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State/Territory Name: Pennsylvania

State Plan Amendment (SPA) #: PA-14-0048

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT # 121220144010

DEC 17 2014

Beverly Mackereth, Secretary
Department of Human Services
Room 333 Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Secretary Mackereth:

Enclosed for your records is an approved copy of Pennsylvania's Alternative Benefit Plan (ABP) State Plan Amendment (SPA), Transmittal Number (TN) 14-0048. This Amendment contains the State's Healthy Plus Benefit Coverage, through an Alternative Benefit Plan (ABP), for newly eligible adult beneficiaries who are determined to be medically frail, newly eligible adult beneficiaries aged 19-20, and as an option for Medicaid beneficiaries with complex health needs, in the Commonwealth. This ABP, which was submitted on October 17, 2014, meets all federal statutory and regulatory requirements for establishing an ABP.

Amendments to the State's approved Medicaid program (benefits, payment rates, reimbursement methodologies, cost-sharing state plan pages, and (if applicable) managed care service delivery systems (waivers, contracts)) may require corresponding amendments to the ABP if the changes to the benefit in the approved State Plan will be mirrored in the ABP.

The plan pages included in this approval reference the "Healthy" benefit package, which is described in a state plan amendment not yet approved by CMS. Until such approval occurs, the current Pennsylvania State Plan remains in effect for populations not served through either the Healthy Plus ABP or the Private Coverage Option ABP approved effective January 1, 2015. Please be aware that any changes to the benefit packages included in this approval will necessitate amendments to the relevant SPA pages.

This ABP SPA PA-14-0048 is approved effective January 1, 2015, as requested by the State.

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan amendment. If you have any questions concerning this letter, please contact Mary McKeon at 215-861-4181.

Sincerely

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

Medicaid Alternative Benefit Plan

PA.1339.R00.00 - Jan 01, 2015

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: Pennsylvania

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

PA-14-0048

Proposed Effective Date

01/01/2015 (mm/dd/yyyy)

Federal Statute/Regulation Citation

48 CFR 447 Subpart E

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$ 0.00
Second Year	2016	$ 0.00

Subject of Amendment

Character Count: 83 out of 2000

State Plan Amendment for Attachment 3.1-L-1, Healthy Plus Alternative Benefit Plan.

Governor's Office Review

Governor's office reported no comment

Comments of Governor's office received
Describe:

No reply received within 45 days of submittal

Other, as specified
Describe:

Character Count: 27 out of 2000

Secretary of Public Welfare

Signature of State Agency Official

Submitted By:	Daniel Sorge
Last Revision Date:	Dec 12, 2014
Submit Date:	Oct 17, 2014

BACK CONTINUE

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 1 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048 | OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Healthy Plus

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Pregnant Women	Voluntary	X
+	SSI Beneficiaries	Voluntary	X
+	Individuals Receiving Mandatory State Supplements	Voluntary	X
+	Individuals Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Voluntary	X
+	Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	Voluntary	X
+	Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	Voluntary	X
+	Working Disabled under 1619(b)	Voluntary	X
+	Disabled Adult Children	Voluntary	X
+	Qualified Medicare Beneficiaries	Voluntary	X
+	Individuals Receiving Home and Community Based Services under Institutional Rules	Voluntary	X
+	Medically Needy Pregnant Women	Voluntary	X
+	Optional State Supplement - 1634 States and SSI Criteria States with 1616 Agreements	Voluntary	X
+	Specified Low Income Medicare Beneficiaries	Voluntary	X
+	Certain Individuals Needing Treatment for Breast or Cervical Cancer	Voluntary	X
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Extended Medicaid due to Spousal Support Collections	Voluntary	X
+	Poverty Level Aged or Disabled	Voluntary	X

Alternative Benefit Plan

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Ticket to Work Basic Group	Voluntary	X
+	Ticket to Work Medical Improvements Group	Voluntary	X
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

☐ Income Standard.

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

The Healthy Plus Benefit Plan targets individuals for voluntary enrollment who are ages 21 through 64, and have complex physical and/or behavioral health needs, all individuals age 65 and older, individuals who are in the New Adult Group and determined to be medically frail, and mandatory enrollment for individuals ages 19 and 20 in the New Adult Group.

Any individual voluntarily enrolled in Healthy Plus retains the choice to be enrolled in the Healthy Benefit Plan if they desire.

Individuals in the medically frail New Adult Group will have a choice to enroll in the Healthy Plus Benefit Plan or the alternative benefit plan that is the State Plan benefit.

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 1 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048 | OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. **No**

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☐ Letter

☐ Email

☒ Other

Describe:

1. INITIAL APPLICATION AND PLACEMENT INTO BENEFIT PLAN

•At application, an individual that meets the criteria for the New Adult Group will have the opportunity to complete a health screen, which will be reviewed by the clinical validation team in the Department of Human Services (Department).
• Individuals deemed medically frail in the New Adult Group will be able to chose to be enrolled in the Healthy Plus Benefit Plan or the Healthy Benefit Plan.

2. TRIGGERS THAT RESULT IN CHANGE OF BENEFIT PLAN PRIOR TO ANNUAL REDETERMINATION
• Individuals enrolled into the Private Coverage Option (PCO) or Medicaid's Healthy benefit plan may "raise their hand" and contact the Department at any time when a change in health conditions occurs or they do not believe their current benefit plan meets their medical needs. Specifically, individuals can call the Department's Statewide Customer Service Center or their local County Assistance Office (CAO). The ability for consumers to pursue this option is described in their eligibility notice. Additionally, if the CAO at any time receives a paper copy of a completed health screen it will be treated as the person "raising their hand" and processed accordingly.

• Upon contact from a client, the Department will send to the individual a paper copy of the Department's health screening tool . This tool will be completed by the individual and returned to the CAO. The health screening tool only needs to be completed by the individual and does not require a signature from a medical professional.

• Once the CAO receives the individual's completed health screening tool it will be electronically transferred over to the Department's Clinical Validation Team (CVT). The CVT will review the completed health screening tool to determine if the individual meets the medical frailty standard. As part of the validation process, the CVT may review current claims data for the individual, reach out to the individual and as necessary contact their medical providers. The CVT review of these health screening tools will be given priority and will be targeted to be completed within 10 business days. The CVT will electronically return its findings to the CAO within the 10 business day time frame.

• If the Department's review determines the individual meets the medical frailty standard, the individual will be notified of this change. The CAO will place the individual in the new benefit plan within 5 business days of the receiving the CVT response. If the individual was in the PCO, they will also be sent information about how to select a plan in the Medicaid HealthChoices program. If the Department believes that no change in a benefit plan is warranted, the Department will notify the individual about this decision and their ability to appeal. Appeals will be handled using the Department's established hearing and appeals process and the individual's right to a fair hearing.

• Separate and apart from the "raise your hand" process described above, the Department will look at claims data three times a year. One of these three times will occur at the individual's annual eligibility re-determination. The Department will review this claims data (FFS and managed care encounter data) using the Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx scoring developed and validated by the University of California, San Diego.

3. ANNUAL RENEWAL AND POTENTIAL CHANGE OF BENEFIT PLAN
• Redetermination of health status based on claims history and health screen as set forth in #1.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

At eligibility determination/redetermination or upon outcome of health screen.

Alternative Benefit Plan

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

Written notice will describe the recipient's ability to disenroll from the Healthy Plus Benefit Plan and move to the Healthy Benefit Plan. The notice will state the following :
"If you would rather receive the Healthy Benefit Plan instead of the Healthy Plus Benefit Plan because you think you do not need extensive medical services, contact the Statewide Customer Service Center at 1-877-395-8930 or 1-215-560-7226 (if you live in Philadelphia) by xx/xx/xxx."

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☒ In the eligibility system.

☒ In the hard copy of the case record.

☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

☒ Copy of correspondence sent to the individual.

☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania

Attachment 3.1-L- 1

OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048

OMB Expiration date: 10/31/2014

Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2b

These assurances must be made by the state/territory if the ABP Population includes any eligibility groups other than or in addition to the Adult eligibility group.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent), prior to enrollment:

☑ The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.

☑ The state/territory assures it will effectively inform individuals who voluntary enroll of the following:

a) Enrollment is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/ territory plan coverage;

c) What the process is for disenrolling.

☑ The state/territory assures it will inform the individual of:

a) The benefits available under the Alternative Benefit Plan; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply.)

☐ Letter

☐ Email

☒ Other:

Describe:

1. INITIAL APPLICATION AND PLACEMENT INTO BENEFIT PLAN

• The following adults (21 years of age and older) will automatically be given the option to enroll in the Healthy Plus Benefit Plan:

o Pregnant Women
o Individuals Receiving SSI and individuals deemed SSI eligible for purposes of Medicaid eligibility
o Former foster care children
o Individuals Receiving Home and Community Based Services under Institutional Rules
o Individuals who are dually eligible for Medicare and Medicaid
o Individuals who are institutionalized
o Individuals participating in Pennsylvania's PACE Program LIFE (Living Independence for the Elderly), PACENET, and PACE Plus Medicare programs
o Individuals who are 65 years of age and older

• All other adults (determined eligible under current State Plan Medicaid eligibility groups) are assessed through the review and analysis of Department claims data using the Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx scoring developed and validated by the University of California, San Diego. These adults will also be given the opportunity to

complete a health screen.
• Individuals from the following groups who do not have claims data available for review will have the opportunity to complete a health screen to determine if they are medically frail and have a need for enrollment in the Healthy Plus Benefit Plan that will be reviewed by Department clinicians:
*Parents and Other Caretaker Relatives
*Transitional Medical Assistance
*Extended Medicaid due to Spousal Support Collections
*Poverty Level Aged or Disabled
• Individuals will be provided with notice of the Department's determination and will have the opportunity to appeal the Department's decision.
• Those individuals determined to meet the high risk category will be given the opportunity to choose the Healthy Benefit Plan.
• All individuals found eligible for either the Healthy or the Healthy Plus Benefit Plan will be provided an insert as part of their eligibility notice that explains their benefit plan and the differences between the two plans.

2. TRIGGERS THAT RESULT IN CHANGE OF BENEFIT PLAN PRIOR TO ANNUAL REDETERMINATION
• Individuals enrolled into the Private Coverage Option (PCO) or Medicaid's Healthy benefit plan may "raise their hand" and contact the Department at any time when a change in health conditions occurs or they do not believe their current benefit plan meets their medical needs. Specifically, individuals can call the Department's Statewide Customer Service Center or their local County Assistance Office (CAO). The ability for consumers to pursue this option is described in their eligibility notice. Additionally, if the CAO at any time receives a paper copy of a completed health screen it will be treated as the person "raising their hand" and processed accordingly.

• Upon contact from a client, the Department will send to the individual a paper copy of the Department's health screening tool . This tool will be completed by the individual and returned to the CAO. The health screening tool only needs to be completed by the individual and does not require a signature from a medical professional.

• Once the CAO receives the individual's completed health screening tool it will be electronically transferred over to the Department's Clinical Validation Team (CVT). The CVT will review the completed health screening tool to determine if the individual meets the medical frailty standard. As part of the validation process, the CVT may review current claims data for the individual, reach out to the individual and as necessary contact their medical providers. The CVT review of these health screening tools will be given priority and will be targeted to be completed within 10 business days. The CVT will electronically return its findings to the CAO within the 10 business day time frame.

• If the Department's review determines the individual meets the medical frailty standard, the individual will be notified of this change. The CAO will place the individual in the new benefit plan within 5 business days of the receiving the CVT response. If the individual was in the PCO, they will also be sent information about how to select a plan in the Medicaid HealthChoices program. If the Department believes that no change in a benefit plan is warranted, the Department will notify the individual about this decision and their ability to appeal. Appeals will be handled using the Department's established hearing and appeals process and the individual's right to a fair hearing.

• Separate and apart from the "raise your hand" process described above, the Department will look at claims data three times a year. One of these three times will occur at the individual's annual eligibility re-determination. The Department will review this claims data (FFS and managed care encounter data) using the Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx scoring developed and validated by the University of California, San Diego.

3. ANNUAL RENEWAL AND POTENTIAL CHANGE OF BENEFIT PLAN
• Redetermination of health status based on claims history and health screen as set forth in #1.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment.

An attachment is submitted.

Alternative Benefit Plan

When did/will the state/territory inform the individuals?

At eligibility determination/redetermination or upon outcome of health screen.

Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.

Written notice will describe the recipient's ability to disenroll from the Healthy Plus benefit plan and move to the Healthy benefit plan. The notice will state the following :
"If you would rather receive the Healthy benefit plan instead of the Healthy Plus benefit plan because you think you do not need extensive medical services, contact the Statewide Customer Service Center at 1-877-395-8930 or 1-215-560-7226 (if you live in Philadelphia) by xx/xx/xxx."

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

Where will the information be documented? (Check all that apply.)

☒ In the eligibility system.

☒ In the hard copy of the case record.

☐ Other:

What documentation will be maintained in the eligibility file? (Check all that apply.)

☒ Copy of correspondence sent to the individual.

☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other:

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.

Other Information Related to Enrollment Assurance for Voluntary Participants (optional):

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 1 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048 | OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Healthy Plus

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

See ABP5

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ○ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.

Alternative Benefit Plan

○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.

◉ Largest insured commercial non-Medicaid HMO.

Plan name: Aetna POS 3.7

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania

Attachment 3.1-L- 1

OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing — ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 1 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048 | OMB Expiration date: 10/31/2014

Benefits Description — ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Aetna POS 3.7

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary Approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services

Collapse All ☐

Benefit Provided: Primary Care Physician Visits

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes services provided by Certified Registered Nurse Practitioners, Outpatient Hospital Clinics and Independent Medical Clinics.

Benefit Provided: Specialist Office Visit

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes services provided by Physicians, Podiatrists, Dental Surgeons, Outpatient Hospital Clinics and Independent Medical Clinics.

Benefit Provided: Outpatient Surgery

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes services provided by Short Procedure Units and Ambulatory Surgical Centers (ASC).
If elective, requires Prior Authorization in advance of procedure.

Benefit Provided: Infusion Therapy

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Provided in an outpatient hospital department, an ASC, or in the home.

Benefit Provided: Vasectomy

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Tubal Ligation

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Subluxation (Chiropractic)

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

10 visits per calendar year

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A Benefit Limit Exception (BLE) required for additional services beyond 10 visits per calendar year. BLE criteria set forth in Attachment 3.1A, page iii of the Pennsylvania State Plan.

Benefit Provided:

Hospice - Outpatient

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See other information below

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Beneficiary must be certified as being terminally ill by a doctor of medicine or osteopathy; agree to waive rights to MA Program covered services related to the treatment of the terminal condition for which hospice care was elected or a related condition.
Respite care is limited to 5 consecutive days in a 60 day certification period.
In accordance with section 2302 of the ACA, individuals under the age of 21 will receive hospice care concurrently with curative care.

Benefit Provided:

Allergy Treatment

Source:

Base Benchmark Commercial HMO

Remove

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Allergy Testing

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Dental Services (Adults)

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
See Below

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Diagnostic, preventative, restorative and surgical dental procedures, prosthodontics and sedation.
Key Limitations: exams/prophylaxis 1 per 180 days; crowns, perodonics and endodontics only via approved Benefit Limit Exception.
A Benefit Limit Exception (BLE) required for additional services beyond those listed above. BLE criteria set forth in Attachment 3.1A, page iii of the Pennsylvania State Plan.

Alternative Benefit Plan

Benefit Provided: Infertility Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: See Below

Duration Limit: See Below

Scope Limit: See Below

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage for only the diagnosis and surgical treatment of the underlying medical cause.

Benefit Provided: Urgent Care Provider

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided: Emergency Room

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Ambulance

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization

Collapse All ☐

Benefit Provided: Inpatient Coverage

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: See Below

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

If an elective admission, Prior Authorization required in advance of admission, to determine medical necessity. Automated Utilization Review is completed for emergency and urgent inpatient admissions.
Services will not be provided in an Institution for Mental Disease (IMD).

Benefit Provided: Hospice - Inpatient

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Beneficiary must be certified as being terminally ill by a doctor of medicine or osteopathy; agree to waive rights to MA Program covered services related to the treatment of the terminal condition for which hospice care was elected or a related condition.
In accordance with section 2302 of the ACA, individuals under the age of 21 will receive hospice care concurrently with curative care.
Services will not be provided in an IMD.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided: Pre-Natal Maternity

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes nurse midwife services and free standing birth center services.

Benefit Provided: Maternity - Delivery and Post-Partum Care

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes nurse midwife services and free standing birth center services.

Benefit Provided: Inpatient Maternity Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services will not be provided in an IMD.

Add

Alternative Benefit Plan

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided: Inpatient Services - Mental Health

Source: Base Benchmark Commercial HMO

Remove

Authorization: Concurrent Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes services provided for Serious Mental Illness (SMI) and non-SMI. Services will not be provided in an IMD.

Benefit Provided: Outpatient Services - Mental Health

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes services provided for Serious Mental Illness (SMI) and non-SMI. Services include Psychiatric clinic services, clozapine services, psychiatric partial hospitalization, and crisis services.

Benefit Provided: Inpatient Detoxification

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services will not be provided in an IMD.

Benefit Provided: Outpatient Detoxification

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes Methadone Maintenance.

Benefit Provided: Inpatient Rehabilitation (Substance Abuse)

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services will not be provided in an IMD.

Benefit Provided: Outpatient Rehabilitation (Substance Abuse)

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Residential Treatment Facility

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services will not be provided in an IMD.

Add

☑ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☐ Limit on days supply	No	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of Pennsylvania's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs, with the exception that the six prescription limitation will not apply in the Healthy Plus Benefit Plan. A Managed Care Plan may offer a prescription drug benefit that is no more restrictive than the state plan benefit.

Alternative Benefit Plan

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices Collapse All ☐

Benefit Provided: Skilled Nursing Facility
Source: Base Benchmark Commercial HMO
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: 120 days per calendar year
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Home Health Care
Source: State Plan 1905(a)
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: See Below
Duration Limit: See Below
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Unlimited for the first 28 days; limited to 15 days per month thereafter. This coverage exceeds the base benchmark plan.
Includes Physical Therapy, Occupational Therapy, and Speech Therapy Services.
A Benefit Limit Exception (BLE) required for additional services beyond those listed above. BLE criteria set forth in Attachment 3.1A, page iii of the Pennsylvania State Plan.

Benefit Provided: Durable Medical Equipment
Source: Base Benchmark Commercial HMO
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior Authorization is required for all orthotic and prosthetic devices, rental in excess of three months, and any DME in excess of $600, or at the Department's discretion.
A Benefit Limit Exception (BLE) required for additional services beyond those listed above. BLE criteria set forth in Attachment 3.1A, page iii of the Pennsylvania State Plan.

Benefit Provided: Outpatient Physical & Occupational Therapy(PT/OT)

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 30 visits combined per calendar year

Duration Limit: None

Scope Limit: Includes Rehabilitative and Habilitative services

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These services are provided in outpatient hospital clinics, home health agencies, and rehabilitation clinics.

Benefit Provided: Outpatient Speech Therapy (ST)

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 30 visits per calendar year

Duration Limit: None

Scope Limit: Includes Rehabilitative and Habilitative services

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These services are provided in outpatient hospital clinics, home health agencies, and rehabilitation clinics.

Add

Alternative Benefit Plan

■ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Benefit Provided: Diagnostic Labratory

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Diagnostic X-Ray

Source: Base Benchmark Commercial HMO

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Diagnostic X-Ray for Complex Imaging Services

Source: Base Benchmark Commercial HMO

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes MRA/MRS, MRI, PET, CT, SPECT, and Nuclear Medical Cardiology scans.

Add

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☒

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:	Source:	
		Remove

Add

Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☒ 11. Other Covered Benefits from Base Benchmark

Collapse All ☐

Other Base Benefit Provided: Routine Eye Exams

Source: Base Benchmark

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: 1 visit per calendar year

Duration Limit: None

Scope Limit: None

Other information regarding this benefit: As performed by an optometrist.

Add

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Subluxation (Chiropractic)

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication and Substitution: Subluxation (Chiropractic) was mapped to EHB1, Ambulatory patient services; the base benchmark plan covers 20 visits per calendar year, the first 10 visits are covered under Pennsylvania's Medicaid State Plan, and Dental Services (Adults) from Pennsylvania's Medicaid State Plan was used as a substitute for the remaining 10 visits covered by the base benchmark plan. This has been certified an actuarially equivalent benefit.

Base Benchmark Benefit that was Substituted: Home Health Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Home Health Care was mapped to EHB7, Rehabilitative and habilitative services and devices; the proposed benefit limit of unlimited for the first 28 days, 15 days per month thereafter exceeds the base benchmark plan's benefit of 60 visits per calendar year.

Add

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Renal Dialysis
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: See Below
Duration Limit: None
Scope Limit: None
Other: Initial training for home dialysis is limited to 24 sessions per beneficiary. Back up visits to the facility are limited to no more than 75 per calendar year.
A Benefit Limit Exception (BLE) required for additional services beyond those listed above. BLE criteria set forth in Attachment 3.1A, page iii of the Pennsylvania State Plan.
No authorization required.

Other 1937 Benefit Provided: Family Planning Clinic Services
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other: No authorization is required.

Other 1937 Benefit Provided: ICF/IID
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other:
An institutional level of care is required.

Other 1937 Benefit Provided:
Medical Supplies

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
$2500 per calendar year

Duration Limit:
None

Scope Limit:
None

Other:
A Benefit Limit Exception (BLE) required for additional services beyond those listed above. BLE criteria set forth in Attachment 3.1A, page iii of the Pennsylvania State Plan. Diabetic supplies provided by a pharmacy are not subject to the above limitation.
No authorization is required.

Other 1937 Benefit Provided:
Tobacco Cessation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
70 visits per calendar year

Duration Limit:
None

Scope Limit:
None

Other:
A Benefit Limit Exception (BLE) required for additional services beyond those listed above. BLE criteria set forth in Attachment 3.1A, page iii of the Pennsylvania State Plan.
No authorization is required.

Other 1937 Benefit Provided:
Extended Services for Pregnant Women

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization is required.

Other 1937 Benefit Provided:
FQHC/RHC

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization is required.

Other 1937 Benefit Provided:
Non-Emergency Medical Transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Only available to and from Medical Assistance covered services.
No authorization is required.

Other 1937 Benefit Provided:
Mobile Mental Health Treatment

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization is required.

Other 1937 Benefit Provided:
Peer Support

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization is required.

Other 1937 Benefit Provided:
Dentures

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1 per lifetime

Duration Limit:
None

Scope Limit:
None

Other:
Beneficiaries are limited to one (1) upper arch complete or partial denture, and one (1) lower arch complete or partial denture, per lifetime. Prior authorization is required for complete or partial dentures. Additional dentures require a Benefit Limit Exception. Benefit limit exception criteria are set forth in Attachment 3.1A page iii.
Denture relines, either full or partial, are limited to one (1) arch, every two (2) years

Other 1937 Benefit Provided:
Vision Corrective Lenses/Contact Lenses

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
See Below

Duration Limit:
None

Scope Limit:
None

Other:
Corrective lenses/contact lenses only available to individuals with aphakia.
Limit of four eyeglass lenses per calendar year.
Limit of two eyeglass frames per calendar year.
Limit of four contact lenses per calendar year.
No authorization is required.

Other 1937 Benefit Provided:
Targeted Case Management - Individuals with SMI

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
Medicaid eligible individuals with serious mental illness or serious emotional disturbance.

X - Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)
Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
Only in the following geographic areas: [Specify areas]
Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

-Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
-Taking the beneficiary's history;
-Identifying the individual's needs and completing related documentation; and
-Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Initial comprehensive assessment will consider the beneficiary's strengths, needs, interests, and circumstances and will be used to prepare a care plan to meet the needs. Periodic reassessments will be completed at least once every six months in order to determine if the beneficiary's strengths, needs, interests, and circumstances have changed and to update the care plan, if appropriate.

-Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
-Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual.
-Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
-Identifies a course of action to respond to the assessed needs of the eligible individual;

-Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
-Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

-Monitoring and follow-up activities:
-Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
-Services are being furnished in accordance with the individual's care plan;
-Services in the care plan are adequate; and
-Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Periodic reviews of the care plan will be completed and documented every six months at a minimum. These activities shall be conducted in accordance with a written care plan, or as frequently as necessary based upon individual need to ensure care plan goals are accomplished.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))
Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Provider Agency Qualifications:
a. Provide case management as a separate and distinct service within the agency organization;

b. Establish referral agreements and linkages with essential social and health service agencies to coordinate access to needed resources;
c. Demonstrate the ability to provide comprehensive full time case management services;
d. Administrative capacity to document and maintain individual case management records in accordance with state and federal requirements;
e. Ability to meet state and federal requirements for documentation, billing and audits.
f. Hold a current certificate of compliance from the state to provide case management services to individuals with serious mental illness.

Case management is provided by a staff person who meets one of the following requirements:
a. A Bachelor's degree; or,
b. Registered nurse; or
c. A high school diploma and 12 semester credit hours in sociology, social welfare, psychology, gerontology, or other social science and two years of experience in direct contact with mental health consumers; or
d. A high school diploma and five years of mental health direct care experience in public or private human services with employment as a case management staff person prior to April 1, 1989.

Mental health direct care experience is working directly with mental health service consumers (adults, children or adolescents) providing services involving casework or case management, individual or group therapy, crisis intervention, early intervention, vocational training, residential care, or social rehabilitation in a mental health facility or in a facility or program that is publicly funded to provide services to mental health consumers, or in a nursing home, a juvenile justice agency, or a children and adolescent service agency.

Case management staff who were employed as case managers prior to September 1, 1993 under federal standards that existed prior to April 1, 1993 are exempt from the qualifications standards listed above.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X Target group consists of eligible individuals with serious mental illness or serious emotional disturbance. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with serious mental illness receive needed services. Agencies providing case management services will need a to hold a current certificate of compliance from the state. This certificate of compliance ensures the provider is appropriately qualified to serve individuals with serious mental illness.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:
-Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
-Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
-Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Other 1937 Benefit Provided:
Targeted Case Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Covered for the target groups, other than individuals with SMI, specified in the supplements and enclosures to 3.1A : Supplement 1 - Individuals with Intellectual Disabilities
Supplement 3 - High risk pregnant women
Supplement 4 - Individuals who have contracted HIV/AIDS

Alternative Benefit Plan

Detailed information described in the above supplements to Attachment 3.1A.
No authorization is required.

Other 1937 Benefit Provided:
Skilled Nursing Facility - long term (custodial)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
245 days

Duration Limit:
None

Scope Limit:
None

Other:
Provided for skilled nursing care that exceeds the 120 days of skilled nursing facility services provided under the base benchmark plan.
No authorization is required.

Other 1937 Benefit Provided:
PACE - LIFE (Living Independence for the Elderly)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
No authorization is required.

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 1 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048 | OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/ territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Medicaid recipients ages 19-20 enrolled in the Healthy Plus Benefit Plan will have access to EPSDT services as defined in 1905(r) and outlined in Pennsylvania's state plan. (All other individuals qualifying for EPSDT will receive services through the Pennsylvania state plan).

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Alternative Benefit Plan

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 1 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048 | OMB Expiration date: 10/31/2014

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [x] Prepaid Inpatient Health Plans (PIHP).
  - [ ] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The Healthy Pennsylvania Plan, including the Alternative Benefit Plan, was announced through a public notice issued on December 6, 2013. There was a 30 day public comment period as well as public hearings held in six cities across the Commonwealth. The Healthy Pennsylvania Plan was also discussed at monthly Medical Assistance Advisory Committee meetings where all stakeholders have had an opportunity to comment and have questions addressed. Additionally, all information related to the Healthy Pennsylvania Plan has been posted on the Department of Human Service's web page.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ( ) Section 1915(a) voluntary managed care program.
- (•) Section 1915(b) managed care waiver.
- ( ) Section 1932(a) mandatory managed care state plan amendment.
- ( ) Section 1115 demonstration.

Alternative Benefit Plan

○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: May 2, 2014

Describe program below:

Pennsylvania's managed care delivery system (HealthChoices) allows at-risk, capitated Managed Care Organizations (MCOs) to provide a comprehensive range of physical health services for all Medicaid populations not excluded from enrollment. Alternative Benefit Plan populations excluded from enrollment in HealthChoices includes Medicare beneficiaries (dual eligibles) and individuals residing in a long-term care facility for more than 30 days.

Physical health MCOs agreements are competitively procured through the Commonwealth Request for Proposals (RFP) process. Contracts are 3 to 5 years in length, and may be extended for 2 or 3 years. The HealthChoices Agreements are formally amended annually for new rates and program changes based upon the Commonwealth Fiscal Budget process (July-June).

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PIHP: Prepaid Inpatient Health Plan

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

○ Section 1915(a) voluntary managed care program.

◉ Section 1915(b) managed care waiver.

○ Section 1115 demonstration.

○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: May 2, 2014

Describe program below:

Pennsylvania's managed care delivery system (HealthChoices) allows at-risk, capitated Prepaid Inpatient Health Plans (PIHP) to provide a comprehensive range of behavioral health services for all Medicaid populations not excluded from enrollment. Alternative Benefit Plan populations excluded from enrollment in HealthChoices includes Medicare beneficiaries (dual eligibles) and individuals residing in a long-term care facility for more than 30 days.

Behavioral health PIHPs agreements are competitively procured through the Commonwealth Request for Proposals (RFP) process. Contracts are 3 to 5 years in length, and may be extended for 2 or 3 years. The HealthChoices Agreements are formally amended annually for new rates and program changes based upon the Commonwealth Fiscal Budget process (July-June).

Additional Information: PIHP (Optional)

Provide any additional details regarding this service delivery system (optional):

Alternative Benefit Plan

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

(•) Traditional state-managed fee-for-service

( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The Fee-For-Service (FFS) delivery system provides services to all newly eligible individuals until they can be enrolled in the HealthChoices Program and to those Medicaid populations that are excluded from enrollment in the HealthChoices managed care program. FFS provides for direct payment to enrolled providers based on the agency's fee schedule rate for the service. Only renal dialysis services and extended services for pregnant women are provided under a bundled payment arrangement. Payment is made for inpatient services using prospective payment rates based on diagnosis related groups or on a prospective per diem rate, as set forth in Attachment 4.19A of the State Plan. Care management, pay for performance and contractual incentives are not provided under the FFS delivery system.
Payment is made for the following services through the FFS delivery system only: Education Agency Services, Department of Health Screening, Targeted Case Management for Individuals with Intellectual Disabilities, Residential Costs for ICF/MR, Early Intervention, and Specialty Pharmacy Drugs for FFS enrollees as authorized under Pennsylvania's "PA67" section 1915(b) waiver.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Individuals who are not enrolled in Managed Care and receive services through the FFS delivery system receive their Special Pharmacy services through the approved 1915(b) Specialty Rx Selective Contracting program.

PRA Disclosure Statement

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Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 1 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048 | OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The Commonwealth assures that employer sponsored insurance (ESI) coverage is established in sections 3.2 and 4.22(h) of the Commonwealth's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package in the alternative benefits plan to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR 447 Subpart A.

The state/territory otherwise provides for payment of premiums. **No**

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 1 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048 | OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/ territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania

Attachment 3.1-L- 1

OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0048

OMB Expiration date: 10/31/2014

Payment Methodology **ABP11**

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

V.20140415