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

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Proposal

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

Facesheet

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

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

The **name of the waiver program** is **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 as defined in the CHC Managed Care Agreements.**

CHC 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 provides managed physical health care and LTSS delivery for those individuals who are age 21 or older in two populations: individuals who are dually eligible for Medicare and Medicaid and individuals who qualify for Medicaid LTSS, both in the community and in nursing facilities. Individuals who are enrolled in the OBRA waiver or a home and community-based waiver administered by the Office of Developmental Programs are excluded from coverage in CHC.

CHC was implemented in three phases across all 67 Pennsylvania counties which are divided into five geographic zones. CHC is the sole Medicaid option for full dual eligibles who do not meet the nursing facility clinically eligible level of care and are considered nursing facility ineligible. Nursing Facility Clinically Eligible participants residing in these five geographic zones will have the choice between CHC and the Program for All-Inclusive Care for the Elderly (PACE), known as Living Independence for the Elderly (LIFE) in Pennsylvania. LIFE is a separate all-inclusive managed care program option that is available in certain geographic areas of the Commonwealth. CHC serves an estimated 450,000 individuals, including 170,000 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) are accountable for most Medicaid-covered services, including preventive services, primary care, acute care, LTSS (Home and Community-Based Services and nursing facility services), prescription drugs, and dental services. Participants who have Medicaid and Medicare coverage (Dual-

Eligible Participants) have the option to have their Medicaid and Medicare services coordinated by an aligned Medicare Part D Special Needs Plan (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.
_X__ renewal request
_X___ 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 renewal is **effective January 1, 2023 through December 31, 2027.** (For beginning date for an initial or renewal request, please choose the first day of a calendar quarter, if possible, or if not, the first day of a month. For an

amendment, please identify the implementation date as the beginning date and the end of the waiver period as the end date.)

State Contact: The State contact person for this waiver is Jennifer Hale and can be reached by telephone at **(717) 346-0495**, or fax at **(717) 772-2527**, or email at jehale**@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 History

CHC is Pennsylvania's Managed Long-Term Services and Supports (MLTSS) program which operates concurrently through a §1915(b) and §1915(c) waiver. The 1915(b)/1915(c) waivers allow the Commonwealth to require Medicaid beneficiaries to receive both LTSS, including nursing facility, hospice, home and community-based services (HCBS), and physical health services through managed care organizations (MCOs). CHC serves the following:

- **Individuals who are 21 years of age or older and who are financially and clinically eligible to receive Medicaid LTSS (whether residing in the community or in a nursing facility).**
- **Individuals who are 21 years of age or older and who are fully eligible for both Medicaid and Medicare, regardless of whether they need or receive LTSS (referred to as "Dual Eligibles") excluding participants who are enrolled in the OBRA waiver, or a home and community-based waiver administered by the Office of Developmental Programs.**

CHC was launched in January 2018 and implemented in three phases across five geographical zones that comprise all 67 counties of the commonwealth. Major implementation milestones are noted in Table 1 below:

Table 1. CHC Implementation Milestones

CHC-MCOs selected through RFP	**August 2016**
CMS Approval of the CHC 1915(b) and 1915(c) waivers	**July 24, 2017**
Readiness reviews for Phase 1	**April through September 2017**
Phase 1 CHC participants receive pre-enrollment and enrollment notices	**September through November 2017**
Implementation of Phase 1 (Southwest zone)	**January 2018**
Phase 2 CHC participants receive pre-enrollment and enrollment notices	**August through November 2018**
Implementation of Phase 2 (Southeast zone)	**January 2019**
Phase 3 CHC participants receive pre-enrollment and enrollment notices	**August through November 2019**
Implementation of Phase 3 (Northwest, Lehigh-Capital and Northeast zones)	**January 2020**

Informing the decision to move to CHC, the Commonwealth convened numerous planning groups, study commissions and work groups on LTSS. During those engagement efforts, stakeholders repeatedly raised a consistent set of themes that included 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 an MLTSS 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 which was distributed through a variety of methods, including six public forums held across Pennsylvania, attended by over 800 stakeholders. Following review of the feedback received on the discussion document, the Commonwealth released a concept paper in September 2015, and received over 2,000 comments. Based on the feedback, a draft Request for Proposal (RFP) for the program was

[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.

released for a 30-day public comment period on November 16, 2015, and a final RFP was issued on March 1, 2016.

In addition to the stakeholder process described above, in August 2015, the Commonwealth established the Managed Long-Term Services and Supports System Subcommittee (MLTSS SubMAAC) as a subcommittee of the Medical Assistance Advisory Committee (MAAC). Fifty percent of the Committee's members are LTSS participants or caregivers. The MLTSS SubMAAC meets on a monthly basis and provides recommendations and ongoing input on the implementation and operation of CHC.

Beginning with the calendar year (CY) 2022 contracts, the CHC-MCOs were required to enter into arrangements with providers to incorporate value-based purchasing strategies such as performance-based contracting, shared savings, shared risk, bundled payments and global payments. The financial goals for the VBP strategies for each calendar year are based on a percentage of the CHC-MCO's expenditures to the medical portion of the risk adjusted capitation revenue without consideration of risk sharing risk pools, P4P or other revenue or revenue adjustments.

The CHC-MCO must achieve the following percentage through their VBP arrangements:

- **15% of the medical portion of the capitation must be expended through VBP. The 15% may be from a combination of low, medium and high-risk strategies and 7.5% of LTSS payments through a VBP arrangement.**

The Department measures compliance through the following reporting requirements:

- **The CHC-MCOs must submit a progress report to the Department by the last workday of each quarter.**
- **By October 1st of each calendar year, the CHC-MCO must submit its proposed VBP plan to the Department that outlines and describes its plan for compliance in that calendar year.**
- **By June 30 of the subsequent calendar year, the CHC-MCO must submit a report as directed by the Department on accomplishments from the prior year. This annual report must include a listing of the VBP arrangements by provider; and an explanation of each arrangement; and the dollar amount spent for medical services and LTSS provided during the previous year through these arrangements**

CHC 2023-2027 Waiver Renewal

With this renewal, the Department is implementing an enhanced Pay for Performance Program (P4P) as described in Section D – Cost Effectiveness, Part 1,

Subsection H-d (relating to incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs).

A. Statutory Authority

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

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

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

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

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

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

   X MCO **Community HealthChoices**
   _ 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)

Pennsylvania's managed care program, HealthChoices, 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 PA-67 HealthChoices Waiver, approved by CMS on December 2, 2021, and effective January 1, 2022, includes language that Behavioral Health services under CHC will be provided through the BH-PIHPs authorized through the PA-67 Waiver.

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

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

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

CHC-MCOs will provide care management, LTSS and other services not available to non-CHC-enrolled beneficiaries.

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.

B. Delivery Systems

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

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

b_ **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

___ 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):

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

CHC-MCOs were chosen through a competitive procurement process. The state is divided into five geographic zones: Southwest, Lehigh-Capital, Southeast, Northwest, and Northeast. Offerors bid on a single zone or any combination of zones. The single procurement process for all five geographic zones took place in 2016, with implementation occurring in 3 phases, from January 2018 through January 2020.

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

C. Choice of MCOs and PIHPs

1. **Assurances.**

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

The state selected three CHC-MCOS to deliver services in the five CHC geographic zones: 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):

X 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.

D. Geographic Areas Served by the Waiver

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

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

   Community HealthChoices was implemented statewide in 3 phases.
   Phase 1 - Southwest Region implemented January 1, 2018
   Phase 2 - Southeast Region implemented January 1, 2019
   Phase 3 – Northwest, Lehigh-Capital, and Northeast Regions implemented January 1, 2020.

   _ **Less than Statewide**

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

CHC-MCO		
City/County/Region	**Type of Program (MCO or PIHP)**	**Name of Entity (for MCO, PIHP, PAHP)**
Phase 1: Southwest Region **(January 1, 2018) Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland Counties**	**All entities listed are MCOs.**	• AmeriHealth Caritas • Pennsylvania Health and Wellness (Centene) • UPMC for You
Phase 2: Southeast Region **(January 1, 2019) Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties**	**All entities listed are MCOs.**	• AmeriHealth Caritas • Pennsylvania Health and Wellness (Centene) • UPMC for You
Phase 3: Lehigh/Capital Region **(January 1, 2020) Adams, Berks, Dauphin, Cumberland, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York Counties**	**All entities listed are MCOs.**	• AmeriHealth Caritas • Pennsylvania Health and Wellness (Centene) • UPMC for You
Phase 3: Northwest Region **(January 1, 2020) Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren Counties**	**All entities listed are MCOs.**	• AmeriHealth Caritas • Pennsylvania Health and Wellness (Centene) • UPMC for You
Phase 3: Northeast Region **(January 1, 2020) Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming Counties**	**All entities listed are MCOs.**	• AmeriHealth Caritas • Pennsylvania Health and Wellness (Centene) • UPMC for You

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

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

X Mandatory enrollment
CHC will enroll Blind/Disabled Adults who receive LTSS in nursing facilities and home and community-based settings, or who are full dual eligibles as defined in the CHC-MCO Agreement. 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

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

X Mandatory enrollment
CHC will enroll Aged beneficiaries who are full dual-eligibles as defined in the CHC-MCO Agreement.
___ 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:

__ **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))

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

X **Other Insurance--**Medicaid beneficiaries who have other health insurance. **Participants who are enrolled in the Health Insurance Premium Payment (HIPP) Program**

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

X **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.

X **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver). **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.

X **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.**

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

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

X **Other** (Please define):

The Department excludes the following populations from this waiver:

- **Individuals who reside in or are admitted to a state psychiatric hospital.**
- **Individuals who are eligible for and who choose 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 Disabilities (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.**

F. Services

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

1. **Assurances.**

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

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

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

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

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

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

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

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

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

__ 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 pay for all family planning services, whether provided by network or out-of-network providers.

___ Family planning services are not included under the waiver.

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

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

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

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.

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**

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

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

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

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

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

1.__ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

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

9.___ Other providers (please describe):

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

1._ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

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

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

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

7.___ Other providers (please describe):

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

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

B. Capacity Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Coordination and Continuity of Care Standards

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

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

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

Persons in CHC may self-identify as having special health care needs during the enrollment process or at any time during their enrollment with the CHC-MCO. Persons indicating long-term service needs during the initial application process with the Independent Enrollment Broker (IEB) will be referred for a level of care determination. A Nursing Facility Clinically Eligible (NFCE) Determination identifies the person to the MCO as a member with

long-term services and supports needs and that information is then forwarded via electronic notification to the CHC-MCO for each person with LTSS needs.

In addition, after enrollment with an MCO, individuals who self-identify or are identified by a healthcare provider with unmet needs, service gaps, or a need for service coordination will have a needs assessment conducted by the MCO utilizing a tool designated by the Department. 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 IEB and the IEB 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 as noted above as having LTSS needs will be referred by the MCO for a level of care determination. The determination is facilitated by the IEB and completed by an independent Assessment Entity 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.

d. **X** **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the

MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

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

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

3.X In accord with any applicable State quality assurance and utilization review standards.

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

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

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

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

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

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

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

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

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

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

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

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

Section A: Program Description

Part III: Quality

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

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

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

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

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. **The State's Quality Strategy was updated and submitted to CMS in December 2020**.

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

Program	Name of Organization	Activities To Be Conducted		
		EQR study	Mandatory Activities	Optional Activities
CHC	**Island Peer Review Organization (IPRO). This contract will be re-procured in 2022 with an effective date of 7/1/2023.**	**Yes**	**Yes** • **Validation of Performance Improvement Projects** • **Validation of Performance Measures** • **Review of MCO compliance** • **Network Adequacy**	

2. **Assurances For PAHP program.**

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

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

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

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

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

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

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

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

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

4._ Refer to program staff for further investigation;

5._ Send warning letters to PCCMs;

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

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

8._ Change an enrollee's PCCM;

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

10._ Further limit the number of assignments;

11._ Ban new assignments;

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

13._ Suspend or terminate PCCM agreement;

14._ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

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

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

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

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

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

A. ___ Initial credentialing

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

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

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

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

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

7. __ Other (please describe).

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

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. **Assurances**

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

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

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

__ 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.

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 marketing materials such as pamphlets and brochures, which can be used by the IEB to assist Participants in choosing a CHC-MCO and PCP.

The CHC-MCO may use indirect marketing materials (i.e., advertisements) only after advance written approval 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. Any items to be offered are subject to advance written approval by the Department.

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

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

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

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

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

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

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

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

The 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 CHC-MCO must require Network Providers to offer interpretation services and prohibit Network Providers from requiring a Participant's family member be used for interpretation. If a Network Provider is unable or unwilling to provide these services, the CHC-MCO must provide interpretation services.

The 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 non-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. This information must also be posted on the Contractor's website.

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

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

___ 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.

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

During the Enrollment Process, the IEB identifies applicants who are limited English proficient. Limited English proficient (LEP) means potential enrollees and enrollees who do not speak English as their primary

language and who have a limited ability to read, write, speak, or understand English. The IEB communicates this information to the chosen CHC-MCO when the participant transfer to the CHC-MCO occurs. The CHC-MCO must identify and communicate using spoken and written language preferences identified by the IEB and CHC-MCO during all contacts with the Participant.

The CHC-MCO must make all vital documents disseminated to Participants available in the prevalent languages designated by the Department. Documents may be deemed vital if related to the access to programs and services and include informational material. Vital documents include Provider Directories, Participant Handbooks, appeal and grievance notices, and other notices that are critical to obtaining services. The 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.

The CHC-MCO must also provide alternative methods of communication for Participants who are visually or hearing impaired or both, including Braille, audio tapes, large print, compact disc, DVD, computer diskette, special support services, and/or electronic communication. The CHC-MCO must, upon request from the Participant, make all written materials disseminated to Participants accessible to visually impaired Participants. The CHC-MCO must provide TTY/Videophone and/or Pennsylvania Telecommunication Relay Service for communicating with Participants who are deaf or hearing impaired, upon request.

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

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 IEB has Call Center staff who speak languages other than English and when necessary, the IEB 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 IEB is an independent link between the CHC-MCOs and Participants and provides information to Participants to make informed decisions about choosing a CHC-MCO. The IEB produces and distributes Department approved materials and brochures to Participants to aid them in the CHC-MCO selection process.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

X State
X contractor (please specify)

The IEB mails pre-enrollment materials that consist of a cover letter, an enrollment form, a CHC-MCO comparison chart, a hospital listing, 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. The IEB also provides information and education on the LIFE program.

__ 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) **X** the State

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

The IEB mails a post-enrollment brochure, which includes information on behavioral health services, and a confirmation letter of the Participant's choice of CHC-MCO. Materials are distributed within one business day of receiving the enrollee file from the Department.

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

All other enrollee information.

C. Enrollment and Disenrollment

1. **Assurances.**

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

__ 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)

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

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

The Department contracts with an IEB contractor which provides community outreach and education activities. The IEB conducts at least 12 presentations each year to community-based organizations and other groups as required by DHS. The IEB must accept LTSS applications and CHC enrollment requests at various

community locations identified by DHS. The IEB serves as a link between participants and various community-based organizations including, the following:
a. Mental health and drug and alcohol agencies;
b. Centers for Independent Living;
c. AAAs;
d. Nursing Facilities;
e. Hospitals;
f. Women's shelters;
g. Homeless shelters;
h. Senior centers;
i. Social Security offices;
j. Churches;
k. Housing projects;
l. Providers and community-based organizations that serve individuals with brain injury or
cognitive impairments;
m. Other community-based organizations;
n. Local ethnic and second language community centers; and
o. Personal care homes.

The IEB engages in outreach and education activities that may include outreach through social media and additional presentations to community groups. The IEB must also take into consideration rural communities and communities that do not speak English, including people who are deaf.

b. **Administration of Enrollment Process**.

__ State staff conducts the enrollment process.

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

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

Broker name: **The department has concluded a procurement for a new vendor of this service. The department is currently in final negotiations with the selected vendor to finalize details.**

The Department contracts with an IEB contractor to perform enrollment activities, including the activities below, to assist and encourage Participants in making informed choices, decrease MCO transfer rates and ensure continuity of care.

- **The IEB provides education to Participants on CHC-MCOs available to them in their zone, provides input to the Participant on plans that their currently utilized providers participate with, and encourages them to make a CHC-MCO selection.**
- **The IEB explains how to access the web site, and what information they can access on the web site, and helps Participants understand the process of selecting a CHC-MCO.**
- **The IEB provides information to Participants on the procedures for accessing behavioral health services.**
- **Choice counseling occurs in person, over the phone, or both depending on the participant's needs.**

Please list the functions that the contractor will perform:

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

Managing enrollments into nursing facilities and the LIFE program and coordinating inter-county transfers

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

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

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

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

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

i. _**X**_ Potential enrollees will have up to **90** days to choose a plan.
Potential enrollees who require LTSS have the term of their eligibility determination process to choose a plan. This typically takes 30 to 90

days. If the individual has not chosen a plan by the time the eligibility determination is processed, he or she will be auto-assigned to a plan. Potential enrollees who do not require LTSS are immediately auto-assigned to a CHC-MCO. Following auto-assignment, enrollees may request a transfer to another CHC-MCO at any time.

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-assignment process is performed by the IEB. Individuals are assigned to plans that align with the way in which they are currently receiving their services, and is based upon the following hierarchy:

- **First, if a Participant is residing in a nursing facility at the time of enrollment, they will be assigned to a CHC-MCO in which his/her nursing facility is a network provider.**
- **Second, a Participant enrolled in a Medicare D-SNP will be assigned to a CHC-MCO aligned with his/her Medicare D-SNP.**
- **Third, if the Participant is transferring from the HealthChoices Program, and the HealthChoices-MCO is also contracted as a CHC-MCO, then the Participant will be enrolled in the affiliated CHC-MCO.**
- **Fourth, if a Participant is receiving HCBS and his/her primary care physician is contracted with a single CHC-MCO, he/she will be enrolled in that CHC-MCO.**
- **Last, if a Participant has a case record that also includes another active Participant in the case with an active CHC-MCO record, then the eligible Participant will be assigned to that same CHC-MCO.**

All remaining eligible Participants who have not voluntarily selected a CHC-MCO are 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 zones

___ 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 IEB Contractor.

Participants 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).

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

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

__ 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.

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.

_____ 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.

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.

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.

___ 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 programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

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

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

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

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

The CHC- MCO is required to have a complaint and grievance system in compliance with 42 CFR Part 438, Subpart F. An enrolled participant may request a State Fair Hearing only after exhausting the CHC- MCO's complaint and grievance process.

__ 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**

X The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must **request review of an adverse benefit determination which will be classified as either a complaint or grievance** is **up to _60__** days (between 20 and 90).

Participants are given 60 days from the date they receive the written notice of decision to file a grievance or a complaint.

X The State's timeframe within which an enrollee must file a **complaint** is – **no time limit on when a complaint must be filed. The participant may file a complaint with the CHC-MCO at any time. A complaint is a dispute or objection regarding a participating Health Care Provider or the coverage, operations or management of a CHC- MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with the Department of Health or the Insurance Department of the Commonwealth. Complaints may include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's right regardless of whether remedial action is requested. Complaints include an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision. They do not include an adverse benefit determination, which will be classified as either a complaint or a grievance.**

The CHC-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated hotline to respond to Participants' inquiries, issues, and problems regarding services. The CHC-MCO's internal Participant hotline staff is required to ask the callers whether or not they are satisfied with the response given to their call. The CHC-MCO must document all calls and if the caller is not satisfied, the CHC-MCO must offer to refer the caller to the appropriate individual within the CHC-MCO for follow-up and/or resolution. This referral must take place within forty-eight (48) hours of the call.

The CHC-MCO is not permitted to utilize electronic call answering methods as a substitute for staff persons to perform this service. The CHC-MCO must ensure that its dedicated hotline meets the following Participant services performance standards:

- **Provides for a dedicated toll-free phone line for its Participants.**
- **Provides for necessary translation and interpreter assistance for LEP Participants.**
- **Requires representatives to document calls and forward call notes to the Participant's Service Coordinator.**
- **Be staffed by individuals trained in:**
  - **cultural, linguistic, and disability competency.**
  - **addressing the needs of covered populations.**
  - **addressing the availability of, contact information for, and the functions of the Service Coordination Unit.**
  - **the requirements for accessibility.**
  - **coordination with BH-MCOs.**
  - **how to identify and handle any emergency.**
  - **when to transfer callers to the nurse hotline.**
  - **Covered Services, the availability of protective and social services within the community. Medicare coverage and to address questions that relate to the CHC-MCO's companion D-SNP plan.**
  - **Medical and non-medical transportation.**

- **Be staffed with adequate service representatives so that the abandonment rate is less than or equal to five percent (5%) of the total calls.**
- **Be staffed with adequate service representatives so that at least 85% of all calls are answered within thirty (30) seconds.**

- **Provide for TTY and/or Pennsylvania Telecommunication Relay Service availability for Participants who are deaf or hard of hearing.**

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 processes and offers to provide assistance in filing the appropriate documents and facilitating dispute resolution. In addition, service coordinators review the fair hearing, 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)

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

___ Establishes and maintains an expedited review process for the following reasons:_____ . Specify the time frame set by the State for this process____

___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

___ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

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

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

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

The prohibited relationships are:

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

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

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

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

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

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

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

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.

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

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

I. Summary Chart of Monitoring Activities

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

Please note:

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

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

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

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												

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					X
Periodic Comparison of # of Providers												
Profile Utilization by												

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**
Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review												
Other: (describe)												
SMART (database to track contract compliance)												

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. _X__ Consumer Self-Report data
X CAHPS (please identify which one(s)) **HCBS CAHPS and CAHPS Health Plan**
_ State-developed survey _ Disenrollment survey
_ Consumer/beneficiary focus groups

CHC-MCOs will be required to conduct HCBS CAHPS surveys on an annual basis. Monitoring of this requirement is included in the Quality Strategy for this initial application.

d. **X** Data Analysis (non-claims)
- __ Denials of referral requests
- **X** Disenrollment requests by enrollee
  - **X** From plan
  - __ From PCP within plan
- **X** 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. **X** Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

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

i.__ Measurement of any disparities by racial or ethnic groups

j. **X** Network adequacy assurance submitted by plan[**Required** for MCO/PIHP/PAHP]

k. __ Ombudsman

l. **X** On-site review - **Readiness review and additional onsite visits for each CHC-MCO.**

m. **X** Performance Improvement projects [**Required** for MCO/PIHP]

- **X**_ Clinical
- **X** Non-clinical

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.

_X_ This is a renewal request.

- _X_ 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.

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)

See Attachment C-1 for the CHC-MCO Monitoring Results.

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming five-year waiver period, called Prospective Year 1 (P1), Prospective Year 2 (P2), Prospective Year 3 (P3), Prospective Year 4 (P4) and Prospective Year 5 (P5). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective five-year period.

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

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

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

Part I: State Completion Section

A. Assurances

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

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.

- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: Daniel Sharar

c. Telephone Number: **717.772.0185**

d. E-mail: dsharar**@pa.gov**

e. The State is choosing to report waiver expenditures based on
_X_ date of payment.
__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

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

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

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

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

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

payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

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

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

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

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

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  1.___ First Year: $____ per member per month fee
  2.___ Second Year: $____ per member per month fee
  3.___ Third Year: $____ per member per month fee
  4.___ Fourth Year: $____ per member per month fee
b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the

providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data

1.___ Base year data is from the same population as to be included in the waiver.

2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

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

d. ___ [Required] Explain any other variance in eligible member months from BY to P5:

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

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

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

For Conversion or Renewal Waivers:

a._X__ [Required] Population in the base year and R1 through R5 data is the population under the waiver.

The R1 and R2 member months were summarized from the program membership as is reported in the Office of Long-Term Living's 820 capitation reports. The R1 period summarizes four quarters of 2020 and the R2 period summarizes four quarters of 2021 for the beneficiaries in all five geographic zones.

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

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

Membership levels increased in the base years partially due to the Coronavirus Disease 2019 (COVID-19) pandemic and the Federal Public Health Emergency (PHE) which halted disenrollment from enrollment rosters for Medicaid. Enrollment is anticipated to continue to increase slightly after the PHE ends, but at a slower pace than the base years for all projected waiver years (P1 to P5).

d. ___ [Required] Explain any other variance in eligible member months from BY/R1 to P5: ____

e.__X__[Required] Specify whether the BY/R1/R2/R3/R4/R5 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

The R1 is for the four quarters of calendar year (CY) 2020 and R2 is for the four quarters of CY 2021.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

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

For Conversion or Renewal Waivers:

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

_____

b._X__[Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single

beneficiary, please document how all costs for waiver covered individuals taken into account:

Beneficiaries eligible for services in multiple waivers have their service costs accounted for in each waiver for the services covered by that waiver. Some beneficiaries are eligible for additional behavioral health (BH) services under the 1915(b) PA-67 Waiver. The BH service costs are not included in the Community HealthChoices (CHC) program reporting and therefore are not duplicative. The BH capitation payments are paid separately from the per member per months (PMPMs) reported under this waiver in order to accurately report both waiver expenditures.

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 through R5 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period

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

a._X__ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a

percentage of total Medicaid enrollees. ***Note: this is appropriate for MCO/PCCM programs.***

Administrative costs reported on the Centers for Medicare & Medicaid Services (CMS) 64.10, the basis for the R1 and R2, include contract costs directly related to statewide managed care operations. Differing from the prior waiver, administrative costs reflect actual program historical experience.

b.__ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. ***Note: this is appropriate for statewide PIHP/PAHP programs.***

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

a.___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

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

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 through P5 on **Column W in Appendix D5**.

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1*

financed from savings from inpatient hospital care. See attached documentation for justification of savings.)			*$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 through R5 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 through P5 on **Column W in Appendix D5**.

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

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

Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c._X__ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1._**X**__ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

By agreement between Pennsylvania and the Community HealthChoices managed care organizations (CHC-MCOs), the High-Cost Risk Pool (HCRP) eliminated the requirement to

purchase stop/loss protection, through MCO pooling of funds and sharing the high-cost recipient risk. The HCRP became effective January 1, 2018, in the Southwest Zone, January 1, 2019, in the Southeast Zone, and January 1, 2020, statewide.

The Pennsylvania Department of Human Services also operates a Peer Group 13 Risk Pool, which is a risk pool for specific nursing facilities (NFs). The Peer Group 13 Risk Pool became effective January 1, 2019, in the Southwest and Southeast Zones, and January 1, 2020, statewide.

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

The risk arrangements described in this section are mutually exclusive to ensure no double counting occurs within each of these pools and as no additional funds would be expended from the Commonwealth of Pennsylvania (Commonwealth), no adjustment is needed to the waiver projections.

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

The Commonwealth will administer a high-cost risk pool to provide protection to the MCOs for high-cost cases. MCOs will pay premiums into the pool, and the Commonwealth will redistribute pool funds based on actual experience of each MCO.

d._**X**___ Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.__X__ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

CHC Pay for Performance (P4P) Program

Effective in CY 2022, the CHC P4P program can be found documented in the CY 2022 CHC Agreement. All CHC-MCOs that operate on a statewide basis are to be eligible. Each participating CHC-MCO will be eligible to earn additional revenue based on their benchmark performance and incremental improvement performance in specific areas such as nursing home transitions, LTSS, overall health plan satisfaction, and participant satisfaction. An adjustment was included in the P1 total program adjustment for all waiver MEGs to ensure consideration for these payments totaling $12 million annually were included in the waiver development.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

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

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 through P5. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

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

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

   2.___ [Required, to trend BY to P1 through P5 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

      i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

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

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

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

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 through P5 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

iv. ___Changes in legislation (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v. __Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

c. _ Administrative Cost Adjustment*: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2.__ An administrative adjustment was made.
i._ __ FFS administrative functions will change in the period between the beginning of P1 and the end of P5. Please describe:
A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B. _ __ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C. ___ Other (please describe):
ii.___ FFS cost increases were accounted for.
A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
C. _ Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P5). Trend adjustments may be service-specific and expressed as percentage factors.

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

2.___ [Required, when the State's BY is trended to P5. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

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

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

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

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

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.

2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe): GME payments are excluded from the waiver and capitated rates.

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P5 (please describe).

2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).

2.___ Determine GME adjustment based on a pending SPA.

3.___ Determine GME adjustment based on currently approved GME SPA.

4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include (please describe):

2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.

2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.

3.___ The State has not made an adjustment because the same copayments are collected in managed care and FFS.

4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1.____No adjustment was necessary
2.___Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
   i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
   ii.___ Other (please describe):

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

Basis and Method:

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

accounting for Part D dual eligibles. Please account for this adjustment in **Appendix D5**.

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

3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from base year data.

2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. _ This adjustment is not necessary as there are no voluntary populations in the waiver program.

1.___ This adjustment was made:

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

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

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2. __ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3.___ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.

4. __Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:
The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

c. Not applicable for an initial application utilizing FFS data for projections.

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact

Adjustment	Capitated Program	PCCM Program
	in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2. _____ This adjustment was made in the following manner:

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

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

  1. ____ No adjustment was made.
  1.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

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

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

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

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

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 through R5 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R5 (BY for conversion) to the end of the waiver (P5). Trend adjustments may be service-specific and expressed as

percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1._X__[Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _**4.7% per year**. Please document how that trend was calculated:

A consistent trend was developed for all waiver Medicaid eligibility groups (MEGs) at an overall trend rate of 4.7%.

The Commonwealth's historical capitation, financial, and encounter data were the primary sources used by the actuary for determining trends for the prospective periods for this waiver request. The Commonwealth considered historical year over year trends in developing trend estimates and also changes to the Medicaid program, consistent with the development of capitation rates. The actuary reviewed historical experience on rolling 12-months for the MEGs.

For the first prospective time period (R2 to P1), the State assumed an overall 4.7% annual trend and applied two years of trend to account for the gap in the length of time from the R2 to P1 years.

For the remaining prospective time periods (P1 to P2, P2 to P3, etc.), the State consistently assumed an overall 4.7% annual trend. The trends to each of the waiver MEGs remain consistent with the R2 to P1 annual trend.

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

2._X__[Required, to trend BY/R2 to P1 through P5 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. __X__ State historical cost increases. Please indicate the years on which the rates are based: base years **January 1, 2020 through**

December 31, 2021. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

The total CHC Waiver trend is 4.7% per year. These trend projections are based on information used to develop the actuarially sound rate ranges and are consistent with historical trends, utilization, program changes, rate changes, and future expectations for CHC.

Although historical capitation, financial, and encounter data were the primary sources for trend development, other sources were utilized as a benchmark. Other sources considered include, but are not limited to: Indices (such as consumer price index), neighboring states (fee-for-service [FFS] trends, managed care trends), CHC-MCOs financial reports, and regional market changes.

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

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

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

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 through P5.

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

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

iii.

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

Others:

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

CHC P4P Program

As described in section H.d.1. of this document, an adjustment for the CHC P4P was included in the total program adjustment and was applied to all waiver MEGs for a total payment of $12 million annually.

Nursing Facility Quality Incentive Program (NFQIP)
The NFQIP can be found documented in the CY 2022 CHC Agreement Amendment. The NFQIP provides financial incentives for the NFs that meet the statewide 50th percentile goals as set by the state or further increase up to the next quartile. Bonuses are awarded according to the NFs achievement of, and improvement upon, measures identified. The NFQIP was effective in CY 2022; therefore, an adjustment was included in the P1 total program adjustment for the Nursing Facility and Community Waiver MEGs to ensure consideration for these payments totaling $15 million annually were included in the waiver development.

NF Staffing Ratio
Effective July 1, 2023, skilled NFs will be required to increase the number of hours of direct care residents receive each day, which will require NFs to increase staffing ratios as well. Additional funding is being provided effective January 1, 2023 to support NFs as they increase staffing in advance of the regulation being implemented July 1, 2023. DHS estimated the annual funding target for this new staffing ratio and is anticipated to result in an upward adjustment of $530 million to the NF services. This funding was included in the P1 total program adjustment for the Nursing Facility and Community Waiver MEGs.

Personal Assistance Fee Schedule Increase
Effective January 1, 2022 the fee schedule rates for personal assistance agency services increased to reflect around $400 million in total additional funding to the CHC program. This funding for the personal assistance fee increase was included in the P1 total program adjustment for the Nursing Facility and Community Waiver MEGs.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Changes in legislation (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

vi.__ Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

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

1.___ No adjustment was necessary and no change is anticipated.

2._X__An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P5. Please describe:

ii._X__Cost increases were accounted for.

A.____ X Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C._X__State Historical State Administrative Inflation. The actual trend rate used is: _**5.0% annually**_. Please document how that trend was calculated:

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

For the P1 year, in addition to trend an adjustment to reflect an additional in $6 million total to the R2 administrative costs was included. This adjustment was necessary as the R2 period was underreported when comparing to prior administrative base years. This $6 million dollars was distributed to each MEG using their membership proportion.

For waiver years P2 to P5, only the 5.0% administration trend was included for all MEGs.

D.____Other (please describe):

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

Administrative costs reported on the CMS 64.10, the basis for the R1 and R2, include contract costs directly related to managed care. Consistent with section G.a. of this waiver submission, projected year administrative costs have been distributed amongst the three CHC MEGs. The actuary reviewed rolling 12-month experience for the MEGs using historically reported CMS 64 administrative information.

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

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

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P5). Trend adjustments may be service-specific and expressed as percentage factors.

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

2.___ [Required, when the State's BY or R2 is trended to P5. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of

State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates
   1. Please indicate the years on which the rates are based: base years_____
   2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

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

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.
   1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____
   2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____
   3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):
   - If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 through P5 to reflect all changes.
   - Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
     - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
     - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
   - **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an

inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.
Basis and Method:

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

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

3.___ Other (please describe):

1.___ No adjustment was made.

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

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

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

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

Consistent with the commentary provided in section E.c. of this waiver submission, enrollment growth is anticipated to continue growing at a slower pace in waiver years P1 to P5. Although the

enrollment growth is projected to be small in the waiver years, caseloads are generally anticipated to be consistent with the prior waiver.

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

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

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

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

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

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

Attachment A-1
Fraud and Abuse Plan for Community HealthChoices

A. Background:

Managed care presents unique opportunities for participants, 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 Office 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 LTSS through CHC-MCOs. The fraud and abuse plan for CHC 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) The CHC-MCO will develop 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 CHC-MCOs must report any act that may affect the integrity of the program by submitting information to BPI, including, but not limited to: provider, participant and caregiver referrals for fraud, waste, abuse and quality of care concerns; MCOs case review status, provider terminations.

3) The CHC-MCO will seek support and provide ongoing education related to Managed Care Fraud/Waste/Abuse.

4) The Department will maintain oversight and collaborative fraud/waste/abuse efforts through strong relationships and coordination amongst the CHC-MCOs.

5) The CHC-MCO will utilize the Department's BPI MCO Quarterly Compliance Report to provide the BPI with compliance data and statistical reports from the CHC-MCOs to detail its fraud, waste and abuse detection and sanctioning activities**.**

6) The CHC-MCO is responsible for fully cooperating with the State oversight agencies in detection and prosecution activities. Such agencies include, but are not limited to the Department's Bureau of Program Integrity, the Governor's Office of the Budget, the Office of Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, the CMS Office of Inspector General, and the United States Department of Justice. Such cooperation must include providing access to all necessary case information.

7) The CHC-MCO must ensure that the Department's toll-free MA Provider Compliance Hotline number and accompanying explanatory statement is distributed to its participants and providers through its participant and provider handbooks.

C. Goals of the CHC Fraud and Abuse Plan:

1) Improve quality and quantity of CHC-MCO reviews and referrals to BPI.

2) Continue to review and revise agreement language with the CHC-MCOs to remain current with regulatory and policy changes/new requirements and ensure standard, clear and strong program integrity measures and requirements.

3) Work collaboratively with other CHC-MCOs and the Department on provider reviews/audits.

4) Continual assessment of compliance with Fraud/Waste/Abuse efforts via feedback from CMS or the Department.

Attachment B-1
Details of CHC-MCO Monitoring Activities
for Upcoming Waiver Period January 1, 2023-December 31, 2027

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	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

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:
			Survey process, to the extent deemed allowable by NCQA, in the NCQA accreditation of the MCO. 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. 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		health care system. 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.

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:
			submit a corrective action plan within thirty (30) days of receipt of notification from the accreditation body 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.		
Steady State Monitoring	MCO	MCO & DHS	Key areas of focus for steady state monitoring: 1. Care coordination 2. Service authorization and delivery	Ongoing	The steady state monitoring allows DHS to evaluate

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:
			3. Provider network management 4. Claims processing and payment 5. Data transfer and management 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		whether the MCOs have the infrastructure needed to operate successfully. Additional reviews may be needed based on the results of the initial review.

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 operations functions 3. Training 4. Demonstration of critical MCO system testing		
Grievances and appeals	MCO	MCO	Each MCO submits a report containing complaint and grievance information. This 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. In addition, each MCO reports the number of complaints or grievances resolved, how many were decided in favor of the participant, and how many were resolved within the	Quarterly	These reports are used to evaluate the MCO's performance of the services included in the program and the Participant experience with those services. Data is analyzed and calculated to measure the rate of complaints or

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:
			established timeliness requirements.		grievances and identify problems or issues for further evaluation. Also, trends in the data may be compared to trends in denials of certain services and resultant complaints or grievances. It is also utilized to conduct across the board comparisons and evaluations among the

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:
					MCO's to identify and monitor outliers or potential areas of concern.
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 and supports, preventive and primary care.	On-going	DHS will monitor network adequacy through review of the plan submitted geo-access documentation as well as review of complaints received from consumers. Should a plan's network be

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:
					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 the plan.
On-site reviews	MCO	MCO & DHS	MCOs are required to provide department staff	Annually	On-site reviews offer

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:
			with an office on-site to facilitate on-site reviews. On-site reviews are conducted by cross-functional, multi-disciplinary department staff. 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. On-site office visits focused on operations, quality and special needs are conducted yearly. Annual on-site reviews are also done in the areas of		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

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:
			Systems, TPL, and HEDIS validation. These reviews take place in addition to the quarterly on-sites.		responding to calls in member or provider service areas, care management or disease management. 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

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:
					document contractual compliance.
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 must work toward identifying and minimizing barriers to care. The MCOs are required to have one clinical PIP and one non-clinical PIP. The topic for the clinical PIP is Strengthening Care Coordination. The topic for the non-clinical PIP is	On-going	DHS staff reviews the on-going identification, progress and analysis of PIPs in the semi-annual quality work plans supplied by the CH-MCOs. Additionally, PIPs from each CHC-MCO will be validated annually by the EQR contractor to

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:
			Transitions from the NF to the Community. For the MCOs PIPs began as the regions were implemented: the Southwest in 2019, the Southeast in 2020 and the remaining three regions is 2021. All PIPs have been extended for an additional three years.		determine compliance with the EQR regulation protocol for validation of PIPs.
Performance measures: ▪ Effectiveness of Care ▪ Access/Availability of Care ▪ Experience of Care ▪ Utilization and Risk Adjusted Utilization ▪ Health Plan Descriptive Information	MCO	MCO	The State requires the MCOs to submit the full set of the updated 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	Annually	The State reviews, trends, and analyzes HEDIS data and compares plan(s) performance to HEDIS National Benchmarks to assess the

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:
▪ PA Performance Measures			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 their overall Quality Improvement Plan (QIP). Additionally, the MCOs are required to submit data for additional performance measures developed by the state.		quality of healthcare services provided to consumers.

Attachment C-1
1915(b) CHC-MCO Monitoring Results
for Waiver Period January 1, 2018-December 31, 2022

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
Accreditation for Non-Duplication	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 NCQA, in the NCQA accreditation of the MCO. If the MCO is accredited as of the contract start date, the MCO shall maintain	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. NCQA Accreditation provides independent evaluation of an organization's ability to coordinate care and be accountable for high-quality,	Y	The Community HealthChoices Agreement (CHC) with the Pennsylvania CHC MCOs contains Quality Management and Utilization Management Program Requirements that include a requirement to obtain accreditation by a nationally recognized organization, such as National Committee for Quality Assurance (NCQA). This accreditation includes the Medicaid HMO Accreditation and the LTSS Distinction, which must be maintained for the full term of the agreement. In addition, by end of calendar year 2022, Pennsylvania requires the NCQA	There were no problems identified.		

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
		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. 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 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		efficient, patient-centered care that is expected from the MCOs.		Multicultural Health Care (MHC) distinction and Health Equity (HE) accreditation. The Department confirms the CHC-MCO's accreditation on an annual basis and will consider failure to obtain accreditation or failure to maintain accreditation a material breach of the agreement. The CHC MCOs are required to submit their reports of accreditation and any updates to their accreditation status within 10 days of the receipt of their report. The chart below illustrates the current accreditation status for each of the CHC MCOs. Accreditation Status of CHC-MCOs.pdf			

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
		accreditation status, based on annual HEDIS scores within ten (10) days of receipt.							
Readiness Review	MCO & DHS	Key areas of focus for readiness review: 7. Care coordination 8. Service authorization and delivery 9. Provider network management 10. Claims processing and payment 11. Data transfer and management 12. Quality monitoring Components of the review: 5. 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 6. Onsite review of critical processes	Ongoing	The readiness reviews allow DHS to evaluate whether the MCOs have the infrastructure needed to operate successfully. Additional reviews may be needed based on the results of the initial review.	Y	For all three implementation phases, a Readiness Review tool (workbook/checklist) was used to track each MCO's compliance to a significant number of Agreement and Waiver expectations. The Readiness Review Tool had been used successfully and effectively by the Physical HealthChoices program in previous years. Each of 6 key areas of focus in the 'Detailed Description of Strategy' column were covered during this comprehensive review of the MCOs preparedness. For each implementation, each MCO demonstrated full compliance.	No significant problems were identified.		

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
		and operations functions 7. Training Demonstration of critical MCO system testing				Noncompliance was closely monitored to avoid any concerns with implementing CHC by a particular MCO in a zone. The significant volume of documentation, training, on-site review and scrutiny of demonstrated preparedness resulted in confidence that the applicable MCO was adequately ready to begin our programming on the first day of implementation. Clean Copy_ CHC RR Tool.xlsx			
Grievances and appeals	MCO	Each MCO submits a report containing complaint and grievance information. This report contains the number of complaints or grievances reported by members, the reason, whether it was first	Quarterly	These reports are used to track trends in denials or recurring problems with a MCO. They are also used to compare the MCOs in relation	Y	The CHC-MCOs submit their complaints and grievances on a quarterly basis using Operations Reports, OPS-003 and OPS-004. The instructions and blank templates	In late 2020, one CHC-MCO's data accuracy and integrity were identified as inaccurate for Quarter 3, Quarter 4, and continued	OLTL completed an audit and issued a Corrective Action Plan (CAP) due to the identified CHC-MCO's issues with data	OLTL is in the process of developing and implementing a random sampling and audit of the Complaints and Grievances Data

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
		or second level, or if it was an expedited request.		to each other in order to indicate problems with a certain provider or new service.		for OPS-003 and OPS-004 are provided below. On January 1, 2022, OPS-003 was decommissioned and it was combined with OPS-004 into one report identified as the OPS-004 report which also aligns with the MCPAR reporting. Using the reports, OLTL identifies the top five categories for complaints and grievances in each quarter. The top five categories have remained the same for calendar years 2018 through 2021. They are: **<u>Top 5 Complaints:</u>** • Non-Covered due to Benefit Limits • Participant Fees/Co-Pay Non-Covered • Provider Courteous Service	into Quarter 1 of 2021.	accuracy and integrity. OLTL has ongoing technical assistance sessions with the identified CHC-MCO.	reported in OPS-004 in order to validate the accuracy and integrity of each CHC-MCOs' quarterly data submission.

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
						• CHC-MCO Administration • Provider Courteous Service **Top 5 Grievances:** • Durable Medical Equipment NFCE • Personal Assistance Services • Benefit Limits – Dental • Non-Medical Transportation • Pharmacy The reasons whether it was first or second level complaint, a grievance or if it was an expedited request were reviewed and validated along with corrections, if applicable. There have been no significant trends identified with the complaints and grievances process.			

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
						OPS-003 (decommissioned January 1, 2022)  OPS-003_Report_Instructions_01.01.2022v  OPS-003_Report_Template_01.01.2021v4.0.xl OPS-004 (with elements combined from OPS-003)  OPS-004_Report_Instructions_01.01.2022v  OPS-004_Report_Template_01.01.2022v5.0.xl			
Network adequacy assurance submitted by plan	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	On-going	DHS will monitor network adequacy through review of the plan submitted geo-access documentation as	Y	Pennsylvania's Department of Health (DOH) reviewed each MCO's network for operating authority prior to	No significant problems have been identified.		

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
		provide assurance that it will offer the whole scope of covered services as well as access to long-term services and supports, preventive and primary care.		well as 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 the plan.		implementation of each of the three phases. All three MCOs' networks received certification from DOH prior to each launch. Additionally, OLTL monitored the contracting between acute hospital systems and behavioral health MCOs to ensure sufficient networks for all participants. During each implementation and the subsequent years when the program was statewide, OLTL tracked, monitored and intervened when necessary for any participant when finding a provider was described as difficult. OLTL uses a software tool called Medicaid Program Oversight Portal (MPOP). Each week, the MCOs submit a file that includes the entire			

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
						listing of their provider network. These files are closely monitored with a response file available to each MCO after their weekly submission. The Weekly Provider File is loaded into MPOP which turns the network listing into other useful presentations of the network. Those presentations include searchable databases with filters, network geo-access visualization, and reports that can be downloaded for review/sharing. The most common step used to ensure a MCO's network is adequate is to research every call or message from a participant or participant representative to determine if the participant's provider			

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
						network needs were being met.			
On-site reviews	MCO & DHS	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. 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. On-site office visits focused on operations, quality and special needs are conducted yearly. Annual on-site reviews are also done in the areas of Systems, TPL, and HEDIS validation. These reviews	Monthly or as needed	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 provider service areas, care management or disease management. The information department staff gains through	N	OLTL initially conducted several on-site reviews through the readiness review/implementation process. However, as more resources and technology became available and reliable, on-site reviews were not conducted as often. Virtual on-sites reviews or screensharing functionalities were utilized. This was especially true once the Public Health Emergency occurred in March 2020. No on-sites have been conducted since March of 2020 however, screen sharing/virtual on-sites reviews have occurred for topics such as grievances and appeals and critical incident management. OLTL has been able to	In 2021 and 2022, OLTL identified mailing delays for one specific MCO. A Corrective Action Plan was implemented which included a virtual walk-through of mail processing. The MCO made the necessary changes and mailing dates are aligned with expectations.	The MCO created a protocol internally to correct handling of mail for holidays, weekends and other interruptions (ex. Inclement weather). The MCO increased the visibility of the entire process with the local leadership so concerns can be identified sooner and be addressed more quickly.	OLTL will continue to utilize virtual options in lieu of physical on-site reviews when appropriate. OLTL does plan on resuming a less frequent on-site schedule when the Federal Public Health Emergency is lifted.

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		take place in addition to the quarterly on-sites.		interviewing, discussion or observation of plan activities is then used to gauge the plan's ability to serve its members and document contractual compliance.		diagnose and assist in correcting issues through the virtual on-site reviews/screensharing utilization.			
Performance Improvement projects (PIPs)- clinical and non-clinical focus areas	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. MCOs will begin developing PIPs in the 2nd year of the waiver period.	On-going	DHS staff reviews the on-going identification, progress and analysis of PIPs in the quarterly quality work plans supplied by the CH-MCOs. Additionally, PIPs from each CHC-MCO will be validated annually by the EQR contractor to determine compliance with the EQR regulation protocol for	Y	With the implementation of Community HealthChoices in three phases from 2018 through 2021, the Department selected PIP topics with the MCOs with all MCOs working on the same Clinical and Non-Clinical topics: **Clinical**: Strengthening Care Coordination **Non-Clinical**: Transition Care Planning Measurement Year (MY) 21/Reporting Year (RY) 22 –	There were no problems identified.		

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				validation of PIPs.		ACP-KF Annual Review of NonClinical ACP-KF Annual Review of Clinical PIP PHW - Annual Review of Non clinical PHW - Annual Review of Clinical PIP UPMC - Annual Review of Non Clinica UPMC - Annual Review of Clinical PIP MY20/RY21 UPMC - Annual Review of Non-Clinica PAHW - Annual Review of Non-Clinica AmeriHealth Caritas - Annual Review of Nor			

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						UPMC - Annual Review of Clinical PIP PAHW - Annual Review of Clinical PIP AmeriHealth Caritas - Annual Review of Clin MY19/RY20 UPMC - Annual Review of Clinical PIP UPMC - Non-clinical PIP Year 1+Update Fi PHW Non-clinical PIP - Year 1 and Update F PHW - CHC Clinical PIP - Year 1 and Upda			

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						ACP - Annual Review of Clinical PIP Year 1_ ACP - Annual Review of Non-clinical PIP Yea Review and Approvals: Copy of PA OLTL_PIP Checklist and Evaluati Copy of PA OLTL_PIP Checklist and Evaluati PA OLTL_PIP Checklist and Evaluati PA OLTL_PIP Checklist and Evaluati Copy of PA OLTL_PIP Checklist and Evaluati Copy of Non-Clinical_PIP_Resp			

Strategy:	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:	Was activity conducted as described in Section B? (Y or N)	Summary of Results	Problems Identified	Corrective Action	Program Change
Performance measures: ▪ 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	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 their overall Quality Improvement Plan (QIP). Additionally, the MCOs are required to submit data for additional performance measures developed by the state.	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.	Y	The MCOs submit information relating to HEDIS, LTSS specific and PA Performance Measures. This information is extracted for trending and various other reporting. It is also used for discussions at Quarterly Quality Review Meetings to assess MCO performance relative to peer MCO organizations and National Benchmarks. The measures are compiled by our EQRO and are submitted to the CMS reporting system. Attached are the Performance Trending reports that summarize key findings for HEDIS, CAHPS, PA Performance Measures and LTSS Measures for MY19-MY21.	Statistical significance and directional findings are identified in the rate charts that are attached.		Changes to HEDIS 2021 did occur but these were due to changes to the specifications made by NCQA. PA Performance Measures did have some changes after 2021. We now have one PA Performance Measure (Adult Annual Dental Visit) instead of six previously.

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						MY2019-MY2021 HEDIS_RATES.pdf LTSS HEDIS MY2019 thru MY2021 Results. HEDIS Results for MCOs on Measures w All MCO's 2019-2021 HEDIS Rat CHC - PAPM_Rate_Chart_20			