Instructions

Regulations at 42 C.F.R. § 438.207(a) - (c) require Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs)—collectively referred to as "managed care plans"—to submit documentation to the state demonstrating their capacity to serve the expected enrollment of their service areas in accordance with the state's standards for access to care, including the state's network adequacy and availability of services standards under 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206. Managed care plans are required to submit this information to the state no less frequently than:

Scenario 1: At the time the plan enters into a contract with the state;
Scenario 2: On an annual basis;
Scenario 3: At any time there has been a significant change (as defined by the state) in the plan's operations that would affect the adequacy of capacity and services, including (1) changes in the plan's services, benefits, geographic service area, composition of or payments to its provider network, or (2) enrollment of a new population in the plan.

After the state reviews the documentation submitted by a plan, 42 C.F.R. § 438.207(d) requires the state to submit to the Centers for Medicare & Medicaid Services (CMS) an assurance that the plan complies with the state's network adequacy and availability of services standards under 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206. The submission must include documentation of an analysis that the state conducted to support its assurance of compliance for the plan.

This document provides instructions and a template for states to use when submitting this information to CMS under any of the three scenarios described above. States should complete one (1) form with information for applicable managed care plans and their applicable managed care programs. For example, if the state submits this form under scenario 1 above, the state should submit this form only for the managed care plan that entered into a new contract with the state. The state should not report on any other plans or programs. As another example, if the state submits this form under scenario 2, the state should submit this form for all managed care plans. If the state's analysis methods and results are contained in separate documents, please also submit those documents with this form.

Consistent with the Managed Care Program Annual Report (MCPAR) required by 42 C.F.R. § 438.66(e), this report defines a program as having a specified set of benefits, eligibility criteria, and capitation rates that are articulated in a contract between the state and managed care plans.

MMPs are considered both Medicaid and Medicare managed care plans and are not exempt from 42 CFR 438.207. Therefore, states must submit the tool for integrated plans; however, to reduce duplication, states can complete network adequacy sections of the tool (II.A.1-II.A.5) for Medicaid-only covered services.

States do not need to submit the tool for Program of All-Inclusive Care for the Elderly (PACE) programs/plans as states are not required to do so under 42 CFR 438.207.

In the future, this report will be collected through the online MDCT-Managed Care Reporting tool. CMS will notify states when the web-based forms are available and will provide adequate notice prior to requiring submission through the web-based forms. The excel template may be submitted to

mcgdmcoactions@cms.hhs.gov

Organization

This template includes two sections (Section I and Section II). Section I covers descriptive information about the state and all of the managed care programs operating in the state; information for this section is contained in one tab. Section II includes detail on program-level access standards, monitoring methods, and plan-level compliance data. For Section II, states should use **one tab for each program** the state is reporting on and leave unused tabs blank.

Tab topic:	Tab name:	Number of tabs available:
I. State and program-level information	I_State&Prog_Info	1
II. Program-level standards, monitoring methods, and plan-level compliance	II_Prog_X	15

Inputting information

Each tab provides instructions in the "Item Instructions" column. Response types are provided in the "Data Format" columns. Only input values in BEIGE CELLS. Program names and program summary information (i.e., plan types included in a program, services covered under a program) in Section II autopopulates from Section I to reduce burden on states.

After reporting information on each applicable program in the Section II tabs, leave any unused tabs blank. For example, if the state is reporting on plans in five managed care programs, it should enter information in tabs "II_Prog_1" through "II_Prog_5", and leave the remaining tabs blank.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0920 (Expires: June 30, 2024). The time required to complete this information collection is estimated to average 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

I. State and program information

A. State information and reporting scenario

States should use this section of the tab to report their contact information, date of report submission, and reporting scenario.

#	Item	Item Instructions	Data Format	Input state-level data in this column Hawaii
I.A.1	Contact name	Enter the name of the individual(s) filling out this document.	Free text	Grant Shiira
I.A.2	Contact email address	Enter the email address(es) of the individual(s) filling out this document.	Free text	gshiira@dhs.hawaii.gov
I.A.3	State or territory	Enter the state or territory represented in this document.	Set values (select one)	Hawaii
I.A.4	Date of report submission	Enter the date on which this document is being submitted to CMS.	Date (MM/DD/YYYY)	6/16/2025
I.A.5	Reporting scenario	Enter the scenario under which the state is submitting this form to CMS. Under 42 C.F.R. § 438.207(c) - (d), the state must submit an assurance of compliance after reviewing documentation submitted by a plan under the following three scenarios: - Scenario 1: At the time the plan enters into a contract with the state; - Scenario 2: On an annual basis; - Scenario 3: Any time there has been a significant change (as defined by the state) in the plan's operations that would affect its adequacy of capacity and services, including (1) changes in the plan's services, benefits, geographic service area, composition of or payments to its provider network, or (2) enrollment of a new population in the plan. As described in the instructions tab, states should complete one (1) form with information for applicable managed care plans and programs. For example, if the state submits this form under scenario 1 above, the state should submit this form only for the managed care plan (and the applicable managed care program) that entered into a new contract with the state. The state should not report on any other plans or programs under this scenario. As another example, if the state submits this form under scenario 2, the state should submit this form for all managed care plans and managed care programs.	Set values (select one)	Scenario 2: Annual report
I.A.6	Reporting scenario - other	If the state is submitting this form to CMS for any reason other than those specified in I.A.5, explain the reason.	Free text	No

B. Program information

States should use this section of the tab to report information on applicable managed care programs under the scenario selected in I.A.5, including reporting periods and providers covered under the programs.

#	Item	Item Instructions	Data Format	Input program-level data in beige cells in columns for Program 1 through Program 15>> Community Care Services Program (CCS)	[Program 2]	[Program 3]
I.B.1	Program name	Enter the name of each managed care program in the state in columns E - S. After entering each managed care program name, leave any unused columns in E - S blank. A program is defined by a specified set of benefits, eligibility criteria, and capitation rates that are articulated in a contract between the state and managed care plans. If more than one program is included in a single contract, enter one program per column, starting with column E. Each program entered into these fields will auto-populate program fields in the remaining tabs of this document.	Free text	Community Care Services Program (CCS)		
I.B.2	Statutory authority	Enter the statutory authority(ies) (e.g. Section 1115, 1915(b), etc.) for each managed care program in the state in columns E - S. After entering the authority(ies) for each program, leave any unused columns in E - S blank.	Free text	1115 Waiver		
I.B.3	Plan type included in program	Indicate the managed care plan type (MCO, PIHP, PAHP, or MMP) that contracts with the state in each program.	Set values (select one) or use free text for "other" response	PIHP		
Reporting Period *For items I.B.4 and I.B.5, indicate the reporting period for the analysis and compliance information entered into this report. CMS expects states to enter a reporting period end date that is no more than one year prior to the submission of this report.* *Under scenario 1 (new contract) and 3 (significant change in plan operations), the reporting period may cover less than one year.* *Under scenario 2 (annual report), the reporting period should cover one year.*			(none)	(header/blank cell)	(header/blank cell)	(header/blank cell)
I.B.4	Reporting period start date	For each program, enter the start date of the reporting period for the analysis and compliance information entered into this report.	Date (MM/DD/YYYY)	7/1/2023		
I.B.5	Reporting period end date	For each program, enter the end date of the reporting period for the analysis and compliance information entered into this report.	Date (MM/DD/YYYY)	6/30/2024		
Providers *For items I.B.6.a - k, indicate whether the program covers each 42 C.F.R. § 438.68 provider type specified.* *For MMPs, only enter providers of Medicaid-only covered services. Do not enter providers of Medicaid and Medicare or Medicare-only covered services.*			(none)	(header/blank cell)	(header/blank cell)	(header/blank cell)
I.B.6.a	Adult primary care	Indicate whether the program covers adult primary care providers.	Set values (select one)	Not covered		
I.B.6.b	Pediatric primary care	Indicate whether the program covers pediatric primary care providers.	Set values (select one)	Not covered		
I.B.6.c	OB/GYN	Indicate whether the program covers Ob/Gyn providers.	Set values (select one)	Not covered		
I.B.6.d	Adult behavioral health	Indicate whether the program covers adult behavioral health providers.	Set values (select one)	Covered		
I.B.6.e	Pediatric behavioral health	Indicate whether the program covers pediatric behavioral health providers.	Set values (select one)	Not covered		
I.B.6.f	Adult specialist	Indicate whether the program covers adult specialist providers.	Set values (select one)	Covered		
I.B.6.g	Pediatric specialist	Indicate whether the program covers pediatric specialist providers.	Set values (select one)	Not covered		
I.B.6.h	Hospital	Indicate whether the program covers hospital providers.	Set values (select one)	Covered		
I.B.6.i	Pharmacy	Indicate whether the program covers pharmacy providers.	Set values (select one)	Covered		
I.B.6.j	Pediatric dental	Indicate whether the program covers pediatric dental providers.	Set values (select one)	Not covered		
I.B.6.k	LTSS	Indicate whether the program covers long-term services and supports (LTSS) providers.	Set values (select one)	Not covered		
I.B.6.l	Other (optional field for the state)	Indicate (1) any notes for items I.B.6.a - k and/or (2) other provider types relevant to the state's network adequacy standards (42 C.F.R. § 438.68) or availability standards (42 C.F.R. § 438.206) covered under the program not listed in items I.B.6.a - k.	Free text (optional field for the state)	Case Management Agencies		

C. Separate analysis and results documents

States should use this section of the tab to report on separate documents submitted with this form that contain the state's analysis and results information requested in tabs "II_Prog_X".

#	Item	Item Instructions	Data Format	Input program-level data in beige cells in columns for Program 1 through Program 15>> Community Care Services Program (CCS)	[Program 2]	[Program 3]
For item I.C.1, indicate for each program in columns E-S whether the state's analysis methods and results regarding plan compliance with the state's 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206 standards are contained in a separate document(s). Before indicating "yes", ensure that the document(s) contains the information requested in tabs "II_Prog_X". If the state reports "yes" in I.C.1 , indicate in items I.C.2 - I.C.4 the name and date of the document(s) as well as the page/section numbers for where the program is addressed in the document(s). Submit the document(s) with this form. For any program for which the state reports "no" in I.C.1 (meaning that the state does not report analysis methods and results in a separate document[s]), the state must enter data in Sections B and C in tabs "II_Prog_X".			(none)	(header/blank cell)	(header/blank cell)	(header/blank cell)
I.C.1	Analysis and results in separate documents	For each program in columns E-S, indicate whether the state's analysis methods and results regarding plan compliance with the state's 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206 standards are contained in a separate document(s). If yes, submit the document(s) with this form.	Set values (select one)	No, analysis methods and results are not contained in a separate document(s)		
I.C.2	Name of analysis and results documents	If the state indicated that analysis methods and results are contained in a separate document(s) for any program in columns E-S, indicate the name of the document(s). If analysis methods and results are not contained in a separate document(s), write "N/A."	Free text			
I.C.3	Date of analysis and results documents	If the state indicated that analysis methods and results are contained in a separate document(s) for any program in columns E-S, indicate the date of the document(s). If analysis methods and results are not contained in a separate document(s), write "N/A."	Free text			
I.C.4	Page/section references in analysis and results documents	If the state indicated that analysis methods and results are contained in a separate document(s) for any program in columns E-S, indicate the page/section numbers for where the program is addressed in the document(s). If analysis methods and results are not contained in a separate document(s), write "N/A."	Free text			

II. Program-level standards, monitoring methods, and plan compliance

Values in the box below auto-populate from the "I_State&Prog_Info" tab.

DATA OK: Assurances correctly reported to II.C.2.a and II.C.3.a

Program summary	Community Care Services Program (CCS)
Plan type included in program contracts	PIHP
Provider types covered in program contracts	Adult behavioral health, Adult specialist, Hospital, Pharmacy, other services
Analysis and results in separate document	No, analysis methods and results are not contained in a separate document(s)
Name of analysis and results document	(Placeholder for separate analysis and results document)
Date of analysis and results document	(Placeholder for separate analysis and results document)

DATA OK: Analysis and results correctly reported to II.B.1-3

Context: Regulations at 42 C.F.R. § 438.207(d) require states that contract with MCOs, PIHPs, and PAHPs to submit to CMS an assurance of compliance that each plan meets the state's network adequacy and availability of services standards under 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206. The submission must include documentation of an analysis that the state conducted to support its assurance of compliance for each plan. The state must submit this information to CMS after receipt of documentation from a managed care plan as specified in 42 C.F.R. § 438.207(c) and described in the instructions tab. The fields below provide a template for states to submit this information for the program listed at the top of the tab.

A. Access and network adequacy standards required for plans participating in the program

States should use this section of the tab to report each standard included in managed care program contracts; report each unique standard in columns E - CZ.

Input program-level data in columns for Standard 1 through Standard 100>>

#	Item	Item Instructions	Data Format	Standard 1	Standard 2	Standard 3	Standard 4	Standard 5	Standard 6	Standard 7	Standard 8	Standard 9	Standard 10	Standard 11	Standard 12	Standard 13	Standard 14	Standard 15	Standard 16	Standard 17	Standard 18	Standard 19	Standard 20	Standard 21	Standard 22	Standard 23	Standard 24	Standard 25	Standard 26	Standard 27	Standard 28	Standard 29	Standard 30	Standard 31	Standard 32	Standard 33	Standard 34	Standard 35
II.A.1	Standard type	Enter the standard type for each standard used in the program.	Set values (select one) or use free text for "other" response	Maximum time to travel	Maximum time to travel	Maximum time to travel	Maximum time to travel	Maximum time to travel	Maximum time to travel	Maximum time to travel	Maximum time to travel	Maximum time to travel	Hours of operation	Appointment wait time	Appointment wait time	Provider to enrollee ratio	Provider to enrollee ratio	Provider to enrollee ratio	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers	Minimum # of network providers				
II.A.2	Standard description	Describe the standard (for example, 60 miles maximum distance to travel to an appointment).	Free text	30 minutes driving time to a	30 minutes maximum driving	30 minutes driving time	15 minutes driving time	60 minute driving time	60 minutes driving time to a	60 minutes driving time	60 minutes driving time	60 minutes driving time	Immediate care 24 hours	Urgent behavioral healt	Standard behavioral he	1:25 Active caseload c	1:40 Active caseload c	1:200 Active caseload	Members have access	Members have access	Members have access	Members have access	Members have access	Members have access	Members have access	Members have access	Members have access	Members have access to crisis services Mobile crisis response and crisis residential services	Members have access to interpretation services providers	Members have access to CIS providers	Members have access to representative payee	Members have access	Members have access to peer specialist				
II.A.3	Provider type covered by standard	Enter the provider type that the standard applies to.	Set values (select one) or use free text for "other" response	Adult behavioral health	Hospital	Emergency Services Facilit	Pharmacy	24-hr pharmacy	Adult behavioral health	Hospital	Emergency Services Facilit	Pharmacy	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health	Adult behavioral health				
II.A.4	Population covered by standard	Enter the population that the standard applies to.	Set values (select one) or use free text for "other" response	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult	Adult				
II.A.5	Applicable region(s)	Enter the region that the standard applies to.	Set values (select one) or use free text for "other" response	Urban	Urban	Urban	Urban	Urban	Rural	Rural	Rural	Rural	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide				

B. Analyses that the state uses to monitor compliance with access and network adequacy standards reported in Section A

States should use this section of the tab to report on the analyses that the state uses to assess plan compliance with the state's 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206 standards; report on each analysis in columns E - L.

Input program-level data in these column unless specified in the item instructions >>

#	Item	Item Instructions	Data Format	Geomapping	Plan Provider Directory Review	Secret Shopper: Network Participation	Secret Shopper: Appointment Availability	EVV Data Analysis	Review of Grievances Related to Access	Encounter Data Analysis	Other (Specify)
II.B.1	Frequency of analysis	Indicate how frequently the state analyzes plan compliance with 42 C.F.R. § 438.68 and/or 42 C.F.R. § 438.206 for the program being reported on in this tab using the methods listed in columns E-L. If the state does not use the method, select "Not used for any plans".	Set values (select one) or use free text for "other" response	Quarterly	Not used for any plans	Not used for any plans	Quarterly	Not used for any plans	Quarterly	Not used for any plans	Not used for any plans
II.B.2	Analysis methods	For each analysis method in columns E-L, indicate whether the state uses the method to analyze plan compliance with 42 C.F.R. § 438.68 and/or 42 C.F.R. § 438.206 for all, some, or none of the plans in the program being reported on in this tab. If the state uses other methods, please explain them in column L. If the state enters "Used for some but not all plans" for any method, report the plans for which it uses the method in II.B.3.	Set values (select one) or use free text for "other" response	Used for all plans	Not used for any plans	Not used for any plans	Used for all plans	Not used for any plans	Used for all plans	Not used for any plans	Not used for any plans
II.B.3	Plan-specific analysis	If the state indicated in Item II.B.2 that it uses an analysis method for some but not all plans in the program, identify the subset of plans for which the method is used. Write the name of the plan(s) under the column corresponding with the type of analysis. If the state indicated in item II.B.2 that it uses the method on all or none of the plans in the program, write "N/A".	Free text								

C. Plan-level compliance data

States should use this section of the tab to report on plan compliance with the state's 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206 standards; report on each plan in columns E - AR.

Input plan-level data in columns for Plan 1 through Plan 40 >>

#	Item	Item Instructions	Data Format	Ohana Health Plan	[Plan 2]	[Plan 3]	[Plan 4]	[Plan 5]	[Plan 6]	[Plan 7]	[Plan 8]	[Plan 9]	[Plan 10]	[Plan 11]	[Plan 12]	[Plan 13]	[Plan 14]	[Plan 15]	[Plan 16]	[Plan 17]	[Plan 18]	[Plan 19]	[Plan 20]	[Plan 21]	[Plan 22]	[Plan 23]	[Plan 24]	[Plan 25]	[Plan 26]	[Plan 27]	[Plan 28]	[Plan 29]	[Plan 30]	[Plan 31]	[Plan 32]	[Plan 33]	[Plan 34]	[Plan 35]
II.C.1.a	Plan name	In columns E - AR, enter the names of the plans that contract with the state for the managed care program identified above.	Free text	Ohana Health Plan																																		
II.C.2.a	Assurance of plan compliance with 42 C.F.R. § 438.68	Indicate whether the state assures that the plan complies with the state's network adequacy standards under 42 C.F.R. § 438.68 based on each analysis the state conducted for the plan during the reporting period indicated in II.B.4 and II.B.5. For example, if the state assessed plan compliance using four quarterly geomapping and two semi-annual plan provider roster review analyses within the reporting period indicated in II.B.4 and II.B.5, and the state determined that the plan complied with the state's 42 C.F.R. § 438.68 standards in all of those analyses, enter "yes, the plan complies based on all analyses." As another example, if the state assessed plan compliance using two semi-annual geomapping analyses and an annual secret shopper analysis within the reporting period indicated in I.B.4 and I.B.5, and the state determined that the plan did not comply with the state's 42 C.F.R. § 438.68 standards in at least one of those analyses, enter "no, the plan does not comply based on all analyses."	Set values (select one)	No, the plan does not comply based on all analyses																																				
II.C.2.b	Description of results: 42 C.F.R. § 438.68	Describe the results of each of the analyses (including dates of the analyses) that support the assurance above of the plan's compliance with the state's 42 C.F.R. § 438.68 standards. In the description of results, please address the standards that apply to the plan and each of the analyses that the state used to assess plan compliance with those standards.	Free text	Member and provider level data was analyzed quarterly to assess adherence to Provider Member ratios, and geomapping, based on member and provider addresses was performed to assess drive times. Maximum time to travel Standards 1-.9 were met for all quarters. Hours of operation Standard 10 for emergency care care was met for all quarters. The licensed case manager and unlicensed case manager to member ratios (Standards 13 and 14) were not met for any of the 4 quarters. The active caseload of case management supervisors (Standard 15) was met during 3 quarters; it was not met in Q3 Jan-Mar 2024. Minimum number of network provider standards were met for standards 16-19, 21, 24-27, and 29. They were not met for standards 20, 22, 23, 28, 30 and 31.																																						
II.C.2.c	Plan deficiencies: 42 C.F.R. § 438.68 (Part 1)	If the state cannot assure plan compliance with the state's 42 C.F.R. § 438.68 standards based on at least one analysis conducted within the reporting period in II.B.4 and II.B.5, describe plan deficiencies identified during the reporting period and indicate which analyses uncovered the deficiencies. If the state selected "Yes, the plan complies based on all analyses" in II.C.2.a, write "N/A."	Free text	Network adequacy analysis revealed higher than specified caseloads for unlicensed case managers (1:25) and licensed case managers (1:40) for all 4 quarters. The ratio of caseload management supervisors to members (1:200) was not achieved in Q3 or Q4. Minimum number of network provider standards were not met for mental health rehabilitation services providers, access to day treatment programs, psychosocial rehab/club house, CIS providers, supported employment, or access to peer specialists.																																						
II.C.2.d	Plan deficiencies: 42 C.F.R. § 438.68 (Part 2)	If the state cannot assure plan compliance with the state's 42 C.F.R. § 438.68 standards based on at least one analysis conducted within the reporting period in II.B.4 and II.B.5, describe what the plan will do to achieve compliance and how the state will monitor the plan's progress. If the state selected "Yes, the plan complies based on all analyses" in II.C.2.a, write "N/A."	Free text	The Provider Network Adequacy report collecting this information was still relatively new during SFY 2024. Therefore, these reports were not in production during this time. This makes it difficult to determine if the standards were actually met. Med-QUEST staff continued to work with the health plan and our contractor to improve data quality and accuracy for future reporting. Reports will move into production for data quality 7/1/2024. MQD will continue to monitor quarterly and assess for compliance.																																						
II.C.2.e	Reassessment for plan deficiencies: 42 C.F.R. § 438.68	If the state identified any plan deficiencies in II.C.2.c, indicate when the state will reassess the plan's network to determine whether the plan has remediated those deficiencies.	Date (MM/DD/YYYY)	10/30/2024																																				
II.C.2.f	Exceptions granted under 42 C.F.R. § 438.68(d)	Describe any network adequacy standard exceptions that the state has granted to the plan under 42 C.F.R. § 438.68(d). If there are no exceptions, write "None."	Free text	None																																				
II.C.2.g	Justification for exceptions granted under 42 C.F.R. § 438.68(d)	If the state identified any network adequacy standard exceptions granted to the plan under 42 C.F.R. § 438.68(d) in II.C.2.f, describe the state's justification for granting the exception(s). If the state has not granted any exceptions, write "N/A."	Free text	N/A																																				
II.C.3.a	Assurance of compliance with 42 C.F.R. § 438.206	Indicate whether the state assures that the plan complies with the state's availability of services standards under 42 C.F.R. § 438.206 based on each analysis the state conducted for the plan during the reporting period indicated in I.B.4 and I.B.5. For example, if the state assessed plan compliance using four quarterly geomapping and two semi-annual plan provider roster review analyses within the reporting period indicated in I.B.4 and I.B.5, and the state determined that the plan complied with the state's 42 C.F.R. § 438.206 standards in all of those analyses, enter "yes, the plan complies based on all analyses." As another example, if the state assessed plan compliance using two semi-annual geomapping analyses and an annual secret shopper analysis within the reporting period indicated in I.B.4 and I.B.5, and the state determined that the plan did not comply with the state's 42 C.F.R. § 438.206 standards in at least one of those analyses, enter "no, the plan does not comply based on all analyses."	Set values (select one)	No, the plan does not comply based on all analyses																																					
II.C.3.b	Description of results: 42 C.F.R. § 438.206	Describe the results of each of the analyses (including dates of the analyses) that support the assurance above of the plan's compliance with the state's 42 C.F.R. § 438.206 standards. In the description of results, please address the standards that apply to the plan and each of the analyses that the state used to assess plan compliance with those standards.	Free text	The dollar assessed appointment wait time (Standards 11 and 12) using Secret Shopper surveys conducted quarterly. Secret Shopper																																				
II.C.3.c	Plan deficiencies: 42 C.F.R. § 438.206 (Part 1)	If the state cannot assure plan compliance with the state's 42 C.F.R. § 438.206 standards based on at least one analysis conducted within the reporting period indicated in I.B.4 and I.B.5, describe plan deficiencies identified during the reporting period and indicate which analyses uncovered the deficiencies. If the state selected "Yes, the plan complies based on all analyses" in II.C.3.a, write "N/A."	Free text	The Secret Shopper surveys for appointment wait time revealed that low compliance with standard (21 days) and urgent (72 hours) access to appointments for all quarters.																																				
II.C.3.d	Plan deficiencies: 42 C.F.R. § 438.206 (Part 2)	If the state cannot assure plan compliance with the state's 42 C.F.R. § 438.206 standards based on at least one analysis conducted within the reporting period indicated in I.B.4 and I.B.5, describe what the plan will do to achieve compliance and how the state will monitor the plan's progress. If the state selected "Yes, the plan complies based on all analyses" in II.C.3.a, write "N/A."	Free text	The Health Plan noted that the challenges of appointment timeliness are typically with the individual proprietor or smaller provider group types as they have their regular patient case load and may have difficulties to establish new patients since they may be operating at regular capacity. In these instances, referral is often more successful with newer providers rather than established provider types or groups. They asserted that their practice is to continue to follow-up with members until an appointment is achieved. The plan is continuing to meet with the Federally Qualified Health Centers to assess and address barriers to improve performance.																																						
II.C.3.e	Reassessment for plan deficiencies: 42 C.F.R. § 438.206	If the state identified any plan deficiencies in II.C.3.c, indicate when the state will reassess the plan's availability of services to determine whether the plan has remediated those deficiencies.	Date (MM/DD/YYYY)	10/30/2024																																				