHCFP and/or the EQRO may conduct on-site review as needed to validate dental measures reported. The vendor must use audited data, and is responsible for ensuring all updates to the measure are reflected in the final, reported rates.

i. **X** Measurement of any disparities by racial or ethnic groups

Entity responsible: The State Medicaid agency and Vendor

The State monitors how the dental plans are meeting the contract provision requiring the plans to strive to improve the quality of oral health care for multicultural populations by ensuring that all services are available, accessible, and provided to members in a culturally and linguistically appropriate manner. The vendor shall have methods of identifying non-English languages spoken by members.

This activity helps ensure that services provided to dental plan enrollees are culturally and linguistically appropriate with the goal of providing better health care for all members.

In accordance with the requirements set forth in 42 U.S.C. §300kk, the vendor

must develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language and disability status for applicant's and recipient's parents or legal guardians if applicants or recipients are minors or legally incapacitated individuals.

An annual review of the vendor will be conducted by the DHCFP or its designee. In addition, the DHCFP will monitor and analyze grievances and appeals, provider disputes and will periodically conduct patient and provider satisfaction surveys.

This data will be utilized to gather baseline data and will lead to the development of a Performance Improvement Projects (PIP) or quality improvement project. Such a project will incorporate data from the State enrollment file according to the race and ethnicity categories as defined by CMS. The data will be used to generate stratified reports as recommended by the CMS and compliant with the Health Insurance Portability and Accountability Act (HIPAA) for race and ethnicity categories to identify disparities. The vendor's will organize interventions specifically designed to reduce or eliminate disparities in health care.

j. **X** Network adequacy assurance submitted by plan (**Required** for MCO/PIHP/ PAHP)

The DBA must maintain an adequate network that ensures the following:

The vendor must have at least one full-time equivalent (FTE) dentist per 1,500 recipients per geographic service area. The vendor's dental provider network must also include at a minimum, pediatric dentist, dental hygienists, and oral surgeons in each geographic service area sufficient to provide necessary access to care. In clinic practice settings where a dentist provides direct supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing, the vendor may request and the DHCFP may authorize the capacity to be increased as follows: one dental resident per 1,000 recipients per vendor. The dentist shall be immediately available for consultation, supervision, or to take over treatment as needed. Under no circumstances shall a dentist relinquish or be relieved of direct responsibility for all aspects of care of the recipients enrolled with the dentist.

In order to increase capacity, the vendor shall submit for prior approval by the DHCFP a detailed description of the dental delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, and a 24-hour access system.

k. **X** Ombudsman

Entity responsible: The State Medicaid agency

The Medicaid agency has recipient services representatives at the district offices whose job is to handle and track all calls received by Medicaid clients related to both fee-for-service and managed care plan and DBA issues. Additionally, the State has the Office for Consumer Health Assistance, Bureau for Hospital Patients, and Office of Minority Health Department of Health and Human Services Website: http://dhhs.nv.gov/Programs/CHA/Statutory Authority: NRS 223.550, 223.575 and 232.474.

l. **X** On-site review

The common goal of the managed care program is a successful partnership with quality dental plan to provide care to the DHCFP recipients, while focusing on continuous quality improvement.

The role of DBA is to ensure accessibility and availability to appropriate dental care, provide for continuity of care, and provide quality care to enrolled recipients. Recipients benefit from preventive dental care services, the quality and availability of which are monitored and evaluated by the DHCFP in conjunction with the DHCFP's EQRO contractor. The vendor is required to work collaboratively with the DHCFP and the EQRO in these quality monitoring and evaluation activities. The vendor will designate a lead person to work with the DHCFP on quality management. By virtue of the DHCFP's contract with the EQRO and the federal regulations which set forth the State's mandates for an EQRO, the vendor will be required to provide reporting data beyond that stipulated in this section and will participate in those additional EQRO activities as assigned and required by the DHCFP.

m. **X** Performance Improvement projects (**Required** for MCO/PIHP)

X Clinical
X Non-clinical

Quality of care studies are an integral and critical component of the health care quality improvement system. The vendor will be required annually to conduct and report on a minimum of one clinical PIP and one non-clinical PIP. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.

n. **X** Performance measures [**Required** for MCO/PIHP]

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

The DHCFP will update Nevada's Quality Strategy to indicate the set of dental quality measures to be reported. The DHCFP and/or the EQRO may conduct on-site review as needed to validate dental measures reported. The vendor must use audited data, and is responsible for ensuring all updates to the measure are reflected in the final, reported rates. The DHCFP reserves the right to require the vendor to conduct special focus studies and report on additional quality measures when requested.

On an annual basis, DBA's are required to report on all performance measures listed in the State Quality Strategy.

Comprehensive Well Child Periodic and Interperiodic Health Assessments/Early Periodic Screening Diagnosis and Treatment (EPSDT)/Healthy Kids.

Standard

1. The vendor shall take affirmative steps to achieve at least a participation rate greater than or equal to the national average for EPSDT dental screenings.

2. The DHCFP and/or the EQRO may conduct desk and/or on-site review as needed, to include, but not be limited to: policy/procedure for EPSDT, service delivery, data tracking and analysis, language in dental care provider contracts and the process for notification of recipients. Vendor internal quality assurance of the EPSDT program shall include monitoring and evaluation of the referrals that are the result of an EPSDT dental screening.

The vendor is required to submit the CMS 416 EPSDT Participation Report to the DHCFP for each quarter of the federal fiscal year (FFY), October 1st through September 30th. The vendor is required to submit the final CMS 416 Report to the DHCFP no later than March 1st after the FFY reporting period concludes. The vendor must send a quarterly report in order to track the progress the Vendor is making throughout the year. The vendor is required to complete all dental line items of the CMS 416 Report applicable for dental care and submit separate reports for the NCU, FMC, and CHIP Medicaid expansion**.**

If the vendor cannot satisfactorily demonstrate to the DHCFP at least a participation rate not less than the Quality Improvement System for Managed Care (QISMIC) improvement measure, as determined by the DHCFP or its contracted EQRO, the DHCFP may require the vendor to submit a Plan of Correction (POC) to the DHCFP.

o. X Periodic comparison of number and types of Medicaid providers before and after waiver

Entity responsible: DBA.

Each month, the State requires the dental plan to provide a complete list of their provider network by type of oral health provider and county. This list will aid the State in monitoring the adequacy of each plans network, trends in each plans network and any potential issues regarding access to care.

p. X Profile utilization by provider caseload (looking for outliers)

The State requires the plan to submit semi-annual reports summarizing information on corrective action taken on dental providers who have been identified by the plan as exhibiting aberrant provider behavior. In addition, the plans are required to report the names of providers who have been removed from the plan's network due to aberrant behavior. The report includes the reasons for the corrective action or removal. These reports provide information on the area related to program integrity ensuring that the plans administrative and management procedures designed to guard against fraud and abuse.

The information provided to the State provides evidence that the dental plans are appropriately monitoring their providers during credentialing and recredentialing and are following up on concerns through corrective actions at the provider level.

q. X Provider Self-report data

X Survey of providers

___ Focus groups

An annual review of the vendor will be conducted by the DHCFP or its designee. In addition, the DHCFP will monitor and analyze grievances and appeals, provider disputes and will periodically conduct patient and provider satisfaction surveys.

r. X Test 24 hours/7 days a week PCP availability

While the Recipient Services Department will not be required to operate after business hours, the vendor must comply with the requirement to provide urgent care and emergency coverage 24 hours per day, seven days per week. The vendor must have written policies and procedures describing how recipients can obtain urgent coverage and emergency services after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified dental professionals. Participants should be given the option to speak with a qualified dental professional during an emergency to advise and direct recipients to the correct service location which may include local emergency departments or dental offices. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical

attention is received. Additionally, the State may perform Secret Shopper Surveys to test availability.

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

The vendor must have a written utilization review management program description, which includes, at a minimum, policies and procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of Dental services.

Scope

The program has mechanisms to detect under-utilization as well as over-utilization.

Pre-Authorization Review Requirements:

Pre-authorization decisions must be supervised by qualified Dental professionals;

Efforts must be made to obtain all necessary information, including pertinent clinical information, and consult with the treating dentist, as necessary;

The reasons for decisions must be clearly documented and available to the recipient;

The vendor's prior authorization policies and procedures must be consistent with provision of covered medically necessary dental care in accordance with community standards of practice;

There must be well-publicized and readily available mechanisms for recipient appeals and grievances as well as provider disputes. Providers may pursue an appeal on the recipient's behalf with the recipient's written authorization. The Notice of Action must include a description of how to file an appeal;

Appeal and grievance decisions are made in a timely manner as warranted by the health of the enrolled recipient;

There are mechanisms to evaluate the effects of the program using data on recipient satisfaction, provider satisfaction or other measures;

Consistent with 42 CFR 438.210, vendors must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary dental services to any recipient; and

If the vendor delegates responsibility for utilization management, it has mechanisms to ensure that the delegate meets these standards.

t. ___ Other: (please describe)

Section C: Monitoring Results

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.

X This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

___ 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, and provides below the results of monitoring activities conducted during the previous waiver.

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.

Please replicate the template below for each activity identified in Section B:

Strategy:

Confirmation it was conducted as described:

___ Yes
___ No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)