Citation		Condition or Requirement
1932(a)(1)(A)	A.	Section 1932(a)(1)(A) of the Social Security Act

The State of **Pennsylvania** enrolls Medicaid beneficiaries on a Mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs) in the absence of Section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans- see D.2.ii below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii-vii below).

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(I)

1. The State will contract with an

____i. MCO
__X_ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____iii Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____i fee for service;
__X_ii. capitation; ***Although the contractor is not responsible for paying claims, the contractor is paid on a PMPM basis and is at risk for reimbursing the Department for guaranteed savings that are not achieved by the disease management program. If the disease management program results in guaranteed savings, the Contractor will receive a percentage of the savings that exceed a specified threshold. Primary Care Providers will be paid by the Department in accordance with the fee schedule. The EPCCM contractor will receive a capitated rate for coordinating case management and providing disease management. While the PMPM includes both case management coordination and disease management, risk is only associated with the disease management component of the PMPM.***
____iii. a case management fee;

Citation		Condition or Requirement
		__X__iv. a bonus/incentive payment; *See ii above* _____v. a supplemental payment, or _____vi. other. (Please provide a description below).
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3.	For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). _____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. _____ii. Incentives will be based upon specific activities and targets. _____iii. Incentives will be based upon a fixed period of time. _____iv. Incentives will not be renewed automatically. _____v. Incentives will be made available to both public and private PCCMs. _____vi. Incentives will not be conditioned on intergovernmental transfer agreements. __X__~~vii.~~ Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4.	Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (Example: public meeting, advisory groups.) ***Before finalizing the ACCESS Plus program design, the Department solicited input from various stakeholders, including MA recipients and their families, providers and provider associations and advocacy groups. Stakeholders offered***

Citation		Condition or Requirement
		valuable feedback that the Department incorporated into the program design. ***When the program is implemented, the Contractor will establish and maintain Regional Advisory Committees to consult with the Contractor and provide a formal structure for the exchange of ideas for ACCESS Plus between the Contractor and the communities to which it provides services. The Contractor will publicly announce the meetings thirty (30) days in advance and the meetings will be open for public attendance.***
1932(a)(I(A)	5.	The state plan program will___/will not_X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory _X_/ voluntary ___ enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) ___________________
Bedford, Blair, Bradford, Cambria, Cameron, Carbon, Centre, Clarion, Clearfield, Clinton, Columbia, Crawford, Elk, Erie, Forest, Franklin, Fulton, Huntingdon, Jefferson, Juniata, Lackawanna, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montour, Northumberland, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Wayne, and Wyoming

Citation		Condition or Requirement		
			ii.	county/counties (voluntary)______________________
			iii.	area/areas (mandatory)_________________________
			iv.	area/areas (voluntary)__________________________
	C.	State Assurances and Compliance with the Statute and Regulations		
		If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.		
1932(a)(l)(A)(i)(l) 1903(m) 42 CFR 438.50(c)(l)		1.		____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(l)(A)(i)(l) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)		2.		__X_The state assures that all the applicable requirements of section 1905 (t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(l)(A)		3.		__X_The state assures that all the applicable requirements of Section 1932.

Citation		Condition or Requirement
42 CFR 438.50(c)(3)		(including subpart (a)(l)(A) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(I)(A) 42 CFR 431.51 1905(a)(4)(C)	4.	__X__ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(l)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	__X__ The state assures that all applicable managed care requirements of 42 CFR Part 438 for ~~MCOs and~~ PCCMs will be met.
1932(a)(l)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	__X__ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(l)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	_____ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	__X__ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

Citation		Condition or Requirement
1932(a)(I)(A)(i)	1.	List all eligible groups that will be enrolled on a mandatory basis. ***All MA recipients age 21 and over unless otherwise exempt***
	2.	Mandatory exempt groups identified in 1932(a)(I)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment of any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(I)		i. _____ Recipients who are also eligible for Medicare.

Citation		Condition or Requirement
		If enrollment is voluntary, describe the circumstances of enrollment *(Example: Recipients who become Medicare Eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii.	____ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii.	____ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.	____ Children under the age of 19 years who are eligible under 1903(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v.	____ Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi.	____ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.59(3)(v)	vii.	____ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(I)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. <u>Identification of Mandatory Exempt Groups</u>

Citation		Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	1.	Describe how the state defines children who receive services that are funded under section 501(a)(l)(D) of title V. (*Examples: children receiving services at a specific clinic or enrolled in a particular program*).

Citation		Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	2.	Place a check mark to affirm if the state's definition of title V children is determined by: ____i. program participation, ____ii. special health care needs, or ____iii. both
1932(a)(2) 42 CFR 438.50(d)	3.	Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. ____i. yes ____ii. No
1932(a)(2) 42 CFR 438.50(d)	4.	Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (*Examples: eligibility database, self-identification*) i. Children under 19 years of age who are eligible for SSI under title XVI; ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; iii. Children under 19 years of age who are in foster care or other out-of-home placement; iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Citation		Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	5.	Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs Criteria as defined in the state plan if they are not initially identified as exempt (*Example: self-identification*)
1932(a)(2) 42 CFR 438.50(d)	6.	Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: (*Examples: usage of aid codes in the eligibility system, self-identification*) i. Recipients who are also eligible for Medicare ***The Department will identify dual eligibles by category and program status code in the Client Information System (CIS) and through an indicator of eligibility for Medicare in the Third Party Liability (TPL) file.*** ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. ***There are no federally recognized Indian tribes in Pennsylvania.***
42 CFR 438.50	F.	List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment: The following groups of adults age 21 and over are exempt: • ***Residents of nursing homes***

Citation | Condition or Requirement

- ***Residents of state-funded ICFs/MR***
- ***Persons who are enrolled in a voluntary managed care program***
- ***Persons who are in out of state placement***
- ***Persons who become eligible retroactively, for the retroactive period.***

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

None

H. Enrollment process

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i.).
Rules for auto assigning PCPs to enrollees are as follows:

Citation	Condition or Requirement

- ***If a claim was paid to a participating ACCESS Plus PCP for service to the enrollee within the past six (6) months, the enrollee is assigned to that PCP;***
- ***If a claim was paid to a participating ACCESS Plus PCP for service to a family member who is already assigned to an ACCESS Plus PCP, the enrollee is assigned to that PCP.***

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

- ***The enrollee will be assigned to the PCP with an open panel closest to the enrollee's home if the enrollee or a member of the enrollee's family has no pre-existing relationship with a PCP. If multiple PCP's meet this criterion, auto-assignment will occur using a random rotation process.***

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56(d)(2). (*Example: No auto-assignments will be made if MCO meets a certain percentage of capacity*).
The enrollee will be assigned to the PCP with an open panel closest to the enrollee's home if the enrollee or a member of the enrollee's family has no pre-existing

Citation		Condition or Requirement
		relationship with a PCP. If multiple PCP's meet this criterion, auto-assignment will occur using a random rotation process.
1932(a)(4) 42 CFR 438.50	3.	As part of the state's discussion on the default enrollment process, include the following information:
		i. The state will ____/will not __X__ use a lock-in for managed care ~~managed care~~.
		ii. The time frame for recipients to choose a ~~health plan~~ PCP before being auto-assigned will be ***14 days***.
		iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (*Example: state generated correspondence*) ***The enrollee will be notified by telephone or in writing of his or her auto-assigned PCP's name, location and office telephone number within five (5) business days of the auto-assignment.***
		iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to ~~disenroll~~ change PCPs without cause during the first 90 days of their enrollment (*Examples: state generated correspondence, HMO enrollment packets, etc.)* ***Recipients are not locked-in to a PCP. They may change PCPs at any time.***

Citation	Condition or Requirement

Recipients will be notified of their right to change PCPs through a welcome call and through the member handbook.

v. Describe the default assignment algorithm used for auto-assignment (*Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators*)
The enrollee will be assigned to the PCP with an open panel closest to the enrollee's home if the enrollee or a member of the enrollee's family has no pre-existing relationship with a PCP. If multiple PCP's meet this criterion, auto-assignment will occur using a random rotation process.

vi. Describe how the state will monitor any changes in the rate of default assignment. (*Example: usage of the Medical Management Information System (MMIS), monthly reports Generated by the enrollment broker*)
The Contractor will submit a quarterly report to the state which details the number of new enrollees who are auto-assigned each month. This report will enable the state to determine if the auto-assignment rate is increasing, decreasing, or remaining the same.

1932(a)(4) I. <u>State assurances on the enrollment process</u>

Citation		Condition or Requirement
42 CFR 438.50		Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment

1. __X__ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the ~~MCO or~~ PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. __X__ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM Model will have a choice of at least two ~~entities~~ *PCPs* unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. _____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   __X__ This provision is not applicable to this 1932 State Plan Amendment

4. _____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a Choice of at least two primary care providers within the entity. (California only)

   __X__ This provision is not applicable to this 1932 State Plan Amendment

5. _____ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   __X__ This provision is not applicable to this 1932 State Plan Amendment

1932(a)(4)
42 CFR 438.50

I. Disenrollment

1. The state will ___/will not_X_ use lock-in for managed care.
2. The lock-in will apply for ___ months (up to 12 months)
3. Place a check mark to affirm state compliance.

   __X__ The state assures that beneficiary requests for disenrollment (with

Citation		Condition or Requirement
		and without cause) will be permitted in accordance with 42 CFR 438.56(c) ***Recipients may change PCPs at any time without cause. Enrollment in the disease management portion of the ACCESS Plus program is voluntary.***
		4. Describe any additional circumstances of “cause” for disenrollment (if any)
	K.	Information requirements for beneficiaries
		Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50		__X__ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to ~~MCOs and~~ PCCM programs 42 CFR 438.10 operated under section 1932(a)(I)(A)(i) state plan amendments. (Place a check mark to affirm state compliance)
1932(a)(5)(D) 1905(i)	L.	List all services that are excluded for each model (MCO) & PCCM) ***No state plan services are excluded***
1932(a)(I)(A)(ii)	M.	Selective contracting under a 1932 state plan option
		To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.
		1. The state will __X__/will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.
		2. __X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.
		3. Describe the criteria the state uses to limit the number of entities it Contracts under a 1932 state plan option. (*Example: a limited number of providers and/or enrollees)* ***The state competitively procures a contractor to manage***

Citation	Condition or Requirement
	the PCCM network and to provide case management and disease management services.
	4. _____ The selective contracting provision is not applicable to this state plan.