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

PA 67 Renewal Sub Date 9/30/2021 Amend Sub #/Date _____

CMS Renewal Approval Date _____ CMS Amend #/App Date _____

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Proposal

Proposal for a Section 1915(b) Waiver
MCO and/or PIHP Program

Facesheet

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

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

The **name of the waiver program** is **PA 67** (Please list each program name if the waiver authorizes more than one program.). **Within the PA 67 waiver there are three components: PH-MCO, BH-PIHP, and FFS Selective Contracting (Specialty Pharmacy Drug Program).**

THE PA 67 WAIVER PROGRAM

On March 1, 2013, the Commonwealth of Pennsylvania completed its statewide mandatory managed care expansion. With statewide HealthChoices managed care implemented for both physical health and behavioral health, the Commonwealth combined the prior 1915(b) waivers known as the PA 42 and PA 25 into a single waiver, which is referred to as the PA 67 Waiver.

On June 30, 2015, CMS approved the transition of beneficiaries enrolled in the Private Coverage Options (PCO) through the *Healthy PA* 1115 Demonstration waiver into the PA 67 HealthChoices waiver through a traditional Medicaid expansion.

The 1915(b) waiver renewal application that follows, is reflective of the Commonwealth's implementation of the PA 67 waiver and HealthChoices statewide.

On January 1, 2020, the Commonwealth completed the implementation of is currently engaged in the development of a new managed care waiver program for the delivery of Medicaid physical health benefits and Long-term Services and Supports (MLTSS), called Community HealthChoices (CHC). This program serves to manage physical health care and long-term services delivery and supports for those who are age 21 and older in two populations: those who are dually eligible for Medicare and Medicaid and those who qualify for Medicaid long-term services and supports, both in the community and in nursing facilities.

Upon approval and implementation, some populations previously excluded from managed care under HealthChoices became covered by CHC as it was phased in across the Commonwealth. Behavioral Health services under CHC are provided through the BH-PIHPs authorized through the PA 67 Waiver as these services are also "carved-out" of CHC.

Those beneficiaries age 21 and older in HealthChoices' PH-MCOs who are enrolled in Medicare part A or B or who are enrolled in HCBS Waivers through the Office of Long-Term Living have been transitioned from HealthChoices into CHC as this program became available in their HealthChoices Zone. These changes are reflected throughout the Waiver renewal application.

The Medicaid Eligibility Groups (MEGs) included under Section D-Cost Effectiveness, are consolidated into three MEGs: "SSI/HH and Other Disabled," "TANF/MAGI" and "Newly Eligible, Ages 19-64." Additional details related to the MEG development and reporting are included under Section D.

Type of request. This is an:
____ initial request for a new waiver. All sections are filled.
____ amendment for existing waiver, which modifies Section/Part _____
_____ Replacement pages are attached for specific Section/Part being amended
(note: the state may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
____ Document is replaced in full, with changes highlighted.
__X__ renewal request **PH-MCO, BH-PIHP, FFS Selective contracting (Specialty Pharmacy Drug Program)**
____ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
_X_ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.
Section A is ____ replaced in full
__X__ carried over from previous waiver period. The State:
____ assures that there are no changes in the Program Description from the previous waiver period.
_X_ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.
Section B is ____ replaced in full
__X__ carried over from previous waiver period. The State:
____ assures that there are no changes in the Monitoring Plan from the previous waiver period.

__X__ assures the same Monitoring Plan from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Effective dates: This waiver renewal is requested to be effective January 1, 2022 and ending , December 31, 2026. (For beginning date for an initial or renewal request, please choose the 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 the end of the waiver period as the end date.)

State Contact: The State contact person for the **PH-MCO portion** of this waiver is **Eve Lickers** and can be reached by telephone at **(717) 772-6341** or fax at **(717) 772-6366**, or email at **elickers@pa.gov**. The contact person for the **FFS Selective Contracting (Specialty Pharmacy Drug Program)** portion of this waiver is **Terri Cathers** and can be reached by telephone at (**717) 346-8156**, or fax at (717) 346-8171, or e-mail at **c-tcathers@pa.gov**. The contact person for the **BH-PIHP portion** of this waiver is **Jamey Welty** and can be reached by telephone at **(717) 772-7763**, or fax at **(717) 772-7964**, or email at **jwelty@pa.gov**. (Please list for each program.)

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 the Commonwealth of Pennsylvania.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

HealthChoices/PA67 Waiver Program History

HealthChoices is Pennsylvania's mandatory managed care program for Medical Assistance (MA) beneficiaries. Pennsylvania began utilization of HealthChoices mandatory managed care in 1996 and has gradually increased the scope of the program

throughout the state with the goal being statewide mandatory managed care. The program was designed to improve access to and quality of care for MA beneficiaries and to stabilize spending.

The move to a statewide HealthChoices program was completed March 1, 2013, resulting in beneficiaries in every Pennsylvania county being enrolled in both the physical health (PH) and behavioral health (BH) managed care components of the HealthChoices Program (PH-MCOs and BH-PIHPs).

HealthChoices Waiver Renewal and Move to Statewide Managed Care 2013-2014

On September 14, 2012, the Department of Human Services (Department) submitted an application to CMS to request approval for the statewide HealthChoices PA 67 waiver, combining the existing 1915(b) waivers, the PA 25 and PA 42, into a single waiver, referred to as the PA 67 waiver. CMS allowed the Department to include the upcoming March 1, 2013, New East Zone implementation in the renewal rather than requiring an additional waiver amendment. Due to the ACCESS Plus program continuing to operate for the first two months of the 2013-2014 waiver period, all aspects of the program were included in the renewal and would be removed at the subsequent renewal. CMS approved this renewal December 11, 2012, for the two-year period of January 1, 2013, through December 31, 2014. Subsequent to the approval, amendments to the waiver were approved as follows:

- December 20, 2013, received CMS approval for a waiver amendment for the reintroduction of selective contracting for the Specialty Pharmacy Drug Program. The program serves beneficiaries in the 67 counties statewide who continue to receive their health care benefits in the Fee-for-Service (FFS) delivery system. The amendment was approved to include selective contracting in the PA 67 waiver for the period of January 1, 2014, through December 31, 2014.
- May 2, 2014, received CMS approval for a cost effectiveness waiver amendment for the period of May 1, 2014, through December 31, 2014. The amendment revised the cost effectiveness data for 2014, prospective year 2 (P2), to incorporate the Section 1202 Primary Care payment increase and the Section 9010 Health Insurance Providers fee.

PA 67 HealthChoices Waiver Renewal 2015-2016

On September 30, 2014, the Department submitted a 1915(b) waiver renewal request to CMS. CMS approved this waiver renewal on December 17, 2014, for a two-year period effective January 1, 2015, through December 31, 2016. Subsequent to the approval, an amendment to the waiver was approved as follows:

- June 30, 2015, received CMS approval to transition beneficiaries enrolled in PCO's through the *Healthy PA* 1115 Demonstration waiver into the PA 67 HealthChoices waiver through a traditional Medicaid expansion. Two new MEG's were added for newly eligible individuals 19-20 years old and 21-64 years old resulting from the Medicaid expansion.

PA 67 HealthChoices Waiver Renewal 2021-2022

On September 26, 2016 the Department submitted a 1915(b) waiver renewal request to CMS. CMS approved this waiver renewal on December 13, 2016, for a five-year period effective January 1, 2017, through December 31, 2021. Subsequent to the approval, an amendment to the waiver was approved as follows:

- April 12, 2021, received CMS approval to implement the North Central zone of the Behavioral HealthChoices program. This amendment reflects the decision by 23 counties to exercise their first right of opportunity to contract with a primary contractor.

HealthChoices/PA25 Waiver Program History

The HealthChoices Program was introduced on February 1, 1997, to provide both physical and behavioral health care services to MA beneficiaries through a managed care delivery system (PH-MCO and BH-PIHP). Initial implementation began in the Southeast Zone and included five counties. On January 1, 1999, the HealthChoices Program added 10 additional counties known as the Southwest Zone. On October 1, 2001 the Commonwealth phased into the program another 10 county region, known as the Lehigh/Capital Zone.

Initial HealthChoices Southeast Waiver Approval for 1997-1999

On December 31, 1996, CMS approved two separate program waivers, physical health and behavioral health managed care, (PH-MCO and BH-PIHP) for the two-year period of February 1, 1997, through January 31, 1999.

HealthChoices Waiver Renewal & Program Growth for 1999-2000

The Department submitted an application to CMS on October 30, 1997, to request approval to broaden the HealthChoices program to the Southwest and Lehigh/Capital Zones. The physical health and behavioral health managed care programs in these two zones were combined in this second 1915(b) waiver application. CMS approved this waiver on October 30, 1998, for the two-year period effective January 1, 1999, through December 31, 2000, with the condition that beneficiaries with HIV/AIDS enrolled in the

1915(c) AIDS Waiver also be enrolled in the 1915(b) HealthChoices Waiver for all services including 1915(c) waiver services.

HealthChoices Waiver Renewal and Consolidation for 1999-2001

On January 20, 1999, the Department submitted an application to CMS to request approval to modify the HealthChoices Southwest and Lehigh/Capital Zones waiver to include the HealthChoices Southeast Zone. CMS approved this waiver modification on December 17, 1999, for the two-year period effective December 19, 1999, through December 18, 2001. Approval of this waiver modification resulted in a single waiver for all HealthChoices zones. Administering HealthChoices under one waiver enabled the Department to improve programmatic efficiencies of its administrative resources statewide, develop consistent statewide program efficiency of its administrative resources, develop consistent statewide program and policy standards, and consolidate monitoring and program evaluation efforts.

HealthChoices Waiver Renewal for 2002-2004

On December 18, 2001, the Department submitted a 1915(b) waiver renewal application. CMS approved this waiver renewal on April 17, 2002, for a two-year period effective June 17, 2002, through June 16, 2004. Subsequent to the approval, amendments to the waiver were approved as follows:

- July 11, 2002, received CMS approval to allow a single contract between the Department and an entity representing one or more multi-county groupings, and establishing a minimum of 10,000 HealthChoices enrollees or has a subcontractor that already covers a minimum of 10,000 enrollees as a condition for a county, a grouping of counties, or a BH-PIHP to qualify for a contract.

- September 6, 2002, received CMS approval to allow the Department to exclude from the HealthChoices Program those beneficiaries who are admitted to or reside in a State-operated ICF/MR.

- February 3, 2003, received CMS approval to allow the Department to cease monitoring and reporting according to CMS's Interim Review Criteria for Children with Special Needs and the Addendum to Section F.

- August 8, 2003, received CMS approval to bring the waiver into compliance with the provisions of the federal Balanced Budget Act of 1997.

HealthChoices Waiver Renewal for 2005-2006

On March 15, 2004, the Department submitted to CMS, a 1915(b) waiver renewal application that included a request to extend the existing waiver period in order to align with the beginning of a quarter enhancing the reporting and monitoring. CMS subsequently approved the initial extension request and granted an additional extension in order to allow the Department time to respond to requests for additional information. The waiver was approved December 9, 2004, and the waiver period was adjusted to be effective January 1, 2005, through December 31, 2006.

Subsequent to the approval, amendments to the waiver were approved as follows:

- October 26, 2005, received CMS approval to allow the MCOs to voluntarily impose co-payments comparable to those in the PA Fee for Service Program.
- May 16, 2006, received CMS approval allowing for the removal of the dual eligibles age 21 and over for PH-MCOs only, cost adjustments for benefit limits and the MCO assessment, and the implementation of the Integrated Children's Services Initiative (ICSI).
- June 6, 2006, received CMS approval to expand the behavioral health component of the program into four additional counties.

HealthChoices/PA 25 Waiver Renewal for 2007-2008

On September 8, 2006, the Department submitted a 1915(b) waiver renewal application that included a streamlined waiver strategy that realigned the existing 1915(b) HealthChoices Waiver and the 1915(b) ACCESS Plus Waiver, into two 1915(b) waivers distinctly based upon the geographic location of counties within Pennsylvania. The waiver formerly known as the HealthChoices Waiver was renamed as the PA 25 Waiver to reflect its coverage of 25 counties in Pennsylvania. The waiver was approved December 7, 2006, for the waiver period effective January 1, 2007, through December 31, 2008.

In compliance with the CMS terms and conditions of the December 7, 2006, CMS approval of Pennsylvania's 1915(b) PA 25 Waiver, the Department submitted to CMS the methodology in place to identify and report home and community based services costs for HIV positive individuals who are enrolled in both the 1915(b) PA 25 and the 1915(c) AIDS Waiver programs and has combined the 1915(b) PA 25 and 1915(c) AIDS waivers.

Subsequent to the approval, amendments to the waiver were approved as follows:

- July 18, 2007, received CMS approval to include enrollees who are ventilator-dependent and hospitalized for more than 30 consecutive days in the PA 25 Waiver, effective August 1, 2007.

- December 14, 2007, received CMS approval to exclude beneficiaries in Dauphin, Cumberland and Lancaster counties who voluntarily enroll in the Autism Capitated Assistance Program (ACAP) from the PA 25 Waiver, effective January 1, 2008.
- July 30, 2008, received CMS approval to revise the cost effectiveness narrative in Section D and the related cost effectiveness appendices.

HealthChoices/PA 25 Waiver Renewal for 2009-2010

On September 25, 2008, the Department submitted a 1915(b) waiver renewal application for the PA 25 Waiver. The PA 25 Waiver was approved by CMS on December 23, 2008, for the waiver period effective January 1, 2009, through December 31, 2010.

Subsequent to approval, an amendment to the waiver was approved as follows:

- March 3, 2010, received CMS approval for an extension of a 5.9% Gross Receipts Tax on revenues received by the PH-MCOs and BH-PIHPs, effective October 1, 2009, and a provider rate increase for improving "Access to Care." The cost effectiveness narrative in Section D and the related cost effectiveness appendices were revised to account for these changes.

HealthChoices/PA 25 Waiver Renewal for 2011-2012

The PA 25 waiver renewal for the period covering January 1, 2011, through December 31, 2012, was submitted on September 29, 2010. On December 22, 2010, CMS approved the renewal.

On December 11, 2012, CMS approved the HealthChoices PA 67 waiver, combining the existing 1915(b) waivers, the PA 25 and PA 42, into a single waiver, referred to as the PA 67 waiver.

HealthChoices and HIV/AIDS Waiver Services

MA beneficiaries with a diagnosis of HIV/AIDS formerly received from their PH-MCO, in addition to their regular MA services, the following services comparable to the services provided under the 1915(c) AIDS Waiver:

- Home Health Services
- Specialized Medical Equipment and Supplies
- Nutritional Consultations
- Personal Assistance Services

The 1915(c) AIDS Waiver expired on September 27, 2015. Those recipients enrolled in the AIDS Waiver were transitioned into other existing Office of Long Term Living (OLTL) Home and Community Based Services (HCBS) Waivers as appropriate. MA beneficiaries enrolled in OLTL HCBS Waivers now receive all previously received, AIDS Waiver services through FFS.

ACCESS Plus/PA 42 Waiver Program History:

The ACCESS Plus program was developed based upon the Commonwealth's experience with an earlier 1915(b) waiver program for primary care case management for MA beneficiaries under 21 years of age known as the Family Care Network and the current mandatory managed care program (HealthChoices).

Implementation of ACCESS Plus and BH-PIHP Expansion

During the calendar years 2005 and 2006, the Commonwealth implemented the PCCM program known as ACCESS Plus in the counties where HealthChoices did not operate. Additionally, the BH-PIHP component of the HealthChoices program was expanded in phases. MA beneficiaries residing in these counties received their physical health services through the ACCESS Plus program or a voluntary managed care program operating in that county and received behavioral health services through the BH-PIHP program. The Northeast Zone, comprised of a four county area, was implemented July 1, 2006. The North/Central State Option Zone implemented January 1, 2007, and is comprised of a 23 county area which was managed by a risk-bearing private sector BH-PIHP, in a direct contract with the Commonwealth. The counties in this zone did not exercise their right of first opportunity to manage the HealthChoices Behavioral Health Program (HC-BH) at that time. These 23 counties, however, elected to exercise their right of first opportunity to administer the HealthChoices contract for the new **North Central Zone** commencing July 1, 2021. The Behavioral Health Alliance of Rural Pennsylvania, a 501(c)(3), became the primary contractor to administer the HC-BH program for the North Central Zone. Starting January 1, 2022, Greene County will join the North Central Zone bringing the number of counties in the North Central Contract to 24. The remainder of the state, known as the North/Central County Option Zone, is comprised of 15 counties and was implemented July 1, 2007.

Move to Statewide HealthChoices Physical Health and the Ending of ACCESS Plus

Effective July 1, 2012, seven of the 42 counties where HealthChoices physical health mandatory managed care did not operate were incorporated into existing HealthChoices zones: Bedford, Blair, Cambria and Somerset counties joined the existing HealthChoices Southwest Zone; and Franklin, Fulton and Huntingdon Counties joined the existing HealthChoices Lehigh-Capital Zone. The ACCESS Plus enhanced Primary Care Case

Management (PCCM) and Disease Management (PAHP) programs, ceased operations in these seven counties effective June 30, 2012.

On October 1, 2012, HealthChoices physical health mandatory managed care was expanded into a new zone previously covered by the PA 42 Waiver Program, the HealthChoices PH New West Zone. The HealthChoices New West Zone includes: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren counties. The ACCESS Plus enhanced Primary Care Case Management (PCCM) and Disease Management (PAHP) programs, ceased operations in these counties on September 30, 2012.

On March 1, 2013, HealthChoices physical health mandatory managed care expanded into a new geographic area, the HealthChoices New East Zone. The HealthChoices New East zone includes: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuykill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming counties. The ACCESS Plus enhanced Primary Care Case Management (PCCM) and Disease Management (PAHP) programs ceased operations in these counties on February 28, 2013 effectively ending the ACCESS Plus program.

FFS SELECTIVE CONTRACTING COMPONENT (Specialty Pharmacy Drug Program) History:

The Specialty Pharmacy Drug Program was a component within the Pennsylvania 42 (PA-42) waiver program that allowed the Commonwealth to selectively contract for specialty drugs. Fee-For-Service Selective contracting for the Specialty Pharmacy Drug Program provided specialty pharmacy drugs, ancillary items and services and clinical supports to MA beneficiaries in the counties where the ACCESS Plus program (PCCM/PAHP) operated. Through the competitive bidding process, the Department selected two contractors to serve as the Department's preferred providers of specialty pharmacy services in the Specialty Pharmacy Drug Program. In the counties where HealthChoices PH managed care did not operate, both Fee for Service and ACCESS Plus-enrolled MA beneficiaries who had a medical need for a specialty pharmacy drug and qualified for coverage of pharmacy services were required to secure the drug from one of the Department's preferred providers. Under the Specialty Pharmacy Drug Program, dispensing providers no longer needed to acquire and stock specialty pharmacy drugs for MA beneficiaries. Instead, they ordered the specialty pharmacy drug from the Department's preferred providers. Dispensing providers continued to submit claims under the MA Program for the administration of the drug.

The Department's goal for the Specialty Pharmacy Drug Program is to maintain access to quality care for MA beneficiaries who have a medical need for specialty pharmacy drugs.

The Specialty Pharmacy Drug Program enables the Department to:

1. Operate an efficient and effective Specialty Pharmacy Drug Program as an alternative to the traditional fee-for-service model;

2. Offer MA beneficiaries a choice of specialty pharmacy preferred providers;

3. Provide a reliable and convenient dispensing and delivery system for providers and MA beneficiaries that facilitates care in clinically appropriate settings;

4. Provide a clinical support system designed to optimize therapy management, care coordination, and patient compliance; and

5. Provide cost-effective services through an accountable Specialty Pharmacy Drug Program.

The Department broadly defines specialty pharmacy drugs as drugs that require a set of services for access not typically provided in a traditional pharmacy outpatient setting. Specialty pharmacy drugs are generally biotechnical in nature and include, but are not limited to drugs that:

- Are used to treat chronic and/or life-threatening medical conditions.
- Are high cost and associated with complex dosing regimens.
- Require training for administering the drug
- Require additional patient education, monitoring, or counseling.
- Require temperature control or other specialized handling.

The Specialty Pharmacy Drug Program consists of the following:

The Department:

- Enrolls the Department's preferred provider(s) of specialty pharmacy drugs in the MA Program
- Designates the list of specialty pharmacy drugs to be included in the Specialty Pharmacy Drug Program
- Outreaches, notifies and educates MA beneficiaries and prescribers about the Specialty Pharmacy Drug Program
- Conducts all prior authorizations
- Resolves MA beneficiaries' appeals

The Specialty Pharmacy Drug Program preferred provider(s):

- Maintain an inventory of specialty pharmacy drugs and ancillary medical supplies and equipment
- Distribute specialty pharmacy drugs to providers and MA beneficiaries
- Assess patient adherence and compliance
- Operate patient assistance programs that include individualized education, guidance, support, and ongoing communication

The Department has periodically updated the list of drugs included in the Specialty Pharmacy Drug Program and notified providers and MA beneficiaries in advance of any changes. The most recent list of drugs included under the Specialty Pharmacy Drug Program can be found at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Specialty-Pharmacy-Program.aspx.

On December 20, 2013, CMS approved the HealthChoices PA 67 waiver amendment expanding selective contracting for the Specialty Pharmacy Drug program to Medicaid beneficiaries in all 67 counties statewide who continue to receive their health care benefits in the Fee-for-Service (FFS) delivery system into the PA 67 waiver.

Public Input Process and Changes During the Previous Waiver Period

Since the inception of HealthChoices, the Department has been committed to including the public in the development of the program. A comprehensive public input process was created that has proven invaluable throughout the implementation of statewide mandatory managed care, and is key to the on-going success of HealthChoices.

Providing stakeholders' information early and often remains the core concept for public involvement whenever program implementation or modification occurs. Examples of past and current stakeholder outreach and input include:

- Public discussion papers - typically describe the draft program design and are posted to the Department's website for review and comment.

- Stakeholder meetings- meetings are conducted in a variety of locations throughout the program area and provide the opportunity for face-to-face stakeholder input. Throughout the COVID-19 Public Health Emergency, stakeholder meetings were held on virtual platforms to ensure continued stakeholder input.

- Medical Assistance Advisory Committee (MAAC) and Subcommittee meetings- regularly scheduled meetings provide a forum to obtain input from stakeholders and providers, distribution of informational material and provide members with updates and address concerns, suggestions and issues for members.

- The Mental Health Planning Council (MHPC, referred to as the OMHSAS Advisory Committee) has three standing advisory committees: the Adult, Older Adult, and Child and Adolescent. The committee/advisory committees are very proactive in providing input and recommendations into the development and implementation of the expanded HealthChoices Behavioral Health Program, and the ongoing monitoring of the program.

- Provider Association Meetings - the Department meets with provider associations when necessary such as the Pennsylvania Medical Society, the Hospital and Health System Association of Pennsylvania, the Pennsylvania Association of Home Health Agencies and the Pennsylvania Community Providers Association. The Department identifies upcoming meetings sponsored by provider associations and secures placement on meeting agendas in order to distribute informational material, field questions and address issues.

- Telephone help lines for beneficiaries - the Department operates a toll-free telephone help line to respond to beneficiary inquiries and to address issues.

As key stakeholders in the program, MA providers are afforded a variety of avenues for the ongoing distribution of information such as:

- Department Web Site postings- public information, updates and training materials are maintained here.

- Training - the Department sponsors regional provider training sessions and teleconferences and conducts e-learning (computer based courses) for providers from the Department's web site. In addition, specialized training is provided for staff in the Department and other offices to respond to inquiries from providers, beneficiaries, advocacy groups and others whenever there is the implementation of a new program or modification of existing practices.

- Provider Newsletters - Prior to the implementation of a new program or initiative impacting the program, the Department circulates current and ongoing news through our *Provider QuickTips* that we distribute via email to PA provider associations and beneficiary organizations and post on the Department's web site. These *QuickTips* are published until the program implementation effective date.

- Bulletins - Bulletins serve as official communication from the Department to explain, clarify and revise Department policy and procedures. RA Alerts, Banner Pages and MA Bulletins are issued electronically on the Department's web site and via U.S. mail.

- Remittance Advice (RA) Alerts/ PROMISe™ Banner Pages - These notices are issued routinely to disseminate information to MA providers.

OTHER PROGRAM ENHANCEMENTS

Expedited Enrollment (BH-PIHP)

In order to allow immediate access to the HealthChoices BH-PIHP for persons who were determined eligible, the Commonwealth implemented the Expedited Enrollment initiative for HealthChoices Behavioral Health in January 2005. Prior to January 2005, individuals were enrolled in the HealthChoices BH-PIHP program after they chose their PH-MCO plan. Since individuals are assigned to the HealthChoices BH-PIHP available in their county of residence, it was not necessary for persons to wait until they chose their physical health plan before being enrolled in behavioral health. This initiative modified the information system logic to automatically enroll an individual into the HealthChoices BH-PIHP when determined MA eligible by the CAO and thus has removed the 30-45 day waiting period.

Multi-County Contracting Option (BH-PIHP)

In June 2002, CMS approved the Commonwealth's request to provide an additional contracting option for two or more counties who are jointly administering the HealthChoices Behavioral Health Program. A Multi-County Entity contracting option allows two or more counties which enter into a legally binding agreement, to have a single agreement with the Department. This option allows greater administrative efficiency for both the counties and the Commonwealth. It is expected that existing and future county groupings will choose this contracting option.

Program Monitoring

Monitoring initiatives have been and will continue to be a primary focus of the Department. The Department has Contract Monitoring Teams that monitor the PH-MCOs/BH-PIHPs. Databases and systems have been developed and implemented to collect monitoring data. Additionally, the Department has several committees that are responsible for a variety of programmatic reviews, such as prior authorization policy and formulary reviews. Examples of ongoing monitoring activities are described below.

Contract Monitoring Teams (PH-MCO)

Working in partnership with the PH-MCOs, Contract Monitoring Teams continue to perform physical health monitoring activities. Ongoing meetings and onsite reviews continue to be an integral component of monitoring. The Contract Monitoring Teams monitor all aspects of a PH-MCO including program quality, contract compliance, and

operational effectiveness. Contract Monitoring team members have various areas of expertise including, but not limited to, finance, information systems, program integrity, clinical services, quality management, special needs, policy, and contract requirements.

For 2012, the Department centered its monitoring attention in two areas: Appropriate Emergency Room Use and Oral Health. Activities being conducted by the MCOs for these two focus areas were discussed with the MCOs during regularly scheduled meetings such as CEO Meetings, Medical Directors' Meetings and Operations Meetings. Information surrounding these two focus topics was incorporated into two comprehensive grids to summarize all MCO current initiatives, member interventions, provider interventions and future initiatives. The information in these grids provides a concise overview of initiatives each MCO has for each of these focus topics.

In 2013, the teams enhanced their current monitoring efforts with an emphasis on quality improvement. The process included quarterly meetings with the MCOs to discuss their holistic performance in comparison to their quality improvement workplan goals, performance improvement targets and HealthChoices performance targets. The teams discussed current performance in relation to the workplan and other performance improvement plans. Teams are driving for performance improvement, improved health outcomes and to promote value-based solutions as part of their ongoing monitoring activities.

During 2016 through 2021 waiver period, the Department enhanced its monitoring activities with an emphasis on provider network geographics, access, provider data accuracy and accessibility. The Department developed an automated solution known as the Medical Assistance Program Oversight Portal (MPOP) to allow easier on-demand access to MCO provider network data to assist in analysis and questions related to network adequacy.

Contract Monitoring Teams (BH-PIHP)

The behavioral health monitoring and oversight process is managed by state/regional Contract Monitoring Teams composed of staff with program, quality management, fiscal, and data systems expertise. These Divisions work collaboratively to oversee, monitor, and perform quality activities to include performance measure collection and reporting; monitoring of operations; monitoring of contract compliance; annual surveys of member and provider satisfaction completed by the BH-MCOs; and satisfaction surveys conducted by local Consumer/Family Satisfaction Teams (CFSTs) contracted with the Behavioral HealthChoices Primary Contractors. OMHSAS incorporates recommendations from the public, the OMHSAS Planning Council, Primary Contractors, BH-MCOs, and the EQRO Technical Report in setting new goals and revising the OMHSAS Quality Strategy.

Systematic Monitoring Access and Retrieval Technology (SMART) (PH-MCO)

SMART, a user-friendly, menu-driven Microsoft Access database application, was originally developed in 1999 to assist Department staff in their contract monitoring efforts. The system goes through an annual review process whereby edits, updates based on changes to the HealthChoices Agreement and improvements are made. SMART is used along with other monitoring and documentation methods, to document results of the monitoring of the physical health managed care organizations and the enrollment broker. This tool ensures that all agreement standards are reviewed annually and MCO compliance is documented.

The Department has developed integrated, automated monitoring tools known as The Medical Assistance Program Oversight Portal (MPOP), that are used to proactively monitor Managed Care Organization Provider Networks, access and accessibility, provider network data accuracy and other program elements. During the upcoming waiver period, Contract Management Teams will refine and expand the use of MPOP in their program monitoring responsibilities. The SMART tool is housed within the MPOP system.

Program Evaluation Performance Summary (PEPS) (BH-PIHP)

OMHSAS uses a monitoring instrument called the Program Evaluation Performance Summary (PEPS). One hundred and seventy-two PEPS sub-standards (which are cross walked to 42 CFR § 438 Subparts C, D and F) are reviewed to determine compliance with federal and state requirements over a rolling three-year period. The tool is used to monitor compliance for the Primary Contractors or the BH-MCOs. The mechanisms for monitoring are quarterly meetings held by the OMHSAS Bureau of Community Operations, quality committee meetings held by the Primary Contractors, and EQR protocol submissions made by the BH-MCOs. The Primary Contractor provides reporting to the OMHSAS operational and quality reviewers prior to the meetings, and there is OMHSAS reviewer staffing at both monitoring and quality meetings. The goal is for each standard to be designated as "met," rather than "partially met" or "not met." Operationally, OMHSAS PEPS reviewers will use the "Partially Met" designation to encourage improvement by the Primary Contractor/BH-MCO in the reviewed PEPS Standard. If a standard is "not met," a CAP will be developed. OMHSAS may also determine that a CAP is necessary if a standard is "Partially Met."

Value-Based Purchasing (VBP)

The PH-MCO must enter into arrangements with providers that incorporate value based payment strategies such as performance based contracts, shared savings, shared risk, bundled payments, and global payments. Goals for value-based purchasing strategies are based on a percentage of the PH-MCO's expenditure of the medical portion of the capitation and maternity revenue received from the Department. The PH-MCO must achieve the following percentages of VBP:

a. Calendar year 2020 – 50% of the medical portion of the capitation and maternity care revenue must be expended through value-based purchasing strategies.

b. Calendar year 2021 – 50% of the medical portion of the capitation and maternity care revenue rate must be expended through value-based purchasing strategies.

c. Calendar year 2022 – 70% of the medical portion of the capitation and maternity care revenue rate must be expended through value-based purchasing strategies.

Compliance with these goals is measured through quarterly reporting requirements. By January 1 of each calendar year, the PH-MCO must submit an informational report to the Department that outlines its plan for compliance in that calendar year.

By January 1, 2018, the Behavioral Health Primary Contractors were to submit their proposed VBP plans to the Department that outlines and describes the plan for compliance in that calendar year. In subsequent years, the Primary Contractor must submit its proposed plan to the Department by October 1.

By June 30 of the subsequent calendar year, the Primary Contractor must submit an annual summary that includes the following:

- A review of the accomplishments and outcomes from the prior contract year;
- A report on the percentage of medical expenses expended through VBP strategies and the associated levels of financial risk; and
- A VBP detail report by provider that identifies the following:

    - Level of financial risk (no, low, medium, high) and Dollar amount spent for medical services expended;
    - VBP payment strategy/model(s) used;
    - Program type(s) included (Federally Qualified Healthcare Centers (FQHC), Certified Community Behavioral Health Clinics (CCBHC), Assertive Community Treatment (ACT) and Behavioral Heath Homes, etc.), if applicable;
    - CBOS and SDOH domains included; and
    - Evidence-based Practices and Programs [must be on the Substance Abuse & Mental Health Services Administration (SAMHSA) list of approved EBPPs and adhere to fidelity requirements]

Further, the financial goals for the VBP strategies for each calendar year are based on a percentage of the Primary Contractor's VBP expenditures to total medical expenses. The Primary Contractor must achieve the following percentages through VBP arrangements:

- Calendar year 2018 – 5% of the medical expenses must be expended through VBP strategies. The 5% may be from any combination of small, moderate or large financial risk categories.

- Calendar year 2019 – 10% of the medical expenses must be expended through VBP strategies. At least 50% of the 10% must be from a combination of moderate or large financial risk categories.

- Calendar year 2020 – 20% of the medical expenses must be expended through VBP strategies. At least 50% of the 20% must be from a combination of moderate or large financial risk categories.

Division of Quality and Special Needs Coordination (DQSNC) (PH-MCO)

The Department's Division of Quality and Special Needs Coordination (DQSNC) is located within the Office of Medical Assistance Programs (OMAP) Bureau of Managed Care Operations. The DQSNC is dedicated to the complete and seamless integration and coordination of physical and behavioral health services to meet the individualized needs of PH-MCO members. The DQSNC oversees the PH-MCO's grievance and appeals process and facilitates the submission of MCO members' requests for fair hearings, PH-MCO's Quality/Utilization Management activities, External Quality Review (EQR) activities, and other PH-MCO quality data and reporting activities. DQSNC produces reports that reflect quality outcomes and consumer satisfaction with the Physical Health HealthChoices Program. These are publicly posted on the Department's Internet site.

DQSNC staff within the Special Needs Unit work closely with the PH-MCOs to ensure those PH-MCO members who will "age-out" of EPSDT services are transitioned effectively to appropriate waiver services upon reaching the age of twenty-one (21). In addition, DQSNC staff is committed to ensuring a beneficiary centered focus by proactively participating with stakeholders in stakeholder activities – workgroups, meetings and community presentations.

In late 2017 the PH-MCOs began reporting information for children who are residing in Pediatric Facilities. The information demonstrates the PH-MCO's efforts to provide case management of those members in facilities, the communication with both the family and the facility, and discharge planning in order to ensure that children are safely discharged to a community environment. The staff in Special Needs evaluate these reports which are received quarterly and provide feedback to the PH-MCO's on their performance.

In 2020 DQSNC staff began holding meetings with each of the PH-MCO's to conduct a review of cases with a considerable number of unstaffed authorized shift care hours. As part of this process, the staff that monitor the PH-MCO's unstaffed shift care cases make

case referrals to the staff in Special Needs. These cases are reviewed during regularly scheduled meetings to not only evaluate efforts to staff the shift care but to evaluate the case management being provided to these members/families. These meetings have provided staff with valuable insight into the barriers to staffing the cases as well as an opportunity to collaborate with the MCO's on potential strategies to staff the case and to provide better case management to support the family.

Traditionally DHS's Special Needs Unit has held an in person annual Special Needs Training Day for the PH-MCO's. Beginning the first quarter of 2021 this has been altered to Quarterly meetings using a virtual platform to allow for broader attendance by the MCO's. This allows DHS to connect more regularly with the PH MCO on subject areas related to the Special Needs population and to address any identified problem areas and/or discuss new initiatives.

In 2014, DQSNC began holding Quarterly Quality Review Meetings (QQRMs) with each PH-MCO. The purpose of the QQRMs is to engage in discussions to address issues with variances in quality outcomes and discuss year-over-year performance through review of various data sources such as Healthcare Effectiveness Data and Information Set (HEDIS) and Pennsylvania Performance Measures. Additional topics of discussion center on the CMS Oral Health initiative and Improving Access to Pediatric Preventive Dental Care. In 2017 the QQRM's touched on all HEDIS quality measures that were below the 50th percentile Benchmark. This trend continued until 2019. In 2019 OMAP set the bar higher and began looking at measures that were below the 75th percentile Benchmark In 2020, the main QQRM topics focus on Women's Healthcare issues, Children's Health Care, Adult measures and the HEDIS Electronic Clinical Data Systems (ECDS) quality measures. DQSNC continues to include all measures in these categories that are below the NCQA HEDIS 75th percentile benchmark. Additional measures may be included due to being a high priority of the Department, even though they may be above the NCQA HEDIS 75th percentile threshold. Starting in 2021 the Dental Topics were removed from the current QQRM format and are discussed during a separate Dental QQRM.

In 2015 the Department added requirements for a Patient Centered Medical Home (PCMH) program. The PCMH model of care includes key components such as: whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team-based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care. The PH-MCOs must contract with high volume providers in their network who meet the requirements of a PCMH, make payments to their contracted PCMHs, collect quality related data from the PCMHs, reward PCMHs with quality-based enhanced payments, develop a learning network that includes PCMHs and other PH-MCOs, and report annually on the clinical and financial outcomes of their PCMH program. In order for a Practice to receive an incentive payment, they must meet the criteria specified by the Department.

OMAP has an MCO Pay for Performance (P4P) Program. The MCO P4P program consists of HEDIS and PA Performance Measures that impact a large portion of the PH-MCOs' membership or are related to either preventive or chronic conditions. PH-MCOs can earn a Benchmark Performance and Improvement Performance incentive payout. To receive an incentive payout there are different tiers and thresholds the PH-MCO must meet. Benchmark Performance requires a PH-MCO to be at or above the 75th percentile NCQA benchmark. Improvement Performance requires a year over year increase in the quality measure. In 2020, OMAP added two (2) Benchmark Bonus Bundles to the MCO P4P program. The first bundle is the Perinatal and Infant Bundle. The second bundle is the Child and Adolescent Well Care Bundle. PH-MCOs are eligible for an additional incentive payout for meeting the 75th percentile HEDIS NCQA benchmark for all the quality measures in the bundle. New for 2021, OMAP added a health equity improvement performance payout to the MCO P4P program focusing on reducing health disparities.

An additional incentive program OMAP continues is the Provider Pay for Performance (P4P) Program. The Provider P4P program targets improvements in quality of and/or access to health care services for HealthChoices members. PH-MCOs are required to develop a Provider P4P program using similar HEDIS and PA Performance Measures as the MCO P4P program. OMAP still requires the Annual Dental Visit measure, that all PH-MCOs build into their provider incentive program some type of incentive for the dentist. Over the last several years, the Department developed a more structured, consistent payout process for its Provider Pay for Performance Program that will more uniformly incent dental providers for completion of preventive dental services. The outcomes of the Provider P4P program is monitored during the QQRM meetings.

PH-MCOs are required to have Program Improvement Plans (PIP). The previous PIP cycle that focused on Pediatric Preventive Dental Care and Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits ended at the end of 2018. In 2019, the Department began a new PIP cycle. The Department chose Preventing Inappropriate Use or Overuse of Opioids and Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department visits. The Department's EQR contractor oversees the PIP process and works closely with DQSNC to track these PIPs including validation, analysis, and the interventions to facilitate improvements for its members for each of the PIP topics mentioned above.

For 2017 through 2020, OMAP continued the Community Based Care Management (CBCM) program that focused on reducing preventable admissions, readmissions, and non-emergent visits to the emergency department (ED); enhancing behavioral and physical health coordination of services; target providers/organizations that serve a large volume of complex MA beneficiaries including high risk pregnant women; and increasing access to pediatric dental preventive and restorative services. In 2019 and

2020, CBCM programs addressing Social Determinants of Health (SDOH), Diabetic Prevention Program (DPP), expanding and capacity building home-based support services, and promoting health education and wellness while encouraging the use of preventative health services were added. In addition, a rapid cycle improvement pilot program to improve health care outcomes and SDOH was added. The CBCM program will continue for 2021 and the Department will continue to track the outcomes of its various initiatives.

In 2016, OMAP in partnership with the Office of Mental Health and Substance Abuse Services (OMHSAS) began an incentive program that fosters collaboration between the PH-MCOs and County/Behavioral Health Managed Care Organizations (BH-PIHPs). The Department will provide financial incentives to the PH-MCOs and the BH-PIHPs for the Integrated Care Plan (ICP) Program. The ICP Program will be based on shared PH-MCO/BH-PIHP performance measures. The Department expects the ICP Program to improve the quality of health care and reduce MA expenditures through enhanced coordination of care between the PH-MCOs, BH-PIHPs and providers for members with Serious Persistent Mental Illness (SPMI). The ICP Program has continued and the Department continues to track the coordination efforts and outcomes that occur as a result of the shared efforts for these members. Starting in 2018, OMAP implemented Quarterly ICP calls to discuss and monitor the PH-MCOs compliance within the ICP program. Also in 2018, OMAP started conducting an annual ICP summit with both the PH-MCOs and BH-PIHPs to discuss successes and challenges and share best practices.

In 2020, OMAP developed the Maternity Home Visiting (MHV) program to address first time parents and parents of infants with additional risk factors. The PH-MCOs were required to expand and build capacity of their existing MHV program with evidence based, evidenced-informed, or outcomes-based maternal home visiting vendors. The MHV program is for all first-time parents and parents of infants with additional risk factors. However, this requirement does not preclude any parent/caregiver who has an infant less than 18 months from entering the MHV program voluntarily. The MHV program is based on parent/caregiver/infant needs. The span of the MHV is from birth to infants 18 months of age. The MHV program has a two generational approach, aimed at improving the well-being of both the parent and the children across the lifespan. The goal of the MHV program is to improve maternal and infant health outcomes and reduce maternal and infant morbidity and mortality. To achieve this goal, the MHV program includes licensed and/or non-licensed staff to evaluate families' strengths and needs and provide services tailored to those needs, such as: teaching positive parenting skills and parent-child interactions, providing information on a wide range of topics including breastfeeding, safe sleep practices, injury prevention and nutrition, conduct screenings and provide referrals to address postpartum depression, substance use disorders and family violence, as well as developmental screenings of children and connecting families to other services and resources as needed. The MHV program will continue in 2021. The Department will track outcomes and make revisions, as necessary, to improve the MHV program.

Division of Quality Management (BH-PIHP)

The Department's Division of Quality Management is located within the Bureau of Quality Management and Data Review in the Office of Mental Health & Substance Abuse Services (OMHSAS). The Division supports the Department's goals by using proven methodologies and evidenced based practices to ensure that adults and children with mental illness and/or substance use disorders and their families receive high quality services. Additionally, the Division works to ensure that those in care are provided a voice in the oversight of services they receive. This is done through the oversight of the satisfaction with complaints, grievance and fair hearing processes for consumers and providers. Technical assistance is also provided when needed to ensure that members understand their rights to file a complaint or grievance. QM is also responsible for the development and implementation of the Quality Management work plan that identifies specific activities, measures and indicators that are the focus of the Quality Management program.

QM also ensures that each Primary Contractor working with their contracted BH-MCO maintains and operates a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR § 438.330, and the HealthChoices Behavioral Health Program-Program Standards and Requirements (HCBH PS&R) Agreement for Primary Contractors. The QAPI is subject to annual review and approval by OMHSAS quality reviewers. The QAPI includes the following documents:

1) Program Description which outlines the quality structure of the program
2) Quality Work Plan which outlines how goals and performance is measured, and the
3) Annual Evaluation which provides the analysis of the Primary Contractor and BH-MCO's effectiveness in meeting their outlined goals from the year.

Further, the Division of Quality Management works in conjunction with the EQRO to select performance measures which are later validated. Each Primary Contractor is assigned a yearly performance goal to meet in performance measure reporting. Primary Contractors expected to improve in their performance measure rates, maintain compliance related to the structure and operations regulations, and to contribute to the planning and implementation of their specific BH-MCO's performance improvement to remediate barriers and improve service performance in their HCBH Contract service areas. If the Primary Contractor does not meet their goal in HEDIS® (FUH) a quality improvement plan (QIP) is assigned. If the BH-MCO does not meet the performance goal for this measure a Root Cause Analysis (RCA) and QIP is assigned. This work should also be reflected on the work plan.

In 2020, OMHSAS selected the topic, "Successful Prevention, Early Detection, Treatment and Recovery (SPEDTAR) for Substance Use Disorders" as a PIP for all BH-MCOs in the State. The PIP will extend from 2021 through 2023, including a final report due in 2024. The Aim Statement for this PIP, reflecting an emphasis on reducing racial

and ethnic health disparities, is: “Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach.”

Prior Authorization Review Panel (PARP) (PH-MCO)

The PARP is an interdisciplinary committee solely responsible for reviewing and approving all prior authorization proposals, policies, and procedures submitted by the PH-MCOs. All policies that require the prior and/or concurrent review of services for medical necessity, place of service, scope of service, or duration of service must be submitted to the Department for review and approval prior to implementation.

The PARP is led by the Division of Quality and Special Needs Coordination, chaired by the Department’s Medical Director and includes representatives from the Bureau of Policy, Analysis, and Planning, the Bureau of Fee-For-Service Programs, and OMHSAS.

Medical Necessity Criteria/Prior Authorization Review Panel (BH-PIHP)

The Medical Necessity Criteria/Prior Authorization Review Panel is the interdisciplinary committee solely responsible to review and approve all prior authorization proposals submitted by the BH-PIHPs. All policies that require the pre-certification, predetermination, concurrent review of services and or any other review for the purpose of authorizing services must be submitted to the Department for review and approval prior to implementation.

The Medical Necessity Criteria/Prior Authorization Review Panel is chaired by the Medical Director of OMHSAS and includes appropriate OHMSAS staff from the Regional Field Offices, the Division of Clinical Review and Consultation; Bureau of Policy, Planning, and Program Development; the Bureau of Quality Management and Data Review; and the Children’s Bureau.

Formulary Reviews (PH-MCO)

Each PH-MCO contracting with the Department has used a formulary in the administration of its pharmacy benefit. The formulary is approved by the Department, meets the clinical needs of the MA population, and allows coverage for other drug products not on the formulary through an exception process.

The PH-MCOs must submit all Formulary changes (additions, deletions) to the Department for review by the MCO Formulary Review Subcommittee. The Department must issue final approval of the changes prior to implementation.

The MCO Formulary Review Subcommittee is comprised of a subset of currently active

Department Pharmacy and Therapeutics (P&T) Committee members (internal and external) and reviews proposed changes (additions and deletions) to the MCO Formularies on a monthly or as needed basis. The Department issues the final decision to approve or disapprove the request and notifies the PH-MCO in writing of the decision. MCO representatives are excluded from this Subcommittee.

Readiness Reviews (PH-MCO/BH-PIHP)

Prior to HealthChoices implementation, physical health contractors and behavioral health contractors are required to successfully complete rigorous Readiness Reviews to document and determine their preparedness to implement the HealthChoices contracts. The Readiness Review process includes comprehensive desk, virtual (IT on line) and on-site reviews of PH-MCOs'/BH-PIHPs' program, financial, information systems, provider network adequacy and operational policies and procedures. PH-MCOs/BH-PIHPs are evaluated on their ability to meet the requirements outlined in the Request for Applications (RFA) procurement documents and to complete the tasks in their proposals, as well as meet HealthChoices Agreement requirements (a part of the RFA). The Readiness Review Assessment Instrument is a review tool that follows the outlined RFA/procurement requirements. Certain sections of the Assessment Instrument are highlighted as critical elements. PH-MCOs/BH-PIHPs must demonstrate the ability to meet the critical elements to the Department's satisfaction prior to initiating the contract. Follow-up occurs on all non-critical elements until they are completed to the satisfaction of the Department.

Behavioral Health Annual Reviews (BH-PIHP)

In addition to ongoing meetings with the counties and the BH-PIHPs, annual performance reviews are conducted using the Program Evaluation Performance Summary (PEPS), an ongoing monitoring tool used to evaluate the Counties/BH-PIHPs compliance with state and federal regulations, and the requirements of the HealthChoices Program. It provides a standardized means to track the on-going performance of county/BH-PIHP HealthChoices operations after Readiness Review. In addition to tracking compliance with the requirements of HealthChoices, PEPS provides a master file of supporting documentation. The major areas of focus are: access and service availability, coordination and continuity of care, medical necessity, in-plan services, provider and member enrollment/disenrollment, credentialing and recredentialing, utilization management, member rights and services, complaints, grievances and appeals, confidentiality, quality management, information systems, and executive management. Contract Monitoring Teams use various program and financial management reports to identify contract specific issues that may require more intensive review. Reports on timeliness of claims payments, service utilization, complaints and grievances files, performance outcome measures, solvency, and quality management must be submitted by

the BH-PIHPs. In addition, clinical chart reviews are conducted, and include appropriate clinical and program staff.

FFS SELECTIVE CONTRACTING COMPONENT (Specialty Pharmacy Drug Program)

The Specialty Pharmacy Drug Program monitoring and oversight process is managed by the pharmacy staff in the Bureau of Fee-For-Service Programs. The staff conducted Readiness Reviews for preferred providers. Ongoing monitoring and oversight is carried out through status meetings and reports submitted to the Department by preferred providers.

ONGOING ADVISORY GROUPS (PH-MCO/BH-PIHP)

Ongoing stakeholder involvement in the implementation and operation of the HealthChoices Program occurs through the various workgroups and beneficiary and advisory groups listed below.

Health Education Advisory Committee (PH-MCO)

A Health Education Advisory Committee that includes MA beneficiaries and community providers has been established by each PH-MCO. Representation on this Committee includes, but is not limited to, women, minorities, persons with special needs and at least one person with expertise on the medical needs of children with special needs. Provider representation includes physical health, behavioral health, and dental health providers. This Committee provides advice on the health education needs of managed care beneficiaries and includes PH-MCO beneficiaries and service providers.

Enrollment Assistance Program (EAP) Advisory Committee (PH-MCO/BH-PIHP)

An EAP Advisory Committee has been developed in each zone to provide a formal structure for the exchange of ideas between the HealthChoices EAP contractor and the communities to which it provides services. Membership is representative of the economic, ethnic, racial, social, special needs, cultural, and community climate in each zone. The committee is involved in promoting an understanding of managed care by MA beneficiaries and in the design and development of materials for beneficiaries and outreach efforts. The committee currently meets three times per year. Meetings are announced publicly, open to public participation, and conducted in a format that invites and encourages dialogue with the general public. Advisory Committee meetings provide a forum for consumer groups to provide input to the Department on the ongoing operation of the EAP.

The website includes a "Contact Us" function which allows MA beneficiaries and other stakeholders to comment on any aspect of EAP.

GENERAL MA PROGRAM SUPPORTS
(Applicable to all programs under this waiver)

Medical Assistance Transportation Program (MATP) Enhancements

The Department has implemented a formal referral process for MATP Grantees to follow for MA beneficiaries in HealthChoices MCOs. MATP Grantees will make referrals to MA consumers' respective PH-MCOs or BH-PIHPs under the following circumstances:

- **When a MA consumer needs non-emergency medically necessary ambulance transportation.**

- **When a non-transportation issue arises that prevents the MATP Grantee from providing otherwise eligible transportation services and the PH-MCO or BH-PIHP may be able to provide assistance in removing the barrier.**

The Department has standard policies and procedures to monitor MATP. This includes:

- **Programmatic and Financial key indicators and Medicaid Program Oversight Portal (MPOP) tool to assist management and staff in identifying possible areas of concern.**

- **Reports and procedures to create and monitor budget projections that includes:**

    - **MATP Budget Analysis Report**
    - **MPOP Budget Forecasting Tab**
    - **MATP Quarterly Actual Expenditure Report**
    - **MATP Reconciliation Report**

- **Reports and procedures to monitor and improve the submission of trip level data that includes:**

    - **MATP Monthly Trip Level Data to Quarterly Report Comparison Report**
    - **MA Ineligibles Report**

o MATP Multiple Data Warehouse Trip Reports

The Department has a website for the transportation program at: matp.pa.gov. The site has both beneficiary (location of county providers, how to reserve a ride, etc.) and provider information (data, eligibility, Operations memorandums, etc.).

MAAC and Subcommittees (PH-MCO/BH-PIHP)

Pennsylvania's MAAC was established in compliance with 42 CFR, Section 431.12. The mission of the MAAC is to provide the Department with advice about access to and delivery of good quality health care services in an efficient, economical, and responsive manner to low income individuals and families. Membership of the MAAC includes:

- Board-certified physicians
- Current providers of MA services
- Other health care professionals
- Managed Care Organizations contracted with the Department
- Representatives of beneficiary and provider organizations
- Current and former beneficiaries
- Families of beneficiaries
- Other persons knowledgeable about the health care needs of low income population groups

Although not a requirement of federal regulations, Pennsylvania has developed a MAAC Subcommittee structure. The mission of the five standing Subcommittees of the MAAC – Consumer, Fee-for-Service Delivery System, Long Term Care Delivery System, Managed Care Delivery System, and Managed Long Term Services and Supports – is to serve as resources to the MAAC. The Subcommittees review and discuss various topics related to the MA Program and forward recommendations and motions for MA program changes and enhancements to the MAAC for consideration. The MAAC, Consumer Subcommittee, and the Managed Care Delivery System Subcommittee meet monthly except August and November; the Fee-for-Service Delivery System Subcommittee meets quarterly, the Long-Term Care Delivery System Subcommittee meets bi-monthly, and the Managed Long Term Services and Supports Subcommittee meets monthly. Committee meeting materials such as minutes and presentations are distributed to the members and subscribers though the Department's listserv.

Department program offices seek the advice of the MAAC on new or revised policies, regulations, procedures, and operations that affect the following:

- Eligibility for MA benefits

- Amount, duration, and scope of benefits that an MA beneficiary is entitled to receive

- Health care delivery systems

- Provider reimbursements in the fee-for-service delivery system

- Access to quality, cost effective health care benefits

Examples of HealthChoices related issues presented to the MAAC for discussion include:

- Performance Based Contracting

- Procurements for expanding the program

- Coordination between Physical Health (PH-MCO) and Behavioral Health (BH-PIHP)

- Selected Regulations and Bulletins for comment

- National Health Care initiatives and their impact on PA

Mental Health Planning Council (MHPC) (BH-PIHP)

The MHPC is federally mandated by the Public Health Services Act and charged with the following four primary responsibilities:

- Review OHMSAS' quality performance measure results annually and provide guidance on quality goals.

- Assist in the annual preparation, review, approval, and submission of the Community Mental Health Services Block Grant proposal.

- Serve as an advocate for persons with serious mental illness, children and adolescents with serious emotional disturbance, and other individuals with mental illness or emotional problems.

- Monitor, review, and evaluate the allocation and adequacy of mental health services in the Commonwealth.

The MHPC is comprised of three committees and one subcommittee: Children's Behavioral Health Advisory Committee, Adult Behavioral Health Advisory Committee, Older Adult Behavioral Health Advisory Committee, and the Persons in Recovery (PIR) Subcommittee. Each of the three committees has 25 members, for a total of 75 individuals having membership in the Planning Council. The representatives on the PIR subcommittee are drawn from the three committees.

Membership of the MHPC includes mental health beneficiaries, persons in recovery from substance abuse disorders, family members of consumers and children and adolescents with serious emotional disturbance and/or substance abuse disorders, advocates, service providers/professionals, and collaborating state agencies. Also members of the MHPC are the co-chairs of each of the standing advisory committees. The MHPC (including its standing advisory committees) has the opportunity to provide input to the HealthChoices program, the development of RFPs and implementation and monitoring of the program.

The Planning Council meets four times a year. The meetings include joint sessions by all of the committees (Children's Advisory Committee, Adult Advisory Committee, and Older Adults Advisory Committee) as well as separate individual sessions by these committees. All actions before the MHPC committees are presented as formal motions and voted on by members. A simple majority constitutes approval of any motion. The approved motions are forwarded to the OMHSAS for required action and follow-up. Actions taken by OMHSAS are reported back to the MHPC at the subsequent meeting.

The meetings are attended, in addition to the MHPC members, by the Deputy Secretary for OMHSAS and other key staff. The Deputy Secretary and other OMHSAS staff provide reports and updates to the Planning Council on issues that are of interest to the stakeholders. Presentations by stakeholder groups and cross-systems partners are also included in the MHPC proceedings as appropriate. In addition to the four meetings in the year, OMHSAS communicates with the MHPC through a listserv to provide updates on issues that matter to the Planning Council.

The Enrollment Assistance Program (EAP) (PH-MCO/BH-PIHP)

The Department is committed to maximizing beneficiary choice and minimizing auto assignments and uses an enrollment broker to educate MA beneficiaries about their managed care plan options and helps assist them to select a plan and a Primary Care Physician (PCP).

The Enrollment Assistance Program serves MA Beneficiaries enrolled in or eligible for HealthChoices, the Department's mandatory physical health and behavioral health managed care program.

A. Statutory Authority

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

   a. **X** **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

   b. **X** **1915(b)(2)** – A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing MCOs/PIHPs in order to provide enrollees with more information about the range of health care options open to them.

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

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

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

      X MCO The HealthChoices physical health mandatory managed care program

      X PIHP MA beneficiaries receive their behavioral health services through the BH-PIHP Program.

      _ PAHP This applies to the disease management (PAHP) component of the program.

      _ 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.)

X FFS Selective Contracting program (please describe)

Under the Department's Selective Contracting Specialty Pharmacy Drug Program, preferred provider(s) are responsible for the distribution of specialty pharmacy drugs, assessing patient adherence and compliance, and operating patient assistance programs that include individualized education, guidance, support, and ongoing communication. A description of the Specialty Pharmacy Drug Program is included in Section A: Program Description, Part I: Program Overview, Selective Contracting Component**. (The FFS Specialty Pharmacy Drug Program serves non-excluded FFS beneficiaries statewide (all 67 counties).**

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.

b.**X** **Section 1902(a)(10)(B)** – Comparability of Services–This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program. **PH-MCO, BH-PIHP, FFS Selective Contracting (Specialty Pharmacy Drug Program)**

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

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

BH-PIHP – For HealthChoices BH-PIHP, the Department requests a waiver of applicable regulations requiring a state to offer beneficiaries a choice of PIHP. Approval of such a waiver will allow the Department to offer only one BH-PIHP per county. The Department will continue to require the contracted BH-PIHP to offer to beneficiaries a choice of providers for each service level (except crisis services).

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

B. Delivery Systems

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

a. **X** **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. **X** **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.

X The PIHP is paid on a risk basis **for all behavioral health services.**
___ 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. **X** **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
X is different than stipulated in the state plan (please describe)

The Department released a Request for Applications (RFA) on October 24, 2019. Bidders propose payments rates and the Department negotiates specialty fees instead of following the payment methodology stipulated in the state plan. Also, no Fee-for-Service beneficiary co-payment will be deducted from the reimbursement as specialty drugs will be excluded from copayment.

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

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

X **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

PH-MCO –MCOs are chosen by a competitive procurement process for all zones. The Department is in the process of completing a statewide reprocurement. The Department will continue to extend its current Agreements with PH-MCOs until it is able to implement the PH-MCOs selected as part of the competitive Request for Application process that was issued in 2019.

BH-PIHP – Sixty-six counties exercised their right of first opportunity. One county (Greene) did not exercise the right of first opportunity (please see chart in Section A for a listing of the counties). For that county, the Department, through a competitive process, selected and directly contracted with a private sector BH-PIHP. The remaining 66 counties' BH-PIHP Agreements were procured in accordance with federal regulation 45 CFR § 92.36(a). Beginning January 1, 2022, Greene county will be joining the North Central Zone consortium, no longer requiring the Commonwealth to procure this contract.

FFS Selective Contracting (Specialty Pharmacy Drug Program) – The Department released an RFA to selectively contract with two preferred

providers to provide specialty pharmacy drugs. The program was originally implemented on January 12, 2009.
The Department issued a new RFA on October 24, 2019 to select two preferred providers. Accredo Health Group and Chartwell Pennsylvania were selected to provide specialty pharmacy drugs statewide to those beneficiaries who are not enrolled in the HealthChoices or Community HealthChoices Programs and receive their pharmacy services through the Fee-for-Service delivery system. The base agreement period with the selected specialty pharmacies is two years beginning on July 1, 2020. The agreement provides for three optional renewal years. Extension of one or both of the contracts is in the sole discretion of the Department.

___ **Open** cooperative procurement process (in which any qualifying contractor may participate)
___ **Sole source** procurement
___ **Other** (please describe)

C. Choice of MCOs and PIHPs

1. **Assurances.**

X 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.

There are four MCOs in the Southwest zone, five in the Lehigh-Capital zone, five in the Southeast zone, four in the New West zone and three in the New East zone.

X The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

BH-PIHP – Beneficiaries are enrolled in the BH-PIHP operating in their county of residence. Beneficiaries have a choice of at least two providers for all services covered by the BH-PIHP (except crisis services).

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

X Two or more MCOs **(for physical health only)**
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
X Other: (please describe)
BH-PIHP – Beneficiaries will have a choice of at least two providers for all services covered by the BH-PIHP (except crisis services).

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**

_X_ Beneficiaries will be limited to a single provider in their service area (please define service area).

Beginning July 1, 2022, DHS may elect to exercise the optional renewal years of the Agreement with one of the preferred specialty pharmacy providers. However. MA FFS beneficiaries covered under the Specialty Pharmacy Drug Program can request an exception to the use of preferred provider thereby allowing them to exercise choice of provider. The service area will be statewide (all 67 counties).

___ Beneficiaries will be given a choice of providers in their service area.

_X_ Beneficiaries will be given a choice of two preferred providers of specialty pharmacy drugs. Through June 30, 2022.

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

   _X_ **Statewide** – all counties, zip codes, or regions of the State **PH-MCO, BH-PIHP,FFS Selective Contracting (Specialty Pharmacy Drug Program)**

   __ **Less than Statewide**

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, PIHPor other entity) with which the State will contract.

PH-MCO		
City/County/Region	**Type of Program (MCO or PIHP)**	**Name of Entity (for MCO, PIHP, PAHP)**
Southeast Zone- **Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties**	**All entities listed are MCOs.**	**Aetna Better Health** **Health Partners Plans** **Keystone First** **UnitedHealthcare Community Plan of PA**
Southwest Zone— **Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland Counties**	**All entities listed are MCOs.**	**UPMC for You** **UnitedHealthcare Community Plan of PA** **Gateway Health** **Aetna Better Health**
Lehigh/Capital Zone— **Adams, Berks, Dauphin, Cumberland, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York Counties**	**All entities listed are MCOs.**	**Aetna Better Health** **AmeriHealth Caritas** **Gateway Health** **UnitedHealthcare Community Plan of PA** **UPMC for You**
New West Zone – **Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren**	**All entities listed are MCOs.**	**AmeriHealth Caritas** **Gateway Health** **UPMC for You** **Aetna Better Health**
New East Zone- **Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and**	**All entities listed are MCOs.**	**AmeriHealth Caritas Northeast** **Geisinger** **Aetna Better Health**

Wyoming		

BH-PIHP		
City/County/Region	**Type of Program (MCO or PIHP)**	**Name of Entity/Subcontractor (for MCO, PIHP, PAHP)**
Southeast Zone Counties:	**All entities listed are PIHPs**	
Bucks		**Magellan Behavioral Health (MBH)**
Chester		**Community Care Behavioral Health**
Montgomery		**Magellan Behavioral Health**
Delaware		**Magellan Behavioral Health**
Philadelphia		**Community Behavioral Health (CBH)**
Southwest Zone Counties:	**All entities listed are PIHPs**	
Allegheny		**Community Care Behavioral Health**
Armstrong, Butler, Indiana, Lawrence, Washington, Westmoreland, Beaver, and Fayette		**Beacon Health Options of PA**

Lehigh/Capital Zone Counties: **Lehigh** **Northampton** **York** **Adams** **Berks** **Cumberland, Dauphin, Lancaster, Lebanon, and Perry**	**All entities listed are PIHPs**	**Magellan Behavioral Health** **Community Care Behavioral Health** **Community Care Behavioral Health** **Community Behavioral Healthcare Network of PA (CBHNP)/DBA PerformCare**
***Northeast Zone Counties*:** **(Northeast Behavioral Health Care Consortium)** **Luzerne** **Lackawanna** **Susquehanna** **Wyoming**	**All entities listed are PIHPs**	**Community Care Behavioral Health**
***North Central Zone Counties*:** **Bradford/Sullivan, Cameron/Elk, Centre, Clarion, Clearfield/Jefferson, Columbia/Montour/Snyder/Union, Forest/Warren, Greene Huntingdon/Mifflin/Juniata, McKean, Northumberland, Potter, Schuylkill, Tioga, and Wayne Counties**	**All entities listed are PIHPs**	**Community Care Behavioral Health**
***North/Central County Option Zone Counties*:** **Bedford/Somerset, Franklin/Fulton** **Carbon/Monroe/Pike, Clinton/Lycoming, Blair, Erie**	**All entities listed are PIHPs**	**Community Behavioral Healthcare Network of PA (CBHNP))/DBA PerformCare**

Cambria, Crawford, Mercer, Venango		**Community Care Behavioral Health** **Magellan Behavioral Health** **Beacon Health Options of PA**

FFS Selective Contracting		
Service Area	**Type of Program (MCO or PIHP)**	**Name of Entity (for MCO, PIHP, PAHP)**
Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Bucks, Butler, Cambria, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Delaware, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montgomery, Montour, Northampton, Northumberland, Perry, Philadelphia, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne and Wyoming, and York	**FFS Selective Contracting (Specialty Pharmacy Drug Program)**	**Accredo Health Group** **Chartwell Pennsylvnia**

E. Populations Included in Waiver

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

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

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

X Mandatory enrollment
PH-MCO, BH-PIHP, FFS Selective Contracting (Specialty Pharmacy Drug Program)
_ Voluntary enrollment

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

X Mandatory enrollment
PH-MCO, BH-PIHP, FFS Selective Contracting (Specialty Pharmacy Drug Program)
___ Voluntary enrollment

X **Blind/Disabled Adults and Related Populations** are beneficiaries, age **21** 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.

X Mandatory enrollment
PH-MCO, BH-PIHP, FFS Selective Contracting (Specialty Pharmacy Drug Program)
___ Voluntary enrollment

X **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age **21**, who are eligible for Medicaid due to blindness or disability.

X Mandatory enrollment
PH-MCO, BH-PIHP, FFS Selective Contracting (Specialty Pharmacy Drug Program)
_ Voluntary enrollment

X **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.

X Mandatory enrollment
PH-MCO, BH-PIHP, FFS Selective Contracting (Specialty Pharmacy Drug Program)
___ Voluntary enrollment

X **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.

X Mandatory enrollment
PH-MCO, BH-PIHP, FFS Selective Contracting (Specialty Pharmacy Drug Program)
_ Voluntary enrollment

X **Women in the Breast and Cervical Cancer Prevention and Treatment Program**

X Mandatory enrollment
PH-MCO, BH-PIHP FFS Selective Contracting (Specialty Pharmacy Drug Program)

___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

X **OTHER**

- **HCBS Waiver (Except those individuals enrolled in the Pennsylvania Department of Human Services Aging Waiver in excess of 30 days.) (Note: Please see HCBS Waiver excluded population on page 41 for Aging Waiver exclusion.)**

- **Individuals 19 to 64 years old, newly eligible through the HealthChoices Expansion (Medicaid expansion).**

- **Former Foster Care children as described at §1902(a)(10(A)(i)(IX) of the Social Security Act**

The Specialty Pharmacy Drug Program will affect all FFS beneficiaries statewide (67 counties) and includes the following:

Except for the populations specified as excluded from the Specialty Pharmacy Drug Program under 2. Excluded Populations.

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

X **Medicare Dual Eligible--**Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E)) **Age 21 and older – PH-MCO, FFS Selective Contracting (Specialty Pharmacy Drug Program)**

___ **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.

X **Other Insurance--**Medicaid beneficiaries who have other health insurance. **FFS Selective Contracting (Specialty Pharmacy Drug Program). Beneficiaries who are enrolled in the Health Insurance Premium Payment (HIPP) Program**

X Reside in Nursing Facility (in excess of 30 days) including beneficiaries in VA LTC Residential Facilities or state-operated ICF/ID**. PH-MCO, Beneficiaries residing in nursing facilities, excluding VA LTC Residential Facilities or state-operated ICF/IDs will receive BH-PIHP services through their HealthChoices BH-PIHP after enrollment in Community HealthChoices.**

X **Enrolled in Another Physical Health Managed Care Program—PH-MCO** Medicaid beneficiaries who are enrolled in another Medicaid managed care

program. **Medicaid beneficiaries who meet the NFCE level of care will be enrolled in Community HealthChoices.**

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

X **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver). **Beneficiaries over age 21 who participate in HCBS Waivers are excluded from PH-MCOs.**

___ **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.

__X_ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program. **SCHIP is not part of the state Medicaid Program.**

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

X **Other** (Please define):

The Department excludes the following populations from this waiver:

PH-MCO and BH-PIHP -

- **Reside in transitional care home (These are tertiary care centers that provide medical and personal care to children upon discharge from the hospital; residing in a tertiary care center usually lasts no longer than 6-10 months. During this time, care givers receive training to care for the children so that the children can be placed in their homes.)**
- **Reside in or admitted to a state psychiatric hospital.**
- **Reside in a Juvenile Detention Center (JDC). Exception: Beneficiaries who are enrolled in a PH-MCO/BH-PIHP prior to their admission to a JDC remain the responsibility of the PH-MCO/BH-PIHP with which they were enrolled for the first 35 consecutive days after placement. During this time,**

beneficiaries are eligible for plan services provided outside (off-site) of the JDC.

- **SLMBs and QMBs without full Medicaid.**
- **Individuals enrolled in LTCCAP.**
- **Aliens who are eligible only for services for emergency medical conditions.**

FFS SELECTIVE CONTRACTING (SPECIALTY PHARMACY DRUG PROGRAM) -

- **All MA eligible beneficiaries in an out-of-state placement.**
- **All MA eligible beneficiaries enrolled in a HealthChoices Program PH-MCO or a Community HealthChoices MCO.**

F. Services

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

1. **Assurances.**

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

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

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

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

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

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

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

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

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

X The PAHP does not cover emergency services. **The PH-MCO, BH-PIHP, and Fee-for-Service (FFS) Selective Contracting (Specialty Pharmacy Drug Program) cover emergency services.**

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.

_**X**_ Other (please explain):

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

___ Family planning services are not included under the waiver.

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

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

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

PH-MCO – The Agreement between the Department and the PH-MCOs contains the following provider network requirement:

The PH-MCO must also include in its Provider Network every FQHC and RHC located within this HealthChoices Zone that is willing to accept PPS rates as payment in full.

BH-PIHP - The behavioral health contract requires BH-PIHPs to include in its Provider Network every FQHC and RHC in their covered area that is willing to accept PPS rates as payment in full.
FFS Selective Contracting (Specialty Pharmacy Drug Program) – The program is mandatory; if the FFS beneficiary elects to have the specialty drug administered at the FQHC, the FQHC is required to order the drug from a preferred provider.

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

5. **EPSDT Requirements.**

X The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act

related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

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

7. **Self-referrals.**

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

PH-MCO:

- **Routine OB/GYN services**
- **Vision, dental, chiropractic services from participating network providers**
- **Emergency services**
- **Family planning services.**

BH-PIHP - Emergency Services

- Some BH-PIHPS allow a set number of self-referrals per beneficiary after the initial assessment for outpatient services.

SELECTIVE CONTRACTING (Specialty Pharmacy Drug Program) -

An MA Fee-for-Service beneficiary does not need a referral to request a preferred provider to fill a prescription for a specialty pharmacy drug. MA beneficiaries and prescribing providers are provided toll free telephone numbers for the preferred provider. The MA beneficiary or the prescribing provider can call and request a prescription and indicate the site of delivery where the drug will be administered (home, prescriber's office, clinic, infusion site, etc.) Prior authorization of drugs as specified in the state plan still apply.

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

Pennsylvania continues to comply with the above referenced statutes and regulations as previously indicated in the CMS approved PA 67 waiver for 2017-2021.

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

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

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

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

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

1.__ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

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

1._ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

c. ___ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

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

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.

Preferred providers of specialty pharmacy drugs have a toll-free telephone system in operation 24 hours per day, 7 days per week, including holidays to receive prescriptions and respond to clinical inquiries, and general inquiries and complaints. Preferred providers must provide prescribed drugs by the "need by" date specified by the prescribing provider or the MA Fee-for-Service beneficiary.

B. Capacity Standards

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

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

Pennsylvania continues to comply with the above referenced statutes and regulations as previously indicated in the CMS approved PA 67 waiver for 2017-2021.

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

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

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

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

a._ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b._ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.

c._ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

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

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

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

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

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

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

Selection and Availability of Providers:

1. Selection Criteria

The Specialty Pharmacy preferred provider(s) were selected through the competitive bidding process. Criteria for selection includes technical (understanding of the problem, corporate background and prior experience, financial condition, personnel qualifications and organization, and soundness of approach) criteria and cost. Specific program requirements are delineated in the final Agreements.

2. Numbers and Types of Qualifying Providers

Provider Types	Number of Medicaid Providers Participating Before the Waiver	Number of Medicaid Providers Expected to Participate Under the Waiver
Pharmacy	**3,485 ***	**2 through 6/30/2022 1 effective 7/1/2022**

***reflective of providers in all 67 counties

3. The selected contractors must be a licensed pharmacy and must have the following staff:

a. Project Manager
b. Clinical Pharmacist
c. Specialty Pharmacy Operations Point-of-Contact
d. Operations Pharmacist Point-of-Contact
e. Pharmacy staff
f. Clinical Center Staff

4. Provider/Beneficiary Ratio

Area (City/County/Region)	Provider-to-Beneficiary Ratio Without the Waiver Under the Waiver
Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Bucks, Butler, Cambria, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Delaware, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montgomery, Montour, Northampton, Northumberland, Perry, Philadelphia, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren,	**1:36 total FFS population of beneficiaries obtaining prescriptions 1:124,000 total FFS population of beneficiaries obtaining prescriptions (1:124 for beneficiaries using specialty drugs*)**

Area (City/County/Region)	Provider-to-Beneficiary Ratio Without the Waiver Under the Waiver
Washington, Wayne and Wyoming, and York	

***Based on past experience with the Specialty Pharmacy Drug Program, the Department determined that the ratio of specialty pharmacies to Fee-for-Service beneficiaries is sufficient to ensure access to services. Approximately 0.1% of the Fee-for-Service population was prescribed a specialty drug during calendar year 2020.**

C. Coordination and Continuity of Care Standards

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

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable. **PH-MCO, BH-PIHP**

Pennsylvania continues to comply with the above referenced statutes and regulations as previously indicated in the CMS approved PA 67 waiver for 2017-2021.

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

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

The following items are required.

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

BH-PIHP - The scope of services is limited to behavioral health services. All beneficiaries receiving behavioral health services are considered to be persons with special needs. Therefore, it is not necessary for the state to implement mechanisms to identify persons with special health care needs to BH-PIHPs.

Assessment Requirements: Since all beneficiaries receiving behavioral health services are considered to be persons with special needs, and the state does not individually identify persons with special needs to BH-PIHPs as described above, BH-PIHPs would not be required to implement mechanisms to assess each Medicaid beneficiary identified by the State.

Treatment Plan Requirements: Behavioral health providers are required to develop an individualized treatment plan with the beneficiary, which addresses the person's strengths, needs, choice/preferences, etc. as identified in the assessments. Since treatment planning is the responsibility of the behavioral health provider who establishes the beneficiary's course of treatment, and behavioral health providers coordinate care with the beneficiary's PCP, it is not practical for PCPs to develop treatment plans for behavioral health services. PCPs may refer a beneficiary at any time for behavioral health services.

Direct Access to Specialists Requirements: Since beneficiaries receive assessments and treatment planning from a behavioral health provider (who is considered to be a specialist), the person already has direct access to a specialist.

b. **X** **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.

PH-MCO –

Persons with a special need, regardless of their age, may self-identify during the enrollment process or at any time during their enrollment with the PH-MCO. Information on persons with special needs identified during the enrollment process is then forwarded to the MCO/PIHP on a regular basis. This information is used to focus PH-MCO outreach efforts to persons with special needs. Persons with special needs are also identified by the PH-MCO through a number of sources, including but not limited to; interactions with the PH-MCO or BH-PIHP, member services unit, requests for utilization of services, interactions between pharmacies and the PH-MCO or new beneficiary assessments, including SDOH assessments.

BH-PIHP - please see 2a above.

c. **X** **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.

PH-MCO – Persons with special needs may be identified at the time of enrollment through self-declaration, or by the person's family. The Enrollment Assistance Program (EAP) contractor forwards this information to the MCOs. The MCO may also identify persons with special needs through sources such as the receipt of authorization requests or referrals from the provider network or required initial physical exams. Additionally, the MCOs also identify enrollees with special needs through contacts and referrals from the beneficiary's families, advocates and Division of Quality and Special Needs Coordination (DQSNC) staff, and calls that come in through their member services and Special Needs Units. Also, the MCOs review utilization patterns to identify persons with special needs. The MCOs conduct new member assessments as well as SDOH assessments which allow for the identification of any members with need which will benefit from management by the Special Needs Units.

For BH-PIHPs, initial assessments are not required upon enrollment. However, persons with behavioral health issues may request an assessment at any time. In Pennsylvania's managed care program, behavioral health services are carved out from physical health managed care. All Medicaid beneficiaries are automatically enrolled in a BH-PIHP when their Medicaid application is approved. When the members seek behavioral health services, assessments are done at the provider level, as needed, to determine the appropriate type of service and level of care. BH-PIHP – please also see 2a above.

d. **X** **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.**X** Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

BH-PIHP - please see 2a above.

2.__ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3.**X** In accord with any applicable State quality assurance and utilization review standards.
BH-PIHP - please see 2a above.

e. **X** **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.
BH-PIHP - please see 2a above.

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

a. _ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

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

c. _ Each enrollee receives **health education/promotion** information. Please explain.

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

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

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

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

h. _ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

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

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

Selective Contracting (Specialty Pharmacy Drug Program):
Prior to implementation and whenever a new drug or class of drugs is added to the Specialty Pharmacy Drug Program, the Department ensures that continuity and coordination of care are not negatively impacted by the selective contracting program through a comprehensive and detailed transition plan that includes the following:

1. Selected contractor requirements for coordination with the Department and the MA beneficiary's PCP and/or prescribing provider.

2. Specific client notices to all MA beneficiaries with a recent history of taking a specialty pharmacy drug explaining the Program, how it works and what to do to continue to receive their specialty drugs.

3. Notices to providers announcing the Program, identifying the preferred providers and how to contact the provider, and explaining how the Program works.

4. Updates to the website.

5. Public information forums including presentations to the MAAC, Subcommittees of the MAAC, other advisory committees, and provider associations.

6. A transition period sufficient to allow MA beneficiaries and providers administering specialty drugs to contact a preferred provider; this includes recognition of existing prescriptions with a current prior authorization and dispensed by non-preferred providers.

7. Department monitoring of selected contractor performance.

Section A: Program Description

Part III: Quality

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

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(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.

X 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's Quality Strategy was updated and submitted to CMS in December 2020.

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

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
PH-MCO	**IPRO**	**Yes**	**Yes – three of the four elements** • **Validation of Performance Improvement Projects** • **Validation of Performance Measures** • **Review of PH-MCO compliance** • **Validation of network adequacy (new) – not implemented, still waiting for CMS guidance**	**Yes** • **Administration of consumer surveys** • **Encounter Date validation** • **Focus Studies**
BH-PIHP	**IPRO**	**Yes**	**Yes – all three elements** • **Validation of Performance Improvement Projects** • **Validation of Performance Measures** • **Review of BH-PIHP compliance**	**Yes** • **Encounter Data validation** • **Focused Studies of Health Care 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 a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

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

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program. **The Department, the Contractor, or both will be responsible for:**

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

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

1._ Provide education and informal mailings to beneficiaries and PCCMs;

2._ Initiate telephone and/or mail inquiries and follow-up;

3._ Request PCCM's response to identified problems;

4._ Refer to program staff for further investigation;

5._ Send warning letters to PCCMs;

6._ Refer to State's medical staff for investigation;

7._ Institute corrective action plans and follow-up;

8._ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10._ Further limit the number of assignments;

11._ Ban new assignments;

12._ Transfer some or all assignments to different PCCMs;

13._ Suspend or terminate PCCM agreement;

14._ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a re-credentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ___ Initial credentialing

B. ___ Performance measures, including those obtained through the following (check all that apply):

___ The utilization management system.
___ The complaint and appeals system.
___ Enrollee surveys.
___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

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

4. **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 FFS Selective Contracting (Specialty Pharmacy Drug Program) preferred provider(s) were selected through the competitive bidding process. Criteria for selection includes technical (understanding of the problem, corporate background and prior experience, financial condition, personnel qualifications and organization, and soundness of approach), criteria and cost. Specific program and performance standards are delineated in the contract.

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances**

X The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable. **BH-PIHP, PH-MCO**

Pennsylvania continues to comply with the above referenced statutes and regulations as previously indicated in the CMS approved PA 67 waiver for 2017-2021.

BH-PIHP – Since there is only one BH-PIHP operating in a given County, and the beneficiaries are assigned to a BH-PIHP in their county of residence, BH-PIHPs do not market. However, the BH-PIHP is required to provide informational materials which the Department reviews and approves.

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

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

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

2. **Details**

a. **Scope of Marketing**

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

BH-PIHP, FFS Selective Contracting (Specialty Pharmacy Drug Program)

2. **X** 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. **(PH-MCO)**

Television, radio, billboard, the internet and printed and electronic media are permitted with advance written approval by the Department.

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

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

1.**X** 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.

PH-MCO – Items, not to exceed $5.00 in retail value, may be offered to the general public at health fairs or other approved community events. Such items cannot be connected in any way to PH-MCOs enrollment activity. Any items to be offered are subject to advance written approval by the Department.

The Department completes a follow-up investigation on all complaints of violations. Fiscal penalties will apply if necessary.

BH-PIHP - Beneficiaries are assigned to BH-PIHPs based on their county of residence. Therefore, prohibiting or limiting incentives to enroll in a BH-PIHP is not necessary.

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

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

i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii.**X** Other (please explain):

PH-MCO/BH-PIHP/FFS Selective Contracting (Specialty Pharmacy Drug Program) – must provide, at no cost to the beneficiary, oral interpretation services in any language to meet the needs of all beneficiaries, upon request by the beneficiary.

The PH-MCO/BH-PIHP/FFS Selective Contracting (Specialty Pharmacy Drug Program) must make all written materials disseminated to English speaking beneficiaries available in each prevalent language, as determined by the Department.

The PH-MCO/BH-PIHP/FFS Selective Contracting (Specialty Pharmacy Drug Program) must include appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternate language. This information must also be posted on the Contractor's website.

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

Pennsylvania continues to comply with the above referenced statutes and regulations as previously indicated in the CMS approved PA 67 waiver for 2017-2021.

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

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

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

2. **Details.**

a. **Non-English Languages**

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

The State defines prevalent non-English languages as:
(check any that apply):
1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. **X** The languages spoken by approximately **5** percent or more of the potential enrollee/ enrollee population.
3. **X** Other (please explain):

PH-MCO – The EAP Contractor shall make materials available in Spanish, and upon request in other prevalent languages, as determined.

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

BH-PIHP – Use a language line to assist with translation services in over 150 languages and will provide on-site translation as reasonable and necessary.

PH-MCO – The EAP Contractor has Call Center staff who speak languages other than English and when necessary, the EAP Contractor also uses a language line to assist with translation services.

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

BH-PIHP -
For beneficiaries whose first language is not English, the Contractor has a toll-free phone line with language/interpretation services available to assist beneficiaries and provide responses to beneficiary requests for information and program clarification, at no cost to the beneficiary.

PH-MCO – The EAP is an independent link between the plans and MA beneficiaries and provides information to beneficiaries to make informed decisions about choosing a MCO. The EAP Contractor produces and distributes Department approved materials and brochures to MA beneficiaries.

The EAP acts as a source of information about, but is independent from, the PH-MCOs and BH-PIHPs.

To aid MA beneficiaries in the PH-MCO selection process, the EAP contractor produces and distributes a variety of printed information and materials. The most important role of the EAP Contractor is to help MA beneficiaries select their PH-MCO and a PCP.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

X State

X contractor (please specify)

PH-MCO – The EAP Contractor mailings include pre-enrollment materials consisting of a cover letter, an enrollment form, a plan comparison chart, a hospital listing, a county option chart, information about the HealthChoices Advisory Committee, and a postage paid return envelope. Materials are distributed within one business day of receiving the daily eligibility file from the Department.

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

c. Enrollee Information

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

(i) **X** the State

(ii) **X** State contractor (please specify):

The EAP Contractor mailings include a post-enrollment brochure which also includes information on behavioral health services, and a confirmation letter of the beneficiary's choice of PH-MCO and PCP. Materials are distributed within one business day of receiving the enrollee file from the Department.

(ii) **X** the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

All other enrollee information

C. Enrollment and Disenrollment

1. **Assurances.**

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

PH-MCO:

Pennsylvania continues to comply with the above referenced statutes and regulations as previously indicated in the CMS approved PA 67 waiver for 2017-2021.

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

BH-PIHP - The state seeks a waiver of Section 1932 (a) (4) and 42 CFR 438.56 (a) and (c) for all BH-PIHPs in the BH-PIHP program. Beneficiaries are afforded a choice of two providers for every service level (except crisis services). For 42 CFR 438.56 (b), only the Commonwealth has the authority to disenroll a beneficiary from the PIHP component.

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

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

- **MA beneficiaries in the Fee-for-Service program will receive specialty pharmacy services through a preferred specialty provider(s). The MA beneficiary or the prescribing provider can call the toll-free telephone**

number for the preferred provider, inform the preferred provider of the need for a specialty pharmacy drug, and provide the preferred provider with the information needed to dispense, deliver and, if necessary, coordinate the administration of the drug.

- **The Department identifies all MA beneficiaries in the FFS delivery system who have a recent history of taking a specialty pharmacy drug. Each MA beneficiary identified receives an individualized notice explaining the operation of the Program. The notice also provides the toll-free telephone numbers of the preferred providers and a toll-free number to contact the Department for any additional questions and information on how to continue to receive the specialty pharmacy drug.**

- **The MA beneficiary is not required to notify the State of provider choice.**

- **There are no specified time frames for beneficiaries to choose a preferred provider.**

- **Beneficiaries will not be auto-assigned to a waiver provider if they do not choose a preferred provider.**

- **The preferred providers of specialty pharmacy drugs must ensure that the toll-free telephone numbers accommodate MA beneficiaries who have Limited English Proficiency or who are hearing impaired.**

- **The Department issues overrides to allow beneficiaries to utilize a non-preferred dispensing providers when needed.**

- **If the MA beneficiary requires a specialty drug that is administered in the home, the MA beneficiary has the freedom to choose an infusion care giver enrolled in the Medical Assistance program that is willing to provide the service.**

- **Preferred providers may not request to reassign a beneficiary from their care.**

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs by checking the applicable items below.

a. **X** **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:

PH-MCO – The Department contracts with an Enrollment Assistance contractor to perform enrollment activities, including general education and outreach.

The EAP contractor's goals in conducting the activities below, are to assist and encourage MA beneficiaries in making informed choices, decrease MCO transfer rates and ensure continuity of care.

During this waiver period the Contractor will focus on the following activities:

- **Meeting with the CAOs and Community Based Organizations (CBOs) for the purposes of providing training and education about the enrollment process for the MA beneficiaries they serve, and specifically, the importance in stressing to the MA beneficiaries, the need to make choices timely.**

- **Reviewing and providing educational materials to CAOs and CBOs.**

- **Educating beneficiaries on how to utilize the enrollment web site, explaining what information they can access on the web site, and helping them to understand the process of selecting a plan and/or PCP online.**

- **Establishing and maintaining ongoing relationships with and providing continuous training, for the CAO caseworkers.**

Ongoing contractor activities will include:

- **Targeting outreach efforts and focusing on highly populated Medicaid areas through the use of field support services.**

- **Providing information to beneficiaries on the BH-PIHPs and the procedures for accessing behavioral health services.**

BH-PIHP - For new behavioral health zone implementations and any major changes to the BH-PIHP component, written notification is sent to the beneficiaries' head of household. The Department's enrollment assistance contractor provides information on the BH-PIHPs and the procedures for accessing behavioral health services. OMHSAS provides information/training sessions for MA beneficiaries and stakeholders.

Sessions are held during conferences and meetings of beneficiaries, advocates and stakeholder organizations.

b. **Administration of Enrollment Process**.

X State staff conducts the enrollment process. **BH-PIHP**

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

X 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: **Maximus**

Through this contract, beneficiaries now have the option to enroll online through the enrollment website, as well as the ability to mail a paper enrollment form or contact an enrollment specialist by calling the PA enrollment services.

Please list the functions that the contractor will perform:

X choice counseling
X enrollment
X other (please describe):

The EAP Contractor will assist beneficiaries with PCP selection and provide information on BH-PHIP

PH-MCO – PCP selection

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

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

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

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

X 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 PCP and plan. (PH-MCO)

i. _X_ Potential enrollees will have up to 4 weeks to choose a plan.
ii. _**X**_ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

All newly eligible MA beneficiaries are provided information to select the HealthChoices PH-MCO of their choice within the service Zone. The Independent Enrollment Assistance Broker (IEAB) takes multiple actions, including written and telephonic outreach, to insure that newly eligible beneficiaries proactively select a PH-MCO. After the defined selection period expires, MA beneficiaries that have not proactively selected a PH-MCO are placed into a group or "pool" of beneficiaries that are auto-assigned to the available PH-MCOs that are operational in the Zone.

All HealthChoices Zones of operation now have an equitable standard distribution of beneficiaries in the Auto Assignment pool based upon the number of PH-MCOs in a Zone. If there would be four (4) MCOs in a Zone, each PH-MCO would randomly receive 25% of the beneficiaries available in the pool each month.

There are several scenarios when a specific PH-MCO assignment will be made based upon household circumstances. They are as follows:

1. **An eligible beneficiary who has not made a PH-MCO selection and who has a case record that also includes another active member in the case with an active PH-MCO record will be assigned to that same PH-MCO.**
2. **Beneficiaries in a family unit will be assigned together to a PH-MCO.**
3. **Beneficiaries that move between Zones of operation will remain in the PH-MCO in which they were previously enrolled if it is available in the new Zone. If a beneficiary relocates to a zone where their previous MCO does not operate, they will have the opportunity to select from any of the MCO's operational in that Zone.**

4. Beneficiaries who lose Medicaid eligibility for a period of less than 6 months will be re-enrolled with the same MCO.

All contracted PH-MCOs have the capability to serve beneficiaries with special health care needs. Therefore, the auto-assignment process is not linked to the medical/behavioral health status of a beneficiary. However, when the beneficiary's existing PCP is known, efforts are made to assign that beneficiary to a PH-MCO with that PCP in their network.

X The State automatically enrolls beneficiaries on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

X on a mandatory basis into a single BH-PIHP 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:

X 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.

Beneficiaries who lose Medicaid Eligibility for a period of 6 months or less are automatically re-enrolled with the same MCO.

d. **Disenrollment:**

X 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.**X** Enrollee submits request to EAP Contractor.

Beneficiaries can choose to transfer to another MCO that provides services in their HealthChoices zone at any time. However, they may not choose to disenroll from managed care entirely.

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

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

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

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

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

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

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

- **The MCO must coordinate with the Department directly to request a disenrollment.**

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

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

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

D. Enrollee rights.

1. **Assurances.**

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

BH-PIHP, PH-MCO

Pennsylvania continues to comply with the above referenced statutes and regulations as previously indicated in the CMS approved PA 67 waiver for 2017-2021.

_____ 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.

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

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

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

E. Grievance System

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

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

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

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

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

Pennsylvania continues to comply with the above referenced statutes and regulations as previously indicated in the CMS approved PA 67 waiver for 2017-2021.

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.

X 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. **PH-MCO and BH-PIHP**

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

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

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

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

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

_**X**__ 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. **BH-PIHP, PH-MCO**

b. **Timeframes**

X The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file a- **grievance** is **up to _45__** days (between 20 and 90).

A Grievance may be filed regarding a PH-MCO/BH-PIHP decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item; 5) deny a request for a BLE.

This definition aligns more consistently with the Federal definition of Appeal.

Beneficiaries will be given 60 days from the date they receive the written notice of decision to file a grievance.

X The State's timeframe within which an enrollee must file a **complaint** is **up to _45_** days.

For both PH-MCOs/BH-PIHPs, the beneficiary has up to 60 days from the date on the written notice to file a complaint when the complaint involves the following: the complaint challenges the failure of the MCO/PIHP to decide a complaint or grievance within the specified timeframes, or failure to meet the required timeframes for providing a service, or disputes a denial made for the reason that a service is not a covered benefit; disputes a retrospective denial of payment because the service(s)/item was provided without authorization by a provider not enrolled in the Pennsylvania MA Program; or disputes a retrospective denial of payment because the service(s)/item(s) provided was not covered service(s)/item(s) for the beneficiary.

This definition aligns more consistently with the Federal definition of Grievance.

c. **Special Needs**

X The State has special processes in place for persons with special needs. Please describe.
When a beneficiary with special needs files a complaint, grievance, or request for a fair hearing (appeal), the PH-MCO's Special Needs Unit or the BH-PIHP's Member Services Department informs the beneficiary of the available complaint, grievance, and fair hearing (appeal) mechanisms and offers to provide assistance in filing the appropriate documents and facilitating dispute resolution.

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

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

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

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

___ 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, which is: _____ (please specify for each type of request for review)

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

___ Establishes and maintains an expedited review process for the following reasons:_____ . 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):

F. Program Integrity

1. **Assurances.**

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

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

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

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

2. **Assurances For MCO or PIHP programs**

X 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.

BH-PIHP/PH-MCO - See Attachment A-1 for the Fraud and Abuse Plan for BH-PIHPs and PH-MCO's.

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

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

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

Section B: Monitoring Plan

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

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

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

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

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

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality

strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

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

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

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

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

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

BH-PIHP Component Quality Monitoring Plan Matrix												
Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Network Adequacy Assurance by Plan	**X**						**X**					
Ombudsman												
On-Site Review				X		**X**					**X**	**X**
Performance Improvement Projects									**X**			**X**
Performance Measures							**X**		**X**			**X**
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												

BH-PIHP Component Quality Monitoring Plan Matrix												
Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Test 24/7 PCP Availability												
Utilization Review												
Other: (describe)												

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

FFS Selective Contracting (Specialty Pharmacy Drug Program) Component Quality Monitoring Plan Matrix												
Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Network Adequacy Assurance by Plan												
Ombudsman												
On-Site Review												
Performance Improvement Projects												
Performance Measures							**X**					**X**
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload							**X**					**X**
Provider Self-Report Data												

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FFS Selective Contracting (Specialty Pharmacy Drug Program) Component Quality Monitoring Plan Matrix												
Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Test 24/7 PCP Availability												
Utilization Review												
Other: (describe)												

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

PH-MCO Component Quality Monitoring Plan Matrix												
Monitoring Activity	**Evaluation of Program Impact**						**Evaluation of Access**			**Evaluation of Quality**		
	Choice	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**	**Timely Access**	**PCP/Specialist Capacity**	**Coordination/ Continuity**	**Coverage/ Authorization**	**Provider Selection**	**Quality of Care**
Racial or Ethnic Groups												
Network Adequacy Assurance by Plan	X		X				X	X		X	X	
Ombudsman												
On-Site Review			X	X	X	X	X	X	X	X	X	X
Performance Improvement Projects							X	X	X			X
Performance Measures					X		X		X			X
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload							X		X			X

PH-MCO Component Quality Monitoring Plan Matrix												
Monitoring Activity	**Evaluation of Program Impact**						**Evaluation of Access**			**Evaluation of Quality**		
	Choice	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**	**Timely Access**	**PCP/Specialist Capacity**	**Coordination/ Continuity**	**Coverage/ Authorization**	**Provider Selection**	**Quality of Care**
Provider Self-Report Data							X	X	X			X
Test 24/7 PCP Availability	X						X					X
Utilization Review					X		X		X	X		X
Other: (describe)												
SMART (database to track contract compliance)	X		X	X	X	X	X	X	X	X	X	X

II. Details of Monitoring Activities

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

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

BH-PIHP and FFS Selective Contracting (Specialty Pharmacy Drug Program) detail requested above is provided for each area indicated by an "X". See Attachment B-1 for PH-MCO, Attachment B-2 for BH-PIHP, and Attachment B-3 for Selective Contracting.

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

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

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

_ NCQA
_ JCAHO
___ AAAHC
X Other (please describe) URAC-**SPECIALTY PHARMACY,**

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

_ CAHPS (please identify which one(s))
X State-developed survey **BH-PIHP**
X Disenrollment survey **(PH-MCO only- enrollment contractor)**

X Consumer/beneficiary focus groups **(PH-MCO only)**

d. **X** Data Analysis (non-claims)
- **X** Denials of referral requests (**PH-MCO and BH-PIHP)**
- **X** Disenrollment requests by enrollee (**PH-MCO)**
  - **X** From plan
  - **X** From PCP within plan
- **X** Grievances and appeals data **(PH-MCO and BH-PIHP)**
- **X** PCP termination rates and reasons **(PH-MCO)**
- ___ Other (please describe)

e. **X** Enrollee Hotlines operated by State **(FFS Selective Contracting (Specialty Pharmacy Drug Program, PH-MCO)**

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

g. **X** Geographic mapping of provider network (**PH-MCO)**

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

i. **X** Measurement of any disparities by racial or ethnic groups **(PH-MCO, BH-PIHP)**

j. **X** Network adequacy assurance submitted by plan[**Required** for MCO/PIHP/PAHP] (**BH-PIHP, PH-MCO)**

k. __ Ombudsman

l. **X** On-site review **(PH-MCO) will do an on-site review if new contractors are selected when the current contracts end**

m. **X** Performance Improvement projects [**Required** for MCO/PIHP] (**BH-PIHP and PH-MCO)**
- **X** Clinical
- **X** Non-clinical

n. **X** Performance measures [**Required** for MCO/PIHP] **(BH-PIHP, FFS SELECTIVE CONTRACTING (Specialty Pharmacy Drug Program) PH-MCO)**
- 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 number and types of Medicaid providers before and after waiver

p. **X** Profile utilization by provider caseload (looking for outliers) **(PH-MCO, FFS SELECTIVE CONTRACTING (SPECIALTY PHARMACY DRUG PROGRAM)**

q. **X** Provider Self-report data
X Survey of providers **(PH-MCO)**
___ Focus groups

r. **X** Test 24 hours/7 days a week PCP availability (**PH-MCO)**

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

t. **X** Other: (please describe) **(PH-MCO)** The Systematic Monitoring Access and Retrieval Technology (SMART) system goes through an annual review process whereby edits, updates based on changes to the HealthChoices Agreement and improvements are made. SMART is used along with other monitoring and documentation methods, to document results of the monitoring of the physical health managed care organizations and the enrollment broker. This tool ensures that all agreement standards are reviewed annually and MCO compliance is documented.

Section C: Monitoring Results

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

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

___ 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.

X This is a renewal request.

- **__** This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
- **X** The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

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

Strategy:
Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

See Attachment

C-1 – PH-MCO

C-2 – PIHP

C-3 – FFS SELECTIVE CONTRACTING (Specialty Pharmacy Drug Program)

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.

- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances:
___Maranatha Perez and Dawn Hamme_____

c. Telephone Number:___717-705-8121 and 717-705-8175_____

d. E-mail:_maraperez@pa.gov and dhamme@pa.gov_____

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

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced*

payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

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._X_ MCO
b._X_ PIHP
c.___ PAHP
d.___ Other (please explain):

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.___ First Year: $____ per member per month fee
  2.___ Second Year: $____ per member per month fee
  3.___ Third Year: $____ per member per month fee
  4.___ Fourth Year: $____ 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.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

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:

_____

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

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

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

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

_____

For Conversion or Renewal Waivers:

a._X__ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

The R1 and R2 member months were reported on the Centers for Medicare & Medicaid Services (CMS) 64 for four quarters of 2019 and four quarters of 2020 for the beneficiaries in all 67 counties, constituting the mandatory HealthChoices managed care zones. The first quarter of 2020 is understated, as December 2019 program month's capitation (normally paid in January) was paid in December 2019; therefore, the Calendar Year (CY) 2020 CMS 64s reflect 11 months of membership rather than 12 months.

On January 1, 2006 dual eligible beneficiaries ages 21 and over were removed from the physical health (PH) component of the mandatory managed care program, but remained in the behavioral health (BH) component of the mandatory managed care program. The member months include the dual eligibles because they remain in the BH-prepaid inpatient health plan (PIHP) component.

b.____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R5 of the previous waiver period.*

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

The December 2019 program month's capitation payments that was previously expected to pay in January 2020 and would have posted in the R2 time period were paid in December 2019; therefore, Q1 of R2 is low compared to other prior quarters. Note that Department of Human Services (DHS) typically pays capitation payments after the month of service delivery so normally capitation payments would be paid to the managed care organizations (MCOs) in January for the December program month. Given this change in capitation payment methodology is not anticipated in the future year, to project P1 membership, annualized R2 member months were used as the base of the calculation to reflect a full year of experience and then projected forward.

Membership levels are anticipated to remain at a similar level as was experienced in CY 2020 during the Coronavirus Disease 2019 (COVID-19) pandemic. Membership growth is anticipated to slow down due to the expiration of the Public Health Emergency (PHE) at the end of CY 2021 or later, but continue to have slow enrollment growth through P5 of the waiver due to economic downturn resulted from the pandemic and other potential policies changes, such as post-partum coverage expansion from the American Rescue Plan Act.

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

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

The R1 is for the four quarters of CY 2019 and R2 is for the four quarters, but only 11 months of CY 2020.

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.

For Conversion or Renewal Waivers:

a.___ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

_____

_____

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

Beneficiaries eligible for services in multiple waivers have their service costs accounted for in each waiver for the services covered by that waiver. Some beneficiaries are eligible for additional services under a 1915(c) Home- and Community-Based Services waiver. The services are not duplicative. In the accounting hierarchy, beneficiary costs are accounted for after other waivers costs are reported. The costs of the additional services are billed under the fee-for-service (FFS) billing system and reported separately on the CMS 64 report for the appropriate waiver.

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 Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

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

a._X_ 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).

Administrative costs reported on the CMS 64.10, the basis for the R1 and R2, include contract costs directly related to statewide managed care operations. Differing from the prior waiver, administrative costs will be allocated to all PH Medicaid eligibility groups (MEGs) utilizing enrollment levels to allocate these dollars for the 2022–2026 waiver.

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.

There are no 1915(b)(3) waiver services in the HealthChoices waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		***(PMPM in Appendix D5 Column W x projected member months should correspond)***

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This

amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	**Amount Spent in Retrospective Period**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
Total	*(PMPM in Appendix D3 Column H x member months should correspond)*		***(PMPM in Appendix D5 Column W x projected member months should correspond)***

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._X__ 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. _X__ 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.

By agreement between Pennsylvania and the PH-MCOs, the High Cost Risk Pool (HCRP) eliminated the requirement to purchase stop/loss protection, through MCO pooling of funds and sharing the high cost recipient risk. The HCRP became effective January 1, 2005 in the Southwest, January 1, 2006 in the Southeast and July 1, 2007 in the Lehigh/Capital zone. In the statewide HealthChoices zones, the HCRP became effective on July 1, 2013 in the seven Counties, on October 1, 2013 in the new West zone, on January 1, 2014 for the Breast and Cervical Cancer program and on April 1, 2014 in the new East zone. All Newly Eligible beneficiaries, were included in the HCRP starting January 1, 2016.

A risk sharing arrangement for under age 1 populations was put in place for the HealthChoices program beginning in CY 2018, as this population is not subject to risk adjustment and has had observable patterns of historical high-cost claims. Due to the implementation of the risk sharing arrangement, the under age 1 population is no longer included in the HCRP.

The HealthChoices program offers a Home Nursing Risk Sharing (HNRS) arrangement for home-nursing costs for the PH-MCO members under age 21. The Department charges the PH-MCOs premiums that reflect the estimated liability for the risk the Department is sharing to fund the program. The PH-MCOs are at risk for the first $5,000 for incurred costs for covered services, per member per year. The Department reimburses the PH-MCOs 80% of the paid expenses in excess of the $5,000 threshold. "Newly Eligible" members, ages 19 and

20, were included in the risk sharing arrangement, effective January 1, 2015.

Finally the HealthChoices program implemented a Home Accessibility Durable Medical Equipment (DME) Risk-Sharing arrangement effective January 1, 2020.

The risk arrangements described in this section are mutually exclusive to ensure no double counting occurs within each of these pools.

2.___ The State provides stop/loss protection (please describe):

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

1._X___ [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.

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.

PH-MCO and BH-MCO Pay for Performance (P4P)

The P4P program can be found documented in the CY 2021 HealthChoices Agreement Amendment. The P4P program provides financial incentives for MCOs that meet medical quality goals, based on HEDIS measures. Bonuses are awarded according to MCOs' achievement of, and improvement upon, measures identified. This P4P arrangement for the PH-MCOs is reported on the CMS 64s and therefore is included in the R2 service costs. No additional adjustments were applied to the PH MEGs. The BH-MCO P4P began in CY 2021 and was therefore not present in the R2 service costs. An adjustment was included in the P1 total program adjustment for the BH MEGs to ensure these payments were included in waiver development.

PH-MCO and BH-MCO Integrated Care Plan (ICP)

The ICP program can be found documented in the CY 2021 HealthChoices Agreement Amendment. Similar to P4P, the ICP program provides financial incentives for PH-MCOs and BH-MCOs that meet medical quality goals, based on shared PH/BH-MCO performance measures such as HEDIS and Pennsylvania Performance Measures (PAPMs). Bonuses are awarded according to MCOs' achievement of, and improvement upon, measures identified. The ICP was effective in CY 2021; therefore, an adjustment was included in the P1 total program adjustment for all MEGs to ensure consideration for these payments were included in the waiver development.

PH-MCO Medication Adherence P4P

Through the medication adherence P4P the Department makes a one-time payment in the amount of $1,000 to the PH-MCOs for each unique member with a diagnosis of Hepatitis C that that has received Hepatitis C medication(s), as identified on the Department's Specialty Drug List, within the given CY and received a subsequent laboratory test that confirms the Member has achieved cure. This P4P became effective in CY 2020, but as settlements are made retrospectively an adjustment was included in the P1 total program adjustment for the PH MEGs.

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)**

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.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

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 through P5. 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 State's 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: _____. Please document how that trend was calculated:

   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 State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

      ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was

determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

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

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 schedule not accounted for in cost increases or pricing (+/-)

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. For each change, 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 describe):
For each change, 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 describe):
For each change, 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):

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 P5. 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).

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):

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

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

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

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 (P5). Trend adjustments may be service-specific and expressed as percentage factors.

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

2.___ [Required, when the State's BY is trended to P5. 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 State's 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 P5 (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):

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 made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's 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):

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**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

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:

a. ___Potential Selection bias was measured in the following manner:

b.___The base year costs were adjusted in the following manner:

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):

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
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

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. _____ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 through P5 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1. _____No adjustment was made.
2. _____This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data

already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P5). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1._X__[Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _*5.3% per year*_____. Please document how that trend was calculated:

Separate trend rates were developed specific to the PH expenditures and the BH expenditures of 5% and 6% respectively to come up with an overall trend rate of 5.3%.

The Commonwealth's historical capitation, financial, and encounter data were the primary sources used by the actuary for determining trends for the prospective periods for this waiver request. The Commonwealth considered historical year over year trends in developing trend estimates and also changes to the Medicaid program, consistent with the development of capitation rates. The actuary reviewed historical experience on rolling twelve-months for the MEGs.

For the first prospective time period (R2 to P1), the State assumed an overall 5.3% annual trend and applied two years of trend to account for the gap in the length of time from the R2 to P1 years.

For the remaining prospective time periods (P1 to P2, P2 to P3, etc.), the State consistently assumed an overall 5.3% annual trend. The trends to the specific MEGs remain consistent with the R2 to P1 annual trend.

The Commonwealth was careful not to duplicate the impact of program changes that would have occurred with the implementation of a capitated program.

2._X__[Required, to trend BY/R2 to P1 through P5 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. _X___ State historical cost increases. Please indicate the years on which the rates are based: base years__*January 1, 2019 through December 31, 2020*__. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

The projected PA 67 Waiver trend is 5.3% per year. These trend projections are based on information used to develop the actuarially sound rate ranges and are consistent with historical trends, utilization, program changes, rate changes, and future expectations for PH and BH.

Although historical capitation, financial, and encounter data were the primary sources for trend development, other sources were utilized as a benchmark. Other sources considered include, but are not limited to: Indices (such as consumer price index), neighboring states (FFS trends, managed care trends), Pennsylvania-specific FFS trends, PH-MCOs financial reports, BH Person Level Encounter (PLE) data, and regional market changes.

Separate trends for unit costs and utilization were not developed, but the trends took into consideration changes in unit cost, utilization, and technology.

ii. _X__ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

See section J.a.2.i for details.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-

specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 through P5.

i. Please indicate the years on which the utilization rate was based (if calculated separately only). ***Utilization trends are not developed separately from unit cost trends.***

ii. Please document how the utilization did not duplicate separate cost increase trends. ***Utilization trends are not developed separately from unit cost trends.***

b. _X___ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

PH-MCO and BH-MCO P4P, ICP, and Medication Adherence P4P

As described in section H.d.1. of this document, an adjustment for the BH-MCO P4P and PH-MCO Medication Adherence P4P was included in the total program adjustment. Similarly, an adjustment was applied for both the PH-MCO and BH-MCO ICP as a consistent impact for all MEGs in the specific program. For more details, please reference section H.d.1.

PH Population Adjustments – Change in Nursing Facility (NF) Policy

Prior to Community HealthChoices (CHC) implementation, the PH-MCOs were responsible for the first 30 days of NF care. Upon implementation of the CHC program, the PH-MCOs are now responsible to cover services for long-term services and supports (LTSS) eligible participants up until the individual's start date in CHC. If the participant utilizes 30 days of NF services and is determined to be LTSS ineligible, their service coverage remains the responsibility of the PH-MCOs. This resulted in an upward adjustment specific to the each PH MEG determined by the NF utilization and CHC start date.

PH Additional Funding for Institutional Outpatient (OP) Services

The Department provides additional funding for Medicaid institutional OP visits to stabilize the Pennsylvania hospital system. In waiver development, the Department applied an upward adjustment to the P1 year for the PH MEGs to reflect an increase in funding from CY 2020 to CY 2021. The funding level varied by the MEGs to reflect the OP visits specific to each population.

Pediatric Shift Nursing Fee Increase

Effective January 1, 2022, the Department will increase the fee schedule for Registered Nurses and Licensed Practical Nurses in a home care setting for children, youth, and young adults under 21 years of age by $5.00 per hour. An upward adjustment was applied to each PH MEG to reflect the increased fee schedule change. This adjustment varies by MEG, reflecting the participant mix of under 21 years of age in each group.

Post-Partum Coverage Expansion

The Department intends to provide coverage to Medicaid post-partum women for up to 12 months (versus 60 days), effective April 1, 2022. The program change looked at how long post-partum women stayed on Medicaid historically. It then calculated how many additional member months and additional funding at a higher acuity per member per month (PMPM) would be needed to reflect 12 months of post-partum coverage. This resulted in an upward PMPM adjustment specific to the each PH MEG.

CHC Consideration

Managed LTSS program for individuals ages 21 and older began implementation within the Commonwealth over three phases starting on January 1, 2018. Phase 1 began January 1, 2018, Phase 2 began January 1, 2019, and Phase 3 began January 1, 2020. As BH services are not part of the CHC benefit package, individuals enrolled in CHC will receive BH services through HealthChoices. The majority of the individuals are expected to be assigned to the SSI/HH and Other Disabled MEG. On average, this population is expected to be lower cost than the current SSI/HH and Other Disabled MEG, and therefore a downward adjustment was applied.

Intensive Behavioral Health Services (IBHS)

New regulations (Title 55, Chapter 1155 and Title 55, Chapter 5240) were developed outlining minimum licensing standards and program requirements for participation in the medical assistance (MA) program and MA payment conditions for agencies that deliver IBHS to children, youth, and young adults under 21 years of age with mental, emotional, and BH needs. The DHS added new procedure codes for IBHS to the MA program fee schedule and announced prior authorization requirements for certain IBHS. An upward adjustment was applied to the P1 year for the BH MEGs to reflect this increase fee schedule change. This adjustment was applied to vary by MEG to reflect the mix of participants under 21 years of age in each group.

Integrated Community Wellness Centers (ICWC)

ICWC replaces the two-year Certified Community Behavioral Health Clinic (CCBHC) demonstration that ended June 30, 2019. ICWC payment rates are determined utilizing the minimum fee schedule methodology. Additional funding was included to account for the expected longer term HealthChoices growth of ICWC spurred by the Substance Abuse and Mental Health Services Administration expansion grants issued to several centers in CY 2020. An upward adjustment was applied to the BH MEGs for the P1 year.

Opioid Use Disorder (OUD) Centers of Excellence (COEs)

DHS implemented OUD COEs during 2016 and 2017 to serve BH and PH needs. The program was aimed at increasing the quality of care as well as the capacity to care for those seeking treatment for OUD. Additional funding was included in waiver development to account for the increase in quality of care with the COEs and the corresponding higher reimbursement rate for providing treatment. An upward adjustment was applied specific to each PH and BH MEG to reflect the applicable COE use by group.

Philadelphia Minimum Wage Ordinance

The City of Philadelphia Century Minimum Wage Standard Ordinance increased the minimum wage for city contractors and subcontractors to $12.20 as of July 2018. This rate will gradually increase until the hourly wage is $15.00 in 2022. An upward adjustment was applied in waiver modeling to account for the increased cost liability to meet the requirements of the Ordinance.

Adult Society of Addiction Medicine (ASAM) Assessment

As a part of Pennsylvania's Substance Use Disorder (SUD) 1115 Waiver, DHS agreed to substantially align with the ASAM assessment and placement criteria, interventions by levels of care and residential staffing standards by July 1, 2021, with full alignment by July 1, 2022. An upward adjustment was applied in waiver modeling to account for the increase in costs to the BH program to meet the ASAM standards.

COVID-19 Acuity

For the BH program, it is assumed that the COVID-19 pandemic will cause an increase in individuals requiring access to general mental health and SUD services as well as increased costs for seriously mentally ill/seriously emotionally disturbed population. Mercer included an upward adjustment to all BH MEGS to account for acuity changes resulting from the COVID-19 pandemic.

COVID-19 Vaccination Consideration

The Department implemented a risk sharing arrangement for the COVID-19 vaccine for CY 2021, which will continue through at least CY 2022. This arrangement includes costs association with the COVID-19 vaccine including both the administration and vaccine dose costs. An upward adjustment was applied to the PH MEGs to account for assumed vaccination costs.

MEG	***Adjustments Included***	***Program Adjustment***
Temporary Assistance for Needy Families/Modified Adjusted Gross Income (TANF/MAGI) – PH	• *Medication Adherence* • *ICP* • *Population Adjustment* • *Additional OP Funding*	*3.7%*

	• *Pediatric Shift Nursing Fee Increase* • *Postpartum Coverage Expansion* • *OUD COE* • *Minimum Wage Ordinance* • *COVID-19 Vaccination Consideration*	
SSI/HH and Other Disabled – PH	• *Medication Adherence* • *ICP* • *Population Adjustment* • *Additional OP Funding* • *Pediatric Shift Nursing Fee Increase* • *Postpartum Coverage Expansion* • *OUD COE* • *Minimum Wage Ordinance* • *COVID-19 Vaccination Consideration*	*6.2%*
Newly Eligible, Ages 19–64 – PH	• *Medication Adherence* • *ICP* • *Population Adjustment* • *Additional OP Funding* • *Pediatric Shift Nursing Fee Increase*	*9.3%*

	• *Postpartum Coverage Expansion* • *OUD COE* • *Minimum Wage Ordinance* • *COVID-19 Vaccination Consideration*	
TANF/MAGI – BH	• *ICP* • *MCO P4P* • *IBHS* • *ICWC* • *OUD COE* • *Minimum Wage Ordinance* • *ASAM* • *COVID-19 Acuity*	*12.5%*
SSI/HH and Other Disabled – BH	• *ICP* • *MCO P4P* • *CHC Consideration* • *IBHS* • *ICWC* • *OUD COE* • *Minimum Wage Ordinance* • *ASAM* • *COVID-19 Acuity*	*3.7%*
Newly Eligible, Ages 19–64 – BH	• *ICP* • *MCO P4P* • *IBHS* • *ICWC* • *OUD COE* • *Minimum Wage Ordinance* • *ASAM* • *COVID-19 Acuity*	*14.4%*

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 and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, 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.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, 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.__ Changes in legislation (please describe):
For each change, 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):

vi.__ 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):

c. _X___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2._X__An administrative adjustment was made.
i.___ Administrative functions will change in the period between the beginning of P1 and the end of P5. Please describe:
ii._X__Cost increases were accounted for.
A._X___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._X___State Historical State Administrative Inflation. The actual trend rate used is: __5.0% annually_____. Please document how that trend was calculated:

In the R2 base period, administrative expenses were lower than expected due to the PHE and less operating costs at the state agency. An adjustment was applied to increase the P1 administration expenses to be at a consistent level as the historical expenses prior to the PHE.

Five percent annual increases in administrative costs are projected for years P1 through P5. From R2 to P1, two years of trend were applied to account for the amount of time between R2 and P1.

For the P1 year, a total trend of 19.6% was applied which included the 5.0% annual trend, and the remainder being attributable to the P1 administration increase as described in the first paragraph of this section. P2 through P5 administrative trend reflects the 5.0% annual trend only.

D.____Other (please describe):

iii._X__ [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:

Administrative costs reported on the CMS 64.10, the basis for the R1 and R2, include contract costs directly related to managed care. The previous eight quarters of the CMS 64 do not allocate administrative costs to the BH component of the MEGs. This methodology of reporting is being carried forward into the 2022–2026 waiver. Consistent with section G.a. of this waiver submission, projected year administrative costs have been distributed amongst the three PH MEGs. The actuary reviewed rolling 12-month experience for the MEGs using historically reported CMS 64 administrative information.

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

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

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program

(P1) and the end of the program (P5). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or R2 is trended to P5. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

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

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

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 through P5 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees

and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

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

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

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.

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.

Enrollment and cost change is based on projected beneficiary population due to program changes, economic conditions, and national and regional medical inflation projections affecting medical cost trends.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P5.

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**:

Consistent with the commentary provided in section E.c. of this waiver submission, enrollment growth is anticipated to slow down from the R2 to P1 time period due to the expiration of the PHE at the end of CY 2021. Although the enrollment growth is projected to be small in the early years after the PHE, caseloads are generally anticipated to be consistent with the prior waiver.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

The Commonwealth did not estimate cost changes separate from utilization changes. Utilization did not duplicate separate cost increase trends. Utilization trend is considered in the Commonwealth's overall analysis of trend.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

Utilization change is accounted for in the medical cost trends in the projections. Separate trends for unit costs and utilization were not developed, but the trends took into consideration changes in unit costs and utilization.

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

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.