

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

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

Facesheet

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

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

The **name of the waiver program is Community HealthChoices** (Please list each program name if the waiver authorizes more than one program.). **Within Community HealthChoices (CHC), there are two components: Long-Term Services and Supports and Physical Health Services.**

THE CHC WAIVER PROGRAM

The CHC Program is the Commonwealth’s statewide mandatory managed care program through which Participants will receive Medicaid physical health services and Long Term Services and Supports (LTSS). CHC will serve the following Participants:

- Adults age 21 or older who require Medicaid LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility.
- Dual Eligibles age 21 or older whether or not they need or receive LTSS excluding participants who are enrolled in the OBRA waiver or a home and community-based waiver administered by the Office of Developmental Programs.

The CHC program will be rolled out in all 67 counties that comprise five (5) geographic zones. CHC will be the sole Medicaid option for full Dual Eligibles. other Nursing Facility Clinically Eligible consumers residing in these five zones will have the choice between CHC and the PACE program known as Living Independence for the Elderly (LIFE) in Pennsylvania, which is a separate managed care program option that is available in certain geographic areas of the Commonwealth. CHC will serve an estimated 450,000 individuals, including 130,000 older Pennsylvanians and adults with physical disabilities who are currently receiving LTSS in the community and in nursing facilities. CHC Managed Care Organizations (CHC-MCOs) will be accountable for most Medicaid-covered services, including preventive services, primary and acute care, LTSS (Home and Community Bases Services and nursing facilities), prescription drugs, and dental services. Participants who have Medicaid and Medicare coverage (dual eligible participants) will have the option to have their

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Medicaid and Medicare services coordinated by an aligned D-SNP operated by the same company.

Medicaid State Plan Behavioral Health Services are excluded from CHC-MCO Covered Services. No mental health or drug and alcohol services, except ambulance, pharmacy and emergency room services, will be covered by the CHC-MCOs.

Type of request. This is an:

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

Effective dates: This waiver is requested **for a period of 3 ½ years; effective January 1, 2017, and ending June 30, 2020.** (For beginning date for an initial or renewal request, please choose the first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date and the end of the waiver period as the end date.)

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State Contact: The State contact person for this waiver is Virginia Brown and can be reached by telephone at (717) 783-4510, or fax at (717) 772-2527, or email at virbrown@pa.gov. (Please list for each program.)

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

There are no federally recognized tribes in the Commonwealth of Pennsylvania.

Program History

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

CHC Program History

The Commonwealth convened ten significant planning groups, study commissions and work groups on LTSS. Across those planning efforts, stakeholders repeatedly raised a consistent set of themes that include the need to expand LTSS options, strengthen care coordination, increase the focus on quality measurement, encourage innovation and ensure sustainability of the LTSS system as demand grows.¹ In February 2015, Governor Wolf directed the Department of Human Services (DHS) and the Department of Aging (PDA) to develop a managed long-term services and supports program to act on these longstanding themes. In June 2015, following a national review of best practices, the Commonwealth outlined the basis for CHC in a public discussion document. In June and July, 2015 officials from DHS and PDA received verbal feedback at six public forums held across Pennsylvania, attended by over 800 stakeholders, and through written feedback following the forums. Following review of the feedback, the Commonwealth released a concept paper in September, 2015, and received over 2000 comments. Based on the feedback, a draft Request For Proposal (RFP) for the program was released for comment on November 16, 2015, and a final RFP on March 1, 2016.

¹ *Summary of Previous Long-Term Care Reports, Recommendations and Accomplishments/Activities; Prepared for the Pennsylvania Long-Term Care Commission. June 30, 2014. http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_091262.pdf Accessed 8/5/15.*

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In addition to the stakeholder process described above, the Commonwealth established in August 2015 the Managed Long-Term Services and Supports System Subcommittee (MLTSS SubMAAC) as a subcommittee of the Medical Assistance Advisory Committee (MAAC) to advise the Commonwealth on the design, implementation, oversight, and improvement of CHC. Fifty percent of the Committee’s members are LTSS participants or caregivers. The MLTSS SubMAAC will continue to meet throughout development and implementation of CHC program and will provide ongoing advice on program improvement in the post-implementation period. The Commonwealth also holds monthly public webinars on the third Thursday of every month, to provide updates on the progress of the CHC program development and to take questions from the public. The Commonwealth has also sponsored several ad hoc meetings and webinars, including two “Meet and Greet” information and networking events, in which several distinct stakeholder groups and MCOs were introduced to one another and encouraged to ask each other questions.

The program is scheduled for implementation in three phases, beginning January 2017. Major milestones are included in Table 1.

Table 1. CHC Implementation Milestones

CHC-MCOs selected through RFP	June 2016
Readiness reviews for Phase 1	June-December 2016
Phase 1 CHC participants receive pre-enrollment and enrollment notices	September –December 2016
Implementation of Phase 1 (Southwest region)	January 2017
Phase 2 CHC participants receive pre-enrollment and enrollment notices	September –December 2017
Implementation of Phase 2 (Southeast region)	January 2018
Phase 3 CHC participants receive pre-enrollment and enrollment notices	September –December 2018
Implementation of Phase 3 (Northwest, Lehigh-Capital and Northeast regions)	January 2019

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A. Statutory Authority

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

- a. **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b. **1915(b)(2)** – A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing MCOs/PIHPs in order to provide enrollees with more information about the range of health care options open to them.
- c. **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- d. **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

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

- MCO The Community HealthChoices program**
- PIHP
- PAHP
- PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
- FFS Selective Contracting program (please describe)

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PA has a managed care program, HealthChoices, which includes physical health and behavioral health services. Individuals served in the CHC waiver will receive their behavioral health services from HealthChoices behavioral health MCOs. The next renewal application for the PA-67 HealthChoices waiver, effective January 1, 2017, will include additional populations to be served under the BH-PIHP authority as a result of the implementation of CHC.

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a. X **Section 1902(a)(1)** – Statewideness–This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State.

CHC will be implemented in geographical phases beginning January 2017 in the southwest region and in effect statewide by January 1, 2019.

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

CHC-MCOs will provide wellness, care management and other services not provided to beneficiaries not enrolled in CHC.

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

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

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

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B. Delivery Systems

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

a. **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. **PIHP:** Prepaid Inpatient Health Plan means an entity that:
 (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

- The PIHP is paid on a risk basis
- The PIHP is paid on a non-risk basis.

c. **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

- The PAHP is paid on a risk basis.
- The PAHP is paid on a non-risk basis.

d. **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
 the same as stipulated in the state plan

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___ is different than stipulated in the state plan (please describe)

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

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

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

CHC-MCOs are chosen by a competitive procurement process. The state is divided into 5 zones: Southwest, Lehigh-Capital, Southeast, Northwest, and Northeast. Offerors may bid on a single zone or any combination of zones. A single procurement process for all 5 zones is taking place in 2016, with implementation occurring in 3 phases, from January 2017 through January 2019.

___ **Open** cooperative procurement process (in which any qualifying contractor may participate)

___ **Sole source** procurement

___ **Other** (please describe)

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C. Choice of MCOs and PIHPs

1. Assurances.

The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

The state plans to procure no fewer than two and no more than five MCOs in each CHC zone: Southwest, Lehigh-Capital, Southeast, Northwest, and Northeast zones.

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

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

- Two or more MCOs
- Two or more primary care providers within one PCCM system.
- A PCCM or one or more MCOs
- Two or more PIHPs.
- Two or more PAHPs.
- Other: (please describe)

3. Rural Exception.

The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** (“rural area” must be defined as any area other than an “urban area” as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting

- Beneficiaries will be limited to a single provider in their service area (please define service area).
- Beneficiaries will be given a choice of providers in their service area.

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D. Geographic Areas Served by the Waiver

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

Statewide – all counties, zip codes, or regions of the State

Less than Statewide

Community HealthChoices will be implemented statewide in 3 phases.

Phase 1 - Southwest Region implemented January 1, 2017

Phase 2 - Southeast Region implemented January 1, 2018

**Phase 3 – Northwest, Lehigh-Capital, and Northeast Regions
implemented January 1, 2019.**

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP or other entity) with which the State will contract.

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CHC-MCO

City/County/Region	Type of Program (MCO or PIHP)	Name of Entity (for MCO, PIHP, PAHP)
<i>Phase 1: Southwest Zone (January 1, 2017)</i> Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland Counties	All entities listed are MCOs.	To be determined
<i>Phase 2: Southeast Zone (January 1, 2018)</i> Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties	All entities listed are MCOs.	To be determined
<i>Phase 3: Lehigh/Capital Zone (January 1, 2019)</i> Adams, Berks, Dauphin, Cumberland, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York Counties	All entities listed are MCOs.	To be determined
<i>Phase 3: Northwest Zone (January 1, 2019)</i> Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren	All entities listed are MCOs.	To be determined
<i>Phase 3: Northeast Zone (January 1, 2019)</i> Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming	All entities listed are MCOs.	To be determined

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E. Populations Included in Waiver

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

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

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

Mandatory enrollment

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

Blind/Disabled Adults and Related Populations are beneficiaries, age **21** or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

Mandatory enrollment

CHC will enroll Blind/Disabled Adults who receive LTSS in nursing homes and HCBS settings, or who are full dual eligibles. All other Blind/Disabled Adults are enrolled in the separate HealthChoices program.

Voluntary enrollment

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

Mandatory enrollment

Voluntary enrollment

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Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

- Mandatory enrollment
- CHC will enroll Aged beneficiaries who are full dual eligibles.**
- Voluntary enrollment

Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

- Mandatory enrollment
- Voluntary enrollment

Women in the Breast and Cervical Cancer Prevention and Treatment Program

- Mandatory enrollment
- Voluntary enrollment

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

- Mandatory enrollment
- Voluntary enrollment

OTHER

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

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Medicare Dual Eligible--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

Poverty Level Pregnant Women -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

Other Insurance--Medicaid beneficiaries who have other health insurance.

Reside in Nursing Facility (in excess of 30 days) including beneficiaries in VA LTC Residential Facilities or state-operated ICF/MR.

Enrolled in Another Physical Health Managed Care Program-- Medicaid beneficiaries who are enrolled in another Medicaid managed care program. **HealthChoices**

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

Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver). **Participants who are enrolled in the OBRA Waiver or an HCBS waiver administered by the Office of Developmental Programs are excluded.**

American Indian/Alaskan Native--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

Special Needs Children (State Defined)--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition. **Individuals up to age 21 are excluded.**

SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

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

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X **Other** (Please define):

The Department excludes the following populations from this waiver:

- **Individuals who reside in or are admitted to a state psychiatric hospital.**
- **Individuals eligible for and choosing to participate in an available PACE program, known as Living Independence for the Elderly (LIFE) in Pennsylvania.**
- **Aliens who are eligible only for services for emergency medical conditions.**
- **Individuals who reside in Veterans Administration Long-Term Care Facilities**
- **Individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID)**
- **Partial dual-eligibles who are receiving cost sharing only from Medicaid, including Special Low Income Medicare Beneficiaries and Qualified Medicare Beneficiaries who do not have a full Medicaid package.**

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F. Services

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

Note: Appendices D2.S and D2.A will be completed prior to submission to CMS

1. Assurances.

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

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

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

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

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

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

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

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

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

___ The PIHP, PIHP, or FFS Selective Contracting program does not cover emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

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

X Other (please explain):

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

___ Family planning services are not included under the waiver.

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

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

The Agreement between the Department and the CHC-MCOs contains the following provider network requirement:

The CHC-MCO must contract with a sufficient number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access to FQHC and RHC services, provided FQHC and RHC services are available, within a travel time of thirty (30) minutes (Urban) and sixty (60) minutes (Rural). If the CHC-MCO’s primary care Network includes FQHCs and RHCs, these sites may be designated as PCP Sites. If a CHC-MCO cannot contract with a sufficient number of FQHCs and RHCs, the CHC-MCO must demonstrate in writing it has attempted to reasonably contract in good faith.

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

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5. **EPSDT Requirements.**

The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

N/A - Individuals up to age 21 are excluded.

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

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

7. **Self-referrals.**

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

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

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Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

Pennsylvania will comply with the above referenced statute and regulation.

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

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

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

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

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Hospitals (please describe):
6. ___ Mental Health (please describe):
7. ___ Pharmacies (please describe):
8. ___ Substance Abuse Treatment Providers (please describe):
9. ___ Other providers (please describe):

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

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Mental Health (please describe):
6. ___ Substance Abuse Treatment Providers (please describe):
7. ___ Urgent care (please describe):

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8. ___ Other providers (please describe):

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

1. ___ PCPs (please describe):

2. ___ Specialists (please describe):

3. ___ Ancillary providers (please describe):

4. ___ Dental (please describe):

5. ___ Mental Health (please describe):

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

7. ___ Other providers (please describe):

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

3. **Details for 1915(b)(4) FFS Selective Contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

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B. Capacity Standards

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

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

Pennsylvania will comply with the above referenced statute and regulation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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C. Coordination and Continuity of Care Standards

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

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

Pennsylvania will comply with the above referenced statute and regulation.

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

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

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

The following items are required.

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

b. **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

Persons in CHC who have long-term services and supports needs or chronic health care needs requiring coordination of services may self-identify as having those special health care needs during the enrollment process or at any time during their enrollment with the

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CHC-MCO. Persons indicating long-term service needs during the initial application process will be referred for a level of care determination. A Nursing Facility Clinically Eligible Determination identifies the person to the MCO as a member with long-term services and supports needs and that information is then forwarded to the CHC-MCO for each person with LTSS needs.

In addition, individuals with unmet needs, service gaps, or a need for service coordination will have a needs assessment conducted by the MCO. The needs assessment will assist the MCO to identify whether an individual has a need for care coordination of their health condition or if the person could benefit from long-term services and supports. If the MCO determines a person can benefit from LTSS the MCO will make a referral to the Independent Enrollment Entity (IEE) and the IEE will facilitate the process to obtain a level of care determination.

- c. **X** **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

Persons identified either through self-referral or other sources during the eligibility determination process as having LTSS needs will be referred for a level of care determination. The determination is facilitated by the IEE and completed by an Area Agency on Aging using a tool developed by the Department. Upon completion of the level of care determination, the information is forwarded to the CHC-MCO. CHC-MCOs will then complete a ‘needs assessment’ for each individual that meets the level of care and complete a participant centered service plan. The needs assessment will be a tool identified by the Department and completed by a service coordinator contracted by or employed by the CHC-MCO.

Additionally, the CHC-MCO may also identify persons that could benefit from coordination of services through sources such as an initial screening upon enrollment in the CHC-MCO, or the receipt of authorization requests or referrals from the provider network or required initial physical exams. Also, the CHC-MCOs review utilization patterns to identify persons with healthcare coordination needs.

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d. **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

- 1. Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
- 2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
- 3. In accord with any applicable State quality assurance and utilization review standards.

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

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

- a. Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
- c. Each enrollee receives **health education/promotion** information. Please explain.
- d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

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- e. _ There is appropriate and confidential **exchange of information** among providers.
 - f. _ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
 - g. _ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
 - h. _ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
 - i. _ **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.
4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

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Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

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

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

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. **The State assures CMS that this quality strategy was initially submitted to the CMS Regional Office on (Date to be added upon submission).**

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

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Program	Name of Organization	Activities To Be Conducted		
		EQR study	Mandatory Activities	Optional Activities
CHC-MCO		Yes	Yes – all three elements <ul style="list-style-type: none"> • Validation of Performance Improvement Projects • Validation of Performance Measures • Review of MCO compliance 	Yes <ul style="list-style-type: none"> • Administration of consumer surveys

2. **Assurances For PAHP program.**

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

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

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

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3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

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

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

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

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

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

4._ Refer to program staff for further investigation;

5._ Send warning letters to PCCMs;

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

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

8._ Change an enrollee's PCCM;

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

10._ Further limit the number of assignments;

11._ Ban new assignments;

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

13._ Suspend or terminate PCCM agreement;

14._ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

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

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

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

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

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

A. ___ Initial credentialing

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

___ The utilization management system.

___ The complaint and appeals system.

___ Enrollee surveys.

___ Other (Please describe).

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4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
 5. ___ Has an initial and recertification process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
 6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
 7. ___ Other (please describe).
- d. ___ **Other quality standards** (please describe):

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

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Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. Assurances

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

Pennsylvania will comply with the above referenced statute and regulation.

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

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

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

2. Details

a. **Scope of Marketing**

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

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- 2. X The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

The CHC-MCO must develop outreach materials such as pamphlets and brochures which can be used by the IEE to assist Participants in choosing a CHC-MCO and PCP.

Indirect outreach materials (i.e., advertisements) may be utilized immediately after final written approval is received by the CHC-MCO from the Department.

The CHC-MCO must not directly or indirectly conduct door-to-door, telephone or other cold-call marketing activities.

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

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

- 1. X The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

The CHC-MCO may offer items of little or no intrinsic value (i.e., trinkets with promotional CHC-MCO logos) at health fairs or other approved community events. Such items must be made available to the general public, not to exceed \$5.00 in retail value and must not be connected in any way to CHC-MCO enrollment activity. All such items are subject to advance written approval by the Department.

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

- 2. ___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of

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new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

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

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

- i. ___ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii. ___ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.
- iii. X Other (please explain):

CHC-MCO must provide, at no cost to Participants, oral interpretation services in the requested language or sign language interpreter services to meet the needs of Participants.

CHC-MCO must also provide specialized interpretive services to ensure access to services for Participants who are deaf and blind.

CHC-MCO must make all vital documents disseminated to English speaking Participants available in the prevalent languages designated by the Department.

CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate language.

Vital documents must be posted on the CHC-MCO’s website.

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B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

Pennsylvania will comply with the above referenced statute and regulation.

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

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

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

2. **Details.**

a. **Non-English Languages**

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

The State defines prevalent non-English languages as:
(check any that apply):

1. ___ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines “significant.”

2. **X** The languages spoken by approximately **5** percent or more of the potential enrollee/ enrollee population.

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3. X Other (please explain):

CHC-MCO must make vital documents disseminated to English-speaking Participants available in Spanish or an alternative language, upon request of the Participant.

The IEE Contractor shall make materials available in Spanish, and upon request in other prevalent languages.

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

CHC-MCO must provide, at no cost to Participants, oral interpretation services in the requested language or sign language interpreter services to meet the needs of Participants.

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

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

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

The IEE acts as a source of information about, but is independent from, the CHCMCOs.

To aid MA beneficiaries in the CHC-MCO selection process, the IEE contractor produces and distributes a variety of printed information and materials. An important role of the IEE Contractor is to help MA beneficiaries determine whether the plan they are selecting contracts with their PCP or other providers.

b. Potential Enrollee Information

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Information is distributed to potential enrollees by:

- State
- contractor (please specify)

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

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

c. Enrollee Information

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

- (i) the State
- (ii) State contractor (please specify):

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

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

All other enrollee information

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C. Enrollment and Disenrollment

1. Assurances.

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

Pennsylvania will comply with the above referenced statute and regulation.

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

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

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

2. Details. Please describe the State’s enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

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The Department will procure contracts with local partners to provide general education and information about the CHC program for potential enrollees. The statement of work solicits vendors to detail a plan, and execute said plan to make contact with 100% of future CHC enrollees. The education and outreach plan will be phased with the rollout of CHC, beginning 6 months before the implementation date in each zone. July 1, 2016 is the projected go live date for this agreement in southwest PA. Grass roots education and outreach efforts will be conducted through targeted contacts with each future enrollee based on data files provided to the Outreach entity. Fields in the data file will include name, address, phone number, and language preference. Efforts may include, but not be limited to cold calls, invitations to community forums for future enrollees, and mailings. The outreach entity will be required to report their methods and contacts with each future enrollee through an electronic form.

Existing community partners reach a large number of future enrollees through existing service networks. Prospective vendors will be required to step beyond the participants receiving daily services to ensure that underserved groups, typically referred to as “healthy duals” are aware of the upcoming opportunity to choose their CHC MCO.

The Department contracts with an IEE contractor to perform enrollment activities, including general education and outreach. The IEE contractor’s goals in conducting the activities below, are to assist and encourage MA beneficiaries in making informed choices, decrease MCO transfer rates and ensure continuity of care.

- **The IEE will provide education to beneficiaries on CHC-MCOs plans available to them in their region, provide input to the beneficiary on plans that their currently utilized providers participate with, and encourage them to make a plan selection.**
- **The IEE will explain how to access the web site, and what information they can access on the web site, and help beneficiaries to understand the process of selecting a plan.**
- **The IEE will provide information to beneficiaries on the procedures for accessing behavioral health services.**

b. Administration of Enrollment Process.

State staff conducts the enrollment process.

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

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The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: **Maximus**

Please list the functions that the contractor will perform:

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

The IEE Contractor provides information on BH-MCOs and assists the beneficiary in selecting an MCO.

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

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

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

**Community Health Choices will be implemented in 3 phases.
Phase 1 - Southwest Region implemented January 1, 2017
Phase 2 - Southeast Region implemented January 1, 2018
Phase 3 – Northwest, Lehigh-Capital, and Northeast Regions implemented January 1, 2019.**

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

If a potential enrollee does not select an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have up to **60** days to choose a plan. **The potential enrollee requiring LTSS will have the term of their eligibility determination process to choose a plan. This typically takes 30 to 60 days. If the individual has not chosen a plan by the time the eligibility determination is processed, he or she will be auto-assigned**

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to a plan. The potential enrollee who does not require LTSS will be immediately auto-assigned to a plan. Following auto-assignment, enrollees may request a transfer to another plan.

- ii. X Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

The auto enrollment process will be run by the Client Information System (CIS). The hierarchy is as follows:

First, if a Participant is residing in a nursing facility at the time of enrollment, they will be assigned to a plan in which their nursing facility is a Network Provider.

Second, a Participant enrolled in a D-SNP will be assigned to a CHC-MCO aligned with their D-SNP.

Third, if the Participant is transferring from HealthChoices, and the HealthChoices-MCO is also contracted as CHC-MCO, and the Participant has not made a CHC-MCO selection, the Participant will be enrolled in the affiliated CHC-MCO.

Last, if a Participant is receiving HCBS and their HCBS provider is contracted with a CHC-MCO, the Participant will be enrolled in that CHC-MCO.

If none of the above conditions apply, an eligible Participant who has not made a CHC-MCO selection and who has a case record that also includes another active Participant in the case with an active CHC-MCO record, the eligible Participant will be assigned to that same CHC-MCO. All remaining eligible Participants, who have not voluntarily selected a CHC-MCO, will be considered in the pool of Participants who will be equally auto- assigned among the available CHC-MCOs.

- X The State automatically enrolls beneficiaries

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

 on a mandatory basis into a single BH-PIHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

X on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: All regions

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___ The State provides guaranteed eligibility of ___ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

___ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

X The State automatically re-enrolls a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 6 months or less.

d. Disenrollment:

X The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i. X Enrollee submits request to IEE Contractor.

Beneficiaries can choose to transfer to another CHC-MCO that provides services in their Community HealthChoices zone at any time. If eligible, they may also choose to enroll in the LIFE program. However, they may not choose to disenroll from managed care entirely.

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

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

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

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

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

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

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

- i. MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:
- ii. The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- iii. If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.
- iv. The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

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D. Enrollee rights.

1. Assurances.

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

Pennsylvania will comply with the above referenced statute and regulation.

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

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

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

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

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E. Grievance System

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

- a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

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

Pennsylvania will comply with the above referenced regulation.

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

X The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

Pennsylvania will comply with the above referenced regulations.

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

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

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

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

The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. **Timeframes**

The State’s timeframe within which an enrollee, or provider on behalf of an enrollee, must file a- **grievance is up to 45 days** (between 20 and 90).

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

Beneficiaries will be given 45 days from the date they receive the written notice of decision to file a grievance.

The State’s timeframe within which an enrollee must file a **complaint is up to 45 days.**

For CHC-MCOs, The participant has up to 45 days from the date on the written notice to file a complaint when the complaint involves the following: the complaint challenges the failure of the CHC-MCO to decide a complaint or grievance within the specified timeframes, or failure to meet the required timeframes for providing a service, or disputes a denial made for the reason that a service is not a covered benefit; disputes a retrospective denial of payment because the service(s)/item was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a retrospective denial of payment because the service(s)/item(s) provided was not covered service(s)/item(s) for the beneficiary.

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c. **Special Needs**

X The State has special processes in place for persons with special needs. Please describe.

When a Participant with long-term services and supports needs files a complaint, grievance, or request for a fair hearing (appeal), the Participant’s service coordinator informs the Participant of the available complaint, grievance, and fair hearing (appeal) mechanisms and offers to provide assistance in filing the appropriate documents and facilitating dispute resolution. In addition, service coordinators review the appeal, complaint, and grievance processes annually with the Participant as part of the service planning process.

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

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

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

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

___ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

___ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

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- ___ Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)
- ___ Establishes and maintains an expedited review process for the following reasons:_____. Specify the time frame set by the State for this process_____
- ___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.
- ___ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.
- ___ Other (please explain):

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F. Program Integrity

1. Assurances.

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

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

- (1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
- (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
- (3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

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

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

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

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

CHC-MCO - See Attachment A-1 for the Fraud and Abuse Plan.

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

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

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

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Section B: Monitoring Plan

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

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under “Evaluation of Program Impact.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Access.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Quality.”
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

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CHC-MCO Component Quality Monitoring Plan Matrix

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

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CHC-MCO Component Quality Monitoring Plan Matrix

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

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CHC-MCO Component Quality Monitoring Plan Matrix

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

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II. Details of Monitoring Activities

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

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

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

See Attachment B-1 for CHC-MCO Monitoring Plan.

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

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

- b. ___ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

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

- c. ___ Consumer Self-Report data

- ___ CAHPS (please identify which one(s))
- ___ State-developed survey ___ Disenrollment survey
- ___ Consumer/beneficiary focus groups

CHC-MCOs will be required to conduct participant surveys on an annual basis. Monitoring of this requirement is not included in the

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Quality Strategy for this initial application; however, it will be incorporated into future renewals.

- d. Data Analysis (non-claims)
 - Denials of referral requests
 - Disenrollment requests by enrollee
 - From plan
 - From PCP within plan
 - Grievances and appeals data
 - PCP termination rates and reasons
 - Other (please describe)
- e. Enrollee Hotlines operated by State
- f. Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).
- g. Geographic mapping of provider network
- h. Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

DHS has commissioned an Independent Assessment from the University of Pittsburgh, Department of Health Policy and Management. The Independent Assessment will focus on the CHC program goals and will address access, quality and costs.

- i. Measurement of any disparities by racial or ethnic groups
- j. Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]
- k. Ombudsman
- l. On-site review - **Readiness review and additional onsite visits for each CHC-MCO.**
- m. Performance Improvement projects [**Required** for MCO/PIHP]
 - Clinical
 - Non-clinical

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- n. X Performance measures [**Required** for MCO/PIHP]
 - Process
 - Health status/outcomes
 - Access/availability of care
 - Use of services/utilization
 - Health plan stability/financial/cost of care
 - Health plan/provider characteristics
 - Beneficiary characteristics

- o. ___ Periodic comparison of number and types of Medicaid providers before and after waiver

- p. ___ Profile utilization by provider caseload (looking for outliers)

- q. ___ Provider Self-report data
 - ___ Survey of providers
 - ___ Focus groups

- r. ___ Test 24 hours/7 days a week PCP availability

- s. ___ Utilization review(e.g. ER, non-authorized specialist requests)

- t. ___ Other: (please describe)

Section C: Monitoring Results

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

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

- This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.
- This is a renewal request.
 - This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.
 - The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

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

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

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

Strategy:

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

Results will be provided in Section C of the waiver renewal

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Section D - Cost-Effectiveness

Section D will be completed at a later date, prior to submission to CMS.

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Attachment A-1
Fraud and Abuse Plan for Community HealthChoices (CHC)

A. Background:

Managed care presents unique opportunities for members, providers, and Managed Care Organizations (MCO) to commit fraud and abuse. The partnership of the Department and the MCOs is an internal tool to effectuate improvement in the prevention, detection, investigation, reporting, recoupment and prosecution of fraud, waste and abuse in the managed care environment. The Department’s Officer of Administration, Bureau of Program Integrity (BPI) monitors the program integrity efforts of the MCOs and reviews services provided by MCO network providers.

The Commonwealth plans to coordinate health care and long-term services and supports (LTSS) through Community HealthChoices Managed Care Organizations (CHC-MCOs). A CHC-MCO builds on the Commonwealth’s experience with HealthChoices, the statewide managed care delivery system for children and adults. Behavioral Health services will continue to be provided through the Behavioral Health Managed Care Organizations (BH-MCOs). The CHC-MCO and BH-MCO will be required to coordinate services for individuals who participate in both delivery systems.

The move to statewide managed care has created a new dynamic within the BPI. Historically BPI has focused efforts on retrospective review of services paid for by the MA fee-for-service (FFS) Program. However, given the predominance of managed care, BPI will begin to complement its review of FFS providers by retrospectively reviewing providers in CHC-MCOs’ networks whose services are paid for through CHC-MCOs.

B. CHC Fraud and Abuse Activities:

- 1) Developing a written compliance plan to prevent, detect, investigate and report suspected fraud, waste, and abuse; includes naming a compliance officer, education of staff and monitoring and maintaining the policies and procedures
- 2) Utilizing the Department’s Online MCO Referral Form process, the MCOs must report any act that may affect the integrity of the program by submitting information to BPI, including, but not limited to: provider, recipient and caregiver referrals for fraud, waste, abuse and quality of care concerns; MCOs case review status, provider terminations.
- 3) BPI Engagement in Continuing Education related to Managed Care Fraud/Waste/Abuse
- 4) Maintaining Oversight and Collaborative Fraud/Waste/Abuse Efforts through Strong Relationships and Coordination between the MCOs.

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- 5) Utilizing the Department’s BPI MCO Quarterly Compliance Report to provide the bureau with compliance data and statistical reports from the MCOs to detail its fraud, waste and abuse detection and sanctioning activities.
- 6) Cooperating fully with the State oversight agencies in detection and prosecution activities.

C. Goals of the CHC Fraud and Abuse Plan:

- 1) Improve quality and quantity of MCO reviews and referrals to BPI.
- 2) Continue to review and revise contract language in agreements with MCOs to remain current with regulatory changes/new requirements and ensure standard, clear and strong program integrity measures and requirements.
- 3) Work collaboratively with MCOs on provider reviews/audits.
- 4) Continual assessment of compliance with Fraud/Waste/Abuse efforts via feedback from CMS or the Department.

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**Attachment B-1
 Details of CHC-MCO Monitoring Activities
 for Upcoming Waiver Period January 1, 2017-June 30, 2020**

Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
Accreditation for Non-Duplication	MCO	MCO & DHS	The MCO must be accredited by NCQA or by a national accreditation body and obtain accreditation within the accreditation body’s specified timelines. A MCO applying for accreditation must select an accreditation option and notify the accrediting body of the accreditation option chosen. Accreditation obtained under the NCQA Full Accreditation Survey or Multiple Product Survey options will be accepted by the Department. The Department will accept the use of the NCQA Corporate Survey process, to the extent deemed allowable by	Yearly	Accreditation helps health care organizations demonstrate their ability to improve quality, reduce costs and coordinate patient care. NCQA’s standards and guidelines incorporate whole-person care coordination throughout the health care system.

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
			<p>NCQA, in the NCQA accreditation of the MCO.</p> <p>If the MCO is accredited as of the contract start date, the MCO shall maintain accreditation throughout the term of the Agreement. If the MCO is not accredited as of the start date, the MCO shall obtain accreditation no later than the end of the second full calendar year of operation and shall maintain accreditation for the term of the Agreement.</p> <p>Failure to obtain accreditation and failure to maintain accreditation will be considered a material breach of the Agreement. A MCO with provisional accreditation status must submit a corrective action plan within thirty (30) days of receipt of notification from the accreditation body</p>		<p>NCQA Accreditation provides independent evaluation of an organization's ability to coordinate care and be accountable for high-quality, efficient, patient-centered care that is expected from the MCOs.</p>

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
			and may be subject to termination of the Agreement. The MCO must submit final hard copy Accreditation Report for each accreditation cycle within ten (10) days of receipt of the report. The MCO must submit to the Department updates of accreditation status, based on annual HEDIS scores within ten (10) days of receipt.		
Readiness Review	MCO	MCO & DHS	Key areas of focus for readiness review: <ol style="list-style-type: none"> 1. Care coordination 2. Service authorization and delivery 3. Provider network management 4. Claims processing and payment 5. Data transfer and management 	ongoing	The readiness reviews allow DHS to evaluate whether the MCOs have the infrastructure needed to operate successfully. Additional

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
			6. Quality monitoring Components of the review: 1. Review of key desk deliverables - policies/procedures, training materials, member handbooks, notices, MCO project implementation plan, staffing plan, provider agreement templates, provider manual, MCO subcontracts 2. Onsite review of critical processes and operations functions 3. Training 4. Demonstration of critical MCO system testing		reviews may be needed based on the results of the initial review.
Grievances and appeals	MCO	MCO	Each MCO submits a report containing complaint and grievance information. This	Quarterly	These reports are used to track trends in

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
			report contains the number of complaints or grievances reported by members, the reason, whether it was first or second level, or if it was an expedited request.		denials or recurring problems with a MCO. They are also used to compare the MCOs in relation to each other in order to indicate problems with a certain provider or new service.
Network adequacy assurance submitted by plan	MCO	MCO	MCOs must provide the DHS adequate assurances that the MCO has the capacity to serve their membership in the CHC zones. The MCO must provide assurance that it will offer the whole scope of covered services as well as access to long-term services	On-going	DHS will monitor network adequacy through review of the plan submitted geo-access documentation as well as

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
			and supports, preventive and primary care.		review of complaints received from consumers. Should a plan's network be deemed inadequate, DHS requires the plans to contract with additional providers, including specialists and ancillary providers. Changes to a plan's network that negatively affect members' access to services may be grounds for termination of

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
On-site reviews	MCO	MCO & DHS	<p>MCOs are required to provide department staff with an office on-site to facilitate on-site reviews. On-site reviews are conducted by cross-functional, multi-disciplinary department staff.</p> <p>On-site reviews are scheduled as often as monthly and on a more frequent basis as needed to resolve issues in a particular area. On-site reviews can occur at the MCOs primary office or at the offices of their subcontractors.</p> <p>On-site office visits focused on operations, quality and special needs are conducted yearly. Annual on-site reviews are</p>	Monthly or as needed	<p>the plan.</p> <p>On-site reviews offer DHS the opportunity to meet with the MCOs to monitor plan activities at the source. Typical on-site visits include a review of policies and procedures, in-depth discussion and questioning around diverse focused topics. Additionally DHS staff observes MCO staff as they are responding to calls in member or</p>

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
			<p>also done in the areas of Systems, TPL, and HEDIS validation. These reviews take place in addition to the quarterly on-sites.</p>		<p>provider service areas, care management or disease management.</p> <p>The information department staff gains through interviewing, discussion or observation of plan activities is then used to gauge the plan's ability to serve its members and document contractual compliance.</p>

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
Performance Improvement projects (PIPs)- clinical and non-clinical focus areas	MCO	MCO & External Quality Review (EQR) Contractor	The MCOs must conduct PIPs that allow for objective and systematic monitoring, measurement and evaluation of the quality and appropriateness of care and service provided to members. PIPs must focus on topics that identify opportunities for continuous and sustained improvement over time. PIPs can be clinical or non-clinical in nature but must work toward identifying and minimizing barriers to care.	On-going	<p>DHS staff reviews the on-going identification, progress and analysis of PIPs in the quarterly quality work plans supplied by the CH-MCOs.</p> <p>Additionally, PIPs from each CHC-MCO will be validated annually by the EQR contractor to determine compliance with the EQR regulation protocol for validation of</p>

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
					PIPs.
Performance measures: <ul style="list-style-type: none"> ▪ Effectiveness of Care ▪ Access/Availability of Care ▪ Experience of Care ▪ Use of Services ▪ Cost of Care ▪ Health Plan Descriptive Information ▪ Health Plan Stability ▪ Informed Health Care Choices ▪ PA Performance Measures 	MCO	MCO	The State requires the MCOs to submit the full set of the current version of Medicaid HEDIS performance measures. Those measures specific to behavioral health are not required since those services are not covered by the CHC-MCO. The MCOs must report the numerator and denominator for each measure following NCQA protocols outlined in NCQA’s Technical Specifications. All HEDIS results are validated by an NCQA licensed entity and submitted to the State by June MCOs are required to demonstrate how HEDIS results are incorporated into	Annually	The State reviews, trends, and analyzes HEDIS data and compares plan(s) performance to HEDIS National Benchmarks to assess the quality of healthcare services provided to consumers.

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Strategy:	Applicable Programs (if waiver authorizes more than one type of Managed Care Plan):	Personnel Responsible (e.g. state, Medicaid, other state agency, delegated to plan, EQR, other contractor)	Detailed Description of strategy:	Frequency of Use:	How it yields information about the area(s) being monitored:
			their overall Quality Improvement Plan (QIP). Additionally, the MCOs are required to submit data for additional performance measures developed by the state.		

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