Table of Contents

State/Territory Name: Pennsylvania

State Plan Amendment (SPA) #: PA-14-0049

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

SWIFT #121220144005

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) 14-0049. This Amendment contains the Department's Private Coverage Option, through an ABP, for newly eligible adult beneficiaries ages 21 to 64, who are not determined to be medically frail. 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 approved effective January 1, 2015 or the Private Coverage Option ABP. 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-14-0049 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 215-861-4481.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

Medicaid Alternative Benefit Plan

PA.1340.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-14-0049

Proposed Effective Date

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

Federal Statute/Regulation Citation

42 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: 79 out of 2000

State Plan Amendment 3.1-L-2 Private Coverage Option, 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- 2

OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049

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: Private Coverage Option

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?	
+	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 Private Coverage Option (PCO) Alternative Benefit Plan targets individuals, ages 21 through 64, who are eligible for Medicaid under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. The eligibility group indicated above as "mandatory" will be enrolled into a private coverage plan. Individuals that meet an exemption (meet the criteria of 45 CFR 440.315) retain the choice to be enrolled in the Healthy Plus Benefit Plan or the alternative benefit plan that is the State Plan benefit, if they desire. Individuals that become pregnant and therefore exempt from mandatory enrollment retain the choice to be enrolled in the PCO, the Healthy Plus, or the Healthy Benefit Plan.

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)

Alternative Benefit Plan

State Name: Pennsylvania

Attachment 3.1-L- 2

OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049

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

Alternative Benefit Plan

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.
• Individuals will receive a notice indicating the results of the Department's determination.
• All Individuals will have the opportunity to appeal the Department's decision.

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 the 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 recipients eligibility for the PCO. If an individual believes they meet exemption criteria from mandatory enrollment in the PCO, they may notify their local CAO to report the change and provide verification of the exemption (for example, a pregnancy or a disability) and will have the option to enroll in the Healthy or the Healthy Plus Benefit Plan.

☑ 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

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 2 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049 | OMB Expiration date: 10/31/2014

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

If an individual states they are medically frail at application, they may request to complete a health screen to determine a need for enrollment in the Healthy Plus or Healthy Benefit Plan. The health screen will be reviewed by the Department of Human Services (Department). If the Department determines the individual is medically frail and therefore meets an exemption for mandatory enrollment, they will be told of the decision and given the choice to enroll in either the Healthy or the Healthy Plus Benefit Plan.

☐ Self-identification

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☐ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☐ Provider identification

☒ Change in eligibility group

☐ Other

Alternative Benefit Plan

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ Ad hoc basis
- ◉ Other

Describe:

The Department will look at claims data three times a year.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

• 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.

Other Information Related to Enrollment Assurance for Mandatory Participants (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- 2 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049 | 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: Private Coverage Option (PCO)

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.

Plan name: Aetna - POS 3.7

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. Yes

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

The Base Benchmark Plan serves as the minimum level of coverage. Individual PCO plans may choose to provide additional services.

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- 2

OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049

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):

Individuals enrolled in the PCO will have the same copayment requirements as individuals in the Healthy and the Healthy Plus Benefit Plan.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 2 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049 | 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."

Largest Commercial HMO

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: 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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Specialist Office Visit

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Outpatient Surgery

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Infusion Therapy

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:

Provided in an outpatient hospital department, an Ambulatory Surgical Center (ASC), or in the home.
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Vasectomy

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Tubal Ligation

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:
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided:
Infertility Treatment

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

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 only for the diagnosis and surgical treatment of the underlying medical cause.
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided:
Subluxication (Chiropractic)

Source:
Base Benchmark Commercial HMO

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
20 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:
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Alternative Benefit Plan

Benefit Provided: Hospice-Outpatient

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Allergy Treatment

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Allergy Testing

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

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 as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Urgent Care Provider

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:

Non-Urgent use of Urgent Care Provider is not covered.
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Add

Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided: Emergency Room

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:

Non-Emergency care in an Emergency Room is not covered.
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Emergency Ambulance

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:

Non-Emergency Ambulance is not covered
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

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:

Includes Transplants
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.
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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.
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: 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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Maternity- Delivery and Post-Partum Care

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Inpatient Maternity Services

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.
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: 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:

Includes services provided for Serious Mental Illness (SMI) and non-SMI. This does not include services in an Institution for Mental Disease.
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.
Services will not be provided in an IMD.

Benefit Provided: Outpatient Services - Mental Health
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:

Includes services provided for Serious Mental Illness (SMI) and non-SMI. Services include Psychiatric clinic services, clozapine services, psychiatric partial hospitalization, and crisis services.
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements. All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Inpatient Detoxification
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:
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.
Services will not be provided in an IMD.

Benefit Provided:
Outpatient Detoxification

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:
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided:
Inpatient Rehabilitation (Substance Abuse)

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:
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.
Services will not be provided in an IMD.

Alternative Benefit Plan

Benefit Provided: Outpatient Rehabilitation (Substance Abuse)

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Residential Treatment Facility

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:

Does not include services in an Institution for Mental Disease.
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.
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:

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: Other

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Home Health Care

Source: Base Benchmark Commercial HMO

Remove

Authorization: Other

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:

Limited to 60 visits per calendar year. No more that 3 intermittent visits per day by a Home Health Care agency. 1 visit equals a period of 4 hours or less.
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Durable Medical Equipment

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided:

Outpatient Physical and Occupational Therapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided:

Outpatient Speech Therapy

Source:

Base Benchmark Commercial HMO

Remove

Authorization:

Other

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Add

Alternative Benefit Plan

■ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Benefit Provided: Diagnostic Labratory

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Diagnostic X-Ray

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:

Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Benefit Provided: Diagnostic X-Ray for Complex Imaging Services

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:

Includes MRA/MRS, MRI, PET, and CAT scans.
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

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:	Source:	
Medicaid State Plan EPSDT Benefits	Base Benchmark Commercial HMO	Remove

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 2 calendar years

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit:
As performed by an optometrist
Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

Add

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

☐ 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: Family Planning

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: Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

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: Prior Authorization as determined by the PCO managed care plans and in compliance with federal parity requirements.
All managed care plans have provided a written assurance of compliance with MHPAEA.

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 ☐

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V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 2 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049 | 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. No

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.

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.

Alternative Benefit Plan

☑ 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

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V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 2 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049 | 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).
  - [ ] 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 Department met with stakeholder groups throughout the state to provide information regarding the PCO. These stakeholder groups include but are not limited to: the Medical Assistance Advisory Committee (MAAC), the Consumer Subcommitee of the MAAC, the Long Term Care Subcommittee of the MAAC, the Fee for Service Subcommittee of the MAAC, the Managed Care Subcommittee of the MAAC, drug & alcohol providers, mental health providers, physical health providers, Federally Qualified Health Centers, the Hospital Association of Pennsylvania, county human service agencies, and advocacy organizations. Additionally, the Commonwealth has contracted with marketing firms to develop television and radio ads, design brochures, and perform grassroots and minority outreach to individuals who may qualify for the PCO. Television and radio ads began airing in November 2014.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. No

- [x] The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

- ○ Competitive procurement method (RFP, RFA).

◉ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

The Department publicly issued a Request for Application (RFA) #04-14 on the Commonwealth's E-marketplace on May 8, 2014. Applications were due by 12:00 pm on June 10, 2014. A Potential Applicant Question and Answer Conference for interested parties was conducted May 15, 2014.

For Applicants to be considered for formal negotiations of Agreements with the Department, they needed to successfully demonstrate the following elements in their Applications:

• Indicate which Regions within the Commonwealth of Pennsylvania they intended to operate as a Private Coverage Organization (PCO). The Regions are consistent with the nine (9) Federally Facilitated Marketplace Regions for Pennsylvania.
• Applicants indicated their proposed Behavioral Health Services Coverage Model—specifically designating entities with whom subcontracts would be developed and the nature of payments and risk in those subcontracts.
• Applicants provided documentation of current valid Pennsylvania HMO certificate of Authority through submission of the documentation issued jointly by the Pennsylvania Insurance Department and the Pennsylvania Department of Health.
• Applicants provided documentation of their process and plan to obtain HMO county operational authority for the Healthy Pennsylvania PCO product provider networks from the Department of Health.
• Applicants provided documentation of their process and plan to submit certification to the Pennsylvania Insurance Department to insure that the PCO plan meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.
• Applicants provided documentation of their most recent National Committee for Quality Assurance (NCQA) Health Plan Accreditation. NCQA accreditation of Excellent, Commendable or New Health Plan Accreditation expected.
• Applicants submitted documentation of economic capacity and financial stability to perform as a PCO under Agreement.
• Applicants submitted an acceptable Emergency Preparedness Statement illustrating their ability to support continuity of operations during a public emergency, including pandemic.
Applications were reviewed by a multi-disciplinary team of executives from within the Department. Applicants that successfully exhibited all the required elements of the RFA were recommended to enter negotiations for formal Agreements with the Department. The Department conducted negotiation sessions with all successful Applicants throughout July and issued final Agreements on 9/22/14.

The RFA and all related documentation can be reviewed on E-Marketplace at the following link, http:// www.emarketplace.state.pa.us/Solicitations.aspx?SID=RFA 04-14

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. No

MCO service delivery is provided on less than a statewide basis. No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: No

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

When an applicant is determined to be eligible for the PCO program, they are enrolled into one of the plans based on the region in

which their county of residence falls. Each region has at least one plan, but many have more.

The PCO enrollment broker is Pennsylvania Enrollment Services. The PCO enrollment broker will work with recipients to select a plan.

The Healthy Pennsylvania PCO eligibility start date is the same as the PCO plan start date, which is based on the processing date. For newly PCO-eligible individuals, if the processing date is between the first and fifteenth day in a month, the PCO plan will start on the first day of the following month. If the processing date is between the sixteenth and last day in a month, the PCO plan will start on the fifteenth of the following month.

Additional Information: MCO (Optional)

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

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.

Individuals determined to be eligible for the PCO receive ongoing health care coverage from their application date and can apply for up to three months of retroactive coverage.

Until PCO coverage begins, a PCO eligible individual is provided with MA Fee-for-Service coverage via an ABP that mirrors the state plan 3.1A (Healthy) benefit, from the application date through the day before the PCO start date and any retroactive period applied for. This Fee-for-Service coverage is automatically created by the system as a single period of non-continuous eligibility. The Fee-For-Service period of eligibility will provide the same scope of benefits as under the ABP that mirrors the Healthy State Plan Benefit. Once coverage is effective in the PCO plan, Fee-for-Service coverage provided via an ABP that mirrors the Healthy State Plan Benefit will end.

Additional Information: Fee-For-Service (Optional)

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

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V.20140417

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 2 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049 | 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. **Yes**

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

Healthy Pennsylvania provides the PCO program to beneficiaries through payment of premiums directly to each of the enrolled managed care organizations contracted as a PCO plan, as authorized by the Section 1115 Demonstration Authority.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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V.20140415

Alternative Benefit Plan

State Name: Pennsylvania | Attachment 3.1-L- 2 | OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049 | 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- 2

OMB Control Number: 0938-1148

Transmittal Number: PA - 14 - 0049

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