ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable N/A

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2.a. Outpatient Hospital Services (Continued)

Maternal Life360 HOME

Women with high-risk pregnancies who are eligible for Medicaid but are not in the New Adult Medicaid Expansion Group can receive home-visiting services.

DHS will contract with approved Life360 hospitals to provide evidence-based home visiting services to women with a diagnosis code of high-risk pregnancy who live in the Life360's selected service area. The services start during pregnancy and will be provided through the baby's first 12 months. Client participation is voluntary, and the home visiting services are supplemental to the medical services they are already receiving through Medicaid.

2.a. Outpatient Hospital Services (Continued)

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2.a. Outpatient Hospital Services (continued)

(6) Border City University-Affiliated Pediatric Teaching Hospitals

Special consideration is given to border city university-affiliated pediatric teaching hospitals due to the higher costs typically associated with such hospitals. Effective for claims with dates of service on or after January 1, 2018, outpatient hospital facility services provided to patients under the age of 21 at border city university-affiliated pediatric teaching hospitals will be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. The State will utilize cost data in a manner approved by CMS consistent with the method used for identifying cost for the private hospital access payments as outlined in this Attachment 4.19-B, Page 1a.

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost settlements. The cost settlements will be calculated using the methods and standards used by the Medicare Program.

A border city university-affiliated pediatric teaching hospital is defined as a hospital located within a bordering city (see Attachment 4.19-A page 3b) that submits to the Arkansas Medicaid Program a copy of a current and effective affiliation agreement with an accredited university, and documentation establishing that the hospital is university-affiliated, is licensed and designated as a pediatric hospital or pediatric primary hospital within its home state, maintains at least five different intern pediatric specialty training programs, and maintains at least one-hundred (100) operated beds dedicated exclusively for the treatment of patients under the age of 21.

(7) Effective for claims with dates of service on or after June 1, 2022, all Arkansas hospitals shall be paid based on 100% of the Medicare average comprehensive payment rate as of June 1, 2022 for the vagus nerve stimulation therapy, device and procedure. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedules are the same for both governmental and private providers.

(8) Maternal Life360 HOME

Effective for claims with dates of service on or after January 1, 2023, Arkansas hospitals who are enrolled as a Maternal Life 360 HOME will be paid a per member, per month fee for providing home-visiting services under the approved 1915(b) waiver.

TOC required

200.000 LIFE360 HOMES GENERAL INFORMATION

201.000 Arkansas Medicaid Life360 HOMEs Overview 1-1-23

This provider manual (manual) offers guidance for eligible Arkansas Medicaid-enrolled hospitals to enroll as a Life360 HOME provider (Life360). The Life360 will ensure clients in target populations are connected to medical services and nonmedical supports in their communities to address their social determinants of health (SDOH) through intensive care coordination. Life360s are designed to supplement not supplant existing supports and services. Medical care will continue to be delivered and billed as it is today. There are three types of Life360s that will target populations to receive intensive care coordination services and supports specifically designed to meet those populations' unique needs (Life360 refers to all three types unless otherwise specified):

A. **Maternal Life360** will support women whose Medicaid or Medicaid-funded Qualified Health Plan (QHP) claims reflect a diagnosis code of needing supervision for high-risk pregnancy. They will be supported either through direct provision of evidence-based home visitation or through contract with evidence-based home visitation programs. Intensive care coordination will be provided through the home-visiting program.

B. **Rural Life360** will support individuals with mental illness as defined in this manual or substance use disorder (SUD) who live in rural areas of the state by providing intensive care coordination through care coordination coaches.

C. **Success Life360** will support young adults most at risk of long-term poverty and associated poor health outcomes due to prior incarceration, involvement with the foster care system, or involvement with the juvenile justice system and young adult veterans who are at high-risk of homelessness. The Success Life360 will provide intensive care coordination directly or contract with community organizations to do so.

201.100 Life360 Provider Eligibility 1-1-23

To be eligible to apply for enrollment as a Life360 provider with Arkansas Medicaid, the entity must:

A. Be a current Arkansas Medicaid hospital provider.

1. Maternal Life360 must be a birthing hospital as defined within this manual.
2. Rural Life360 must be a small rural hospital as defined within this manual.
3. Success Life360 must be an acute care hospital as defined within this manual.

203.000 APPLICATION AND APPROVAL PROCESS

203.100 Letter of Intent 1-1-23

The approval to be a Life360 happens in a four-phase process. The process is designed to ensure that eligible providers demonstrate capacity and ability to implement the program requirements outlined in this manual to achieve the goals and outcomes of the Life360 program.

Submitting all required information in the application process does not guarantee approval as a Life360. The Arkansas Department of Human Services (DHS) Division of Medical Services (DMS) will review and determine whether approval is warranted for all applicants.

To become an approved Life360, a hospital must first submit a letter of intent (LOI) to DMS that includes:

A. The type(s) of Life360 the hospital is applying to become;

B. Hospital location, Medicaid provider ID, and proposed service area (area to be served); and

C. Name and contact information for staff member serving as program lead.

D. For a **Maternal Life360**, the LOI must include

1. Estimated number of individuals the hospital expects to serve with home-visiting supports and services in the proposed service area and a description of how the hospital arrived at that estimate. (Indicators could include local birth rates, number of child-bearing age women in poverty, Medicaid enrollment or healthcare access, and other SDOH needs and health outcomes);
2. Number of women receiving maternity or obstetric services annually through hospital and/or its clinics (note: "hospital" in this section means the hospital submitting the LOI);
3. The name of the evidence-based home visiting model the hospital intends to use;
4. Whether the hospital will use its own staff to conduct home-visiting OR partner with an external organization to provide home-visiting; and
5. If partnering with an external organization, name, and contact information of organization.

E. For a **Rural Life360**, the LOI must include:

1. Estimated number of adults in the service area with mental illness and/or substance use disorder, the hospital expects to serve and a description of how the hospital arrived at that estimate.
2. Estimated number of adults in the proposed service area likely to be eligible due to mental illness and/or substance use disorder;
3. Brief description of the mental health and substance use disorder services provided by the hospital or its clinics;
4. Names of behavioral health service providers in the proposed service area and brief description of services and/or supports they could provide to Life360 clients; and
5. Number of acute crisis unit beds the hospital currently operates or will develop.

F. For a **Success Life360**, the LOI must include:

1. Names of community service organizations currently serving the employment, educational, or training needs of the proposed service area and the estimated number served by the programs, if available;
2. Estimated number of adults in the proposed service area likely to be eligible for Success Life360;
3. Identification of community service organizations that will serve as the subcontractors or community partner organizations; and
4. Description of the way in which the Success Life360 would supplement and not supplant existing community organization services.

DMS will review the LOI to determine if the hospital meets the eligibility criteria and provided all requested information. DMS reserves the right to refuse an LOI if necessary to allow time to process Life360 applications previously submitted. DMS will inform the hospital either:

A. The LOI is approved and the hospital may move to the application phase

B. More information is needed before approval can be made

C. The hospital does not meet the criteria outlined in this manual to move forward to application, including but not limited to proposing to serve too few clients or proposing a service area that is already adequately being served by other Life360s.

203.200 Application 1-1-23

Upon approval of the LOI, the hospital will submit a Life360 application within ninety (90) calendar days. The application must include a:

A. Program narrative that describes:

1. How intensive care coordination will be designed and delivered according to requirements in this manual
2. Staff and organizational experience
3. Subcontractor experience, if applicable
4. Description of community partners

B. Community network assessment (template provided) and capacity-building plan (see section 203.210 for more details)

C. A copy of the hospital's most recent Community Needs Analysis (if available)

D. At least two letters of support from potential community partner organizations

E. Plan for community outreach, education, and client communication

F. How services will supplement, not supplant, services already provided in the community

G. Description of proposed referral network, intent to partner with organizations, and signed agreements with community partner organization, pending approval of the Life360 application (See section 203.210)

H. Plan for monitoring client milestones and goals, collecting data on client outcomes, and monitoring other quality improvement measures identified by DMS

I. Startup and first year program budget and narrative justification

DMS will review the hospital's application and materials upon receipt of a complete application package and will respond within a specified timeframe in writing to approve, deny, or request additional information. If additional information is needed, the applicant hospital will have thirty (30) calendar days to provide the additional information. DMS will review and approve or deny any application within a specified timeframe.

The following sections 203.210-203.230 provide criteria for each application requirement.

203.210 Community Network Assessment and Capacity Building 1-1-23

As part of the application, the hospital will:

A. Complete an assessment of the service area population demographics and a community resource inventory to determine the available community resources and gaps. That inventory should include community medical providers, community service organizations, and social service providers that the Life360 can refer clients to access appropriate services and supports.

1. Once a hospital becomes a Life360, the hospital will update this information annually as a requirement of the annual Life360 HOME agreement and will be responsible for ongoing program and resource development and capacity-building.

2. Access to medical services and availability of non-medical supports should be described (i.e., number of primary care/specialists, number of organizations providing supports and type of supports, data on wait times or distance to care, if available).

B. Identify providers and others in the service area who can serve as a referral network to refer someone for Life360 services.

1. Referrals can be from a diverse array of health and social service organizations, medical providers, and non-medical supports in the community through formal and informal agreements and based on the target population served.

2. Determine which organizations will require formal community partner agreements, particularly an entity that would share personal client information, to ensure health information is protected. Applicant hospital will submit those agreements as part of the application, and DMS will review them as part of the application and/or readiness review process.

203.220 Referral Network Outreach **1-1-23**

After application approval, the selected applicant and its partners will be responsible for community outreach to ensure entities that can make referrals are aware of Life360 services and the referral process, for general outreach and awareness activities directed at the target population as well as key community groups that would have direct contact with and are trusted by the Life360 target population.

203.230 Community Partner Organization Criteria **1-1-23**

To be eligible to partner with a Life360 hospital to offer services and supports, an organization must meet the qualifications for the relevant Life360 type, as described below. Hospitals are responsible for confirming the organization has a tax identification number, is in good standing with relevant government entities, and other due diligence of partner organizations. Community partner organizations will work with the Life360s to conduct outreach to ensure providers and local entities are aware that they can refer clients for services.

A. **Maternal Life360** - The Life360 or the organization with which the Life360 contracts to provide home-visiting services and supports must use an evidence-based home visitation model. The selected model(s) must cover home visiting services from pregnancy through at least the first two (2) years of the baby's life.

B. **Success Life360** - The organization with which the Life360 contracts must be experienced in working with young adults most at risk of long-term poverty to build their skills to be physically, socially, and emotionally healthy in order to live in and contribute to their communities.

This section criteria does **not** apply to **Rural Life360.** Hospitals will directly provide intensive care coordination to the target population. Providers of behavioral health services will be engaged by the hospital as key partners for referrals and delivery of services.

203.300 Startup **1-1-23**

Once an application is approved, the selected applicant must sign a startup agreement before DMS will release the first round of startup funding. For information about the amount of startup funding allowed, see the rate sheet. After the agreement is signed the selected applicant will be in the startup phase, and DMS will release the first installment of startup funds. The hospital must follow the startup plan and budget outlined in the approved application. Hospitals may not

receive more than one package of startup funding for more than one application of the same type of Life360s.

For both **Maternal Life360s** and **Rural Life360s**, startup funds will be:

A. Provided in two initial payments to be used for the cost of starting the program.

1. The first upon DMS approval of the application
2. The second after successful completion of the readiness review

B. Based on the approved program budget and contained in the startup agreement.

C. Allowed to cover the cost of staff, equipment, and supports identified in the selected applicant's startup budget or otherwise approved by DMS. Expenditures will be subject to audit.

For **Success Life360s**, startup funds will be:

A. Provided in three initial payments to be used for the cost of starting up the program.

1. The first upon DMS approval of the application and signed startup agreement
2. The second after successful completion of the readiness review
3. The third payment will be released by DMS in accordance with the selected applicant's approved startup agreement

B. Based on the approved annual program budget contained in the startup agreement.

C. Allowed to cover the cost of staff, equipment, and supports identified in the applicant's startup plan budget or other uses approved by DMS. Expenditures will be subject to audit.

Each selected applicant must complete the startup phase within the timeframe specified in their startup plan, not to exceed one-hundred-eighty (180) days from the receipt of startup funds or funds may be subject to recoupment. During the startup phase, DMS and the hospital working to become a Life360 will meet monthly to assess progress toward readiness review. DMS will schedule readiness review at the end of the startup phase.

203.400 Readiness Review 1-1-23

After approval of the application and completion of the startup phase, a readiness review will be conducted by DMS or its contractor to determine the selected applicant's readiness to fully implement the Life360 program. Readiness review will include an onsite visit to each location. Each selected applicant will demonstrate that it is operationally ready to fulfill all Life360 requirements including:

A. Having the ability to confirm client eligibility

B. Having the ability to report required data to DMS in the format requested

C. A SDOH screening tool and the necessary staff training, a platform for capturing results, and a process for linking clients to resources

D. Any other client assessment tools to be used by the program

E. A person-centered action plan (PCAP) template and plan for updating the PCAP regularly, at a minimum annually

F. Adequate program staff and appropriate staff training

G. Fully executed community partner agreements

H. Referral network, agreements, and a process for accepting and transferring protected health information

I. Demonstrating that the Life360 and its partners have a communication, outreach, and referral plan

J. Fund controls to correctly submit payment for Life360 funding that is separate from medical services paid for by Medicaid, Medicare, other insurance, and any other third-party payer

K. Operational acute crisis bed(s), for Rural Life360 only

DMS will schedule the readiness review within five (5) business days after being notified by the selected applicant that it is ready to complete the review. DMS will complete readiness review and provide the outcome of the review in writing within a specified timeframe of the onsite visit. Following the completion of the readiness review, DMS will either:

A. Enroll the hospital as a Life360 provider, enter into the Life360 HOME agreement, and release the second installment of startup funds;

B. Release all or a portion of the second installment of startup funds and provide in writing a list of deficiencies and the timeframe by which the deficiencies must be addressed for the hospital to demonstrate readiness; or

C. Deny enrollment as a Life360 for failure to successfully complete readiness review.

203.500 Life360 HOME Agreement 1-1-23

To enroll in the Life360 program, applicants that successfully complete the application process and readiness review will provide their tax ID number and enter into the Life360 HOME agreement. The agreement will outline required program obligations and legal requirements pertaining to the Life360 scope of work. Through execution of the agreement, providers agree to adhere to all requirements in this manual and all applicable federal regulations and state statutes.

203.700 Electronic Signatures 1-1-23

Medicaid will accept electronic signatures, provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

210.000 PROGRAM REQUIREMENTS

210.100 Client Eligibility 1-1-23

Life360 client participation is voluntary. An individual is not required or entitled to receive services from a Life360 as a condition of Medicaid eligibility. Life360s are responsible for ensuring clients who participate in Life360s are eligible. To be screened for SDOH and/or Life360 eligibility, clients must live in the service area served by the Life360. Residence can be determined by the person's geographic residence, shelter residence or other temporary residence, such as a health facility. If experiencing homelessness, residence may be established by the last documented residence or shelter, work history/place of employment, or child's school/childcare enrollment.

A client may be enrolled in only one Life360 program at any time.

A client who moves from one Life360 service area to another may continue receiving services through the new Life360 if the new Life360 type is the same as the previous (e.g., Maternal to Maternal). If the Life360 type in the new service area is different, the client may receive services from the new Life360 only if the client qualifies for those services.

Additional eligibility requirements by Life360 type include:

A. A woman is eligible for **Maternal Life360** intensive care coordination supports if she:

1. Is enrolled in Arkansas Medicaid or was enrolled in Arkansas Medicaid when she began receiving Maternal Life360 services and is either pregnant with a high-risk pregnancy (a diagnosis of needing supervision for high-risk pregnancy) OR
2. If enrolled in ARHOME at any point during enrollment in the Maternal Life360 program, was enrolled in the Maternal Life360 while pregnant with a high-risk pregnancy and delivered the baby within the previous twenty-four (24) months

   OR If enrolled in a Medicaid program that is not ARHOME for the full duration of enrollment in the Maternal Life360 program, was enrolled in the Maternal Life360 while pregnant with a high-risk pregnancy and delivered the baby within the previous twelve (12) months. High-risk pregnancy must be verified through a completed referral form from the client's physician that includes the most current clinical note.
3. Is not currently receiving state- or federally funded home visiting services through a provider whose services cover pregnancy or the first two (2) years of a baby's life.

B. An individual who needs assistance confirming a high-risk pregnancy diagnosis will be eligible for assistance in connecting with medical services until the need for supervision for high-risk pregnancy is confirmed. The Life360 HOME will not receive per member per month (PMPM) funding until the woman's pregnancy and Medicaid eligibility are confirmed.

C. All adults living in the **Rural Life360** service area are eligible for SDOH screening and referrals to needed community supports. To be eligible for intensive care coordination, the individual also must:

1. Be enrolled in ARHOME through a qualified health plan (QHP) or Medicaid fee-for-service (FFS);
2. Have a mental health and/or substance use disorder diagnosis;
3. Have at least one SDOH need identified through an SDOH screening; and
4. Not be enrolled in the Provider-led Arkansas Shared Services Entity (PASSE) program.

D. An individual is eligible for **Success Life360** intensive care coordination and supports if the person:

1. Is enrolled in ARHOME through a QHP or Medicaid FFS;
2. Is at risk of poor health due to poverty, meaning under one hundred thirty eight percent (138%) Federal poverty level;
3. Is not enrolled in the Provider-led Arkansas Shared Services Entity (PASSE) program; and
4. Meets the criteria for at least one of the following categories:
   a. Is between nineteen (19) and twenty-four (24) years of age and has been previously placed under the supervision of the DHS Division of Youth Services as verified by DHS.
   b Is between nineteen (19) and twenty-four (24) years of age and has been previously placed under the supervision of the Arkansas Department of Corrections, as verified by the Arkansas Department of Corrections.
   c Is between nineteen (19) and twenty-seven (27) years of age and has been previously placed under the supervision of the DHS Division of Children and Family Services; as verified by DHS.
   d Is between nineteen (19) and thirty (30) years of age and is a veteran verified by DD214 Certificate or Release of Discharge from Active Duty.

210.200 General Program Requirements 1-1-23

All Life360s must:

A. Submit an annual budget and budget narrative, including staff, to DMS for approval.

B. Provide an explanation of how the Life360 will meet targeted number of clients to be served, if you failed to meet expected numbers in the previous year

C. Provide service projections (e.g., the number of clients the Life360 expects to serve, the number of visits anticipated for each client, the number of individuals screened, etc.)

D. Provide all other required supports specified in the Life360 HOME agreement.

E. Provide or contract to provide supports that demonstrate cultural competency and are provided in the languages frequently spoken by the targeted population as identified in the community assessment.

F. Comply with all reporting requirements and deadlines specified in the Life360 HOME agreement and any additional reporting requirements required by the Centers for Medicare and Medicaid Services and/or the Arkansas Legislature.

G. Maintain fund controls to correctly submit payment for Life360 funding that is separate from medical services paid for by Medicaid, Medicare, other insurance, and any other third-party payer.

H. Provide a monthly expenditure report. The expenditure report must provide all expenditures compared against budgeted categories. Maternal Life360s will provide all program expenditures, but only the expenditures for startup and transportation funding will be compared against budgeted categories. For **Rural** and **Success Life360s**, the monthly expenditure report also must include an estimate of funds the Life360 anticipates will be unspent by the end of the program year. DHS may adjust the annual budget in the middle of the year, if necessary, to bring the Life360's operations in line with actual spending patterns.

I. For **Rural** and **Success Life360s**, unspent funds will be applied to the Life360's budget for the following year, and DMS will reduce new funds provided by the amount of unspent funds the Life360 is carrying forward. Life360s with unspent funds cannot submit a budget in the subsequent year that exceeds the budget for the year in which the unspent funds accumulated. DMS may make an exception for circumstances that were unique to a particular program year.

210.300 Service Area Criteria 1-1-23

The Life360 may define its service area to include only the county in which the Life360 is located and a service area of one or more counties contiguous to that county or each other. As part of the application process, DHS will assess whether the applicant hospital can serve the selected service area adequately or it needs to be adjusted.

Rural Life360 service areas may include counties containing a Metropolitan Statistical Area (MSA), but the Life360 must be established to primarily serve the hospital's patient population and non-MSA counties. DHS will assess whether the applicant hospital's selected service area adequately serves rural populations.

Success Life360 service areas must include the county in which the hospital is located and the county in which the community partner organization is located. If the hospital and the community partner organization are in separate counties, the counties must be adjoined.

210.400 Required Maternal Life360 Activities 1-1-23

The **Maternal Life360** will provide the following services and supports for their clients:

A. Determine and verify eligibility for individuals referred or identified for intensive care coordination and home-visiting supports, including assisting individuals with the diagnosis of need for supervision for high-risk pregnancy.

B Obtain a signed consent form from clients to share the client's personal information with DHS, partner organizations, relevant community service providers, and relevant health care providers.

C Incorporate screening that includes SDOH screenings (upon client enrollment in Life360 and every six (6) months during program participation) as well as other required health screenings for all eligible clients that will help inform the supports delivered to improve outcomes in:

1. Maternal Health
2. Child Health
3. Family Economic Self-Sufficiency
4. Positive Parenting Practices

D Provide home visitation services with fidelity to an evidence-based model and linkages to community resources and supports. Home visiting may be provided directly by the hospital or through contract with evidence-based home visitation program.

E. Assist with any needs for coordination of medical services including support identifying and connecting both the client and her baby to a PCP or OB/GYN and any other needed medical and behavioral health providers or culturally relevant supports.

F. Document home-visiting services provided.

G. Disenroll individuals who have asked to stop receiving services or who are uncooperative with receiving services after five consecutive attempts to schedule a visit. Disenrolled clients can re-enroll at their request within their pregnancy or within the first twenty-four (24) months after deliver.

H. Ensure coordination with other home visiting programs as applicable.

210.500 Required Rural Life360 Care Coordination Activities 1-1-23

The **Rural Life360** will provide the following community screening and referral supports to the general population and care coordination to identified clients.

A. Create a plan and employ staff to screen anyone in the community for SDOH needs and provide support for community providers to complete and submit SDOH screens for the people they serve.

B. Connect individuals whose SDOH screen identifies a SDOH need to local medical and non-medical resources, including food, housing, and transportation.

C. Accept referrals for care coordination supports for eligible clients from health care providers treating individuals with mental illness or substance use disorder.

The **Rural Life360** will provide the following healthcare capacity building activities:

A. Develop and operate acute crisis unit or psychiatric unit beds for individuals in need of mental health or substance use disorder crisis services in the Rural Life360 hospital. The

Rural Life360 hospital must begin acute crisis unit or psychiatric services within the timeframe approved by DMS.

The **Rural Life360** will provide the following care coordination supports:

A. Determine and verify eligibility under 210.100 for individuals referred or identified for intensive care coordination supports.

B. Obtain a signed consent form from clients to share the client's personal information with DHS, partner organization, relevant community service providers, and relevant health care providers.

C. Provide intensive care coordination and coaching supports for enrolled clients. Intensive care coordination and coaching includes:

1. Collecting or completing SDOH screen upon client enrollment in Life360 and every six (6) months during program participation
2. Conducting an in-depth personal interview related to the health-related social needs identified in the screening and the barriers to resolving health-related social needs. Rural Life360 is responsible for developing the interview tool to be used, the implementation process and the staff training process for engaging clients
3. Developing and maintaining a person-centered action plan (PCAP) for each client that includes:
    a. The client's goals and preferences for addressing needs. Goals must include accessing a PCP and all needed medical providers and services. Goals also may include mental and emotional wellness, financial goals, applying for or completing workforce training or education programs, obtaining or maintaining employment, and obtaining or sustaining safe housing.
    b. Results of the SDOH screen and personal interview including strengths and relevant personal history, for example, criminal justice involvement.
    c. Plan for overcoming barriers for accessing services and for avoidance of non-emergency ED visits.
    d. Unmet needs for medical services and non-medical community supports and a plan for meeting those needs.
4. Working directly with clients and their families to improve their skills to be healthy physically, socially, emotionally and to thrive in their communities. Follow up supports may include the following activities as specified in the PCAP:
    a. Engaging clients in promoting their own health
    b. Coordinating with external medical and non-medical providers to connect clients with needed health services and community supports
    c. Assisting clients with applying for services including scheduling and completing assessments for entry into the PASSE program, if needed
    d. Assisting clients in obtaining services that reduce preventable utilization of emergency departments and inpatient hospital settings
    e. Increasing client engagement in educational and employment opportunities and other supports that reduce the risk of poverty
    f. Transporting clients to non-medical appointments. Life360 funds cannot be used for costs incurred transporting a client or assisting with transportation of a client to a job interview
5. Providing supports through any of the following:
    a. Home visits in such frequency as is necessary to assist the client meet his/her documented PCAP goals
    b. Office visits

c. Video-supported telemedicine visits

d. Telephone or text message contacts in conjunction with in-person visits

6. Documenting client's progress toward meeting goals established on person-centered action plan, including:

a. Weekly update of client and staff activities

b. Gaps in available community services

c. Responsiveness from client

d. Any completed or newly identified goals or unmet needs

210.600 Required Success Life360 Care Coordination Activities 1-1-23

The **Success Life360** will work with its partner organization to provide the following services:

A. Verify eligibility for individuals referred or identified for intensive care coordination and supports.

B. Obtain a signed consent form from client to share the client's personal information with DHS, partner organizations, relevant community service providers, and relevant healthcare providers.

C. Provide intensive care coordination and coaching supports for clients to include:

1. Collecting or completing a SDOH screen (upon client enrollment in Life360 and every six (6) months during program participation)

2. Conducting an in-depth personal interview related to SDOH identified in the screening and the barriers to addressing those needs. The Life360 is responsible for developing the interview tool to be used, the implementation process and the staff training process for engaging clients

3. Developing and maintaining a PCAP for each client that includes:

a. Client goals and preferences for addressing needs. Goals should address:

i. Obtaining a primary care physician and addressing unmet medical needs

ii. Mental and emotional wellness

iii. Financial needs, including applying for or completing workforce training or education programs

iv. Obtaining or maintaining employment, and

v. Obtaining or sustaining safe housing

b. Identified SDOH needs and personal interview results, including strengths and personal history if applicable, such as criminal justice involvement

c. Plan for overcoming barriers for accessing services and avoidance of non-emergent emergency department visits

d. Unmet needs for non-medical community supports and a plan for meeting those needs

4. Working directly with clients and their families to improve their skills to be healthy physically, socially, emotionally, and to thrive in their communities. Services may include the following activities as specified in the PCAP:

a. Engaging clients in promoting their own health

b. Coordinating with external medical and non-medical providers to connect clients with needed health services and community supports

c. Assisting clients in obtaining services that reduce preventable utilization of emergency departments and inpatient hospital settings

d. Strengthening client life skills and implement plan to maximize participation in

education, employment training and other supports that reduce the risk of poverty

e. Transporting clients to non-medical appointments. Life360 funds cannot be used for costs transporting a client or assisting with transportation of a client to a job interview.

5. Providing supports through:

a. home or community visits

b. office visits including career center

c. video-supported telehealth visits

d. telephone or text message contacts, though not exclusively so

6. Documenting client's progress toward meeting goals established in the PCAP, including:

a. Weekly update of client and staff activities

b. Gaps in available community services

c. Responsiveness from client

d. Any completed or newly identified goals or unmet needs

210.700 Program Funding **1-1-23**

After the startup phase and successful completion of readiness review, Maternal Life360 will receive the following payments:

A. A PMPM: global payment will be made to a Maternal Life360 to cover the costs of all home visiting services necessary to implement home visiting model fidelity and administrative costs of operating the program (staff recruitment and training, data collection and reporting, financial management, etc.). The global payment will be actuarially sound and made to each Maternal Life360 on a per member per month (PMPM) basis. The global capitation payment amount is determined by Arkansas Medicaid.

B. Transportation: An annual amount specified in the Life360 HOME agreement. DMS will divide the amount into equal monthly amounts and pay the Life360 monthly. The funding may be used for transportation costs incurred during home visits to clients, to transport clients to non-medical appointments (excluding transportation to job interviews), or to obtain other SDOH-related supports. Allowable uses of this funding include:

1. The purchase of vehicles for the Life360

2. Vehicle parts and maintenance for Life360 vehicles only

3. Gasoline for the Life360s travel

4. Bus travel, car rental, and taxi or other driver service for non-medical appointments for clients (excluding transportation to job interviews)

5. Staff time for operating a vehicle for transporting clients to and from non-medical appointments.

210.800 Prorated Payments **1-1-23**

The **Maternal Life360** will receive a prorated PMPM for clients beginning upon client enrollment in in the Maternal Life360. Payments will be prorated for the number of days in the month from the client enrollment date.

Rural Life360s will receive three (3) additional types of payments following startup costs for:

A. Transportation: An annual amount specified in the Life360 HOME agreement. DMS will divide the amount into equal monthly amounts and pay the Life360 monthly. The funding

may be used for transportation costs incurred during home visits to clients, to transport clients to non-medical appointments (excluding transportation to job interviews), or to obtain other SDOH-related supports. Medicaid clients should utilize non-emergency transportation services for medical appointments. Allowable uses of this transportation funding include:

1. The purchase of vehicles for the Life360
2. Vehicle parts and maintenance for Life360 vehicle only
3. Gasoline for the Life360s travel
4. Bus travel, car rental, and taxi or other driver service for non-medical appointments.

B. Emergency Equipment and Training: In a monthly amount based on the approved annual program budget and specified in the Life360 HOME agreement. DMS will divide the annual amount by twelve (12) and pay the Life360 monthly up to the annual allotment amount. The funding may be used for costs related to improving emergency medical services in the rural communities that the Life360 serves, including enhanced equipment and staff training, and to support improvements in equipment necessary for the delivery of medical services through telemedicine. An accounting of these funds must be provided as part of the monthly expenditure reports.

C. Intensive Care Coordination: In a monthly amount based on the approved program budget and specified in the Life360 HOME agreement. DMS will pay an all-inclusive flat rate monthly to pay for assisting clients through intensive care coordination, one-on-one engagement, the cost of supervisors, and other program costs. The fee includes both direct program costs and indirect costs as outlined in the program payment section. Allowable uses include staff, equipment, and supports identified in startup plan and budget, and other uses approved by DMS. Time-limited expenses to enable a client to access services or supports to meet an identified SDOH also are allowable program costs. Refer to the glossary under SDOH reimbursable costs. The all-inclusive rate will include an amount up to 20 percent of the direct staff costs for indirect costs associated with managing the program.

D. Acute Care Unit Observation and Stabilization Staff: In a monthly amount based on the amounts listed in the rate sheet and specified in the Life360 HOME agreement. DMS will divide the annual amount used for costs related to maintaining continuous clinical staff in the acute care unit. This funding is intended to assist the hospital with paying for the ACU to be staffed and available even when patient services are not immediately needed.

Success Life360 will receive three additional types of payments following the startup payments:

A. Technology: an annual amount specified in the Life360 HOME agreement. DMS will divide the amount into equal monthly amounts and pay the Life360 monthly. The funding may be used for technology costs incurred to support data-sharing with partner organizations and providers that serve clients, including equipment, infrastructure, and technology and data services.

B. Intensive Care Coordination: In an annual amount based on the approved program budget and specified in the Life360 HOME agreement. DMS will pay an all-inclusive flat rate monthly to pay for assisting clients through intensive care coordination, one-on-one engagement, the cost of supervisors, and other program costs. The fee includes both direct program costs and indirect costs as outlined in the program payment section (See 230.000, Payment Details). Allowable uses include staff, equipment, and supports identified in startup plan and budget, and other uses approved by DMS. Time-limited expenses to enable a client to access services or supports to meet an identified SDOH also are allowable program costs. Refer to the glossary under SDOH reimbursable costs. The all-inclusive rate will include an amount up to 20 percent (20%) of the direct staff costs for indirect costs associated with managing the program.

C. Success Payments: DHS will award a success payment to the Life360 for each client who achieves the following goal(s):

1. Clients who were formerly in the custody of the DHS Division of Youth Services or the Arkansas Department of Corrections remain out of the judicial system (no arrests or criminal charges) and out of incarceration for twelve (12) consecutive months after enrollment in the Life360.

2. Attains an educational diploma, certificate, or degree, including a General Educational Development certificate, high school diploma, associate degree, certificate program through an accredited institution of higher education, or completes a workforce training, trade, or other work certification program after enrollment in the Life360.

3. Achieves full-time employment and maintains it for twelve (12) consecutive months after enrollment in the Life360.

4. Maintains full-time employment for twelve (12) consecutive months after enrollment in the Life360.

5. Clients who have a diagnosis of SUD maintain sobriety for twelve (12) consecutive months as confirmed by a treatment program, rehabilitation program, sponsor, or support group leader after enrollment in the Life360.

Success Life360s will inform DHS of any clients who have achieved any of these milestones. DHS will review and determine whether the Life360 may receive one (1) or multiple success payments for a single client who achieves in more than one (1) category. The amount of the payments will be established annually and published in the Life360 HOME agreement. Life360s may provide enrolled clients nominal incentives valued at no more than two-hundred and fifty dollars ($250) annually for achieving milestones or goals.

Maternal, Rural and Success Life360 expenditures will be subject to audit.

210.900 Acceptable Performance and Performance Measures 1-1-23

Life360's supports must meet acceptable performance, which will be determined based on whether it has been able to fulfill the program requirements and performance measures outlined in the Life360 HOME agreement with DMS, including:

A. Serving the targeted number of clients, number of visits, number of individuals screened, as specified in the Life360 HOME agreement

B. Meeting all reporting requirements specified in the Life360 HOME agreement in the specified timelines

C. Client avoidance of non-emergent use of an emergency department for twelve (12) months; and

D. Demonstrating client success as evidenced by meeting annual targets outlined in the Life360 provider agreement.

Life360 performance measures are proposed and subject to change based on the final evaluation and monitoring plan approved by CMS.

DHS will ensure that Life360s meet acceptable performance and that action is taken to address any identified non-compliance with Life360 funding parameters. If DHS determines that a Life360 has failed to demonstrate appropriate performance, including enrolling an insufficient number of clients, DHS may impose corrective actions that could include:

A. A corrective action plan

B. Caps on funding

C. Recoupment of funds

D. Discontinuation of Life360 funding

DHS also may impose corrective actions for a Life360 if it determines the Life360 is out of compliance with requirements included in the Life360 HOME agreement and/or policy letters or guidance set forth by DHS or CMS ARHOME 1115 Demonstration Special Terms & Conditions or the CMS 1915(b) Standard Terms & Conditions. Prior to initiating any corrective action on a provider, DHS shall provide the provider notice and an opportunity to comment regarding the identified area of non-compliance.

220.000 DELIVERY OF SERVICES

220.100 Life360 Client Engagement 1-1-23

This manual is not exhaustive of what will need to be in place to ensure consistency and integrity of services provided to Life360 clients. Programs are expected to establish policies and procedures prior to implementation to ensure successful client engagement, safety, and adherence to all applicable laws and/or requirements in serving clients. To that end, Life360s will be responsible for ensuring the following guidance for services as well as any requirements contained in the Life360 HOME agreement, or in this manual pertaining to provision of services, are incorporated.

220.200 Consent 1-1-23

Each client who is confirmed eligible by the Life360 will complete a consent form prior to intensive care coordination services beginning. Clients must be informed of relevant program policies and procedures relative to their participation in the program including client and staff safety, confidentiality, how long/frequent services are available, program expectations, and that services are voluntary. This program communication must be approved by DHS.

The program must notify clients at the time of consent if there will be a delay in starting services for any reason (i.e., program at capacity, facility, or staff issue), inform the client of the wait time, and the referral partner, if applicable. The Life360 should connect waiting clients with other supports/services until Life360 services may begin. Life360s will not receive a PMPM payment for clients awaiting Life360 services. The Life360 must notify its referral network when clients cannot be assigned to a care coordinator due to capacity or other factors. The Life360 must notify DHS if the program is delaying services for new clients or suspending services to existing clients. The notification must be made within five days of denying or suspending services to eligible clients.

220.300 Duration of Services 1-1-23

The total length of time in which clients can receive intensive care coordination services is as follows:

A. **Maternal Life360** - Services begin during pregnancy through home-visiting and continue up to two years after birth of the baby for clients enrolled in a QHP through ARHOME and one year for clients enrolled in any other Medicaid category of assistance and based upon continued need of home-visiting support.

B. **Rural Life360** - Services can be provided by care coordination coaches for up to twenty-four (24) months if the individual is actively working towards his or her goals and the individual remains eligible for the ARHOME program. DMS may extend the amount of time someone is eligible for a Rural Life360 based on a review of goals and progress toward those goals. If an enrolled client moves to another Medicaid aid category, the client will be disenrolled from the Rural Life360 program.

C. **Success Life360** – Services are based upon PCAP goals, and obtainment of goals is expected to be achieved in twenty-four (24) months or less. Services provided by Life360 partner organizations may remain in place at lesser intensity for longer than twenty-four (24) months if PCAP goals have not been completed, the individual remains eligible for Success Life360 and is actively working toward achieving goals. If an enrolled client moves to another Medicaid aid category, the client will be disenrolled from the Success Life360 program.

220.400 Person-Centered Action Plan (PCAP) 1-1-23

Rural Life360 and **Success Life360** clients will develop an individualized person-centered action plan (PCAP) facilitated by their care coordination coach or community partner organization to address health needs and SDOH. The PCAP will be updated regularly to reflect goals met, new circumstances or needs, annually at a minimum. The PCAP must describe the client's strengths, preferences, and SDOH as identified by the SDOH screen as well as needs for linkage with medical providers. The plan must include short-term (less than 6 months) goals, a crisis plan, and longer-term goals (more than 6 months). Each PCAP must include goals in areas identified through screening and ongoing interaction with the client, including:

A. Safe housing including utilities, if necessary

B. Food security and nutrition

C. Employment and/or education

D. Financial stability and any needed social services

E. Health and emotional wellness

F. Establishing a relationship with a PCP and all needed healthcare providers for preventative care (and to avoid non-emergent emergency department visits)

G. Criminal justice involvement, if applicable

H. Transportation

Maternal Life360 will implement the approaches of the evidence-based model selected and/or processes set by the program that utilize best practices and tools for quality and effectiveness of home visits and to document observations and assessments of maternal/child health and any other family outcomes included. Therefore, a separate PCAP will not be required.

220.500 SDOH Screening and Other Assessments 1-1-23

A SDOH screening will be conducted with every Life360 client as part of the initial eligibility determination within fifteen (15) calendar days of referral and every six (6) months during program participation. This screening also starts the process to identify areas for intensive care coordination. The screening should be done in a manner that is consistent, or asks the same questions across individual clients, is accessible or engaging for the client, and is coordinated with any additional screening and assessment that may part of the program. The screening tool must address the following core elements.

A. Housing instability

B. Food insecurity

C. Utility needs

D. Interpersonal safety

E. Transportation needs

F. Financial strain

G. Employment

H. Family and community support

I. Education

J. Physical activity

K. Substance use

L. Mental health

M. Disabilities

DHS will review the screening tool(s) during the application process. DHS may provide feedback on the tools and require revisions to ensure alignment with program goals. If a Life360 changes its SDOH screening tool, it must submit its new tool before making the change to DHS for approval. Life360s may only change screening tools at the beginning of a calendar year.

220.600 Intensive Care Coordination 1-1-23

Care coordination will be conducted by:

A. Home-visiting staff who meet the qualifications of the evidence-based home-visiting model the Life360 implements for the Maternal Life360 program

B. Care coordination coaches for the Rural Life360 program who are vetted and approved by the hospital. Individuals may be a peer or someone with lived experience, and/or an individual familiar with local resources

C. Staff or volunteers vetted and approved by community partner organizations for Success Life360 program

The individuals in these roles are expected to form a trusting relationship with the client and serve as a significant source of support to the client. Individuals in these roles will meet with the client as frequently as needed and provide life skills development and training as appropriate and directly connects the client with medical, educational, and social services and supports needed to meet the client goals. They also will actively assist the client in obtaining services and supports, communicating with providers about referrals and outcomes of services and supports, encourage and motivate the client to set and attain goals and meet milestones, and provide advocacy as needed.

220.700 Frequency and Duration 1-1-23

Frequency of interaction, or how much time lapses in between, is to be determined based on the selected program model or evidence-based, home-visiting model. Meetings/visits with client should be based on the client's needs and occur consistently. The duration of client meetings/visits (i.e., one (1) hour) should be sufficient to address client needs, follow any program model guidance or policies, and be flexible enough to accommodate the client's work schedule/life circumstances.

220.800 Setting and Location 1-1-23

Intensive care coordination may be delivered in the client's home, or in the community, medical clinic, behavioral health clinic, or hospital settings. For some clients, services may occur in a shelter setting or educational/job training settings. Video supported telehealth visits also may be

appropriate, particularly for **Rural Life360** or clients being served in remote areas or for clients experiencing contagious illness.

220.900 Client Termination of Services 1-1-23

A client may terminate services at any time by informing the DHS enrollment broker or Life360 provider if they no longer wish to participate. Clients may be allowed to re-enroll at any time if they remain eligible for the program.

Life360s must disenroll clients for the following reasons:

A. Client moved outside of the program's service area

B. Client is living in an institution for more than thirty (30) days

C. Client is incarcerated or in jail

D. Client has died

E. Client has an illness that does not allow for continued participation

F. Client continues to display disruptive or unsafe behavior that threatens staff safety

G. Client is no longer eligible for the program

H. Client stops participating in services for thirty (30) days and is non-responsive to Life360 contact efforts

I. Other reasons approved by DMS

If the reason for disenrollment is failure to participate in the program, the Life360 must attempt to contact the client at least three times before moving forward with disenrollment. The Life360 must provide notification of disenrollment to DHS for E, F, H, and I that provides the reason for the disenrollment and supporting information.

Life360s may not terminate services because a client is experiencing homeless or housing instability. The Life360 or its community partner organization should work with the client to identify resources to move toward stable housing as well as arrange other settings for meetings where client confidentiality can be maintained and that are safe. Clients who enter a residential treatment program or who may have an illness for a brief period (60 days or less) can be temporarily suspended in the program and resume when the client is able to participate in services.

220.950 Documentation of Intensive Care Coordination in Client File 1-1-23

Providers must develop and maintain sufficient written documentation for each client being served. This documentation, at a minimum, must consist of:

A. Signed consent by client, or client's legal guardian, to receive services and share data with DHS, community partners

B. Date services begin and referral documentation

C. A copy of all PCAPs, home-visiting assessments, and SDOH assessments

D. Services or supports rendered or obtained by client

E. Referrals and outcomes of referrals for SDOH

F. The date and time intensive care coordination occurs

G. The name and title of the individual who provided the service

H. Updates for each client contact describing the client's progress toward milestones and goals and any concerns/issues with engagement

I. Completed forms as required by DHS or other entity

Additional documentation and information may be required depending on the service to be provided.

230.000 PAYMENT DETAILS

230.100 Allowable Life360 costs 1-1-23

Subject to the funding limits in the ARHOME 1115 Waiver, DHS will review, approve, and make payments for Life360 funding in accordance with the requirements in the 1115/Life360 Special Terms and Conditions. DHS will make payments directly to the approved and enrolled hospitals. Life360 funding must not supplant funding provided by other federal, state, or local funding sources.

Providers must attest during readiness review to DHS that they have appropriate fund controls to correctly submit payment for Life360 funding that is separate from medical services paid for by Medicaid, Medicare, other insurance, and any other third-party payer. Expenditure authority will make funding available to selected Medicaid-enrolled hospitals for:

A. Intensive care coordination service for target populations, including direct costs of recruiting, training, and employing care coordinators to provide intensive care coordination to the targeted Life360 population

B. Indirect costs necessary to support ongoing project costs such as information technology or personnel directly responsible for the project including fiscal, programmatic, etc.

C. Startup costs necessary for the development of capacity, infrastructure, and systems to begin the program, complete a community network assessment, and formulate partners/subcontractors, and

D. Nonmedical client supports as outlined in this manual.

Medical care costs are not reimbursable and should be billed as usual through the client's Medicaid program.

More details on included costs for each type of Life360 are described in 210.700, Program Funding.

Capital improvement costs beyond specific allowed costs included in the start-up period are not allowable. Please refer to SDOH-reimbursable costs in this manual in 240.000, Glossary and in 210.700, Program Funding sections for more details on allowable expenditures.

230.200 Maternal Life360 Monthly PMPM Fee 1-1-23

A. Arkansas Medicaid will pay the Maternal Life360 a per member per month (PMPM) fee based on the established program rates.

1. Providers must enroll clients to receive the PMPM payment for each enrollee and do not have to submit claim for reimbursement for the PMPM fee.

2. Refer to the Rate Sheet for the current fee. Fees will be updated based on rate review on an as needed basis.

B. Monthly transportation fees will be paid to the hospital's provider ID.

C. Programs will be able to reconcile cost differences at the end of the year (or more frequently) based on any changes to their program that may warrant a rate adjustment within the established program rate structure.

230.300 Rural Life360 Payment Instructions 1-1-23

Payment will be made to the hospital's provider ID and per terms of the Life360 HOME agreement.

Instructions by cost type:

A. Care Coordination: Upload into MMIS or forward to the fiscal agent's claims department the completed monthly cost report using an excel budget spreadsheet or other approved form. Report should be for the actual cost of care coordination services and indirect costs for that month. Note the amount may vary based on ongoing expenditures/costs but will not exceed the total approved annual budget in the Life360 HOME agreement.

B. Transportation/Emergency Equipment and Training: Prepare and submit a monthly cost report invoice for the prorated annual transportation and emergency services.

C. Startup: Programs shall provide start-up cost(s) once they have a letter from DHS acknowledging successful completion of the application or readiness review. Startup costs will be reported monthly.

230.400 Success Life360 Payment 1-1-23

Instructions by cost type:

A. Care Coordination: -Upload into MMIS or forward to the fiscal agent's claims department the completed monthly cost report using an excel budget spreadsheet or other approved form. Cost report should be for the actual cost of care coordination services and indirect costs for that month. Note the amount may vary based on ongoing expenditures/costs but will not exceed the total approved annual budget in the Life360 HOME agreement.

B. Technology: Prepare and submit a monthly report for the prorated annual technology costs.

C. Success payments: At the end of each year, Life360 will submit a request for payment for the number of clients who have been approved for Success payments by DHS and/or its partner. See Program Funding section for more details.

D. Startup: programs shall receive payment for the approved startup cost(s) once they have a letter from DHS acknowledging successful completion of the application or readiness review. Startup costs will be reported monthly.

240.000 GLOSSARY

Acute care hospital means a hospital that:

A. Is licensed by the Department of Health under § 20-9- 19 201 et seq., as a general hospital or a surgery and general medical care hospital; and

B. Is enrolled as a provider with the Arkansas Medicaid Program.

Birthing hospital means a hospital in this state or in a border state that:

A. Is licensed as a general hospital;

B. Provides obstetrics services; and

C. Is enrolled as a provider with the Arkansas Medicaid program.

Care coordination coaches mean those individuals who establish relationships with their clients to ensure effective participation in the Rural Life360 program. Coaches may work under various titles including peer specialists, peer counselors, family support workers, and home visitors. They work directly with clients and their families to improve their life skills to be physically, socially, and emotionally healthy to live successfully in their communities.

Client means an eligible individual who receives care coordination and related support through a Life360.

Community services mean any resource or services provided by public or private organizations to community residents to assist with a particular social need such as mental health or counseling or health-related needs including housing or food or job training and employment. It may also include other general services or programs offered through libraries or other local government funding that benefit the community.

Evidence-based home visitation means a home visitation program that is based on one of the models recognized by the U.S. Department of Health and Human Services to be effective in improving maternal and child health.

Healthcare coverage means coverage provided under this subchapter through either an individual qualified health plan (QHP), a risk-based provider organization, managed care organization, employer health insurance coverage, or the fee-for-service (FFS) Medicaid program.

High-risk pregnancy means a pregnancy with a diagnostic code of supervision of high-risk pregnancy, as evidenced by a physician or Advanced Practice Registered Nurse (APRN) referral. High-risk diagnosis includes medical and/or social risk.

Home-visiting means an evidence-based program that provides direct support and intensive care coordination of services for clients served by Maternal Life360s with the goals of improving maternal and infant health outcomes, promoting child development and school readiness, connecting families to needed community resources and supports, and increasing a family's education and earning potential.

SDOH reimbursable cost means time-limited expenses to enable a client to access services or supports to meet an identified SDOH allowable under Life360. These must be identified through a Social Determinants of Health (SDOH) screening, or the client's engagement with the care coordinator, and are transitional in nature. Examples include housing safety inspections, pest control, security deposit and first month's rent that is required to obtain a lease on an apartment or home, and nutritional instruction for disease control/prevention.

SDOH screening means a standardized way of capturing a Life360 client's health-related social needs to determine any needs or barriers a client may experience at the time of screening. For example, an individual may have trouble paying rent on time and be at risk of losing their apartment. A pregnant individual may experience difficulty going to her doctor's appointments due to not having a car and lack resources for food. Information gathered through the screening may be used to help inform care coordination plans or referrals to community services and supports.

Individual Qualified Health Plan (QHP) means an individual health insurance benefit plan offered in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations.

Intensive care coordination is an umbrella term for a collaborative process in which a care coordinator or others assess, plan, implement, coordinate, monitor and evaluate the options, services and supports required to meet the client's health and SDOH needs. It is characterized by advocacy, communication, and resource management, and promotes quality interventions

and outcomes. In addition to addressing medical services, care coordination coaches ensure that clients have safe housing, employment, education, financial stability, and emotional/mental wellness.

Mental illness refers to clients with a diagnosis of one or more of the following: neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma- and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, and personality disorders.

Non-Reimbursable Community Contribution (NRCC) means a payment, including an in-kind payment, for goods or services provided to a client to assist the client with meeting a SDOH identified in the client's person-centered action plan but is not a SDOH-reimbursable cost or reimbursable through other Medicaid funds under the Life360 HOME agreement. NRCC may include rent or utility costs for example, or excluded categories (i.e. job preparation expenses such as clothing or personal care). The identification of sources of NRCC and the types of NRCC provided shall be included in the application and in program reports.

Partner agreement means the sub contractual agreement executed between the Life360 and its partner subrecipients. The subrecipient has its performance measured against whether the objectives of the program as outlined in the Life360 HOME agreement between DHS and the Life360 are met; has responsibility for programmatic decision-making; and uses funds to carry out the program by providing goods or supports to clients. Subrecipients are identified in the application and in programmatic and financial reports. Additional subrecipients can be requested during the program period by contacting the Life360 program manager at DHS. Subrecipients will need to be updated into the Life360 HOME agreement.

Person-Centered Action Plan (PCAP) means a plan completed by the Life360 that identifies a client's strengths, preferences and includes information from the SDOH screen and additional information gathered from the client through meetings and any other tools utilized by the program. The PCAP includes short and longer-term goals and objectives to address the client's SDOH and other personal goals as well as details on how and what services and supports will be obtained, a crisis plan, and documentation of progress on goals and successes and barriers encountered. The PCAP is updated as the client meets goals, circumstances change, or the sets new goals.

Life360 HOME agreement means the administrative instrument to be executed between the Arkansas Department of Human Services (DHS) Division of Medical Services (DMS) and an Arkansas Medicaid enrolled hospital Life360 provider.

Referral network agreement means an agreement or memorandum of understanding (MOU) between the Life360 and medical providers, community organizations, and social services organizations serving the target population to make referrals of potential clients to the Life360 and will accept referrals from the Life360.

Rural area means an Arkansas county where a hospital designated as a critical access hospital or participant in the Small Rural Hospital Improvement Program is located or an Arkansas county with a population of fifty-thousand (50,000) or less.

Small rural hospital means a critical access hospital or a general hospital that:

A. Is located in a rural area;

B. Has fifty (50) or fewer staffed beds; and

C. Is enrolled as a provider in the Arkansas Medicaid program.

Social Determinants of Health (SDOH) means conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Vendor means an entity that operates in a competitive environment to provide similar goods and services to different purchasers and receives payment from a Life360 for a good or service that is ancillary to the operation of the program or does not have a partner agreement with the Life360. Vendor expenditures are identified separately in financial reports.

Veteran means a person who served in the active military, naval, or air service and who was discharged or released there from as verified by DD214 documentation.

Facesheet: 1. Request Information (1 of 2)

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

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

Short title (nickname)	Long title	Type of Program	
Life360	Maternal Life360 HOME	FFS;	

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

Maternal Life360 HOME

C. Type of Request. This is an:

☒ **Initial request for a new waiver.**

☐ **Migration Waiver** - this is an existing approved waiver
Provide the information about the original waiverbeing migrated

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: (mm/dd/yy)

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

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

Draft ID:AR.059.00.00

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

Proposed Effective Date: (mm/dd/yy)

01/01/23

Proposed End Date:12/31/24

Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.

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

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

Name:

Elizabeth Pitman

Phone: (501) 244-3944 **Ext:** ☐ **TTY**

Fax:

E-mail:

elizabeth.pitman@dhs.arkansas.gov

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

☐ **Maternal Life360 HOME**

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

Section A: Program Description

Part I: Program Overview

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

There are no federally recognized tribes in Arkansas.

Program History required for renewal waivers only.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

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

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

   ☐ **Life360**

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

   ☐ **Life360**

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

   ☐ **Life360**

   d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
   -- Specify Program Instance(s) applicable to this authority

☒ **Life360**

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

☐ **MCO**

☐ **PIHP**

☐ **PAHP**

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

☒ **FFS** Selective Contracting program

Please describe:

In January 2022, Arkansas Medicaid replaced the Arkansas Works program by implementing the Arkansas Health and Opportunity for Me program (ARHOME), which was passed by the Arkansas General Assembly as Act 530 of the 2021 Regular Session. ARHOME provides coverage for eligible individuals ages 19-64 who are in the Adult Expansion Group. As part of the new ARHOME program, Arkansas is creating a Maternal Life360 HOME program –that will create Community Bridge Organizations (CBOs) for women enrolled in ARHOME with a high-risk pregnancy. Maternal Life360 HOME (Maternal Life360) was developed to address the state's low-ranking in maternal and child health indicators. The goal of the Maternal Life360 HOME is to improve state maternal health and child health outcomes, particularly birth outcomes and other maternal health indicators.

Medicaid finances more than 60 percent of all births in Arkansas. To improve the state's ranking and the lives of moms and babies, Arkansas must focus on all high-risk pregnancies in the Arkansas Medicaid population, not just those in the ARHOME population. In Arkansas, Medicaid spends approximately $140 million each year on costs related to poor birth outcomes.

This waiver will expand the Maternal Life360 HOME program to pregnant women in any Medicaid aid category with a high-risk pregnancy. High risk pregnancy is defined as a pregnancy with a diagnostic code that requires supervision of high-risk pregnancy, as evidenced by a physician or Advanced Practice Registered Nurse (APRN) referral and includes medical and/or risk related to social determinates of health (SDOH). For eligible women, services can begin at any point during pregnancy and will continue up to one (1) year after the birth of the baby.

Expanding the Maternal Life360 HOME services to women with high-risk pregnancies in all Medicaid aid categories will promote greater use of preventative care services, reduce non-emergent use of emergency department services, lower the use of potentially preventable emergency department services, reduce the likelihood of preventable hospital admissions and readmissions, and result in improved birth outcomes for infants.

Only evidence-based home-visitation models—those defined as meeting the U.S Department of Health and Human Services department's criteria as an evidence-based home visiting service delivery model—will be used to support the mother and the child.

There are currently four evidence-based home-visiting programs in use in Arkansas that serve families at some point between pregnancy and the baby's first two years of life:

- Healthy Families America
- Nurse Family Partnership
- Early Head Start
- Parents as Teachers

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

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

   a. ☐ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
   -- Specify Program Instance(s) applicable to this statute

   ☐ **Life360**

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

   ☒ **Life360**

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

   ☒ **Life360**

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

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

   ☐ **Life360**

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

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

   ☐ **Life360**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

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

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

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

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

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

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

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

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

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

Please describe:

This FFS selective contracting waiver will expand the Maternal Life360 HOME program to pregnant women in any Medicaid aid category with a high-risk pregnancy. High risk pregnancy is defined as a pregnancy with a diagnostic code that requires supervision of high-risk pregnancy, as evidenced by a physician or Advanced Practice Registered Nurse (APRN) referral and includes medical and/or risk related to social determinates of health (SDOH). For eligible women, services can begin at any point during pregnancy and will continue up to one (1) year after the birth of the baby.

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

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

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

☐ **Procurement for MCO**

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

☐ **Procurement for PIHP**

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

☐ **Procurement for PAHP**

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

☐ **Procurement for PCCM**

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

☒ **Procurement for FFS**

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

Any entity that meets the licensure and provider requirements may participate. First, the entity must be licensed as a general hospital and be enrolled as an Arkansas Medicaid provider. Each entity must then apply to participate and be approved by DHS. Approved Life360s then will sign a Maternal Life360 Provider Agreement with DHS to enroll become a Maternal Life360 HOME.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

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

Section A: Program Description

Part I: Program Overview

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

1. Assurances.

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

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

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

Program: " **Maternal Life360 HOME.** *"*

☐ **Two or more MCOs**

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

☐ **A PCCM or one or more MCOs**

☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☐ **Other:**
please describe

Section A: Program Description

Part I: Program Overview

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

3. Rural Exception.

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

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

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

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

Section A: Program Description

Part I: Program Overview

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

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

Section A: Program Description

Part I: Program Overview

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

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- Specify Program Instance(s) for Statewide
     ☐ **Life360**
   - **Less than Statewide**
     -- Specify Program Instance(s) for Less than Statewide
     ☒ **Life360**
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)
To be determined based on hospitals approved to become Maternal Life360 HOMEs		

Section A: Program Description

Part I: Program Overview

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

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

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

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

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

☒ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
- ○ **Mandatory enrollment**
- ◉ **Voluntary enrollment**

☒ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
- ○ **Mandatory enrollment**
- ◉ **Voluntary enrollment**

☒ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
- ○ **Mandatory enrollment**
- ◉ **Voluntary enrollment**

☒ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
- ○ **Mandatory enrollment**
- ◉ **Voluntary enrollment**

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

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

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

○ **Mandatory enrollment**

◉ **Voluntary enrollment**

☒ **Other** (Please define):

Population to be served are pregnant women and girls receiving Medicaid in any category who are diagnosed with a high-risk pregnancy. The home visiting program will be the duration of the pregnancy and up to one year after the birth of the child (based on the mother's due date).

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

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

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

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

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

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

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

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

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

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

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

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

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

☒ **Other** (Please define):

Women must enroll in Life360 HOME during pregnancy. Women who have children older than one year of age are not eligible to receive services through Life360 HOME.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

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

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

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

1. Assurances.

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

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

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

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

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

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

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the

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

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

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

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

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

Emergency Services Category General Comments (optional):

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

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

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

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

☐ Other (please explain):

☒ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

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

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

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

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

FQHC Services Category General Comments (optional):

5. EPSDT Requirements.

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

EPSDT Requirements Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

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

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

7. Self-referrals.

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

Self-referrals Requirements Category General Comments:

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

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

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

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

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

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

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

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

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

To participate in the Maternal Life360 HOME waiver program, the provider must maintain fidelity to an evidence-based home-visiting model, including appropriately timed home visits in accordance with the guidelines set in this waiver. The guidelines provide flexibility for the visiting care coordinator to also consider the individual needs of the family when scheduling home visits. Hospitals enrolled as Maternal Life360 HOMEs will be required to develop and implement written policies and procedures to ensure clients receive timely access to appropriate home visit services tailored to the specific needs of each client. Whiles these policies and procedures are agency (Life 360 HOME) specific, the agency is responsible for ensuring the policies and procedures are consistent with the evidence-based home visiting model.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

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

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with

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

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

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

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

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

Please describe the enrollment limits and how each is determined:

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

Please describe the States standard:

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

Please describe the States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

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

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

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

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

Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

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

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

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

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

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

The Maternal Life360 Home services are services provided in an enrollee's home and their use does not impact bed availability in facilities or other services such as transportation.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

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

Section A: Program Description

Part II: Access

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

1. Assurances for MCO, PIHP, or PAHP programs

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

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

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

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

Section A: Program Description

Part II: Access

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

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

The following items are required.

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

Please provide justification for this determination:

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

Please describe:

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

Please describe the enrollment limits and how each is determined:

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

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

Please describe:

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

Please describe:

Section A: Program Description

Part II: Access

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

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

a. ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.

b. ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees overall health care.

c. ☐ Each enrollee is receives **health education/promotion** information.

Please explain:

d. ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. ☐ There is appropriate and confidential **exchange of information** among providers.

f. ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

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

h. ☐ **Additional case management** is provided.

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

i. ☐ **Referrals.**

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

Section A: Program Description

Part II: Access

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

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

The State does not anticipate any negative impact to coordination or continuity of care due to the fact that the Maternal Life360 HOME Visiting waiver program clients are not losing access to services, but rather are gaining additional services tailored to meet the needs of pregnant and new mothers. The Maternal Life360 HOME home visiting program is expected to improve the coordination and continuity of care for pregnant women who are at high-risk and their child by encouraging receipt of the appropriate prenatal care, postpartum care, and well child visit care.

Section A: Program Description

Part II: Access

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

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

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

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

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

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

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

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

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

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

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

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

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

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

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

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

   Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

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

The Letter of Intent (LOI) must include proposed service area, estimated number of clients the hospital expects to serve with home-visiting supports, the evidence-based home-visiting model the hospital will use and whether hospital will use its own staff to conduct all home-visiting or partner with an external organization to provide home-visiting.

After approval of the LOI, the hospital will submit the Life360 HOME application that includes the program narrative; community analysis and capacity-building plan; plan for community outreach, education, and client communication; description of proposed referral network, plan for monitoring client milestones and goals and collecting data on client outcomes, and monitoring other quality improvement measures identified by DMS; startup and first year program budget and narrative justification; and signed agreements with community partner organization, pending approval of the Life360 application.

For approved applications, the selected applicant will receive startup funding and will be in the startup phase. Each Life360 must complete the startup phase within the specified timeframe set by the Life360 Home Agreement. During the startup phase, DMS and the selected applicant will meet monthly to assess progress toward readiness review. DMS will schedule readiness review at the end of the startup phase.

After approval of the application and completion of the startup phase, DMS or its contractor will conduct a readiness review to determine the applicant's readiness to begin providing services to clients. Readiness review will include an onsite visit to each location. Each selected applicant also will demonstrate that it is operationally ready to fulfill all Life360 requirements including having enroll clients, report required data to DMS, administer SDOH screening, and link clients to resources. The applicant must also show that it has adequate staffing levels, a fully executed community partner agreement (if using a partner), a process for accepting and transferring protected health information and fund controls to correctly submit payment for Life360 Home funding that is separate from medical services paid for by Medicaid, Medicare, other insurance, and any other third-party payer.

Following the successful completion of the readiness review, DMS will enroll the hospital as a Life360 provider and enter into the "Life360 Home Provider Agreement".

During the first year of the waiver program, the State will assure quality through continuous monitoring of program implementation and process measures. Specifically, the Maternal Life360 HOME providers will be required to ensure that all services provided are provided by home visitors who meet the criteria for the evidence-based model being used to deliver services. In addition, the Maternal Life360 HOMEs and DMS will conduct regular monitoring to ensure the Maternal Life360 Home is in compliance with all program and provider agreement requirements.

The State will to track and monitor quality outcomes for purposes of conducting and concluding the rigorous independent evaluation of the Maternal Life360 Home program. As part of the performance review of the project, the state will collect and analyze quality data, including birth outcomes, rates of deliveries by elective C-section, use of preventative and other primary care services, use of emergency department services for non-emergent care, use of potentially preventable emergency department services and preventable hospital admissions, Medicaid expenditures among mothers and children up to one year after birth and improvements in health-related social needs.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

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

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

listed for PIHP or PAHP programs.

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

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

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

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

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

Please list types of indirect marketing permitted:

Each Life360 HOME may have a website for information regarding its home visiting services, referral network, and community resources. This website may be linked to the DHS Life360 HOME webpage and is designed to provide information for clients when making a decision to enroll in a Life360 program. The Life360 HOME may also produce written marketing materials to distribute to enrollees and potential enrollees.

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:

Medicaid or ARHOME qualified health plans may send mailers, postcards or emails to clients identified as potential Life360 clients based on high risk pregnancy diagnosis code reported indicated through claims data.

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

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

1.

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

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

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

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

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

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

The Maternal Life 360 Home Providers will be required to provide all allowable written marketing materials in English, Spanish, and Marshallese if, in any county in the Life360's service area, the county population is comprised of at least 3% or more of individuals who speak the language.

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

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

Please describe the methodology for determining prevalent languages:

b. ☒ The languages comprise all languages in the service area spoken by approximately 3 percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

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

Section A: Program Description

Part IV: Program Operations

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

1. Assurances

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

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

2. Details

a. Non-English Languages

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

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

The Maternal Life360 HOMEs will be required to provide all potential waiver enrollees and enrollee materials in Spanish and Marshallese, or any other prevalent non-English language that may be identified by the State in any county in the Life360 HOME's service area.

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

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

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

Please explain how the State defines significant.:

b. ☒ The languages spoken by approximately 3.00 percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

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

When oral translation services are required, the language is identified, the Maternal Life360 HOMEs will be contractually required to provide language interpreter and translation services to a client in the program, free of charge, who needs such services.

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

Please describe:

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☒ State

☒ Contractor

Please specify:

Maternal Life360 HOME

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

Section A: Program Description

Part IV: Program Operations

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

2. Details (Continued)

c. Enrollee Information

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

☒ the State

☐ State contractor

Please specify:

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

Section A: Program Description

Part IV: Program Operations

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the States enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

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

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

Referral Network and Outreach

Each Maternal Life360 must identify community medical providers, community service organizations, and social service providers to serve as a referral network. The Maternal Life360 Home must work with providers located in the identified service and are able to identify clients in need of Life360 supports. The Maternal Life360 Home must enter into "Referral Network Agreements" with each referral entity to ensure the exchange of health information is protected. Prior to implementation and as part of the readiness review process, DMS will review the agreements.
Outreach materials will be developed by DHS, Office of Communications and Community Engagement (OCCE) with the information about the Maternal Life360 HOME program and services provided. Those materials will be available for distribution and will be available on the DHS website.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☐ State staff conducts the enrollment process.

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

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

Broker name: To be determined

Please list the functions that the contractor will perform:

☐ choice counseling

☒ enrollment

☒ other

Please describe:

Each Maternal Life360 HOME will share eligibility verification efforts with the enrollment broker. Once all verifications are complete, the enrollment broker will assign clients to the Life360 HOME.

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

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

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

☒ This is a **new** program.

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

Sept. 1, 2022 – Begin accepting letters of intent from hospitals that want to become a Life360
Oct. 1, 2022 – Begin accepting applications from applicant hospitals. Submit final waiver to CMS for approval.
December 2022 – Begin readiness reviews for selected hospital applicants that have signaled they are ready for such a review.
Upon approval by CMS and the Arkansas Legislature, launch Maternal Life360s and begin enrolling pregnant mothers.

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

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

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

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

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

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

☐ The State automatically enrolls beneficiaries.

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

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

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

Please specify geographic areas where this occurs:

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

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

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

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

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

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

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

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

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

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

Please describe the reasons for which enrollees can request reassignment

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

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

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

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

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

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

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

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

be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

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

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

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

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

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

   ☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the

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

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

a. Direct Access to Fair Hearing

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

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

b. Timeframes

☐ The States timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is [ ] days (between 20 and 90).

☐ The States timeframe within which an enrollee must file a **grievance** is [ ] days.

c. Special Needs

☐ The State has special processes in place for persons with special needs.

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. Optional grievance systems for PCCM and PAHP programs. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollees freedom to make a request for a fair hearing or a PCCM or PAHP enrollees direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

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

☐ the State

☐ the States contractor.

Please identify: [ ]

☐ the PCCM

☐ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

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

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

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

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

☐ Has time frames for resolving requests for review.

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

☐ Establishes and maintains an expedited review process.

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

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

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

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

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

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

The prohibited relationships are:

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

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

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

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

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

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

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

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☒ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

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

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Access

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

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

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

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

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

Please note:

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

Summary of Monitoring Activities: Evaluation of Quality

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

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

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

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

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

Programs Authorized by this Waiver:

Program	Type of Program
Life360	FFS;

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

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Maternal Life360 HOME

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

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

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

Activity Details:

☐ **NCQA**
☐ **JCAHO**
☐ **AAAHC**
☐ **Other**
Please describe:

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

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☐ **Consumer Self-Report data**

Activity Details:

☐ **CAHPS**

Please identify which one(s):

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

- Personnel responsible: DHS Division of Medical Services, with data collected by DHS Office of Appeals
- Detailed description of activity: DMS will monitor disenrollments by reason code (e.g., client's service window expires (one year after baby's birth), client request, Life360 HOME request, etc.
- Frequency of use: quarterly
- How it yields information about the area(s) being monitored: These data will help us understand whether the Life360 HOMEs are handling eligibility and enrollment appropriately and whether clients are disenrolling in disproportionate numbers compared with other Life360 HOME programs.

☐ **Denials of referral requests**

☒ **Disenrollment requests by enrollee**

☒ **From plan**

☐ **From PCP within plan**

☒ **Grievances and appeals data**

☐ **Other**

Please describe:

e. ☒ **Enrollee Hotlines**

Activity Details:

- Personnel responsible: DHS's call center contractor
- Detailed description of activity: DHS's call center contractor is already responsible for handling grievances. Life360 HOME enrollees will be informed of the phone number to call for any grievance they may have with the program.
- Frequency of use: Data on Life360 HOME grievances will be collected by DMS quarterly
- How it yields information about the area(s) being monitored: These data will help us understand client satisfaction with the Life360 HOME services.

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

Activity Details:

g. ☐ **Geographic mapping**

Activity Details:

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

Activity Details:

- Personnel responsible: DHS will procure an independent contractor to conduct an independent assessment of the Life360 HOME program
- Detailed description of activity: The activities will be designed by the contractor.
- Frequency of use: The assessment will be conducted once for the two-year waiver
- How it yields information about the area(s) being monitored: The independent assessment will help determine the impact on health outcomes, the cost effectiveness of the services and any issues to be addressed in program delivery.

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

Activity Details:

- Personnel responsible: DHS will procure an independent contractor to conduct an independent assessment of the Life360 HOME program that includes measurement of disparities by racial and ethnic groups served by the program.
- Detailed description of activity: The activities will be designed by the contractor.
- Frequency of use: The assessment will be conducted once for the two-year waiver
- How it yields information about the area(s) being monitored: The independent assessment will help determine whether disparities by racial or ethnic groups are present in the program's delivery and whether the program is successful in reducing maternal/child health disparities already present in the communities served by Life360 HOMEs.

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

Activity Details:

k. ☐ **Ombudsman**

Activity Details:

l. ☐ **On-Site Review**

Activity Details:

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

Activity Details:

☐ **Clinical**

☐ **Non-clinical**

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

Activity Details:

- Personnel responsible: The Life360 HOME is responsible for collecting and reporting data for performance measures. DMS or a DMS contractor will share some claims data from providers outside the hospital with the Life360 HOME
- Detailed description of activity: Data on the quality metrics below will be reported by each Life360 HOME to DMS.

- Frequency of use: Each Life360 HOME will be required to report performance metrics as outlined in the Life360 HOME provider agreement.
- How it yields information about the area(s) being monitored: The performance measures will help determine whether the services are being delivered as expected under the provider agreement, document health outcomes, and identify any issues to be addressed in program delivery.

☐ **Process**

☐ **Health status/ outcomes**

☐ **Access/ availability of care**

☐ **Use of services/ utilization**

☐ **Health plan stability/ financial/ cost of care**

☐ **Health plan/ provider characteristics**

☐ **Beneficiary characteristics**

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

Activity Details:

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

Activity Details:

- Personnel responsible: DMS will be the responsible party.
- Detailed description of activity: DMS will analyze Life360 HOME data on home visiting services provided and claims data in MMIS.
- Frequency of use: Analysis will occur at least annually
- How it yields information about the area(s) being monitored: The data will be used to determine utilization and to monitor program integrity, quality of care, and coverage of services by the Life360 HOMEs.

q. ☒ **Provider Self-Report Data**

Activity Details:

- Personnel responsible: The Life360 HOMEs are required to report specified data.
- Detailed description of activity: DMS will analyze Life360 HOME data, including the following information:
- Home visits
- Client milestone achievements
- PCP assigned
- Hospital admissions/re-admissions
- Emergent and non-emergent use of the emergency department
- Prenatal visits
- C-section rates
- Live births
- Pre-term/term births
- Birthweight
- NICU stays
- EPSDT visits
- Postpartum contraceptive care
- Frequency of use: At least quarterly
- How it yields information about the area(s) being monitored: The data will be used to determine utilization and to monitor program integrity, quality of care, and coverage of services by the Life360 HOMEs.

☐ **Survey of providers**

☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

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

Activity Details:

t. ☒ **Other**

Activity Details:

The Maternal Life360 HOMEs must submit all marketing and beneficiary communication materials to the SMA for review and approval prior to distribution. The SMA reviews for accuracy and compliance with the state and federal requirements.

Section C: Monitoring Results

Initial Waiver Request

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

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

This is an Initial waiver request.

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

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Pregnant Women	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	01/01/2010	12/31/2020	01/01/2021	12/31/2021
Enrollment Projections for the Time Period*	01/01/2023	12/31/2023	01/01/2024	12/31/2024
**Include actual data and dates used in conversion - no estimates *Projections start on Quarter and include data for requested waiver period				

Section D: Cost-Effectiveness

Services Included in the Waiver

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

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Maternal Life360 HOME	☐	☐	☒	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

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

b. Name of Medicaid Financial Officer making these assurances:

c. Telephone Number:

d. E-mail:

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☐ **MCO**
b. ☐ **PIHP**
c. ☐ **PAHP**
d. ☐ **PCCM**
e. ☐ **Other**

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. ☐ **Management fees are expected to be paid under this waiver.**
The management fees were calculated as follows.
1. ☐ **Year 1: $ per member per month fee.**
2. ☐ **Year 2: $ per member per month fee.**
3. ☐ **Year 3: $ per member per month fee.**
4. ☐ **Year 4: $ per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**
Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

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

d. ☐ **Other reimbursement method/amount.**
$
Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☐ Population in the base year data

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

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

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

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

No increase in membership is assumed from BY1 and BY2 to P1.

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

A 50% increase is membership is projected from P1 to P2. This increase reflects the addition of new Maternal Life360 homes as well as increased capacity of homes established in P1.

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

If multiple years are being used, please explain:

The based years are calendar year (CY) 2020 and CY 2021.

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

Base year data is on a CY basis.

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

The base year data is estimated using projected costs and inflation trend.

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

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

For Initial Waivers:

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

No services were excluded. It is estimated that the care coordination expenses for this population will be $300 PMPM based on the services provided by the Maternal Life360 homes.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Maternal Life360 HOME	☐	☐	☐	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. Appendix D5 should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administrative Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Maternal Life360 HOME			
Total:			

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

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

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

c. ☒ **Other**
Please explain:

Projected administrative costs include broker and member support fees. These costs were estimated based on costs from a similar PCCM program.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

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

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

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

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

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

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

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

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

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

Appendix D3 Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

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

1. ☒ [Required, if the States BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present)
The actual trend rate used is:
5.00
Please document how that trend was calculated:

Confirmed that trend is applied from the base period to P1. A 5.0% annual trend was assumed consistent with the trend assumed for services offered by Maternal Life360 Homes as part of the Arkansas' 1115 waiver for the ARHOME program.

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

i. ☐ State historical cost increases.
Please indicate the years on which the rates are based: base years

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

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

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

A 5.0% annual trend was assumed between P1 and P2 consistent with the trend assumed for the services offered by Maternal Life360 Homes as part of Arkansas' 1115 waiver for the ARHOME program.

3. ☐ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

Others:

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

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ☐ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i. ☐ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.

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

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

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

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

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☐ Other:
Please describe

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

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

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

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

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

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

D. ☐ Other
Please describe

iv. ☐ Changes in legislation.
Please list the changes.

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

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

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

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

D. ☐ Other
Please describe

v. ☐ Other
Please describe:

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

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

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

D. ☐ Other
Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

     - **A.** ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
     - **B.** ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP)
       Please describe

     - **C.** ☐ Other
       Please describe

   - **ii.** ☒ FFS cost increases were accounted for.
     - **A.** ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
     - **B.** ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
     - **C.** ☒ Other
       Please describe

       Administrative expenses are trended from the base period to P1 and from P1 to P2 at the same annual trend rate as the state plan service costs.

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

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

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

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

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

Please provide documentation.

2. ☐ [Required, when the States BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the States trend for State Plan Services.

i. State Plan Service trend

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

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

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

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

3. Explain any differences:

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

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

3. ☐ Other
   Please describe

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

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

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

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

Method:

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

1. ☐ Payments outside of the MMIS were made.
   Those payments include (please describe):

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

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

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

Basis and Method:

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

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

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

***Method*:**

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

Basis and method:

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

j. Pharmacy Rebate Factor Adjustment: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

***Basis and Method*:**

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

k. Disproportionate Share Hospital (DSH) Adjustment: Section 4721 of the BBA specifies that DSH payments must

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

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

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

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

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

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

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

Special Note Section:

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

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

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

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

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

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

Adjustment	Capitated Program	PCCM Program	

Section D: Cost-Effectiveness

Part I: State Completion Section

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

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

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

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

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

3. ☐ Other
Please describe

o. ***PCCM Case Management Fees (Initial PCCM waivers only)*** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on ***Appendix D5.***

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

p. ***Other adjustments:*** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

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

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 Waiver Cost Projection

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

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 RO Targets

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

Appendix D6 RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

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

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

Please see the discussion of enrollment changes in Section D.I.E.c.

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

Please see the discussion of trends in Section D.I.I.

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

Please see the discussion of trends in Section D.I.I.

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

Appendix D7 - Summary

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Human Services

DIVISION Medical Services

DIVISION DIRECTOR Elizabeth Pitman

CONTACT PERSON Mac Golden

ADDRESS P. O. Box 1437, Slot S295 Little Rock, AR 72203-1437

PHONE NO. 501-320-6383 **FAX NO.** 501-404-4619 **E-MAIL** Mac.E.Golden@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Elizabeth Pitman

PRESENTER E-MAIL Elizabeth.Pitman@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? Life360 HOME Program

2. What is the subject of the proposed rule? See Attached.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐

   If yes, please provide the federal rule, regulation, and/or statute citation. § 23-61-1001 (ARHOME Act 530)

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?

   Yes ☐ No ☒

   If yes, what is the effective date of the emergency rule? _____

   When does the emergency rule expire? _____

   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

   Yes ☐ No ☐

5. Is this a new rule? Yes ☒ No ☐
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☐ No ☒
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

See attached.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

7. What is the purpose of this proposed rule? Why is it necessary? See Attached.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:

Date: October 20, 2022
Time: 10:00am
Place: https://us02web.zoom.us/j/82030061926

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
November 7, 2022

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
January 1, 2023

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. See Attached.

13. Please provide proof of filing the rule with the Secretary of State as required pursuant to Ark. Code Ann. § 25-15-204(e). See Attached.

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. Unknown

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Human Services

DIVISION Medical Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE 501-320-6540 **FAX** _____ **EMAIL:** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Life360 HOME Program

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$	General Revenue	$
Federal Funds	$	Federal Funds	$
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	

Other (Identify)		Other (Identify)	
Total	$	Total	$

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$1,224,190	General Revenue	$3,219,284
Federal Funds	$5,239,310	Federal Funds	$13,651,716
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$6,463,500	Total	$16,871,000

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$	$

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 1,224,190	$ 3,219,284

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;
The Director of the Division of Medical Services (DMS) creates the Life360 HOME program to contract with hospitals to provide Medicaid clients in target populations with intensive care coordination services to ensure they are connected to medical services and nonmedical supports in their communities and to address their social determinants of health needs.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute**;**

This rule is necessary to:

- **Reduce the maternal and infant mortality rates in the state and reduce long-term costs;**
- **Reduce the additional risk for disease and premature death associated with living in a rural county;**
- **Strengthen financial stability of small, rural hospitals, and enhance access to medical services in rural counties;**
- **Fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;**
- **Increase their engagement in educational and employment opportunities among Medicaid beneficiaries most at risk for poor health outcomes associated with poverty;**
- **Reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings; and**

Increase the use of preventative care and health screenings

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

This rule is necessary to:

- **Reduce the maternal and infant mortality rates in the state and reduce long-term costs;**
- **Reduce the additional risk for disease and premature death associated with living in a rural county;**
- **Strengthen financial stability of small, rural hospitals, and enhance access to medical services in rural counties;**
- **Fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;**
- **Increase their engagement in educational and employment opportunities among Medicaid beneficiaries most at risk for poor health outcomes associated with poverty;**
- **Reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings; and**

Increase the use of preventative care and health screenings

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **N/A**

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **N/A**

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and **N/A**

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives. **The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.**

Statement of Necessity and Rule Summary
Life360 HOME Program

Why is this change necessary? Please provide the circumstances that necessitate the change.
DHS is creating the Life360 HOME program to contract with hospitals to provide Medicaid clients in target populations with intensive care coordination services to ensure they are connected to medical services and nonmedical supports in their communities and to address their social determinants of health (SDOH) needs. Life360's are designed to supplement not supplant existing supports and services. Medical care will continue to be delivered and billed as it currently is. This rule is necessary to:

- Reduce the maternal and infant mortality rates in the state and reduce long-term costs;
- Reduce the additional risk for disease and premature death associated with living in a rural county;
- Strengthen financial stability of small, rural hospitals, and enhance access to medical services in rural counties;
- Fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;
- Increase their engagement in educational and employment opportunities among Medicaid beneficiaries most at risk for poor health outcomes associated with poverty;
- Reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings; and
- Increase the use of preventative care and health screenings

What is the change? Please provide a summary of the change.

To achieve the above, the Division of Medical Services creates the Life360 HOMES Provider Manual, seeks a new 1915(b) waiver, and amends the State Plan. This rule provides for intensive care coordination services to high-risk Medicaid populations. The services include home visiting services for women with high-risk pregnancies and care coordination services for individuals in rural areas with mental illness or substance use disorder. The aim of the program is to improve maternal and child health outcomes, fill gaps in the continuum of care client with mental illness, and increase engagement in educational and employment opportunities among Medicaid clients most at risk for poor health outcomes associated with poverty. In addition, the State Plan is amended to provide women with high-risk pregnancies who are eligible for Medicaid, but are not in the New Adult Medicaid Expansion Group can receive home-visiting services through Arkansas's Life360 HOME program, authorized under the ARHOME Section 1115 waiver program; and allows for hospitals approved to provide Maternal Life360 HOME services can receive $300 per member per month for women enrolled in the Maternal Life 360 HOME who are enrolled in an Arkansas Medicaid aid category that is not the 06 ARHOME Medicaid aid category.

Please attach additional documents if necessary

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, 23-61-1004, and 25-10-129.

Effective January 1, 2023:

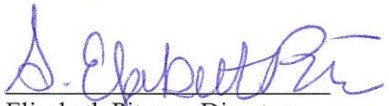
The Director of the Division of Medical Services creates the Life360 Manual and corresponding 1915(b) waiver, and amends the State Plan, to comply with Act 530 of the 93rd General Assembly. Act 530 directs that the Arkansas Health and Opportunity for Me Program reduces the maternal and infant mortality rates in the state through initiatives that promote healthy outcomes for eligible women with high-risk pregnancies and promotes the health, welfare, and stability of mothers and their infants after birth through hospital-based community bridge organizations; increases opportunities for full-time work and attainment of economic independence, to reduce long-term poverty that is associated with additional risk for disease and premature death; and addresses health-related social needs of Arkansans in rural counties through hospital-based community bridge organizations and reduces the additional risk of disease and premature death associated with living in a rural county. The State Plan Amendment also allows hospitals approved to provide Maternal Life360 HOME services can receive $300 per member per month for women enrolled in the Maternal Life 360 HOME who are enrolled in an Arkansas Medicaid aid category that is not the 06 ARHOME Medicaid aid category. The proposed rule estimates a financial impact of $6,463,500 ($5,239,310 of which is federal funds) for state fiscal year (SYF) 2023 and $16,871,000 ($13,651,716 of which is federal funds) for SYF 2024.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than November 7, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on October 20, 2022, at 10:00 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/82030061926. The webinar ID is 820 3006 1926. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-534-4138.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502100209



Elizabeth Pitman, Director
Division of Medical Services