DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services 7500
Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Managed Care Group

June 26, 2023

Jacey Cooper, Chief Deputy Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Re: California 1915(b) Waiver CA-17.10.01

Dear Director Cooper:

We are writing to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving California's request to amend its 1915(b) Waiver, CMS control number CA-0017.R10.01, entitled California Advancing and Innovating Medi-Cal. This waiver amendment allows California to limit plan choice in rural counties to participate either in the COHS or Single Plan models. The rural county model changes are being authorized under this section 1915(b) waiver amendment utilizing the rural exception under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b). This waiver amendment also includes language describing the direct contract with Kaiser Foundation Health Plan, allows for voluntary early adaptation of integrated contract structure for the Specialty Mental Health and DMC-ODS delivery systems, allows for streamlining TCM documentation requirements and updates language to align with the updated cost effectiveness workbook. This waiver amendment is approved effective January 1, 2024. The ability for California to effectuate the expanded COHS and Single Plan models in the Metro, Large Metro, and Urban counites is contingent upon approval of the 1115 CalAIM Medi-Cal Managed Care Model Changes waiver amendment granting expenditure authority to limit plan choice in non-rural counties.

This 1915(b) waiver is authorized under section(s) 1915(b)(1) and 1915(b)(4) of the Social Security Act (the Act) and provides a waiver of the following section of Title XIX:

- Section 1902(a)(1) Statewideness
- Section 1902(a)(10)(B) Comparability
- Section 1902(a)(23) Freedom of Choice

Our decision on the 1915(b) waiver is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all statutory and regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to those beneficiaries in California's Medicaid population.

If you have any questions regarding the 1915(b) waiver, please contact Kitaho Kato at (415) 744-3639 or via email at Kitaho.Kato@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Director
Division of Managed Care Operations

cc: Lindy Harrington, DHCS
John Giles, CMS
Shantrina Roberts, CMS
Matthew Rodriguez, CMS
Brian Burdullis, CMS

Enclosure: Revised Special Terms and Conditions
1915(b) Worksheet for State Reporting of Member Months

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California Advancing & Innovating Medi-Cal (CalAIM) Waiver
Revised Special Terms and Conditions via CA-0017.R10.01 Amendment
Waiver Control # CA 17.R10
January 1, 2022 through December 31, 2026

In addition to the waiver requirements outlined in the 1915(b) application, the following Special Terms and Conditions (STCs) apply to California's 1915(b)(1)/(4) CalAIM Waiver.

A. General Reporting Requirements. The following STCs are intended to assist the state with access and utilization for all/any programs authorized under this 1915(b) waiver:

1. **State Work-Plan for Access Improvement.** The State must provide to CMS a work-plan detailing how it intends to strengthen its monitoring and oversight of managed care plans in order to improve beneficiary access to care for Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health, and the Drug Medi-Cal Organized Delivery System programs. The work-plan must (1) identify the data the state must collect and rely on in its efforts to improve beneficiary access to care; and (2) explain why this data will assist the State in improving access. The measures for assessing access will be proposed by the State and agreed upon by CMS. The state must submit the work-plan to CMS 6 months after the approval of the 1915(b) renewal and publish it on the State's public-facing website. Updates to the work-plan must be reflected on the state's website and submitted to CMS.

2. **Access Improvement Results Reporting**. Eighteen months after the submission of the work-plan detailed in STC A1, the State must submit a report detailing areas with marked improvement, and areas without marked improvement. For areas without improvement, the State must make recommendations on actions the State and CMS may take to effectuate clear improvement. The report must also include a comparison of the medical loss ratio data detailed in STC A11 and the Access Reporting data detailed in STC A4 inclusive of delegated plans within Medi-Cal Managed Care.[1] Finally, the State must publish this report on its public website.

3. **Inability to Collect Data**. If during the course of implementing any of the STCs, managed care plans, counties, or the State are unable to provide the required data, the State must amend the managed care plan or county contracts, if necessary, to ensure access to data and enforce the data requirements.

[1] Risk-based plans contracted with the State delegate functions to other subcontractor plans and downstream contracted plans via sub-capitation (referred to hereinafter as "delegated plans"). For purposes of the STCs, delegated plans include any entity accepting significant financial risk for Medi-Cal managed care enrollees from the Prime risk-based plan, including if that entity is a provider receiving a capitated payment.

4. **Assurances of Adequate Capacity and Services**. For all managed care plans that furnish services to Medicaid beneficiaries enrolled in the managed care programs authorized by this 1915(b) waiver, the State must submit the Assurance of Compliance detailed in 42 CFR § 438.207(d) using the Access Reporting Template provided by CMS, including but not limited to:
    a. Non-risk PIHPs;
    b. Risk-based plans for which the State receives federal financial participation (FFP) for associated expenditures;
    c. Full and partially delegated plans;
    d. Other subcontractors, as applicable, that assume delegated risk from either the prime managed care plan directly contracted with the State, or plans referenced in STC A4.c; and
    e. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC A4.d.

5. **Timing of Submission of Assurances of Adequate Capacity and Services**. The State must begin submitting the Access Reporting Templates across the Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health, and the Drug Medi-Cal Organized Delivery System program by January 1, 2023. For the initial submissions in Calendar Year (CY) 2023, the State must tailor Access Reporting Template submissions based on operational readiness and data availability. For submissions in CY 2024 through CY 2026, the State must provide the complete set of data outlined in the Access Reporting Template across the Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health, and the Drug Medi-Cal Organized Delivery System programs, as outlined in STC A4.

6. **Independent Access Assessment (Specialty Mental Health Program)**. The State must arrange for an independent evaluation or assessment of access to care in the Specialty Mental Health program, and submit the findings ninety (90) days after the end of the second year of the waiver.

7. **Independent Access Assessment (Drug Medi-Cal Organized Delivery System)**. The State must arrange for an independent evaluation or assessment of access to care in the Drug Medi-Cal Organized Delivery System, and submit the findings ninety (90) days after the end of the second year of the waiver.

8. **Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business.** The State must produce and publish an independent access assessment report that includes a comparison of Medi-Cal managed care plans' network adequacy compliance across different lines of business, including Medi-Cal managed care, Medicare Advantage, and the private market. In the report, the State must make recommendations in response to any systemic network adequacy issues, if identified. The report must describe the State's current compliance with the access and network adequacy standards set forth in the Medicaid Managed Care regulations at 42 CFR Part 438. The assessment must:

a. Measure managed care plan compliance with network adequacy requirements as set forth in state law, including the Knox-Keene Health Care Service Plan Act of 1975 (KKA), and in Medicaid managed care plan contracts, as applicable. The assessment must consider State Fair Hearing and Independent Medical Review decisions, grievances and appeals, complaints data, and other factors.
b. Review encounter data including a review of data from all full and partially sub-capitated delegated plans of the managed care plans for Medi-Cal managed care beneficiaries.
c. Review compliance with network adequacy requirements for managed care plans set by the state (including standards set pursuant to 42 CFR § 438.68), and other lines of business for primary and core specialty care areas and facility access, as set forth in state law, Medi-Cal managed care plan contracts, and the Medicaid Managed Care regulations at 42 CFR Part 438, as applicable, and across the entire managed care plan network.
d. Determine managed care plan compliance with network adequacy through reviewing information/data from a one-year period and utilize it for the time period agreed upon by CMS and the State.
e. Account for:
    i. Geographic differences including provider shortages at the local and state levels, as applicable;
    ii. Previously approved alternate network access standards;
    iii. Access to in-network providers and out-of-network providers separately (presented and evaluated separately) when determining overall access to care; and
    iv. Number of providers accepting new patients.

9. **Timeline for Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business.** The State and CMS will work together to establish a timeline for the Access Report in STC A8. This timeline must be agreed upon no later than September 30, 2022, otherwise the Access Report will default to being due 90 days after December 31, 2025.

10. **Consumer Experience and Advocate Engagement**. As part of all Independent Assessments detailed in these STCs, the State must make recommendations for improving consumer experience in these delivery systems. As part of these recommendations for improving the consumer experience, the State must:
    a. Conduct on-going coordination with consumer advocates and stakeholders on no less frequent than a quarterly schedule regarding the state's monitoring and oversight activities with the managed care plans.
    b. Establish a Member Stakeholder Committee.
    c. Ensure that the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey or similar consumer satisfaction survey is conducted annually for beneficiaries enrolled in the Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health, and the Drug Medi-Cal Organized Delivery System programs, starting in 2023.
        i. Beginning in 2023, the CAHPS survey must be conducted annually for managed care plans by the State. By 2026, managed care plans must be

required to administer the CAHPS survey directly, in alignment with National Committee for Quality Assurance (NCQA) accreditation requirements. Managed care plans must be required to be NCQA accredited beginning 2026.

ii. The dental version of the CAHPS survey must be conducted annually for beneficiaries receiving care through the Dental Managed Care program.

iii. The Consumer Perception Survey must be conducted annually for beneficiaries receiving care through the Specialty Mental Health program by county mental health plans.

iv. The Treatment Perception Survey must be conducted annually for beneficiaries receiving care through the Drug Medi-Cal Organized Delivery System (DMC-ODS) program.

11. **State Oversight of Medical Loss Ratio (MLR)**.

a. For risk-based plans, the State must submit the plan generated reports detailed in 42 CFR § 438.8(k) as well as any other documentation used to determine compliance with 42 CFR § 438.8(k) to CMS at DMCPMLR@cms.hhs.gov.

i. For managed care plans that delegate risk to subcontractors, the State's review of compliance with 42 CFR § 438.8(k) must consider MLR requirements related to third-party vendors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf. The State must submit its plan to operationalize this STC A11.a to CMS for review and approval at DMCPMLR@cms.hhs.gov.

b. Effective January 1, 2023, the State must require risk-based plans contracted with the State to impose reporting requirements equivalent to the information required in 42 CFR § 438.8(k) on their subcontractor plans or entities.

c. No later than January 1, 2025, the State must require risk-based plans contracted with the State to impose remittance requirements equivalent to 42 CFR § 438.8(j) on their subcontractor plans or entities. The State is required to submit a work-plan to CMS, no later than July 1, 2022, that outlines the key deliverables and timelines to meet this remittance requirement.

d. STC A11.a, STC A11.b and STC A.11.c must apply for all of the following entities:

i. Risk-based plans for which the State receives federal financial participation for associated expenditures;

ii. Full and partially delegated plans;

iii. Other subcontractors, as applicable, that assume delegated risk from either the prime managed care plan contracted with the State, or plans referenced in STC A11.d.ii; and

iv. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC A11.d.iii.

12. **MLR Auditing.** The State must work with CMS to effectuate an audit of the MLR data covering all years of this 1915(b) renewal package. The audit must occur no sooner than

January 2028 (12 months after the end of the CY 2026 rating period), and ideally later in 2028 to allow DHCS time to review and finalize the CY 2026 MLRs.

13. **Quarterly Appeals and Grievance Report**. Beginning with state fiscal year 2023-24 reporting period, the State must submit 60 days after of the end of each quarter, appeals and grievance data for the Specialty Mental Health program. In effectuating this requirement, the State must utilize the Appeals and Grievance Reporting Template provided by CMS.

14. **CMS Ability to Request Quarterly Appeals and Grievance Data**. CMS reserves the right to request quarterly appeals and grievance data for all programs authorized under this 1915(b) waiver. CMS must provide notice to the State via email if it intends to operationalize this reporting requirement. If CMS requests quarterly appeals and grievance data for a program, it will be due 60 days after the first full quarter from the date of CMS's notice to the State. In effectuating this requirement, the State must utilize the Appeals and Grievance Reporting Template provided by CMS to provide data for all of the following entities:
    a. Non-risk PIHPs;
    b. Risk-based plans for which the State receives federal financial participation for associated expenditures; and
    c. Full and partially delegated plans.

15. **Specialty Mental Health (SMH) Program**. The following STCs reflect ongoing CMS concerns that waiving beneficiary freedom of choice, if it results in mandatory enrollment into underperforming managed care plans, exerts a negative impact on access, equity, and quality of care. The following STCs are intended to ensure clear, comparative information by plan and county to monitor plan performance and drive improvement.
    a. **Monitor Plan Performance**. The State must report on the following measures on a CMS approved format by July 1, 2022 and update information annually. All reports must be disaggregated by county of residence and/or county Mental Health Plan.
        i. The State must continue to report state-developed measures reflecting the percentage of high cost beneficiaries receiving targeted case management services in the Specialty Mental Health program, the percentage of patients offered timely initial appointments, and timely psychiatry appointments, by child and adult. In addition, the State must report State-developed measures reflecting the percentage of patients offered timely psychiatric appointments, by child and adult, by July 1, 2023.
        ii. NQF 0576 FUH-AD and FUH-CH: Follow-Up After Hospitalization for Mental Illness (adult and child)
        iii. NQF 1879 SAA-AD: Adherence to Antipsychotic Medications for Individuals with Schizophrenia
        iv. NQF 0105 AMM-AD: Antidepressant Medication Management for Adults

v. NQF 2801 APP-CH: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

b. **Corrective Action Plans.** The State must continue to publicly post any Corrective Action Plans (CAPs) used to address deficiencies in the Specialty Mental Health program.

c. **SMH Dashboard.** The State must make readily available to beneficiaries, providers, and other interested stakeholders, a county mental health plan dashboard that is based on performance data of each county and/or county mental health plan included in the annual EQR technical report and/or other appropriate resources. Each dashboard must present an easily understandable summary of quality, access, timeliness, and translation/interpretation capabilities regarding the performance of each participating mental health plan. The dashboard data must be updated no less than annually.

16. **Current Procedural Terminology Coding Transition.** The State must transition the Specialty Mental Health and Drug Medi-Cal Organized Delivery Systems programs to Healthcare Common Procedure Coding System (HCPCS) Level I coding, known as Current Procedural Terminology (CPT) coding, in all cases where a suitable code exists, by July 1, 2023. If a suitable CPT code does not exist, the State must identify an appropriate HCPCS Level II code. The transition will allow for more granular claiming and reporting of services provided and allow for enhanced monitoring of plan performance.

B. In Lieu of Services. The following STCs are intended to outline the State's commitment to deliver in lieu service(s) and setting(s) (ILOS) in place of service(s) or setting(s) covered under the Medicaid state plan, as appropriate, within the State's contracts with its managed care plans for the CalAIM 1915(b) waiver.

17. **Compliance with Federal Requirements.** The State must ensure that each ILOS is delivered in accordance with all federal statute, regulation and guidance, including but not limited to 42 CFR Part 438. Additionally, each ILOS must not cover any room and board costs in accordance with the general prohibitions that apply to Medicaid payments for room and board under Title XIX of the Social Security Act.

18. **CMS Approval of ILOS.** CMS considers the following ILOS approved contingent on the conditions and framework outlined in the approval letter and these STCs: Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Respite Services, Day Habilitation Programs, Nursing Facility Transition/Diversion to Assisted Living Facility, Community Transition Services/Nursing Facility Transition to a Home, Personal Care and Homemaker Services, Environmental Accessibility Adaptations (Home Modifications), Asthma Remediation, Medically Tailored Meals, and Sobering Centers. These ILOS may be provided as a substitute for a service(s) or setting(s) covered under the Medicaid state plan or applicable waivers when consistent with 42 CFR § 438.3(e)(2).

a. As part of the State's submission of associated Medicaid managed care plan contracts and capitation rates to implement CalAIM, the State must provide ILOS documentation, including but not limited to:
    i. **Required in Managed Care Plan Contracts.** The State must include in its managed care plan contracts the following detail:
        1. ILOS requirements consistent with those outlined in federal statute, regulation or guidance, including but not limited to 42 CFR § 438.3(e)(2).
        2. A definition of each ILOS and which Medicaid state plan service(s) or setting(s) that each ILOS will be provided as a substitute for, when determined appropriate. Definitions and target populations for each ILOS (described in STC B18.a.i.4) must be consistent with the definitions and standards provided to CMS as part of this waiver application or otherwise determined by CMS. In addition, such definitions and standards must be clinically oriented definitions for the target population(s) for which each ILOS has been determined to be a medically appropriate and cost effective substitute, including assuring that each ILOS must be determined by a provider (at the plan or network level), and documented, to be appropriate for beneficiaries for whom there is an assessed risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits.
        3. Beneficiary and plan protections, including but not limited to:
            a. Each ILOS must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid state plan covered services.
            b. Medicaid beneficiaries always retain their right to receive the Medicaid state plan covered service on the same terms as would apply if an ILOS were not an option in accordance with regulatory requirements.
            c. Medicaid beneficiaries always retain the right to file appeals and/or grievances if they request one or more ILOS offered by their Medicaid managed care plan, but were not authorized to receive the requested ILOS because of a determination that it was not medically appropriate or cost effective.
            d. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that the beneficiary has been offered an ILOS, is currently receiving an ILOS, or has received an ILOS in the past.
            e. Managed care plans are prohibited from requiring a beneficiary to utilize an ILOS.
            f. Managed care plans have the discretion to adopt a more narrowly defined eligible population than the State has outlined, provided that the narrower definition(s) and

eligibility standards are clinically oriented, ensure that each ILOS is medically appropriate and cost effective for the eligible enrollee, and is subject to a determination by a provider that an eligible enrollee has an assessed risk of incurring other Medicaid state plan services (such as inpatient hospitalizations or emergency department visits) for which the ILOS is a medically appropriate and cost effective substitute. Managed care plans must receive state approval and provide public notice of any such limitations on each ILOS, including specifying such limitations in the enrollee handbook. Managed care plans are not allowed to extend any ILOS to individuals beyond those for whom the State has determined the ILOS will be cost effective and medically appropriate. Managed care plans must ensure all eligibility standards are designed and applied on a non-discriminatory manner.

g. Managed care plans must timely submit any related data requested by the State or CMS, including but not limited to:
    i. Data to evaluate the utilization and effectiveness of an ILOS.
    ii. Data necessary to monitor health outcomes and quality metrics at the local and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities.
    iii. Data necessary to monitor appeals and grievances for beneficiaries associated with an ILOS.

4. Documentation to ensure appropriate clinical support for the medical appropriateness of an ILOS, including but not limited to:
    a. Well defined, clinically oriented definitions developed by the State for the target population(s) for which each ILOS has been determined to be a medically appropriate and cost effective substitute. These definitions, included within the managed care plan contracts, must outline the population(s) for whom each ILOS is clearly likely to improve overall health outcomes, reduce cost, and reduce or prevent utilization of other state plan services (e.g., acute care).
    b. A documented process to authorize an ILOS for beneficiaries for whom there is an assessed risk of incurring other Medicaid state plan services, such as inpatient hospitalizations, skilled nursing facility stay or emergency department visits. This process must document that a provider (at the plan or network level) using their

professional judgment has determined it to be medically appropriate for the specific beneficiary as provision of the ILOS is likely to reduce or prevent the need for acute care or other Medicaid services. This documentation could be included in a care plan developed for the beneficiary. In addition to this clinical documentation requirement, the State may also impose additional provider qualifications or other limitations and protocols and these must be documented within the managed care plan contracts.

c. Any data determined necessary by the State or CMS to monitor and oversee the ILOS as a medically appropriate substitute.

5. All data and related documentation necessary to monitor and evaluate cost effectiveness, including but not limited to:
    a. The managed care plans must submit timely and accurate encounter data to the State for each ILOS provided to beneficiaries. The State must seek CMS approval on what is considered an appropriate and reasonable timeframe for plan submission of encounter data. This encounter data, when possible, must include data necessary for the State to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the State.
    b. Any additional information requested by CMS, the State or an oversight body to aid in on-going evaluation of the cost effectiveness of the ILOS or any independent assessment or analysis conducted by the State, CMS or an independent entity.
6. Any additional information determined reasonable, appropriate and necessary by CMS.

ii. **Additional State Documentation.** The State must provide additional documentation to CMS to aid CMS's review of the ILOS as part of our review and approval of the managed care plan contracts and capitation rates. This may include, but not be limited to:

1. A state assurance that implementation of the ILOS will be consistent with documentation reviewed as part of this waiver application and the STC requirements.
2. Any documentation determined necessary for CMS to determine whether the ILOS is a cost effective, reasonable, and appropriate component of the overall Medicaid program costs.
3. Any documentation determined necessary for CMS to understand how the ILOS was taken into account in the development of the actuarially sound capitation rates and to comply with statutory and regulatory requirements.
4. The State's on-going oversight and evaluation plan consistent with STC B19.

5. A description of the State's financing arrangement(s) that are used to support the non-federal share associated with the cost of ILOS.

b. **Response to CMS Questions.** As part of CMS's review of the ILOS, as a component of CMS's review and approval of the State's contracts with its managed care plans for FFP, CMS reserves the right to ask all necessary questions related to the State's contracts with its Medicaid managed care plans and associated rate certifications. California must respond to all CMS questions within 30 calendar days or request an extension determined reasonable by CMS.

c. **CMS Review and Approval of ILOS.**
   i. CMS reserves the right to not approve a managed care plan contract that does not satisfy the objectives of Medicaid or meet federal statute, regulation, guidance and other requirements, including but not limited to those outlined in 42 CFR § 438.3(e)(2).
   ii. CMS has the right to rescind its approval for an ILOS if CMS becomes aware that an ILOS is not medically appropriate and/or a cost effective substitute for service(s) or setting(s) covered under the Medicaid state plan. Additionally, CMS may require appropriate corrective action as CMS deems appropriate. CMS will determine an appropriate phase out of such ILOS to ensure beneficiary protections and access to care in the event an ILOS is discontinued, and may consult with the State.

19. **On-Going Monitoring and Oversight.** The State must conduct monitoring and oversight of ILOS as well as associated operational activities, including but not limited to:

a. The State must monitor ILOS, using appropriate quantitative and qualitative measures, no less than annually, to ensure compliance with federal requirements, including that each ILOS remains a medically appropriate and cost effective substitute for the service(s) or setting(s) covered under the state plan. CMS reserves the right to require certain quantitative and qualitative measures for the State's monitoring and oversight activities. The State must provide its monitoring and oversight findings to CMS within the Annual Report on ILOS in STC B20.

b. The State must notify CMS in writing within 30 days of determining that an ILOS is no longer a medically appropriate or cost effective substitute for service(s) or setting(s) covered under the state plan, and of its proposed plan to modify or phase out the affected ILOS consistent with beneficiary protections and access to care, subject to CMS approval.

c. The State must ensure that it receives clean claims data from managed care plans and all related data and documentation necessary to support ongoing monitoring efforts, evaluation, and transparency efforts, including the data outlined in STCs B18, B19, B20 and B21. The State is also required to randomly audit such claims to ensure accuracy.

d. The State must submit timely, accurate and validated encounter data on ILOS to T-MSIS as required at 42 CFR §§ 438.242(d) and 438.818. Failure to do so may jeopardize FFP. CMS has discretion on what it defines as timely submission for this purpose.

20. **Annual Report on ILOS**. The State must submit an annual report on ILOS no later than 120 days after the end of each calendar year. The components of this annual report must be provided to the State by CMS no later than by September 30, 2022, and must include but not be limited to:
    a. A description of any programmatic or operational changes implemented by the State and/or managed care plans related to ILOS.
    b. The State's annual oversight and monitoring activities, including those required in STC B19.
    c. Utilization data for ILOS and any other data related to the cost effectiveness of ILOS.
    d. Grievances and appeals data for ILOS.
    e. Data, stratified when possible, related to the State's monitoring of health outcomes and quality metrics.
    f. Data reflecting the timeliness and accuracy of managed care plans' encounter data as well as data reflected the State's submission of timely, accurate and validated data to T-MSIS.
    g. The State must provide routine data and analyses of the cost effectiveness of each ILOS as determined appropriate and necessary by CMS. Examples may include, but not be limited to, supplemental data requirements on cost and utilization data.
    h. Any other documentation or data requested by CMS.

21. **Independent Evaluation of ILOS.** The State must submit to CMS a rigorous independent evaluation of ILOS. CMS has discretion on when this independent evaluation will be required and the required timeframe to be evaluated. CMS will determine the timing, required components and timeframe to be evaluated for the independent evaluation. CMS will communicate these terms to the State within a reasonable timeframe agreed to between CMS and the State, but not later than December 31, 2022. This evaluation must include key components critical to evaluate the ILOS, including but not limited to:
    a. Whether the ILOS advanced the objectives of Medicaid.
    b. Whether the ILOS were determined to be medically appropriate and cost effective substitutes for the services or settings covered under the state plan.
    c. Any other evaluation criteria and components requested by CMS.

C. Dental Program. The following STCs are intended to ensure that the managed care plans operating in the Dental Managed Care program improve on measures of access and utilization. CMS encourages the State to re-imagine its dental delivery system to assure that beneficiaries in all counties have adequate access to dental services.

22. **Monitor Plan Performance**. Annually, the State must continue to track performance using measures of Annual Dental Visit, Preventive Dental Services, and Use of Sealants for children and adults or successor measures for all beneficiaries enrolled in a managed care plan operating in the Dental Managed Care program and in its fee-for-service dental program.

23. **Plan Performance and Re-procurement**. The State must consider prior performance for managed care plans operating in the Dental Managed Care program as a component in any re-procurement that occurs during the period of this waiver renewal. If a potential awardee's five-year historic performance on the performance measures referenced in STC C22 is below the historic performance of the State's fee-for-service dental program, the State must provide its justification to CMS for awarding the contract to that managed care plan.

24. **Independent Assessment.** The State must arrange for an independent evaluation or assessment of the Dental Managed Care program, and submit the findings ninety (90) days after the end of the second year of the waiver.

25. **Payment Withholds**. The State must establish payment withhold arrangements linked to timely deliverables and performance improvement targets linked to the performance measures referenced in STC C22. Payment withhold arrangements linked to performance targets must be established prospectively for the Calendar Year 2023 rating period. The State must submit its plan for these withhold arrangements to CMS for review and approval in accordance with 42 CFR § 438.6(b)(3).

26. **Corrective Action Plans.** The State must submit a summary log of activities related to any dental Corrective Action Plans (CAPs) to address identified managed care plan deficiencies to CMS, including the Division of Quality and Health Outcomes in the Children and Adults Health Programs Group, quarterly. The log must include state-issued audit findings necessitating CAPs, and deficiencies that are self-reported by dental managed care plans. The log must include applicable federal and/or contract citation, and date cleared. CMS may request backup documentation for items within the log for review. If, upon review, CMS does not find the remedies for self-reported deficiencies acceptable, CMS will provide concerns in writing, if any, for State consideration and response. Quality of remedies for self-reported deficiencies shall be considered at time of the 1915(b) renewal. The State must publicly post any Corrective Action Plans (CAPs) used to address identified managed care plan deficiencies.

27. **Plan Parity with FFS**. The State must require parity of performance between managed care plans operating in the Dental Managed Care program and fee-for-service delivery systems with respect to the measures referenced in STC C22. If parity is not achieved in each measure referenced in STC C22 for each plan by December 31, 2022, then pursuant to 42 CFR § 438.56(d)(2)(v), beneficiaries in counties where mandatory enrollment has been in place for more than two years must be allowed to disenroll from any such plan that is not assuring adequate quality of services.

28. **Plan Review by State**. For any managed care plan operating in the Dental Managed Care program where disenrollment has been allowed under STC C27, the State must undertake a review of such managed care plan within four months and make a determination on whether that managed care plan's contract should be suspended or terminated.