pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Healthy PA
ACCESS • AFFORDABILITY • QUALITY

Draft *Healthy Pennsylvania* 1115 Demonstration Application

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1. Executive Summary

Healthy Pennsylvania is Governor Tom Corbett's plan to ensure that Pennsylvanians have increased access to quality, affordable health care. Governor Corbett's *Healthy Pennsylvania* plan focuses on three key priorities: improving access, ensuring quality, and providing affordability. It touches all areas of health care to encourage better care coordination for patients, providers, and insurers. It is built upon common sense reforms that provide coverage options to our most vulnerable citizens in a flexible and sustainable way that protects taxpayers. The Medicaid reforms and the Private Coverage Option encompassed in the *Healthy Pennsylvania* plan will:

1. Increase health care access for more than 500,000 Pennsylvanians.
2. Promote healthy behaviors, improve health outcomes and increase personal responsibility.
3. Ensure that benefits match health care needs.
4. Implement a strategy for sustainability by aligning the current Medicaid program with private health care coverage.

Pennsylvania is home to a robust, world-class health care delivery system that has led the way nationally from covering children in the CHIP program to providing access to top physicians and hospitals. Additionally, the Commonwealth has been a national leader in successfully accessing commercial market innovation, which was demonstrated when it implemented statewide managed care through the HealthChoices program. Pennsylvania seeks to continue to be a leader through its pursuit of innovative reforms that prove to the nation that the best solutions are developed at the state and local level.

To implement the Medicaid reforms and *Healthy Pennsylvania* Private Coverage Option within the *Healthy Pennsylvania* plan, various Federal Medicaid waivers and State Plan Amendment approvals are necessary.

As it stands today, Pennsylvania taxpayers and the federal government spend approximately $20 billion annually on Medicaid programs that play a critical role in serving approximately 2.2 million Pennsylvanians. The Medicaid population includes low-income parents and families, children, persons with disabilities, and older Pennsylvanians.

Unfortunately, economic shifts and market factors threaten the sustainability of the program. Currently, one in six Pennsylvanians receive Medicaid benefits, and the costs of

the Medicaid program account for 27% of the Commonwealth's entire general fund budget and continue to grow by hundreds of millions of dollars each year. Program innovations and reforms are necessary to improve health outcomes and ensure sustainability so that an adequate and appropriate health care safety net can be provided for those who need it.

The Department of Public Welfare (Department) anticipates the following additional objectives to be met through the 1115 Demonstration application:

- Promoting access to health insurance through the private insurance marketplace and increasing access to Employer-Sponsored Insurance (ESI).
- Encouraging healthy behaviors and appropriate care, including early intervention, prevention, and wellness.
- Increasing quality of care and efficiency of the health care delivery system.

Pennsylvania relies on several funding sources to draw down additional federal revenues to support our existing programs. Our ability to provide quality health care to low income Pennsylvanians will rely on a commitment from the federal government to maintain without change or disruption to the existing funding programs.

This 1115 Demonstration request is also predicated on enhanced federal funding under the Affordable Care Act. If these enhanced funds and the existing federal funding sources are not available, Pennsylvania will withdraw its request and cease the Demonstration program operations or develop and implement an alternative plan as further described in section 2.6.

Approval for this initial 1115 Demonstration is requested for five years (2015 through 2019).

2. Program Description

2.1. 1115 Demonstration Overview

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

Pennsylvanians should have increased access to quality, affordable health care. Under this 1115 Demonstration, the Commonwealth will continue to be a leader through its pursuit of innovative reforms that prove to the nation that the best solutions are developed at the state and local levels. With approval of this 1115 Demonstration application (and a set of Medicaid State Plan Amendments), the Department is seeking to improve access to quality, affordable health care by:

- Increasing access to private market coverage through the *Healthy Pennsylvania* Private Coverage Options for Pennsylvanians 21 years of age or older but under 65 years of age with incomes up to 133% of the Federal Poverty Level (FPL).
- Realigning the existing Medicaid benefit plan designs to provide health coverage based on health care needs.
- Promoting healthy behaviors and improved health outcomes through a cost sharing design and work search activities.

The Commonwealth can accomplish these goals through common sense reforms that provide coverage options to our most vulnerable citizens in a sustainable way. Pennsylvania is committed to providing a pathway to prosperity for all Pennsylvanians and creating health care choices for consumers.

Medicaid Reforms

Pennsylvania and the federal government currently spend approximately $20 billion annually on Medicaid programs that play a critical role in serving approximately 2.2 million Pennsylvanians. The Medicaid Program includes low-income parents and families, children, pregnant women, persons with disabilities, and older Pennsylvanians. As such, this 1115 Demonstration is critical to ensure the sustainability of the Medicaid program and its ability to maintain a safety net for those vulnerable populations. Reforms to Pennsylvania's Medicaid program for the 21st century are needed to ensure access to affordable, quality health care for the future in a manner that is sustainable for Pennsylvania taxpayers.

The Commonwealth seeks to reform its existing Medicaid program through the following activities:

- Realigning the existing benefit designs to provide the health care coverage that Medicaid recipients need through two simplified, commercial-like adult benefit packages that are consistent with national standards and include: essential health benefits, mental health parity, and encourage preventive services, including drug and alcohol services. The Commonwealth aims to move away from a 'one size fits all' approach and focus on the needs of individuals. Most adults, 21 through 64 years of age, eligible under the current Medicaid eligibility levels, will be enrolled in the Low Risk Benefit Plan. The Low Risk Benefit Plan will be described in Pennsylvania's Medicaid State Plan and contains both mandatory and optional services. All who are determined eligible will be screened to determine the extent of their health needs. Those whose screening indicates that they have higher, more complex, health care needs, both physical and behavioral health, will be enrolled in the High Risk Alternative Benefit Plan (ABP). Both the Low Risk Benefit Plan and the High Risk Alternative Benefit Plan will be offered by managed care plans through the current HealthChoices program. The HealthChoices program is a mandatory managed care program that provides both physical health services, administered through managed care organizations, and behavioral health services, administered through pre-paid inpatient health plans. The benefit package for individuals under 21 years of age will not change.
- Promoting personal responsibility and healthy behaviors through a cost-sharing design and work search activities.
- Improving access and quality of care within the existing Medicaid program.
- Continuing emphasis on the reduction of waste, fraud, and abuse.

These Medicaid reforms will apply to the entire program and are designed to work with the *Healthy Pennsylvania* Private Coverage Option.

Increase Access to Coverage – The *Healthy Pennsylvania* Private Coverage Option

The Department seeks to use premium assistance to purchase a private coverage plan offered in the Federally-Facilitated Marketplace (FFM), the commercial market, or

through ESI for individuals deemed newly eligible under Title XIX of the Social Security Act who are:

1. Childless adults (who are not entitled to Medicare coverage), 21 years of age or older, but under 65 years of age, with incomes up to 133% of the FPL.
2. Adult parents/caretaker relatives (who are not entitled to Medicare coverage), 21 years of age or older but under 65 years of age, with incomes greater than 33% FPL (Pennsylvania's current income limit of this group), but not greater than 133% FPL.

These participants include individuals who are currently covered through Pennsylvania's General Assistance (GA) Medical Assistance, the State Blind Pension medical program, the Medical Assistance for Workers with Disabilities (MAWD) (under the Medicaid category added through the Ticket to Work and Work Incentives Improvement Act), and the SelectPlan for Women Program (a demonstration project to provide family planning services to women of childbearing age). Pennsylvania will transition these adults into the newly eligible group.

The participants in this option, known throughout this application as the *Healthy Pennsylvania* Private Coverage Option, will receive Essential Health Benefits (EHB) through a private coverage plan and they will have cost sharing obligations consistent with the reformed cost-sharing approach described in *Section 4: 1115 Demonstration Benefits and Cost Sharing Requirements*. Participants who are determined medically frail will be covered through the existing Pennsylvania Medicaid program. The medically frail will be determined using the same screening tool and criteria used to identify High Risk recipients. These individuals will be enrolled in the High Risk Alternative Benefit Plan, but may choose the *Healthy Pennsylvania* Private Coverage Option.

This 1115 Demonstration aims to reduce the amount of churn that will occur when newly eligible individuals move between Medicaid and private coverage plans. By providing individuals with consistent health plan access through established private health insurance carriers and providing opportunities for increased personal responsibility, this 1115 Demonstration will provide an improvement in their health outcomes.

The 1115 Demonstration will further the objectives of Title XIX by promoting continuity of coverage for adults, improving access to providers, allowing for more coordinated

care, and furthering quality improvement and delivery system reform initiatives. Ultimately, the 1115 Demonstration will provide truly integrated coverage for low-income Pennsylvanians--leveraging the efficiencies of the private market to improve continuity, access, and quality for *Healthy Pennsylvania* Private Coverage Option participants, improving health outcomes and lowering health care costs for Pennsylvanians.

Through the inclusion of more than 500,000 Pennsylvanians in the private health insurance market, the Department will improve affordability by driving more competitive premium pricing and reducing the overall federal burden for potentially more than eight million Pennsylvanians anticipated to receive the advanced premium tax credit (APTC).[1]

2) Include the rationale for the 1115 Demonstration

In order to provide affordable, quality health care services to Pennsylvania's most vulnerable citizens, Pennsylvania must transform its Medicaid program. Pennsylvania's current Medicaid program continues to grow and requires substantial new state revenue on an ongoing basis. As in years past, these costs are projected to grow by more than $400 million in fiscal year 2013-2014. This cost growth does not include additional costs that the Commonwealth may incur as a result of the mandatory provisions of the Affordable Care Act (ACA), nor does it include the projected 1.7% reduction in federal financial participation for Pennsylvania during federal fiscal year 2015.

While Medicaid provides critical health care to millions of Pennsylvanians, its continued annual growth places an increased burden on the taxpayers of Pennsylvania and makes it increasingly difficult to fund other critical program areas, such as education. Pennsylvania is committed to providing a program that meets the needs of Pennsylvanians into the future.

Pennsylvania's approach to Medicaid reform is based on a comprehensive benefit and cost-sharing design that encourages healthy behaviors and increased independence and personal responsibility through work search activities. This design will assist

[1] Based on Kaiser and US Census data in 2010-11 (http://kff.org/other/state-indicator/population-up-to-400-fpl/#table) for the total number of individuals below 400% FPL.

Pennsylvanians currently receiving Medical Assistance to move to the *Healthy Pennsylvania* Private Coverage Option and, ultimately, to private employer-sponsored insurance.

By using premium assistance available through the *Healthy Pennsylvania* Private Coverage Option to purchase a private coverage plan, the Department will promote continuity of coverage, reduce churn between Medicaid and private insurance coverage, increase provider access, and lower health care costs for all Pennsylvanians.

- **Churn Reduction and Continuity of Coverage** – The *Healthy Pennsylvania* plan is expected to decrease the amount of insurance coverage churn for participants, which will result in greater continuity of care. Because of the frequent income fluctuations at higher FPL percentages, Pennsylvanians closer to 133% FPL are more likely to move between Medicaid eligibility and a private coverage plan through the use of the APTC available through the FFM. The *Healthy Pennsylvania* Private Coverage Option provides a mechanism for households to stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid or APTCs. This approach results in greater coverage stability for individuals and their families, increased continuity of care, and improved health outcomes.

- **Increased Provider Access** – Pennsylvania Medicaid provides payment rates for most services that are lower than Medicare or commercial payers, causing some providers to forego participation in the program and others to cross subsidize their Medicaid patients by charging more to private insurers. This 1115 Demonstration will seek to stabilize provider payments across payers, expand provider access and reduce the need for providers to cross-subsidize.

- **Lower Health Care Costs for All Pennsylvanians** – Pennsylvania's approach brings more than 500,000 individuals to the private health coverage market, which is intended to increase competition and result in lower premiums and costs for potentially more than eight million Pennsylvanians who are expected to receive APTCs. Bringing more competition into the private health care market will result in more choices and lower costs overall.

- **Personal Responsibility –** The Department wants to ensure that Medicaid remains a transitional benefit available to vulnerable, low-income Pennsylvanians. To encourage personal responsibility, while still maintaining a safety-net program for our most vulnerable, a three part approach is being proposed:

    1. **Premium Requirement:** In lieu of other cost sharing (other than a nominal co-payment for non-emergent use of the emergency room), individuals with incomes greater than 50% FPL will be required to pay a nominal portion of their income toward a monthly premium. This requirement provides a mechanism for participants to engage in their health care encouraging them to make healthier choices, both in their daily lives and when making decisions about their health care. Additionally it will prepare these individuals for health coverage financial obligations that will become their responsibility when their income increases and they move into private health care coverage either through APTC subsidized coverage via the FFM, commercial market, or ESI.

    2. **Healthy Behaviors Incentives**: Reducing the cost of health coverage needs to be the responsibility of both the health care provider and the individuals receiving care. In the past, Pennsylvania has implemented payment reforms to incentivize providers to improve care. Following the lead of commercial health plans, Pennsylvania will address the participant side of the equation by offering reductions in the monthly premium amount as individuals practice healthy behaviors. In the first year, individuals will be incentivized to assess their own health condition by completing a Health Risk Assessment, paying their monthly premium on time and having a physical exam. All Pennsylvanians should be encouraged to be active participants in improving their health.

    3. **Work Search Activities**: The program will create an opportunity for unemployed and under-employed individuals to connect with potential employers. Adults, 21 through 64 years of age, who are able to work, will engage in work search activities as part of an integrated approach to improve their health and help them move out

of poverty and become self-sufficient through employment. The Department is seeking a waiver to require work search registration and activities as a condition of eligibility, with limited exceptions. Additionally, for those individuals who are working more than 20 hours per week, the Commonwealth will reduce the amount of their monthly premium.

2.2. 1115 Demonstration Hypotheses

3) Describe the hypotheses that will be tested and evaluated during the 1115 Demonstration's approval period and the plan by which the State will use to test them.

The 1115 Demonstration provides reforms to the existing Medicaid program, increases access to health care coverage and stabilizes financing by delivering private market health insurance benefits to a new group of low-income adults through use of the *Healthy Pennsylvania* Private Coverage Option. As described above, some of the core innovations in the 1115 Demonstration include:

1. **Increasing access to health care coverage through the *Healthy Pennsylvania* Private Coverage Option.** Premium assistance will be used to purchase private coverage plans for individuals with income up to 133% FPL. The *Healthy Pennsylvania* Private Coverage Option will increase access to private market health plans and their network providers, reduce churn, maintain administrative costs, and reduce both premium costs in the Commonwealth and average per-capita uncompensated care costs.

2. **Implementing work search activities to improve health outcomes and move individuals out of poverty.** Published research shows that being employed results in improved physical and mental health.[2] In order to promote improved health conditions, as well as help individuals move out of poverty and become self-sufficient, 1115 Demonstration participants who are able to work and working less than 20 hours per week will be required to seek

[2] F. M. McKee-Ryan, Z. Song, C. R. Wanberg, and A. J. Kinicki, "Psychological and physical well-being during unemployment: a meta-analytic study," Journal of Applied Psychology, vol. 90, no. 1, pp. 53–76, 2005. K. I. Paul, E. Geithner, and K. Moser, "Latent deprivation among people who are employed, unemployed, or out of the labor force," Journal of Psychology, vol. 143, no. 5, pp. 477–491, 2009.

employment through work search registration, available through JobGateway[SM], and participate in ongoing work search activities that connect them with employment opportunities.

3. **Implementing a unique incentive plan to encourage personal accountability, incentivize healthy behaviors, and develop cost-conscious consumer behaviors in the consumption of health care services.** The 1115 Demonstration will implement a unique incentive plan to encourage personal responsibility, healthy behaviors, and the development of cost-conscious consumer behaviors in the consumption of health care services. As such, in lieu of most other cost sharing, individuals with incomes greater than 50% FPL will be required to pay a nominal portion of their income toward a monthly premium. Reductions in the nominal monthly premium amount will occur as individuals engage in healthy behaviors and activities.

4. **Utilizing a health screening tool for all adult participants, both initially and periodically, will help identify the benefit plan that best serves their needs.** All adult participants will be screened initially and annually thereafter to help identify the benefit plan that best serves their needs. The goal of this screening is to promote utilization of necessary services and appropriate levels of care, while still maintaining continued coverage and a safety net for the Commonwealth's vulnerable populations.

The core hypotheses in the 1115 Demonstration include:

1.) Increasing access to health care coverage through the *Healthy Pennsylvania* Private Coverage Option.

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
1.1	*Healthy Pennsylvania* Private Coverage Option participants will have adequate provider access.	1. Conduct a survey of *Healthy Pennsylvania* Private Coverage Option participants related to timeliness of care and other provider access issues. Possible metrics include: 1) percent of individuals who report getting care quickly; 2) reported travel times/distance to Primary Care Physicians (PCP) and specialists; 3) size of network/ availability of PCPs. 2. Comparison of *Healthy Pennsylvania* Private Coverage Option provider networks to private market provider networks. Comparisons made on a regional basis to account for differences in network size. Plan is to collect data from *Healthy Pennsylvania* Private Coverage Option plans and other non- *Healthy Pennsylvania* Private Coverage Option private market health plans. May also use NCQA HEDIS/CAHPS data, if appropriate.
1.2	*Healthy Pennsylvania* Private Coverage Option participants will have continuous insurance coverage.	1. Analysis of the number of participants that stay in the same plan as their income increases above 133% FPL. Possible metrics include: 1) percent of individuals that stay in the same plan over time; 2) percent of individuals with any period of uninsurance during the year (i.e., a coverage gap). Determine baseline data and analyze changes in that data over time. Plan is to use *Healthy Pennsylvania* Private Coverage Option enrollment data in the analysis. 2. Hypothetical analysis of *Healthy Pennsylvania* Private Coverage Option participant transfers to APTC coverage. Measure the percent of *Healthy Pennsylvania* Private Coverage Option participants who would have otherwise had to change coverage if not in the *Healthy Pennsylvania* Private Coverage Option. Test *Healthy Pennsylvania* Private Coverage Option participants against a hypothetical control group (those who would have potentially churned between Medicaid and APTC coverage).

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
1.3	Per capita administrative costs will be maintained through the use of the *Healthy Pennsylvania* Private Coverage Option.	1. Comparison of per capita administrative costs expended for the *Healthy Pennsylvania* Private Coverage Option and how those costs change over time. Determine demonstration group and compare the administrative costs of that group to the group's administrative costs in previous years. Alternatively, compare to the administrative costs of a non-demonstration control group.
1.4	*Healthy Pennsylvania* Private Coverage Option will reduce overall premium costs in the Commonwealth.	1. Analysis of the impact of increased volume and competitive pricing requirements for plans offered to *Healthy Pennsylvania* Private Coverage Option participants. Compare aggregate-level private market premium costs with the inclusion of the *Healthy Pennsylvania* Private Coverage Option to historical costs and/or a non-demonstration sample. Determine baseline data and analyze changes in that data over time. Plan to use aggregate level *Healthy Pennsylvania* Private Coverage Option/private market premium cost information.
1.5	Average per capita uncompensated care costs will decrease as a result of fewer numbers of uninsured.	1. Comparison of average per capita uncompensated costs before and after implementation of the 1115 Demonstration. Determine baseline data and analyze changes in that data over time. Data sources may include CMS data, hospital-level data, or an analysis of Disproportionate Share Hospital Payments.

2.) Implementing work search activities to improve health outcomes and move individuals out of poverty.

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
2.1	Implementation of work search activities will result in increased employment for the 1115 Demonstration population (which will ultimately lead to improved health outcomes—see 2.2 below).	Measure the change in the employment rate of individuals who complete work search activities. Compare the employment rate of those required to complete work search activities to the same group's historical employment rate. Or compare to a non-demonstration control group with similar income levels and other demographic characteristics (who don't engage in work search activities). Data sources may include state employment data (L&I work/wages data), census data, measuring the number of individuals moving from the *Healthy Pennsylvania* Private Coverage Option to the private market, and/or survey results.
2.2	Encouraging work search activities will promote employment, which will result in better physical and mental health outcomes.	Based upon published research being employed results in improved physical and mental health. To test whether this holds true for the 1115 Demonstration population, changes in physical and mental health outcomes of participants who engage in work search activities will be measured over time (analysis will occur in 1115 Demonstration Year 3 or 4). Possible metrics include: 1) specific behavioral health/physical health diagnoses (reduced depression and anxiety, improved functional health status, etc.); 2) service utilization (e.g., less hospitalization, reduced use of ED, etc.). Data sources may include claims data, survey results, and/or Behavioral Risk Factor Surveillance System (BRFSS) data.

3.) Implementing a unique incentive plan to encourage personal accountability, incentivize healthy behaviors and develop cost-conscious consumer behaviors in the consumption of health care services.

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
3.1	Reductions in monthly premiums will promote healthy behaviors and improve physical and mental health outcomes.	1. Analysis of the number of individuals who pay a premium and engage in healthy behaviors and activities. Metrics may include: 1) consistently paying premiums; 2.) completing a health risk assessment; 3) completing an annual physical exam; 4) appropriately using ER services. Determine baseline data and analyze changes in that data over time. Data sources may include claims data, survey results, and/or BRFSS data.

4.) Utilizing a health screening for all adult participants, both initially and periodically, will help identify the benefit plan that best serves their needs.

#	Hypothesis	Potential Methodology, Metrics, and Data Sources
4.1	The Low Risk Benefit Plan sufficiently meets the needs of the participants placed in it by the screening tool.	1. Analyze the number of exception requests from the Low Risk Benefit Plan over a predetermined time period. Determine appropriate baseline percentage of exceptions (e.g., 5%) and compare to actual percentage. Examine aggregate level results.
4.2	The High Risk Alternative Benefit Plan sufficiently meets the needs of the participants placed in it by the screening tool.	1. Analyze the number of exception requests from the High Risk Alternative Benefit Plan over a predetermined time period. Determine appropriate baseline percentage of exceptions (e.g., 5%) and compare to actual percentage. Examine aggregate level results.

2.3. 1115 Demonstration Area

4) Describe where the 1115 Demonstration will operate, i.e., statewide, or in specific regions within the State. If the 1115 Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the 1115 Demonstration will operate.

The 1115 Demonstration will operate statewide.

2.4. 1115 Demonstration Timeframe

5) Include the proposed timeframe for the 1115 Demonstration

The 1115 Demonstration will operate five years beginning on January 1, 2015 and lasting until December 31, 2019.

2.5. 1115 Demonstration Impact to Medicaid and CHIP

6) Describe whether the 1115 Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems

This 1115 Demonstration will change current Medicaid eligibility, benefits, cost sharing, and delivery systems, as detailed in the following sections. With respect to the current Medicaid program in Pennsylvania, outside of eligibility, benefits, cost sharing, and delivery systems, this 1115 Demonstration makes changes to:

- Payment Rates, as described in *Section 5: Delivery System and Payment Rates for Services.*
- Financing, as described in *Section 5: Delivery System and Payment Rates for Services* and *Section 7: 1115 Demonstration Financing and Budget Neutrality.*
- Administration, to extent needed by the 1115 Demonstration itself, as described in *Section 10: 1115 Demonstration Administration.*

This waiver will not impact CHIP.

2.6. CONTINGENCY FOR REDUCTION IN FEDERAL FINANCIAL PARTICIPATION:

Implementation and operation of this 1115 Demonstration, in particular the *Healthy Pennsylvania* Private Coverage Option, is dependent on the federal medical assistance percentage (FMAP) for the newly eligible adult group under the Affordable Care Act (ACA), as provided in section 1905(y) of the Social Security Act (42 U.S.C. § 1396d(y)). Therefore, in the event any of the following occur, the Department shall develop and implement an alternative plan:

- The methodology for calculating the FMAP for individuals in the *Healthy Pennsylvania* Private Coverage Option is modified through federal law, regulation, or sub-regulatory guidance in a manner that reduces the percentage of federal assistance to Pennsylvania in a manner inconsistent with section 1905(y) of the Social Security Act (42 U.S.C. § 1396d(y)), as enacted March 23, 2010.
- The amount of federal financial participation for this 1115 Demonstration is reduced through a modification or restriction in the federal Medicaid appropriation.
- Our ability to provide quality health care to low income Pennsylvanians under this 1115 Demonstration and the current Medicaid program relies on a commitment from the federal government to maintain without change or disruption to existing federal funding and revenue sources. Should changes be required or use of these existing federal funding and revenue sources become unavailable for the current Medicaid program or newly eligible populations under this 1115 Demonstration, it may necessitate changes or discontinuance of this proposal.
- Federal law, regulation, or sub-regulatory guidance affecting eligibility, benefits, payment, delivery systems, financing, administration, health insurance exchanges, or qualified health plans is modified in a manner that conflicts with or materially hinders the operation or financing of this 1115 Demonstration as described herein.

Such an alternative plan may involve:

- Discontinuation of the 1115 Demonstration.
- Discontinuation of the *Healthy Pennsylvania* Private Coverage Option.

- Increasing premiums and cost sharing in the *Healthy Pennsylvania* Private Coverage Option.
- Amendments to the 1115 Demonstration.

3. 1115 Demonstration Eligibility

3.1. Eligibility Groups

1) Include a chart identifying any populations whose eligibility will be affected by the 1115 Demonstration.

The *Healthy Pennsylvania* 1115 Demonstration will provide access to basic health care coverage for uninsured Pennsylvanians, and it creates incentives and opportunities for low-income individuals to engage in more healthy behaviors and to connect with prospective employers through work search activities. The plan will affect the newly eligible populations and other adults in existing categories of assistance who may be subject to two additional conditions of eligibility related to paying premiums and work search activities. The addition of the premium requirement and work search activities will potentially affect at least some adults in several non-institutional categories the Department currently covers. This includes newly eligible adults, adults in low-income families, and other groups as depicted in Table 1. Additionally, most non-institutional adult categories will be affected by the $10 co-payment for the non-emergent use of the emergency room. (See Appendix 1 for a list of these categories.)

Individuals who qualify and enroll in the *Healthy Pennsylvania* Private Coverage Option will be required to receive coverage through a private coverage plan. Those individuals who are not exempt and decline coverage through the private coverage plans will not be permitted to receive benefits through the Medicaid program.

The plan does not impact the eligibility of pregnant women or children under 21 years of age. It also does not affect the eligibility of Pennsylvanians who are institutionalized, those who are receiving Supplemental Security Income (SSI) or are deemed to be receiving SSI, those who are dually eligible for Medicaid and Medicare, and those in categories limited to Medicare cost sharing programs such as Qualified Medicare Beneficiaries. Persons deemed SSI eligible for purposes of Medicaid eligibility are specified under sections 1939(a)(2) and 1939(a)(5) of the Social Security Act. 42 U.S.C.A. § 1396v(a)(2) and (a)(5). Throughout this notice, the term 'institutionalized' means that an individual is likely to reside or has already resided in a medical institution for more than 30 continuous days.

The following adult eligibility categories set forth in the State Plan will be affected by the 1115 Demonstration as indicated in Table 1: 1115 Demonstration Eligibility Group:

Table 1. 1115 Demonstration Eligibility Group[3]

Eligibility Group Name Social Security and CFR Citations	Brief Description of Population, if needed	Maximum Income Limit Single/couple asset limit	Premium Applies	Work Search Applies
Low Income Families **1931**	Low income parents and caretaker relative based on income and family size.	33% FPL No asset test	NO	YES
Extended Medicaid due to Child or Spousal Support Collections **408(a)(11)(B), 42 CFR 435.115, 1931(c)(1)**	Individuals who lose eligibility under Section 1931 due to spousal support.	N/A No asset test	YES	YES
Individuals Receiving Mandatory State Supplement **42 CFR 435.130[4]**	Low income seniors or an adult with a severe disability. State increases SSI payment by $22.10.	76% FPL[5] $2,000/$3,000	NO	NO
Individuals Who Are Essential Spouses **42 CFR 435.131** **1905(a)**	Spouse of aged, blind, disabled individual who was grandfathered into program at time of SSI implementation.	74% FPL $2,000/$3,000	NO	NO

[3] Individuals under age 21 years are not affected by this waiver.
[4] Many of the federally defined categories include individuals age 65 and older as part of the definition. A waiver of comparability will be requested, so individuals age 65 and older will not be affected by the waiver.
[5] Poverty level income limits for SSI groups are approximate and based on the 2013 Federal Benefit Rate (FBR) for SSI/2013 Federal Poverty Level (FPL). Individuals in SSI protected groups will have different incomes based on their individual circumstances.

Eligibility Group Name Social Security and CFR Citations	Brief Description of Population, if needed	Maximum Income Limit Single/couple asset limit	Premium Applies	Work Search Applies
Blind or Disabled Individuals **Eligible in 1973** **42 CFR 435.133**	Continuously eligible based on 1973 requirements.	Meet 1973 requirements	NO	NO
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972 **42 CFR 435.134**	Low income seniors or an adult with a severe disability with incomes slightly above 74% FPL.	>74% FPL $2,000/$3,000	NO	NO
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977 **1939(a)(5)(E), 42 CFR 435.135, Section 503 of P.L. 94-566**	Adult with a severe disability. Had been receiving SSI but lost it due to Social Security Administration (SSA) income increases from Cost Of Living Adjustments (COLA).	>74% FPL, but low income	NO	NO
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI **1634(b), 42 CFR 435.137**	Adult with a severe disability. Not eligible for SSI because the increased amount of widow's or widower's insurance benefits which resulted from eliminating the additional reduction factor for disabled widows and widowers under age 60.	>74% FPL, but likely low income	NO	NO

Eligibility Group Name Social Security and CFR Citations	Brief Description of Population, if needed	Maximum Income Limit Single/couple asset limit	Premium Applies	Work Search Applies
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security 42 CFR 435.138,1634(d)	Disabled widows and widowers who are at least age 60; not entitled to Medicare Part A; and become ineligible for SSI or a State Supplement because of mandatory receipt of widow's or widower's social security disability benefits.	>74% FPL $2,000, $3,000	NO	NO
Working Disabled under 1619(b) 1902(a)(10)(A)(i)(II), 1905(q),1619(b)	Would receive SSI but for earnings. Blind or disabled individual whose earnings from employment make the individual ineligible for an SSI cash payment. The SSA makes the determination for Special SSI Recipient Status.	N/A	NO	NO

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population, if needed**	**Maximum Income Limit** Single/couple asset limit	**Premium Applies**	**Work Search Applies**
Disabled Adult Children (DAC) 1634(c)	Individual who became disabled before age 22, and receives Title II Social Security benefits as dependent on parent's claim. Benefits received upon disability, retirement, death of the parent. When SSI benefits are terminated due to receipt of or increase in Social Security benefits, a DAC may be eligible for continued Medical Assistance (MA) coverage under SSI Extended Non-Money Payment Coverage – Special Circumstances.	N/A	NO	NO
Individuals Eligible for Cash except for Child Care Subsidy 1902(a)(10)(A)(ii)(II), 42 CFR435.220	Low income caretakers.	33% FPL $1,000/$1,000 asset test	NO	YES

Eligibility Group Name Social Security and CFR Citations	Brief Description of Population, if needed	Maximum Income Limit Single/couple asset limit	Premium Applies	Work Search Applies
Individuals Eligible for but not Receiving Cash 42 CFR 435.210, 1902(a)(10)(A)(ii)(I), 1905(a), 1902(v)(1)	Have the same characteristics as an SSI recipient or Aid to Families with Dependent Children (AFDC) (Temporary Assistance for Needy Families (TANF)) recipient, but are not receiving payments from the program.	33% and 74% FPL $2,000/$3,000	YES, if TANF related; NO, if SSI related	YES, if TANF related; NO, if SSI related
Individuals Receiving Home and Community Based Services under Institutional Rules 42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	Special income level group, with gross income that does not exceed 300% of the SSI income standard; receives Long-Term Services and Supports (LTSS) in the community.	222% FPL $2,000 with 6,000 disregard	YES, unless otherwise exempt	YES, unless otherwise exempt
Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements 1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	Low income seniors or an adult with a severe disability. Receives a $22.10 state supplement.	76% FPL $2,000	NO	NO
Poverty Level Aged or Disabled 1902(a)(10)(A)(ii)(X), 1902(m)(1)	Low income senior or an adult with a severe disability. (Note: does not affect those age 65 and older)	100% FPL $2,000/$3,000	YES, unless otherwise exempt	YES, unless otherwise exempt

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population, if needed**	**Maximum Income Limit** Single/couple asset limit	**Premium Applies**	**Work Search Applies**
Individuals at or below 133% FPL Age 19 through 20 1902(a)(10)(A)(i) (VIII)[6]	Newly eligible singles and couples**. Only those with incomes greater than 44% FPL will be affected by the waiver.**	Income between 44% FPL and 133% FPL No asset test	NO	NO
Individuals at or below 133% FPL, 21 through 64 years of age 1902(a)(10)(A)(i) (VIII) **NOTE: Those individuals who are receiving coverage through Medical Assistance for Workers with Disabilities, SelectPlan for Women, Medically Needy for parents, caretakers, persons with disabilities and the blind, and through General Assistance and State Blind Pension participation will move to this group.**	Newly eligible singles and couples.	133% FPL No asset test	YES, unless otherwise exempt	YES, unless otherwise exempt

[6] This group is separated from the rest of the newly eligible to clarify that they will be treated differently.

Eligibility Group Name Social Security and CFR Citations	**Brief Description of Population, if needed**	**Maximum Income Limit** Single/couple asset limit	**Premium Applies**	**Work Search Applies**
Former Foster Care Children 1902(a)(10)(A)(i)(IX)	Individuals who were receiving Foster Care and Medicaid at age 18 and aged out of the foster care program. The changes included in this waiver will only apply to those in this group who are age 21 to 25 years.	Not otherwise categorically or income eligible	NO, if less than 21 years of age YES for 21 years and older	NO, if less than 21 years of age YES for 21 years and older

3.2. Eligibility Standards and Methodologies

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the 1115 Demonstration, to the extent those standards or methodologies differ from the State plan.

When determining whether an individual is eligible for the *Healthy Pennsylvania* Private Coverage Option, The Department will use the same process and system as well as apply the same financial eligibility standards and methodologies in the Medicaid State plan.

Retroactive coverage will not be provided to those who enroll in the *Healthy Pennsylvania* Private Coverage Option. For those who enroll in the *Healthy Pennsylvania* Private Coverage Option, eligibility will be effective on the first day of private coverage plan enrollment. Those adults, who could enroll in the *Healthy Pennsylvania* Private Coverage Option but qualify as Medically Frail and choose to receive coverage in the traditional MA program, will be enrolled in the High Risk ABP.

Premium Requirement

Currently, the Medicaid cost sharing structure does not provide positive incentives for healthy choices or personal responsibility. *Healthy Pennsylvania* emphasizes individual responsibility and improved health outcomes for the existing Medicaid adult population, similar to insurance coverage through the commercial market.

Unless exempt, all adults, age 21 and older, will be required to pay a monthly premium as a condition of initial and continuing eligibility. These monthly premiums will replace the current co-payments applicable in the Medicaid program. Premium changes based upon fluctuations in income or household composition will be adjusted at the annual redetermination, except if income decreases to a level that is at or below 50% FPL or increases above the eligibility income limit. The premiums are structured in an upwards sliding scale of no more than $25 (one adult) or $35 (household with more than one adult) at the maximum threshold of 133% FPL. The premiums required are described in *Section 4.9: Cost Sharing*. The following individuals are exempt from paying the premium:

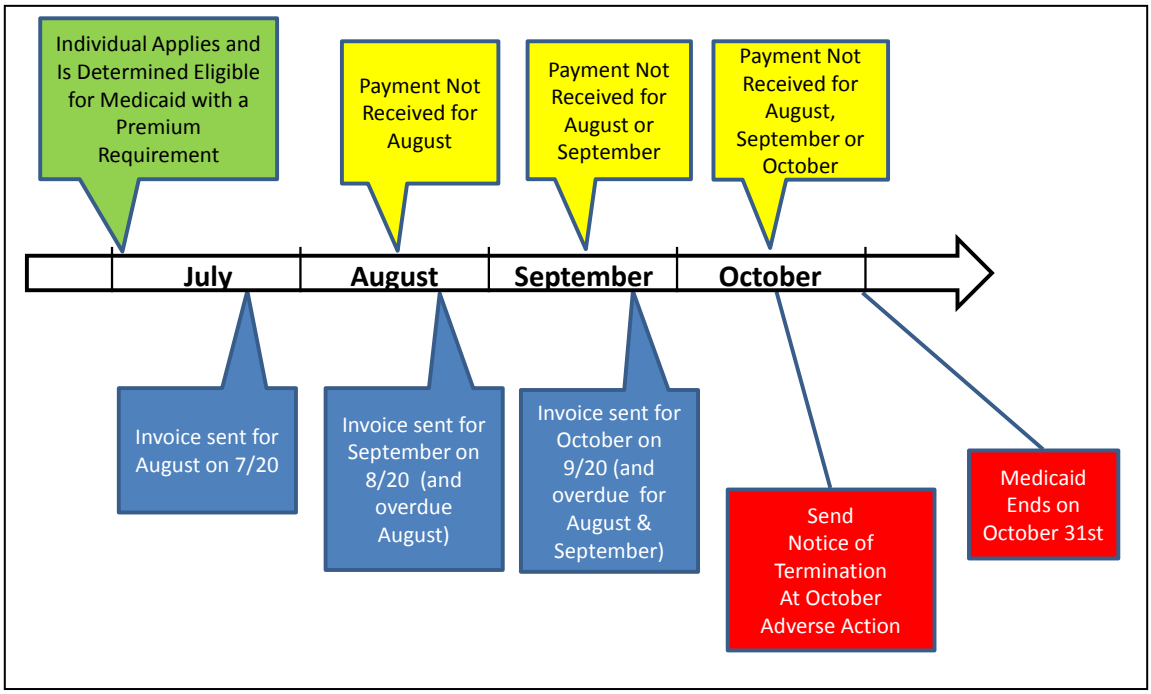
- Individuals with household income that does not exceed 50% FPL,
- Pregnant women,
- Individuals 65 years of age and older,
- Individuals under 21 years of age,
- SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility,
- Individuals who are dually eligible for Medicare and Medicaid, and
- Individuals who are institutionalized.

Premiums will be required to be paid a month in advance. A new applicant subject to a premium will not be charged the first month's premium. Monthly premium invoices will be sent to participants.

Participants will be required to pay their premium by the date printed on the invoice. However, there will be a grace period after that date where the premium can still be accepted without affecting eligibility, except in situations described below.

Ineligibility for an adult or household will occur whenever an individual or household fails to pay the premium in full for three consecutive months by the end of the third month. For an applicant, the first eligibility month will not require a premium, but if the eligible adult or household fails to pay their premium for the three subsequent months, the adult's or household's eligibility will be terminated (see Figure 1 – Initial Premium Payment (Medicaid)).

Figure 1. Initial Premium Payment (Medicaid)



In an ongoing case, if the individual, whose eligibility has been reestablished, fails to pay the premium for three consecutive months, there will be progressively longer periods of ineligibility.

The first time that an adult or the household fails to pay their premium for three consecutive months and eligibility is terminated, the adult or the household will be ineligible for three months. After eligibility is reestablished, a second failure to pay the premium for three consecutive months will result in a six-month period of ineligibility. A third such failure will result in a nine-month period of ineligibility. Previously ineligible individuals who subsequently become exempt from premium payment due to a change in circumstances will be allowed to immediately re-enroll in the Medicaid program.

Premium Reduction

Participants who continuously pay their monthly premium will be able to reduce their premium obligation by engaging in approved healthy behaviors or by working at least 20 hours per week, or both. Successful completion of healthy behavior activities can reduce the premium by 25% and working can reduce the premium by up to another 25% for a total reduction up to 50%.

In the first 3 years of eligibility, adults' premiums will be reduced if they meet all of the following healthy behavior requirements:

- Paying premiums on time (during most recent 6 months).
- Completing a Health Risk Assessment (HRA) annually.
- Completing a physical exam annually.

After 3 years, the Commonwealth will evaluate HRA data and determine broader healthy behaviors that should be used, such as cholesterol testing. The 1115 Demonstration application seeks flexibility and authority to change or expand the list of healthy behaviors for which premium reductions are available.

Adults who at the time of initial application or redetermination are working 30 or more hours per week will receive an initial 25% reduction in their monthly premium. Adults who are working less than 30 hours but at least 20 hours per week will have their premiums reduced by 15% after 6 months of eligibility.

Premium amounts will be set annually, but evaluated for reductions every 6 months. If the participant successfully completes the required activities in the first 6-month period, then the premium will be reduced in the second 6-month period. These 6-month cycles will continue throughout the span of enrollment.

Work Search Activities

Research has demonstrated that employed individuals are both physically and mentally healthier, as well as financially stable. Under the 1115 Demonstration application, the Department will require able-bodied adults to engage in work search activities as part of an integrated approach to improving their health and helping them move out of poverty.

Unless exempt, all adults 21 years of age or older, who are working less than 20 hours per week, will be required to register with JobGateway^{sm}, the online system currently utilized for Pennsylvania's Unemployment Compensation program. Participants will be required to engage in specified work search related activities as a condition of initial and continuing eligibility.

JobGateway^{sm} provides individuals with access to current job openings, the ability to create and upload a resume, and view job opening recommendations based on their

preferences. JobGateway[SM] includes a mobile application allowing easy use for those individuals seeking jobs using a smart phone and a career exploration tool providing real time labor statistics for existing jobs. Individuals will have access to training for job interviews and the ability to put that training into practice with virtual mock interviews. Individuals may also wish to participate in work search activities provided by PA CareerLink®, with core services being accessible either online or in person at 66 locations. Services include the ability to look for employment opportunities by career, employer, and geography. Referrals are also available to other partner programs that may be capable of helping individuals become gainfully employed.

The following individuals are exempt from required work search activities:

- SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility,
- Pregnant women,
- Individuals 65 years of age and older,
- Individuals under 21 years of age,
- Individuals who are institutionalized, and
- Individuals who are dually eligible for Medicare and Medicaid.

Full-time and part-time students are exempt from participating in work search activities for each year they are enrolled in a postsecondary education institution or technical school. The Department will annually review students' status. Students are not exempt from registration with JobGateway[sm] (students will benefit from the services provided by JobGateway[sm] as they transition into the workforce).

Due to the requirements of TANF, individuals who are receiving TANF payments are deemed to have met their *Healthy Pennsylvania* work search activity.

Individuals may request an exemption from work search activities from the Department if they are suffering a crisis, serious medical condition, or temporary condition or situation that prevents them from searching for work, such as domestic abuse or substance abuse treatment.

As part of the application process, non-exempt Medicaid and *Healthy Pennsylvania* Private Coverage Option participants who are working less than 20 hours per week must

register with JobGateway[sm]. Following application approval, individuals must be actively engaged in either work search or job training activities. Those non-exempt individuals who successfully complete 12 approved work search activities per month during their first 6 months will continue to be eligible for health care coverage. The Department will assist the individual in meeting these eligibility requirements by providing linkages and referrals to employment, work search, and job training resources through JobGateway[SM] and PA CareerLink®.

Job training activities that can substitute for the work search activities include participation in a federal workforce development program, on-the-job training, a full-time internship, and other activities approved by the Department.

Failure to comply with the work search activities will result in a three-month period of ineligibility for Medicaid and *Healthy Pennsylvania* Private Coverage Option participants. For an adult who re-establishes eligibility for Medicaid or the *Healthy Pennsylvania* Private Coverage Option and fails to follow through with work search or job training activities again, eligibility will be terminated for six months. If the individual fails to follow through on the work search related activities a third time, eligibility will be terminated for a period of nine months. Previously ineligible individuals who subsequently become exempt from work search activities due to a change in circumstances will be allowed to immediately re-enroll in the *Healthy Pennsylvania* Private Coverage Option or Medicaid program. Participants will receive reminders about the work search activity requirement every three months. The Department will review participant activities at the end of every six months, and if the activities are not completed the participant will receive a notice of ineligibility.

3) **Specify any enrollment limits that apply for expansion populations under the 1115 Demonstration.**

There are no caps on enrollment in the 1115 Demonstration.

3.3. Projected Eligibility and Enrollment

1) **Provide the projected number of individuals who would be eligible for the 1115 Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such**

as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

The 1115 Demonstration will cover all adults currently in the Medicaid program.

- Current adult populations: 1,240,859
- Newly eligible adults: More than 500,000

2) **To the extent that long term services and supports are furnished (either in institutions or the community), describe how the 1115 Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the 1115 Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment).**

Not Applicable

3) **Describe any changes in eligibility procedures the state will use for populations under the 1115 Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment).**

The State will utilize modified adjusted gross income (MAGI) methodologies for the newly eligible adult populations with incomes up to 133% of the FPL.

4) **If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if additional space is needed, please supplement your answer with a Word attachment).**

The State will utilize modified adjusted gross income (MAGI) methodologies for the newly eligible adult populations with incomes up to 133% of the FPL.

4. 1115 Demonstration Benefits and Cost Sharing Requirements

1) **Indicate whether the benefits provided under the 1115 Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

__X__ Yes ____ No

2) **Indicate whether the cost sharing requirements under the 1115 Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

__X_ Yes ___ No

4.1. Benefit Chart

3) **If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the 1115 Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the 1115 Demonstration:**

The Department understands that those individuals who are currently eligible for Medicaid have varying health care needs and *Healthy Pennsylvania* benefits need to be designed based upon those needs and not a one-size fits all approach. Additionally, our current program has various benefit designs. The Department needs to simplify our approach and remove the bureaucratic complexity for our participants, for our providers and for our staff. For these reasons, *Healthy Pennsylvania* will provide:

- Children under 21 years of age and newly eligible adults ages 19 and 20 with the current health care package for children.
- Those eligible within the current Medicaid eligibility limits with a base benefit plan tailored to those with lower health care needs. This plan is referred to as the Low Risk Benefit Plan.
- Those adults, 21 through 64 years of age, who are eligible under the current Medicaid eligibility limits and have more complex health care needs, when measured using the health screening tool, will be enrolled in the High Risk Alternative Benefit Plan.
- All SSI beneficiaries, pregnant women, individuals who are dually eligible for Medicare and Medicaid, residents of institutions, and individuals receiving

home and community based services will be enrolled into the High Risk Alternative Benefit Plan.

- Those adults who are newly eligible, but are not determined to be medically frail, will only be eligible for the *Healthy Pennsylvania* Private Coverage Option and will be enrolled into a private market health care plan. *Healthy Pennsylvania* Private Coverage Option will pay for their monthly premiums and cost sharing for services provided by providers who are contracted as described in *Section 4.9: Cost Sharing*. *Healthy Pennsylvania* Private Coverage Option will not pay for those services not offered by the commercial insurer, which are included in the Low Risk Benefit Plan. Those adults who are newly eligible, who are determined through the screening tool to be medically frail, will be enrolled into the High Risk Alternative Benefit Plan, but will have the option to opt into the *Healthy Pennsylvania* Private Coverage Option.

Individuals enrolled in the *Healthy Pennsylvania* Private Coverage Option will receive the EHB package through their private coverage plan. The EHB package for Pennsylvania is the benchmark package of covered services specified under 45 CFR §156.100(c) and 45 CFR §156.110, based on the package provided under the small group plan with the largest enrollment. For adults this includes ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management. Details on the EHB package in Pennsylvania are available on the web at: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/pennsylovania-ehb-benchmark-plan.pdf

4.2. Social Security Act Section 1937 Alternative Benefit Plans

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
_X_ Secretary Approved

As described in *Section 4.1: Benefit Chart*, adults, 21 through 64 years of age, who are eligible under the current eligibility requirements of the Pennsylvania Medicaid program will have their health condition assessed using a screening tool. The outcome of that assessment will determine if they are provided with the Low Risk Benefit Plan or the High Risk Alternative Benefit Plan. All who qualify as high risk will be enrolled into the High Risk Alternative Benefit Plan, but will be given the choice of opting into the Low Risk Plan. The following adults will always be enrolled into the High Risk Alternative Benefit Plan:

- Individuals who are institutionalized,
- SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility,
- Enrolled in a home and community-based services program,
- Participating in Pennsylvania's PACE program, LIFE,
- Individuals who are dually eligible for Medicare and Medicaid, or
- Pregnant women.

4.3. Covered Benefits

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the 1115 Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.

Table 2. Benefit Plan Comparison

Services	State Plan (Baseline) Low Risk	Alternative Benefit Plan High Risk
	Proposed	Proposed
Category 1: Ambulatory Services		
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of 5 days in a 60-day certification period.	The only key limitation is related to respite care, which may not exceed a total of 5 days in a 60-day certification period.
Primary Care Physician Visits*	A combined (*) maximum of 12 visits per year	A combined (*) maximum of 18 visits per year.
Routine Adult Physical Exams/Immunizations*		
Specialists Office Visits*		
Certified Registered Nurse Practitioner*		
Federally Qualified Health Center/Rural Health Clinic*		
Outpatient Clinic/Independent Clinic*		
Hearing Screening*		
Radiology (X-Rays)	$500 per year	$750 per year
Dentists	Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. Key Limitations: Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception	Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. Key Limitations: Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception
Outpatient Surgery	2 visits per year	4 visits per year

Services	State Plan (Baseline) Low Risk	Alternative Benefit Plan High Risk
	Proposed	Proposed
Category 2: Emergency Services		
Emergency Room	No limits	No limits
Ambulance	No limits	No limits
Category 3: Hospitalization		
Inpatient Acute Hospital	2 non-emergency admits per year	3 non-emergency admits per year
Inpatient Rehab Hospital	1 admit per year	2 admits per year
Inpatient Psychiatric Hospital	30 days per year	45 days per year
Inpatient Drug & Alcohol	30 days per year	45 days per year
Category 4: Maternity and Newborn		
Maternity – Physician, CNM, Birth Centers	No limits	No limits
Category 5: Mental Health and Substance Abuse (Behavioral Health)		
Outpatient Mental Health Treatment (Clinic)	30 visits per year	40 visits per year
Outpatient Drug and Alcohol Treatment	30 visits per year	40 visits per year
Methadone Maintenance	7 visits per week	7 visits per week
Clozapine	Limited to persons with Schizophrenia	Limited to persons with Schizophrenia
Psychiatric Partial Hospital	540 hours per year	540 hours per year
CSS – Peer Support	4 hours per day/900 hours per year	4 hours per day/900 hours per year
Targeted Case Management – Behavioral Health Only	**NOT COVERED**	Limited to persons with SMI diagnoses
Category 6: Prescription Drugs		
Prescription Drugs	6 per month	6 per month
Category 7: Rehabilitation and Habilitation Services and Devices		
Skilled Nursing Facility	120 days per year	365 days per year

Services	State Plan (Baseline) Low Risk	Alternative Benefit Plan High Risk
	Proposed	**Proposed**
Home Health Care	60 visits per year	Unlimited visits for 1st 28 days, Limited to 15 days per month thereafter
ICF/ID and ICF/ORC	**NOT COVERED**	365 days per year
Durable Medical Equipment	$1,000 per year (Combined with Supplies)	$2,500 per year (Combined with Supplies)
Medical Supplies	$1,000 per year (Combined with DME)	$2,500 per year (Combined with DME)
Category 8: Laboratory Services		
Laboratory	$250 per year	$350 per year
Category 9: Preventive/Wellness Services and Chronic Care		
Tobacco Cessation	70 per year	70 per year

The Department will grant exceptions to the limits specified above when it determines that one of the following criteria applies:

- The recipient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of or result in the serious deterioration of the health of the recipient.
- Granting the exception is a cost-effective alternative for the MA Program.
- Granting the exception is necessary in order to comply with Federal law.

4.4. Health Screening

An integral part of the 1115 Demonstration is simplifying the outdated, complex existing benefit designs to two risk-tiered benefit plans for adults. The two Medicaid benefit plans, the Low Risk Benefit Plan and the High Risk Alternative Benefit Plan, will be offered through managed care plans delivered through the HealthChoices Program. For some limited populations, such as the dual eligible population, the physical health benefits will be delivered through the Department's fee for service program. The 1115

Demonstration population enrolled in the *Healthy Pennsylvania* Private Coverage Option will have access to private coverage plans.

Enrollment in the Medicaid benefit plans is based on a health screening of the individual. The health screening will be completed as part of an online application process in the Commonwealth's COMPASS system. Health screening will be part of a seamless continuation of the eligibility process. Paper questionnaires will be available in cases where electronic application submittal is not possible. Call Centers may be used to facilitate the health screening process.

The health screening tool will consist of a self-administered questionnaire that is completed by the individual, family member or guardian. The questionnaire includes questions about an individual's health care needs and conditions. The questions are specifically designed to identify an individual's medical and behavioral health needs that align with the two Medicaid benefit plans—particularly any presence of complex medical conditions. The responses will be analyzed by an algorithmic process, which will allow the Department to match the applicant's health care needs to the benefit plan that best serves those needs.

Participants will be enrolled in the Low Risk Benefit Plan or the High Risk Alternative Benefit Plan based on the results of the health screening tool and eligibility status. For individuals eligible for the *Healthy Pennsylvania* Private Coverage Option, the health screening tool will be used to determine if they are medically frail.

The goal of this health screening is to promote use of necessary services and appropriate levels of care, while still maintaining continued coverage and a safety net for the Commonwealth's vulnerable populations. The health screening tool aligns benefits to actual participant health care needs rather than using a system that bases benefit decisions on broad categories of eligibility. It also ensures provision of critical care to Pennsylvanians most in need, while still increasing the financial stability of the Medicaid program.

Completion of the health screening tool is not a condition of eligibility. If newly eligible applicants fail to complete the health screening tool, they will be enrolled into a *Healthy Pennsylvania* Private Coverage Option plan. If individuals who are eligible under the current Medicaid eligibility rules fail to complete the health screening tool, they will be enrolled into the Low Risk Benefit Plan.

The health screening tool is meant to be prospective at the time of initial eligibility. Most adult participants will be screened at initial application and at their annual redetermination.

All requirements set forth in Section 1937 of the Social Security Act will be met in this 1115 Demonstration, including, but not limited to, ensuring that all individuals determined to be medically frail, as well as individuals in other Alternative Benefit Plan-exempt populations identified in Section 1937 of the Social Security Act, will be given the option to receive services through the Medicaid State Plan low risk benefit plan. SSI and deemed SSI individuals do not need to be screened for the High Risk ABP, because they are deemed by their category to be High Risk. As such they are enrolled into the High Risk Alternative Benefit Plan.

Once an individual is determined to be eligible for Medicaid and their health screening results are determined, they will receive a notice indicating whether they qualify for the Low Risk Benefit Plan, the High Risk Alternative Benefit Plan, or the *Healthy Pennsylvania* Private Coverage Option. (Refer to Appendix 2, Enrollment Flow Chart)

4.5. MEDICALLY FRAIL

Under the *Healthy Pennsylvania* Private Coverage Option, newly eligible individuals who are determined to be medically frail will have the option to receive premium assistance to enroll in a private coverage plan or to be enrolled in the High Risk Alternative Benefit Plan within the Medicaid program.

Individuals will be determined to be medically frail if they have a condition based upon one or more of the following:

- A disabling mental disorder.
- An active chronic substance abuse disorder.
- A serious and complex medical condition.
- A physical, intellectual, or developmental disability that significantly impairs their functioning.
- A determination of disability based on Social Security Administration criteria.

Appendix 3 contains more detailed criteria that will be utilized in the determination of who meets the definition of medically frail.

Medically frail adults who do not otherwise meet exemption criteria are subject to premium and work search activities as described in *Section 3.2 Eligibility Standards and Methodology* and in *Section 4.9 Cost Sharing*.

4.6. Appeals

For appeals relating to determinations of eligibility decisions and plan placement, Healthy Pennsylvania Private Coverage Option participants must use the Department's appeal process. For appeals relating to coverage determinations and provider access decisions, Healthy Pennsylvania Private Coverage Option participants must go through their private coverage plans appeals process. Private coverage plans must comply with all Affordable Care Act and Commonwealth standards governing review of insurance coverage appeals. Unless and until the Commonwealth is determined by the federal Department of Health and Human Services (HHS) to have a satisfactory external appeal process, appeals of adverse benefit determinations will be processed as outlined in the July 29, 2011 letter from HHS to Commissioner Consedine and the joint notice of the Pennsylvania Insurance Department and Department of Health, Notice 11/2254, 41 Pa. B. 7041 (12/31/11). Both of these documents may be accessed at http://www.portal.state.pa.us/portal/server.pt/community/health_insurance/9189/federal_health_reform_-_2011_key_dates/1070488 . Insofar as any plan is subject to the standards in Act 1998-68, the requirements of that act are found in Appendix 4.

4.7. Long Term Services and Supports Coverage

6) Indicate whether Long Term Services and Supports will be provided.

___ Yes (if yes, please check the services that are being offered) _X_ No

Pennsylvania is not currently requesting to include long term services and supports or personal care under the 1115 Demonstration. Pennsylvania will continue to provide long term services and supports, including the LIFE program (Pennsylvania's PACE program) under the existing approved §1915(c) or §1934 authorities.

The *Healthy Pennsylvania* initiative is built on three core objectives – reform Medicaid, increase access, and stabilize funding. As part of meeting these objectives, Pennsylvania is looking to improve its current long-term care system, which is fragmented and not easy for older adults and individuals with physical disabilities to navigate. Pennsylvania will convene a committee to review and make recommendations to improve the current system in alignment with the 1115 Demonstration's core objectives. Pennsylvania will revise the 1115 Demonstration program to address any necessary changes through a future amendment.

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf

- ☐ **Homemaker**
- ☐ **Case Management**
- ☐ **Adult Day Health Services**
- ☐ **Habilitation – Supported Employment**
- ☐ **Habilitation – Day Habilitation**
- ☐ **Habilitation – Other Habilitative**
- ☐ **Respite**
- ☐ **Psychosocial Rehabilitation**
- ☐ **Environmental Modifications (Home Accessibility Adaptations)**
- ☐ **Non-Medical Transportation**
- ☐ **Home Delivered Meals Personal**
- ☐ **Emergency Response**
- ☐ **Community Transition Services**
- ☐ **Day Supports (non-habilitative)**
- ☐ **Supported Living Arrangements**
- ☐ **Assisted Living**
- ☐ **Home Health Aide**
- ☐ **Personal Care Services**
- ☐ **Habilitation – Residential Habilitation**
- ☐ **Habilitation – Pre-Vocational**
- ☐ **Habilitation – Education (non-IDEA Services)**
- ☐ **Day Treatment (mental health service)**

- ☐ **Clinic Services**
- ☐ **Vehicle Modifications**
- ☐ **Special Medical Equipment (minor assistive devices)**
- ☐ **Assistive Technology**
- ☐ **Nursing Services**
- ☐ **Adult Foster Care**
- ☐ **Supported Employment**
- ☐ **Private Duty Nursing**
- ☐ **Adult Companion Services**
- ☐ **Supports for Consumer Direction/Participant Directed Goods and Services**
- ☐ **Other (please describe)**

4.8. Premium Assistance for Employer-Sponsored Coverage

7) Indicate whether premium assistance for employer-sponsored coverage will be available through the 1115 Demonstration.

_X_ Yes (if yes, please address the questions below)
__ No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

Pennsylvania currently operates a successful premium assistance program, the Health Insurance Premium Payment (HIPP) program. It is operated under section 1906 of the Social Security Act. The Commonwealth is seeking to modify its current program for the newly eligible population, minus Medicaid wraparound coverage.

b) Include the minimum employer contribution amount.

There is no minimum employer contribution.

c) Describe whether the Demonstration will provide wrap-around benefits and cost- sharing.

Under the 1115 Demonstration for newly eligible individuals, Pennsylvania will not provide wraparound benefits, including Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services beyond what is provided by the commercial insurers or Qualified Health Plans (QHP).

Healthy Pennsylvania Private Coverage Option will cover the cost sharing for in-network services. In-network services are those obtained from providers who have a contract with the commercial market plans or QHPs. Providers without a contract with a commercial market plan or QHP are considered out-of-network.

In accordance with federal and state law, commercial market plans and QHPs must cover emergency services and out-of-network care when Act 1998-68 access standards are not met. Some commercial market plans and QHPs may cover additional out-of-network services. In these instances, *Healthy Pennsylvania* Private Coverage Option will not cover cost sharing for other services provided by out-of-network providers.

d) Indicate how the cost-effectiveness test will be met.

For each selected individual, the following calculation will be completed:

1. Identify group recipients according to age (in years):
   - Under age 1 year,
   - Age 1 through 20 years, and
   - Age 21 through 64 years.

2. Retrieve the plan rates for *Healthy Pennsylvania* Private Coverage Option comparison or the physical and behavioral health MCO rates for the medically frail
3. Validate the Medicaid costs via the plan respectively for the individual
4. Adjust rates, if applicable, based upon age group
5. Calculate Annual Premium amount by multiplying the premium amount by a factor based on premium frequency
6. Calculate Policy Deductible and co-payment amount

7. Validate the final calculation (for newly eligible)
    - Total commercial market plan or QHP Cost is equal to commercial market plan or QHP Costs for selected recipient plus deductible and co-payment amounts[7]
    - Total ESI Cost is equal to the ESI Annual Premium, the Policy Deductible and the Supplemental Cost
    - Annual Cost Effectiveness Amount is equal to the Total commercial market plan or QHP Cost minus the Total ESI Cost

4.9. Cost Sharing

All existing co-payments will be removed from the current State plan. The only co-payment that will be implemented under the waiver is a $10 co-payment for non-emergent use of the emergency room in accordance with the Act 1998-68 emergency definition, see Appendix 4.

Healthy Pennsylvania Private Coverage Option will cover the cost sharing for in-network services. In-network services are those obtained from providers who have a contract with the QHP. Providers without a contract with a QHP are considered out-of-network.

In accordance with federal and state law, QHPs must cover emergency services and out-of-network care when Act 1998-68 access standards are not met. Some QHPs may cover additional out-of-network services. In these instances, *Healthy Pennsylvania* Private Coverage Option will not cover cost sharing for other services provided by out-of-network providers.

A nominal monthly premium will be required of all non-exempt Medicaid eligible adults over 50% of the federal poverty level and *Healthy Pennsylvania* Private Coverage Option participants.

[7] Note. For medically frail, the calculation would be similar using the existing HIPP cost effectiveness tests against the MCO costs less wraparound services

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

Pennsylvania will implement a cost sharing structure for Medicaid adults, 21 through 64 years of age, which encourages healthy behaviors and emphasizes personal responsibility. With the exception of a $10 copayment for non-emergent use of the emergency room (ER), all copayments for services provided by contracted providers will be eliminated from the program.

The primary cost sharing requirement will be a monthly premium. The premium cost structure is based on the commercial practice of pricing premiums based on a one-person, two-person, or family amount. Since no premiums will be assessed to children under age 21, there will be only two rates: one for a single adult, and another for a household of two or more adults. A sliding premium amount based on annual household income will be used.

Premium changes based upon fluctuations in income or household composition will be adjusted at the annual redetermination, except if income decreases below 50% FPL or increases above the eligibility income limit.

The premiums are structured in an upwards sliding scale of no more than $25 (one adult) or $35 (household with more than one adult) at the maximum threshold of 133% FPL as follows:

Table 3. *Healthy Pennsylvania* Premiums

Federal Poverty Level	One Adult			Household with More Than One Adult		
	Annual Income Excluding MAGI Disregard		Monthly Premium	Annual Income Excluding MAGI Disregard		Monthly Premium
	from	to		from	to	
0–50%	$ -	$ 5,745.00	$ -	$ -	$ 7,755.00	$ -
>50%–100%	$ 5,745.01	$11,490.00	$ 13	$ 7,755.01	$ 15,510.00	$ 17
>100%–133%	$ 11,490.01	Maximum	$ 25	$15,510.01	Maximum	$ 35

These FPL figures are for calendar year 2013. The FPL is adjusted annually; therefore, the eligibility income levels will be updated each year for that year's applicable FPL, with

annual incomes determined using the Modified Adjusted Gross Income (MAGI) methodology. The premiums will be adjusted annually by the inflationary increase in the medical care component of the Consumer Price Index (CPI-U).

As explained in *Section 3.2: Standards and Methodologies* this 1115 Demonstration looks to incentivize healthy behaviors, including providing an opportunity for individuals who engage in healthy behaviors and work, by offering the opportunity to reduce the monthly premium.

4.10. Participant Copayments and Deductibles

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

All adults, who are at least 21 years old and enrolled in the Low Risk Benefit Plan or High Risk Alternative Benefit Plan or the *Healthy Pennsylvania* Private Coverage Option, and whose income is greater than 50% FPL will pay a monthly premium, unless they meet one of the specified exemptions as described in *Section 4.11: Participant Exemptions*.

All adults, who are at least age 21, will be responsible for a $10 copayment for non-emergent use of an emergency room, except as described in *Section 4.11: Participant Exemptions*.

Table 4. *Healthy Pennsylvania* Copayments

Service	Copayment
Non-emergent Use of Emergency Room	**$10 per visit**

4.11. Participant Exemptions

10) Indicate if there are any exemptions from the proposed cost sharing.

All Medicaid recipients under the age of 21 and those residing in an institution are exempt from the $10 copayment for non-emergent use of the emergency room.

The following individuals are exempt from paying the premium:

- Individuals with household income that does not exceed 50% FPL,
- Pregnant women,
- Individuals 65 years of age and older,
- Individuals under 21 years of age,
- SSI recipients and individuals deemed SSI eligible for purposes of Medicaid eligibility,
- Individuals who are dually eligible for Medicare and Medicaid, and
- Individuals who are institutionalized.

5. Delivery System and Payment Rates for Services

5.1. Delivery System Reforms

1) **Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:**

   _X_ Yes

   ___ No

2) **Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.**

   The delivery system reforms that will occur as a result of the 1115 Demonstration will improve access, ensure quality, and create increased affordability in Pennsylvania's health care system.

   In terms of access, the *Healthy Pennsylvania* Private Coverage Option program will increase health care coverage access to uninsured adult Pennsylvanians with incomes up to 133% FPL by using premium assistance to purchase a private coverage plan offered in the FFM, the commercial market or through ESI. Purchase of private insurance will allow *Healthy Pennsylvania* Private Coverage option participants to maintain their same health plan and providers as their income fluctuates, promoting continuity of coverage, and reducing churn between Medicaid and private insurance coverage.

   The 1115 Demonstration will also improve *Healthy Pennsylvania* Private Coverage Option participants' access to care by expanding the number of in-network providers. Because reimbursement rates in Medicaid have been historically lower than Medicare or commercial rates, many providers in Pennsylvania accept only limited numbers of Medicaid patients. Other providers cross subsidize their Medicaid patients by charging more to their privately insured patients. Under the 1115 Demonstration, the *Healthy Pennsylvania* Private Coverage Option participants will have access to the full provider

networks of their selected health plan, which include many providers who do not currently participate in Medicaid. As such, the 1115 Demonstration will seek to stabilize provider payments across payers, expand provider access, and reduce the need for providers to cross-subsidize.

In terms of quality, the *Healthy Pennsylvania* Private Coverage Option participants will be enrolled in private plans, which are held to federally and state required quality, benefit, and network standards. This ensures 1115 Demonstration participants will have access to quality care and robust provider networks. In addition, by adding over a half a million individuals to carriers' enrollment rosters, the 1115 Demonstration dramatically expands the number of patients that have access to primary care providers. Coupled with incentives to improve personal responsibility, this will improve health status and patient satisfaction, increase the use of preventive and appropriate care, and reduce uncompensated care costs.

The 1115 Demonstration is expected to encourage carrier entry, expanded service areas, and competitive pricing in the private market. This in turn enables the private health plans to better leverage economies of scale to drive down premium pricing, which increases value in the health care system for all Pennsylvanians.

Taken together, the factors described above will improve quality, promote access, and reduce costs statewide. As a result, all Pennsylvanians will benefit from improved quality and reduced costs.

Information on which populations and geographic areas will be affected by the reforms is detailed in the sections below.

5.2. Delivery System Type

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☐ **Managed care**
- ☐ **Managed Care Organization (MCO)**
- ☐ **Prepaid Inpatient Health Plans (PIHP)**
- ☐ **Prepaid Ambulatory Health Plans (PAHP)**

☐ **Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)**

☐ **Health Homes**
☒ **Other (please describe)**

For *Healthy Pennsylvania* Private Coverage Option participants, the Commonwealth will use premium assistance to purchase a private coverage plan offered in the FFM, the commercial market, or through ESI. As explained in earlier sections, this approach will help reduce churn, improve access to providers, improve health outcomes, and stabilize financing for Pennsylvania taxpayers.

Each *Healthy Pennsylvania* Private Coverage Option participant will choose between at least two health plans offered in the private market or, if available, receive coverage from an ESI plan. Pennsylvania's existing commercial market and private coverage plans through the FFM together provide a broad variety of private market delivery system options and robust benefit packages. This approach is consistent with *Healthy Pennsylvania's* goal of using the Private Coverage Option to help reduce churn and increase continuity of care. *Healthy Pennsylvania* Private Coverage Option participants will have cost sharing obligations consistent with the reformed cost-sharing approach proposed in this 1115 Demonstration (see *Section 4.9 – Cost Sharing*).

While not part of the waiver request, Pennsylvania will concurrently operate its HealthChoices program that uses an innovative and market driven managed care delivery system. The HealthChoices benefit offering will be modified as described in *Section 4.3: Covered Benefits*, but there are no plans to modify the delivery system as part of this project. Certain populations will also continue to be served through the traditional fee-for-service (FFS) delivery.

4) **If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:**

Table 5. Delivery System Chart

Eligibility Group	Delivery System	Authority
New adults, who are not parents or caretaker relatives, 21 through 64 years of age, who are not medically frail with income up to 133% FPL.	*Healthy Pennsylvania* Private Coverage Option through (a) Qualified Health Plans (QHPs) in the Individual Market in Federal Facilitated Marketplace (FFM), (b) commercial market, or (c) private health plans in ESI	s. 1115 Waiver
New adults, who are parents or caretaker relatives, 21 through 64 years of age, who are not medically frail, who have income greater than 33% FPL, but no greater than 133% FPL.		
Adults, who are parents or caretaker relatives, individuals 21 through 64 years of age, who are qualified as medically frail or are currently covered by the current Pennsylvania Medicaid program (excluding MAWD, Select Plan, and GA)	HealthChoices Physical and Behavioral Health Managed Care (MCO)	s. 1915(b)
Children, ages 19 and 20, who are newly eligible with incomes greater than 44% FPL but no greater than 133% FPL		

5.3. Managed Care Delivery System

5) If the Demonstration will utilize a managed care delivery system:

The 1115 Demonstration uses premium assistance to purchase private health insurance coverage from (a) private coverage plans through the FFM, (b) other private plans in the commercial market, or (c) ESI. The delivery systems, including robust provider

networks, serving *Healthy Pennsylvania* Private Coverage Option participants will therefore be the same serving these plans' other members.

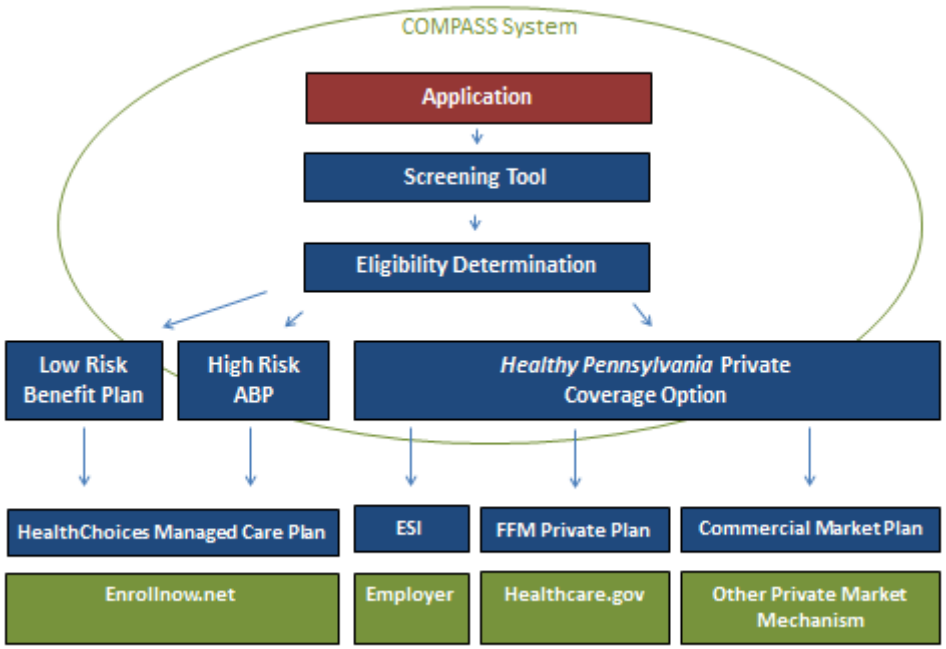
Medicaid managed care plans and pre-paid inpatient health plans will continue to be used to provide physical health and behavioral health services for the HealthChoices populations under the mandatory managed care authority provided through the current HealthChoices Section 1915(b) waiver. Although Medicaid managed care regulations do not apply to the proposed premium assistance model, responses are offered to the questions below to provide additional detail and context for the proposal and how it intersects with the Commonwealth's existing Medicaid managed care programs.

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

Enrollment into the *Healthy Pennsylvania* Private Coverage Options will be mandatory for individuals eligible for the *Healthy Pennsylvania* Private Coverage Option, except for those who are determined to be medically frail and other exempt groups. Medically frail new adults will have the option of either the *Healthy Pennsylvania* Private Coverage Option, the High Risk Alternative Benefit Plan or the Low Risk Benefit Plan (they will be enrolled in the High Risk Benefit Plan with the ability to choose to instead receive services through the Low Risk Benefit Plan). Both of these benefit plans will be delivered through the Commonwealth's HealthChoices Program.

If eligible for the *Healthy Pennsylvania* Private Coverage Option, the individual will move on to shopping and enrollment for a private coverage plan. The enrollment may be through (a) the FFM's eligibility and enrollment system, (b) other private market enrollment mechanism, or (c) purchase ESI. Beneficiaries will be informed of their private coverage plan choices and instructed on how to select their private coverage plan. Pennsylvania will also remind participants of their choices via their renewal notice and provide them the opportunity to change their private coverage plan at re-enrollment.

Figure 2. Benefit Plan Enrollment Process



b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

The 1115 Demonstration will be statewide.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

There will not be a phased-in rollout. It is proposed that the 1115 Demonstration will begin statewide on January 1, 2015.

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

The *Healthy Pennsylvania* Private Coverage Option participants will be able to choose from at least two health plans offered in the private market or, if

available, from ESI offered by the participant's employer. *Healthy Pennsylvania* Private Coverage Option participants without access to ESI will be permitted to choose among all private plans offered in their geographic area, assuring the choice of at least two commercial health plans.

All private health plans must meet Act 68 network adequacy and access to care standards (see Appendix 4). In addition, Pennsylvania will rely on the FFM to evaluate network adequacy as part of the federal private coverage plan certification process, which includes assuring compliance with Essential Community Provider network requirements. As a result, *Healthy Pennsylvania* Private Coverage Option participants will have access to the same networks as other Pennsylvanians who purchase coverage in the private insurance market. This complies with the requirement under section 1902(a)(30)(A) of the Social Security Act that Medicaid beneficiaries have access to care comparable to the care of general population in the same geographic area.

Under the *Healthy Pennsylvania* Private Coverage Option, participants will use the private insurance plan's appeals process for all coverage and provider access decisions, consistent with existing federal and state requirements. Pennsylvania's Medicaid appeals process will be used for all eligibility decisions, including decisions related to the payment of required financial contributions. For more information on the appeals process and Act 68, see *Section 4.6 Appeals* and Appendix 4.

HealthChoices managed care plans that provide services to 1115 Demonstration participants will be governed by the same choice, access, and provider network rules and policies established in that program.

e) Describe how the managed care providers will be selected/procured

Private coverage plans offered through the FFM will be selected through the FFM's regular certification process. As needed to ensure choice and competition, health plans offered through the commercial market that are not already participating in the FFM will be selected through a certification process. As noted above, *Healthy Pennsylvania* Private Coverage Option participants who do not have access to an ESI plan will be able to choose among private plans available in their geographic region.

In future years of the 1115 Demonstration, the Commonwealth will review carrier competition and premiums and may develop more selective criteria for private market plan participation for the *Healthy Pennsylvania* Private Coverage Option to ensure both participant choice and cost-effective purchasing that meets the terms and conditions of this waiver.

HealthChoices managed care plans that provide services to 1115 Demonstration participants will be governed by the same selection and procurement policies and rules established in that program.

Agreements with Healthy Pennsylvania Private Coverage Option Health Plans

To facilitate the administration of the *Healthy Pennsylvania* Private Coverage Option and the provision of health care services by the private plans the Department will contract with: (a) the FFM and private coverage plans offered through the FFM, (b) other commercial market plans, or (c) employers covering participants enrolled through ESI. The following describes each of these agreements:

Private Coverage Plans in the FFM:

- CMS, in its capacity as the operator of the FFM in Pennsylvania, will exercise its authority at 42 USC § 18021(a)(1)(C)(iv) to establish an additional requirement for private coverage plans by requiring all Pennsylvania private coverage plans participating in the FFM to execute the necessary agreement with the Department.
- FFM/CMS and the Department will agree on the language outlining the standards, responsibilities, and requirements of each party within 60 days following waiver approval.
- The agreement between the Department and each private coverage plan will address, for example:
    - Enrollment and disenrollment of individuals in populations covered by the 1115 Demonstration;
    - Payment of premium assistance for premiums and cost-sharing reductions;
    - Collection of participants' share of premiums;

- Data and reporting requirements necessary for federal claiming;
- Data and reporting requirements necessary to monitor and evaluate the *Healthy Pennsylvania* Private Coverage Option;
- Handling of enrollee rights, grievances, and appeals;
- Program integrity and auditing requirements; and
- Coordination with the Department and other requirements to facilitate the *Healthy Pennsylvania* Private Coverage Option.

Commercial Market Plans:

- After selecting commercial market plans through the certification process, the Department will execute an agreement with each commercial insurer.
- The agreement between the Department and each commercial insurer will address, for example:
  - Enrollment and disenrollment of individuals in populations covered by the 1115 Demonstration;
  - Payment of premium assistance for premiums and cost-sharing reductions;
  - Collection of participants' share of premiums;
  - Data and reporting requirements necessary for federal claiming;
  - Data and reporting requirements necessary to monitor and evaluate the *Healthy Pennsylvania* Private Coverage Option;
  - Handling of enrollee rights, grievances, and appeals;
  - Program integrity and auditing requirements; and
  - Coordination with the Department and other requirements to facilitate the *Healthy Pennsylvania* Private Coverage Option.

Employer-Sponsored Insurance:

- The Department will execute agreements with employers covering ESI participants. The agreement between the Department and each employer will address, for example:
  - Enrollment and disenrollment of employees covered by the 1115 Demonstration;
  - Payment of premium assistance for premiums and cost-sharing reductions; and

- Other provisions relevant to operation and monitoring of the ESI.

Healthy Pennsylvania Private Coverage Option Selection and Payment
The Department will determine individuals' eligibility for premium assistance under the *Healthy Pennsylvania* Private Coverage Option and notify the FFM, commercial market plan, or employer covering an ESI participant. The Department will handle annual re-determinations. FFM applicants will be pre-screened for *Healthy Pennsylvania* Private Coverage Option eligibility in the same way as potential Medicaid/CHIP eligible and referred to the Department for eligibility determination.

Eligible adults will go directly to the FFM website, commercial market, or employer for ESI participants to shop for health coverage using their approved premium assistance amount. To be enrolled in a *Healthy Pennsylvania* Private Coverage Option and become eligible for premium assistance, an affirmative choice of a private coverage plan must be made.

For individuals who select a private coverage plan through the FFM, commercial market, or ESI plan between the first and fifteenth day of a month, private market coverage will become effective as of the first day of the month following plan selection. For individuals who select a plan between the sixteenth and last day of a month, coverage will become effective no later than the first day of the second month following plan selection. These rules are consistent with the current mandatory managed care and coverage rules and the process used by the FFM.

5.4. Services Outside the Proposed Delivery System

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

Wrap-Around Benefits
Medicaid wraparound benefits will not be provided for individuals receiving premium assistance to purchase coverage under the Healthy *Pennsylvania* Private Coverage Option. The Department has requested waivers for all wraparound services, including non-emergency transportation and family planning services (to the extent such services are not covered under the private plan). Due to the federal EHB requirement, it is

assumed that all other benefits potentially subject to wrap around services are provided sufficiently through *Healthy Pennsylvania* Private Coverage Option plans.

Medically frail new adults will be enrolled into the High Risk Alternative Benefit Plan. Individuals who are 19 or 20 years of age will be able to obtain coverage in the current children's plan and will receive all medically necessary services in accordance with the Medicaid Early and Periodic, Screening, Diagnosis and Treatment provisions, even though they are included in the 1115 Demonstration.

Retroactive Coverage

Pennsylvania will not provide retroactive coverage for the *Healthy Pennsylvania* Private Coverage Option. Effective coverage will be determined by the enrollment date in the private plan.

Out-of-Network Services

Healthy Pennsylvania Private Coverage Option will cover the cost sharing for in-network services. In-network services are those obtained from providers who have a contract with a private coverage plan. Providers without a contract with a private coverage plan are considered out-of-network.

Similar to the current HealthChoices program, private coverage plans must cover emergency services and services provided by out-of-network providers when required under 31 Pa. Code §§ 154.14 and 154.15 (relating to emergency services and continuity of care). Some private coverage plans may cover additional out-of-network services. In these instances, *Healthy Pennsylvania* Private Coverage Option will not cover cost sharing for other services provided by out-of-network providers. All out-of-network deductibles, co-payments, coinsurance, penalties, and the difference between the out-of-network provider's charge and the amount paid by the private plan will be the individual's responsibility.

5.5. Provision for LongTerm Services and Supports

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in

the Demonstration and any financial management services that will be provided under the Demonstration

___ Yes
_X_ No

Pennsylvania is not currently requesting to include long-term services and supports or personal care under the 1115 Demonstration.

The *Healthy Pennsylvania* initiative is built on three core objectives – reform Medicaid, increase access, and stabilize funding. As part of meeting these objectives, the Department is looking to improve its current long-term care system, which is fragmented and not easy for older adults and individuals with physical disabilities to navigate. The Department will convene a committee to review and make recommendations to improve the current system in alignment with the 1115 Demonstration's core objectives. The Department will revise the 1115 Demonstration program to address any necessary changes through a future amendment.

5.6. Fee-For-Service

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

Providers will be reimbursed for covered services provided to *Healthy Pennsylvania* Private Coverage Option participants at the rates providers negotiate with the respective private coverage plan. Any payment for an enrollee under the Medicaid program will be made in accordance with Pennsylvania's approved State plan.

5.7. Capitation Payments

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

The rate setting methodology for private coverage plans serving *Healthy Pennsylvania* Private Coverage Option participants in the 1115 Demonstration will be the same used for other populations served in the commercial market. Private coverage plans serving *Healthy Pennsylvania* Private Coverage Option participants in the 1115 Demonstration will be paid premium assistance for the private coverage plan in an amount equal to the premium and cost sharing components combined of the private coverage plan's Essential Health Benefit (EHB) package, less the amount of the participant's own monthly premium.

This amount (prior to deduction of the amount of the participant's own monthly premium) shall be equal to the actuarial value of the EHB package, inclusive of premium and cost sharing components.

Payment to employers for ESI will be made in accordance with the existing ESI program, which is based on the employer's commercial insurance cost, included benefits, and deductible amounts.

Any impact to cost sharing or benefits for HealthChoices participants will be addressed via modification to HealthChoices capitation rates. The Department will continue to use its existing HealthChoices rate setting process.

5.8. Quality-Based Supplemental Payments

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

The Commonwealth will bring together all relevant stakeholders including consumers, physical and behavioral health care providers, commercial insurers, business leaders, and other stakeholders to design new payment and delivery models for health care services in Pennsylvania. By focusing on the quality of care provided rather than how much is provided, Pennsylvania can become a patient-centered, evidence-based care delivery system that improves patient outcomes. This will empower consumers, employers, and insurers to purchase health care coverage based on value and quality in order to improve the health of Pennsylvanians and control the escalating costs of health care.

As stated, Pennsylvania recognizes the need to continually improve quality within our health care delivery system. The Commonwealth will use the federal State Innovation Model (SIM) Design grant as an additional opportunity to plan and build upon current private and public sector payer and provider initiatives to advance new care delivery models and payment methodologies.

SIM is focused on the following three priorities:

- Testing new payment and service delivery models,
- Evaluating results and advancing best practices, and
- Engaging a broad range of stakeholders to develop additional models for testing.

Recognizing that health care will continue to evolve, the Department will seek to promote an environment that permits the development of innovative insurance coverage and shared savings that reward wellness and healthy behaviors. This direction continues to reinforce Governor Corbett's *Healthy Pennsylvania* plan of increasing access to quality, affordable health care for all Pennsylvanians.

6. Implementation of Demonstration

6.1. Implementation Schedule

1) **Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.**

Contingent on federal approval, applications for the *Healthy Pennsylvania* Private Coverage Option will begin on October 1, 2014 for enrollment in a private coverage plan effective January 1, 2015.

6.2. Enrollment

2) **Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.**

Notices

Upon determination of eligibility for Medicaid or the *Healthy Pennsylvania* Private Coverage Option, participants will receive a notice from Pennsylvania Medicaid advising them of the following:

- *Premiums and Cost Sharing:* The notice will include a description of the premium requirement and process for those with income over 50% FPL, a description of the $10 copayment for non-emergent use of an emergency room, and a description of financial responsibility for out-of-network services.

- *Healthy Behavior Incentives:* The notice will include a description of the incentives for healthy behaviors that are expected from the participant in order to reduce the monthly premium.

- *Work Search Activity.* The notice will include a description of the ongoing work search activities (See *Section 3.2 Eligibility Standards and Methodology*) that are required to maintain eligibility and further reduce the monthly premium.

- *Appeals.* The notice will also include information regarding the grievance and appeals process. Specifically, the notice will inform *Healthy Pennsylvania* Private

Coverage Option participants that, for all services covered by the private plan or ESI plan, the participant should begin by filing a grievance or appeal pursuant to the private plan's or ESI's grievance and appeals process. This is described in greater detail in *Section 4.6 Appeals*.

For *Healthy Pennsylvania* Private Coverage Option participants, the following additional language will be included:

- *Private Coverage Plan Selection.* The notice will include, among other things, information regarding how *Healthy Pennsylvania* Private Coverage Option participants can select a private coverage plan, including information on the Department's auto-enrollment process in the event that the participant does not select a plan.

- *Exemption from the* Healthy Pennsylvania *Private Coverage Option.* The notice will include information describing how *Healthy Pennsylvania* Private Coverage Option participants who believe they may be exempt from premium assistance provided through the private coverage plan, including pregnant women and the medically frail, can request a determination of whether they are exempt from the High Risk Alternative Benefits Plan/Low Risk Benefit Plan and, if they are exempt, choose between receiving coverage through the standard Medicaid benefit package or the private coverage plan. The notice will include information on the difference in benefits under the Alternative Benefits Plan as compared to the standard (State Plan) benefit package. The exemption process is described in *Section 4.5: Medically Frail*.

For Medicaid Low Risk and High Risk ABP participants, the following additional language will be included:

- *Low Risk Benefit Plan participants only.* The notice will include information regarding their eligibility for the Low Risk Benefit Plan, as well as enrollment information.

- *High Risk Benefit Plan participants only.* The notice will include information regarding their eligibility for the High Risk Alternative Benefits Plan, as well as their option in selecting the Low Risk plan.

Enrollment

Individuals eligible for private coverage plan enrollment through the *Healthy Pennsylvania* Private Coverage Option will begin to enroll during the open enrollment period through the following process:

- Individuals will submit a single application for insurance affordability programs—Medicaid and the *Healthy Pennsylvania* Private Coverage Option— through the web portal, via phone, by mail, or in-person.

- The individual will then complete the participant screening tool.

- An eligibility determination will be made.

- Individuals who are required to pay a premium will be sent invoices as described in *Section 3.2 Eligibility Standards and Methodology*.

- Individuals who have a work search activity will be monitored as described in *Section 3.2 Eligibility Standards and Methodology*.

- Individuals who are determined eligible to receive coverage through the *Healthy Pennsylvania* Private Coverage Option will enter an eligibility/enrollment system to shop among private coverage plans available to *Healthy Pennsylvania* Private Coverage Option eligible individuals and to select a plan.

- The Medicaid Management Information System (MMIS) will capture their plan selection information and will transmit the 834 enrollment transactions to the carriers.

- Carriers will issue insurance cards to *Healthy Pennsylvania* Private Coverage Option participants.

- MMIS will pay premiums on behalf of participants directly to the carriers.

- MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects a different private coverage during the next open enrollment period; or the individual is determined to be more effectively treated through the traditional Medicaid program.

- In the event that an individual is determined eligible for coverage through the *Healthy Pennsylvania* Private Coverage Option, but does not select a plan, the Department will auto-assign the individual to one of the available private coverage plans available in that individual's geographic area.

6.3. Managed Care

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

Pennsylvania Medicaid will enter into an agreement with the plans to outline functions such as, but not limited to, the process for verifying plan enrollment and paying premiums. Under the terms of the agreement, the QHP or private coverage plan will be provided a roster of its enrollees who are *Healthy Pennsylvania* Private Coverage Option participants. The Commonwealth will verify that the individuals listed on the roster are *Healthy Pennsylvania* Private Coverage Option participants. The MMIS will then transmit payment for premiums to the QHP or private coverage plan. See *Section 5.3: Managed Care Delivery System* for more detail.

7. Demonstration Financing and Budget Neutrality

Federal policy requires that section 1115 Demonstration applications be budget neutral to the Federal government. This means that an 1115 Demonstration should not cost the Federal government more than what would have otherwise been spent absent the 1115 Demonstration. Particulars, including methodologies, are subject to negotiation between the Commonwealth and CMS.

The Department is proposing a per capita budget neutrality model for the populations covered under the demonstration, including the *Healthy Pennsylvania* Private Coverage Option participants. Actual waiver expenditures for these populations will be applied against the without waiver budget limit.

8. List of Proposed Waivers and Expenditure Authorities

1) Provide a list of proposed waivers and expenditure authorities.

Federal Waiver and Expenditure Authorities Requested

To the extent necessary to implement the proposal, the 1115 Demonstration application requests that CMS, under the authority of section 1115(a)(1) of the Social Security Act (42 U.S.C.A. § 1315), waive the following requirements of Title XIX of the Social Security Act (42 U.S.C.A. § 1396) to enable the Department to implement the Healthy Pennsylvania plan:

Table 6. Waiver Requests

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(10) (42U.S.C.A. § 1396a(a)(10))	To permit the Commonwealth to deny eligibility for up to nine months to otherwise eligible individuals who fail to engage in required work search.	This waiver authority will allow the Commonwealth to instill a sense of personal responsibility into the program, encourage employment, and provide incentives for healthier behaviors.
§ 1902(a)(10) (42 U.S.C.A. § 1396a(a)(10))	To enable the Commonwealth to deny eligibility for up to 9 months to otherwise eligible individuals who fail to comply with premium payment requirements.	This waiver authority will allow the Commonwealth to instill a sense of personal responsibility into the program and reinforce incentives for healthier behaviors.
§ 1902(a)(10) (42 U.S.C.A. § 1396a(a)(10)(B))	To permit the Commonwealth to provide benefits which are different in amount, duration and scope.	This waiver authority will allow the Commonwealth to design alternate benefit packages that are more aligned with the needs of the individuals who use them across and within eligibility groups. It will also provide the medically frail options that better fit their needs.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(10)(A) (42 U.S.C.A. § 1396a(a)(10)(B))	To enable the Commonwealth to provide coverage for the newly eligible population on the date of enrollment in the *Healthy Pennsylvania* Private Coverage Option.	This waiver authority will allow the Commonwealth to provide eligibility for the newly eligible population effective on the date of enrollment in a Qualified Health Plan.
§ 1902(a)(10) (42 U.S.C.A. § 1396a(a)(10)(B))	To enable the Commonwealth to provide medically needy coverage to institutionalized blind and disabled individuals.	This waiver authority will allow blind or disabled individuals with incomes above 133% FPL to be enrolled in a QHP while still providing institution coverage through Medicaid for those above the State's special income level.
1902(a)(10)(a)(i)(IX)(42 U.S.C.A. § 1396a(a)(10)(A)(i)(IX))	To permit the Commonwealth to charge premiums for non-exempt individuals and to require work search activities eligible for former Foster Care recipients 21 years of age or older but under 26 years of age.	This waiver authority, allows the Commonwealth to require premiums and work search activities of those former Foster Care recipients, 21 years of age or older but under 26 years of age, in order to provide equitable treatment with other adults of the same age.
§ 1902(a)(10)(C) (42 U.S.C.A. § 1396a(a)(10)(C))	To enable the - Commonwealth to eliminate the Medically Needy optional group for adults who are disabled or blind, but retain it for individuals who are 65 years of age and older.	This waiver authority will allow the Commonwealth to eliminate the complexity of the Medically Needy optional coverage group and the income 'spend down' and allow this group to become part of the newly eligible population.
§ 1902(a)(14) (42 U.S.C.A. § 1396a(a)(14)	To permit the Commonwealth to charge ER copayments in amount that exceeds the maximum allowed under regulation, without regard to the requirements of 1916(f).	This waiver authority, in conjunction with other incentives for healthy behaviors, will allow the Commonwealth to improve health outcomes by encouraging the use of primary care settings when appropriate.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(14) (42 U.S.C.A. § 1396a(a)(14))	To permit the Commonwealth to charge premiums to individuals whose family income is below 150%.	This waiver authority will allow the Commonwealth to test the effect of combining positive and negative incentives on healthy behaviors and health outcomes.
§ 1902(a)(14) (42 U.S.C.A. § 1396a(a)(14))	To permit the Commonwealth to require prepayment of a premium.	This waiver authority will allow the Commonwealth to test the premise that payment of premiums aligns with improved patient involvement in care and better health outcomes.
§ 1902(a)(14) (42 U.S.C.A. § 1396a(a)(14))	To permit the Commonwealth to make payments to reduce cost sharing, for certain individuals eligible under the approved state plan new adult group described in section 1902(a)(10)(A)(i)(XVIII).	This waiver authority will allow the Commonwealth to provide individuals enrolled in a private coverage plan cost sharing that is equivalent to that required for those enrolled in MA.
§ 1902(a)(17) (42 U.S.C.A. § 1396a(a)(17))	To permit the Commonwealth to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit the Commonwealth to provide coverage for *Healthy Pennsylvania* Private Coverage Option eligible Medicaid beneficiaries through private coverage plans.	This waiver authority will allow the Commonwealth to test using premium assistance to provide coverage through private coverage plans for a subset of Medicaid beneficiaries.
§ 1902(a)(17) (42 U.S.C.A. § 1396a(a)(17))	To permit the Commonwealth to provide different premium amounts for different populations of Medicaid beneficiaries.	This waiver authority will allow the Commonwealth to charge different levels of premiums to different individuals based on their response to work search and healthy behavior incentives.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(23) (42 U.S.C.A. § 1396a(a)(23))	To make premium assistance for private coverage plans mandatory for *Healthy Pennsylvania* Private Coverage Option participants and to permit the Commonwealth to limit participants' freedom of choice among providers to the providers participating in the network of the private coverage plan.	This waiver authority will allow the Commonwealth to require that *Healthy Pennsylvania* Private Coverage Option eligible beneficiaries receive coverage through ta private coverage plan if they are not medically frail, and not through the State Plan. This waiver authority will also allow the Commonwealth to align the network available to *Healthy Pennsylvania* Private Coverage Option participants with the network offered to other private coverage plan enrollees who are not Medicaid beneficiaries.
§ 1902(k) (42 U.S.C.A. § 1396a(k))	To permit the State to automatically enroll groups other than those described in subclause VIII of 1902(a)(10)(A)(i) into the States benchmark plan, including those otherwise exempt from enrollment into a benchmark plan.	This waiver will allow the State to more efficiently enroll higher need individuals into the benefit plan most likely to meet their needs while still providing these individuals a choice of State plan benefits.
§ 1902(a)(34) (42 U.S.C.A. § 1396a(a)(34))	To enable the Commonwealth to eliminate retroactive coverage for the newly eligible population enrolled in *the Healthy Pennsylvania* Private Coverage Option.	This waiver will allow the Commonwealth to efficiently enroll newly eligible adults in commercial plans, aligning with private market processes.
§ 1902(a)(54) (42 U.S.C.A. § 1396a(a)(54)(A))	To permit the Commonwealth to limit a *Healthy Pennsylvania* Private Coverage Option participant to receiving coverage for drugs on the formulary of the participant's private coverage plan.	This waiver authority will allow the Commonwealth to align the prescription drug benefit for *Healthy Pennsylvania* Private Coverage Option participants with the prescription drug benefit offered to private coverage plan enrollees who are not Medicaid beneficiaries.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(54) (42 U.S.C.A. § 1396a(a)(54)(A))	To permit the Commonwealth to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.	This waiver authority will allow the Commonwealth to align prior authorization standards for *Healthy Pennsylvania* Private Coverage Option participants with standards in the private coverage plans.
§ 1902(a)(10)(A) §1902(k) (42 U.S.C.A. § 1396a(a)(10)(A)) and § 1902(k) (42 U.S.C.A. § 1396a(k))	To permit the Commonwealth not to cover wraparound services in the *Healthy Pennsylvania* Private Coverage Option.	This waiver authority will allow the Commonwealth and private coverage plans to align the benefits offered to non-frail *Healthy Pennsylvania* Private Coverage Option enrollees with enrollees who are not Medicaid beneficiaries.
§1902(a) (42CFR431.53) (42 U.S.C.A. § 1396a and 42 CFR 431.53))	To permit the Commonwealth not to cover non-emergency transportation for the newly eligible enrolled in the *Healthy Pennsylvania* Public Coverage Option.	This waiver authority will allow the Commonwealth to meet its goal of aligning the program and delivery of services for the healthier newly eligible population with common private coverage plan practices.
§1902(a)(10)(A) and §1902(k) (42 U.S.C.A. § 1396a(a)(10)(A)) and § 1902(k) (42 U.S.C.A. § 1396a(k))	To permit the Commonwealth not to provide family planning services to individuals 21 years of age or older but under 65 years of age and who are enrolled in the *Healthy Pennsylvania* Private Coverage Option.	This waiver authority will allow the Commonwealth to meet its goal of aligning the program and delivery of services for the healthier newly eligible population with common private coverage plan practices.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(10)(A) and § 1902(k) (42 U.S.C.A. § 1396a(a)(10)(A)) and § 1902(k) (42 U.S.C.A. § 1396a(k))	To permit the Commonwealth not to cover FQHCs and RHCs in the *Healthy Pennsylvania* Private Coverage Option.	This waiver authority will allow the Commonwealth to provide premium assistance through private coverage plans that do not meet Medicaid specific FQHC/RHC requirements and permit the private coverage plans to maintain control of their negotiated provider panels.
§ 1902(a)(15) and § 1902(bb) (42 U.S.C.A. § 1396a(a)(15)) and § 1902(bb) (42 U.S.C.A. § 1396a(bb))	To permit the Commonwealth to limit reimbursement to FQHCs and RHCs to the amount negotiated with the private coverage plan under the *Healthy Pennsylvania* Private Coverage Option and not pay under the prospective payment system.	This waiver authority will allow the Commonwealth to limit its financial exposure and the private coverage plans to align reimbursement to FQHCs/RHCs for *Healthy Pennsylvania* Private Coverage Option enrollees with the private coverage plan's contracted rates.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Reference Table 6: Waiver Requests above.

9. Public Comment and Stakeholder Input

Section Reserved

This section is reserved for information to be included in the final Demonstration application submitted to the Centers for Medicare and Medicaid Services. Specifically, following completion of the public comment period and consideration of the public comments, this section will be completed. It will include:

- Details of the public comment process, including the Public Notice, public comment period, process for seeking public input, and stakeholder involvement in providing feedback on this proposed application.

- A synopsis of public comments received during the comment period and the Commonwealth's response to the public comments.

For information about opportunities for public comment on this proposed Demonstration, please visit the *Healthy Pennsylvania* website at www.dpw.state.pa.us/healthypa.

10. DEMONSTRATION ADMINISTRATION

Please provide the contact information for the state's point of contact for the Demonstration application.

- **Name and Title:** Leesa Allen, Executive Medicaid Director
- **Email Address:** RA-PWHealthyPA1115@pa.gov

APPENDIX 1: GROUPS SUBJECT TO $10 NON-EMERGENT USE OF EMERGENCY ROOM UNDER *HEALTHY PENNSYLVANIA*

Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
Low income families 1902(a)(10)(A)(ii)(I); 1931; 435.110	Low income parents and caretaker relatives.	33% FPL No asset test
Transitional Medical Assistance 1902(e)(1)(a), 1931(c)(2)	4-month continued medical due to increase in earnings or hours of employment.	N/A No asset test
Extended Medical due to spousal support collections 408(a)(11)(B), 42 CFR 435.115, 1931(c)(1)	Individuals who lose eligibility under 1931 due to spousal support.	N/A No asset test
Pregnant women group - consolidated under 42 CFR 435.116 Qualified and poverty level pregnant women: 1902(a)(10)(A)(i)(III); 1905(n)(1), 1902(a)(10)(A)(i)(IV); 1902(l)(1)(A)(B). 1902(a)(10)(A)(ii)(I); 1902(a)(10)(A)(ii)(IV);1931	• Qualified Low income pregnant women 33% FPL. • Poverty level women with incomes below 133% FPL (mandatory). • Pregnant women with income between 133%-185% FPL (215% MAGI converted).	215% FPL No asset test
Individuals Receiving SSI	Adult with a severe disability.	74% FPL 100% FBR $2,000/$3,000

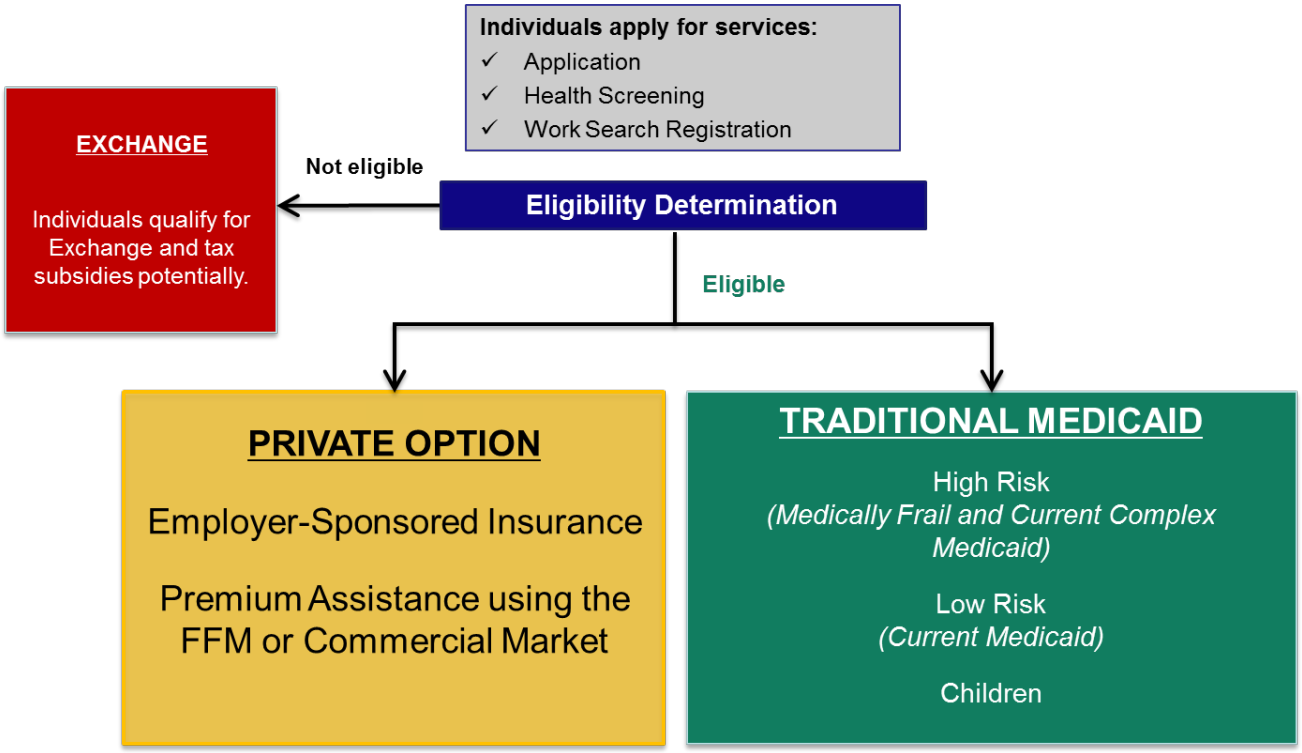
Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
1902(a)(10)(A)(i)(II)(aa) 42 CFR 435.120		
Individuals Receiving Mandatory State Supplement 42 CFR 435.130	Low income seniors or an adult with a severe disability. State increases SSI payment by $22.10.	76% FPL $2,000/$3,000
Individuals Who Are Essential Spouses 42 CFR 435.131 1905(a)	Spouse of aged, blind, disabled individual who was grandfathered into program at time of SSI implementation. Few beneficiaries remaining in program.	74% FPL 100% FBR $2,000/$3,000
Blind or Disabled Individuals Eligible in 1973 42 CFR 435.133	Continuously eligible based on 1973 requirements. Few beneficiaries remaining in program.	Meet 1973 requirements
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972 42 CFR 435.133	Low income seniors or an adult with a severe disability with incomes slightly above 74% FPL. Few beneficiaries remaining in program.	>74% FPL $2,000/$3,000
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Adult with a severe disability. Had been receiving SSI but lost it due to SSA income increases from COLAs.	>74% FPL, but low income

Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
1939(a)(5)(E),42 CFR 435.135, Section 503 of P.L. 94-566		
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI 1634(b),42 CFR 435.137	Adult with a severe disability. Not eligible for SSI because the increased amount of widow's or widower's insurance benefits which resulted from eliminating the additional reduction factor for disabled widows and widowers under age 60.	>74% FPL, but likely low income
Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security 42 CFR 435.138,1634(d)	Disabled widows and widowers who are at least age 60; not entitled to Medicare Part A; and become ineligible for SSI or a State supplement because of mandatory receipt of widow's or widower's social security disability benefits.	>74% FPL $2,000, $3,000
Working Disabled under1619(b) 1902(a)(10)(A)(i)(II)1905 (q),1619(b)	Low income Working adult with a severe disability. Would receive SSI but for earnings.	N/A
Disabled Adult Children 1634(c), 1935	An unmarried disabled adult, age 18 or older, with disability that started before age 22. Receives SSA based on parents benefits.	N/A

Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
Individuals Eligible for Cash except for Child Care Subsidy 1902(a)(10)(A)(ii)(II), 42CFR435.220	Low income caretakers.	>74% FPL, but likely low income
Individuals Receiving Home and Community Based Services under Institutional Rules 42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	Special income level group, with gross income that does not exceed 300% of the SSI income standard; receives LTSS in the community.	222% FPL 300%FBR $2,000 with 6,000 disregard
Individuals Eligible for but not Receiving Cash 42 CFR 435.210, 1902(a)(10)(A)(ii)(I), 1905(a), 1902(v)(1)	Have the same characteristics as an SSI recipient or AFDC (TANF) recipient, but are not receiving payments from the program.	N/A
Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements 1902(a)(10)(A)(ii)(IV) 42 CFR 435.232	Low income seniors or an adult with a severe disability. Receives a $22.10 State supplement.	76% FPL $2000
Poverty Level Aged or Disabled 1902(a)(10)(A)(ii)(X), 1902(M)(1)	Low income senior or an adult with a severe disability.	100% FPL $2000/$3000

Eligibility Group Name **Social Security, CFR Citations**	**Brief Description of Population, if needed**	**Maximum Income Limit Single/couple asset limit**
Individuals at or below 133% FPL, 21 through 64 years of age 1902(a)(10)(A)(i)(VIII), 1902(a)(10)(A)(i) (VIII)	Newly eligible adults GA population (PD, TD)/ childless adults/ parent caretakers >33% FPL.	133% FPL No asset test
Medically Needy Aged 1902(a)(10)(C) 42 CFR 435.320 and 435.330	Individuals age 65 and older who have income above categorical levels and must spend down to the medically needy income limit.	44% FPL $2,400/$3,200
Medically Needy Pregnant Women 1902(a)(10)(C)(ii)(II) 42 CFR 435.301(b)(1)(i) and (iv)	Pregnant woman with income that exceeds 185% FPL (215% FPL MAGI converted) and must spend down to the medically needy income limit.	44% FPL No asset test
Former Foster Care Children 1902(a)(10(A)(i)(IX)	Individuals who were receiving foster care at age 18 and aged out of the foster care program. The co-payment waiver applies only to those in this group who are 21 to 25 years of age.	Not otherwise categorically or income eligible

APPENDIX 2: ENROLLMENT FLOW CHART



APPENDIX 3: CRITERIA FOR MEDICALLY FRAIL

DEFINITION of Medically Frail: includes individuals with disabling mental disorders (including adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their functioning, or individuals with a disability determination based on Social Security criteria.

Pennsylvania has outlined the criteria for who is medically frail or otherwise has special medical needs, as set forth below:

Category	Definition
Individuals with a Disabling Mental Disorder	The individual has a diagnosis of at least one of the following: • psychotic disorder; • schizophrenia; • schizoaffective disorder; • major depression; • bipolar disorder; • delusional disorder • anxiety disorder (obsessive compulsive disorder, post-traumatic stress disorder, or severe panic disorder)
Individuals with chronic substance use disorder	The individual has a chronic substance use disorder: • The individual has a diagnosis of substance use disorder.

Category	Definition
Individuals with serious and complex medical conditions	The individual meets one of the following conditions: • Receiving chemotherapy or radiation therapy for cancer OR • Enrolled in hospice OR • A resident of LTC facility or public/private ICF OR • Has any of the following medical conditions- hemophilia, Gaucher's disease, immune deficiency, HIV, sickle cell, cystic fibrosis or post-transplant of lung, heart, liver, pancreas, or small bowel OR • Is ventilator dependent OR • Has 2 or more inpatient admissions within 12 months AND o has 3 or more ED visits in 6 months AND o has 4 or more prescription medications per month.
Individuals with a physical disability	The individual has a permanent physical disability that significantly impairs their functioning.
Individuals with an intellectual or developmental disability	The individual has an intellectual or developmental disability and therefore exhibits: Intellectual Disability: • Significantly subnormal general intellectual functioning based on standardized testing (IQ). • Significantly subnormal adaptive functioning based on standardized testing. • Occurred in the developmental period before the 22nd birthday. Developmental Disability: • Autism spectrum disorder: The individual is diagnosed with autism and meets the ICF/ORC level of care which is an institutional level of care. The ICF level of care requires functional deficits in addition to the diagnosis.
Individuals with a disability determination	Any individual with a current disability designation by the Social Security Administration

APPENDIX 4: EXCERPTS FROM ACT 1998-68

Section 2101. Scope.—This article governs quality health care accountability and protection.

Section 2102. Definitions. - Words and phrases shall have the meanings given to them in this section:

"Active clinical practice." The practice of clinical medicine by a health care provider for an average of not less than twenty (20) hours per week.

"Ancillary service plans." Any individual or group health insurance plan, subscriber contract or certificate that provides exclusive coverage for dental services or vision services. The term also includes Medicare Supplement Policies subject to section 1882 of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395ss) and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

"Clean claim." A claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

"Complaint." A dispute or objection regarding a participating health care provider or the coverage, operations or management policies of a managed care plan which has not been resolved by the managed care plan and has been filed with the plan or with the Department of Health or the Insurance Department of the Commonwealth. The term does not include a grievance.

"Concurrent utilization review." A review by a utilization review entity of all reasonably necessary supporting information which occurs during an enrollee's hospital stay or course of treatment and results in a decision to approve or deny payment for the health care service.

"Department." The Department of Health of the Commonwealth.

"Drug formulary." A listing of managed care plan preferred therapeutic drugs.

"Emergency service." Any health care service provided to an enrollee after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the enrollee or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

Emergency transportation and related emergency service provided by a licensed ambulance service shall constitute an emergency service.

"Enrollee." Any policyholder, subscriber, covered person or other individual who is entitled to receive health care services under a managed care plan.

"Grievance." As provided in subdivision (i), a request by an enrollee or a health care provider, with the written consent of the enrollee, to have a managed care plan or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

(1) disapproves full or partial payment for a requested health care service;
(2) approves the provision of a requested health care service for a lesser scope or duration than requested; or
(3) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.
(4) The term does not include a complaint.

"Health care provider." A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of this Commonwealth, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

"Health care service." Any covered treatment, admission, procedure, medical supplies and equipment or other services, including behavioral health, prescribed or otherwise provided or proposed to be provided by a health care provider to an enrollee under a managed care plan contract.

"Managed care plan." A health care plan that uses a gatekeeper to manage the utilization of health care services, integrates the financing and delivery of health care services to enrollees by arrangements with health care providers selected to participate on the basis of specific standards and provides financial incentives for enrollees to use the participating health care providers in accordance with procedures established by the plan. A managed care plan includes health care arranged through an entity operating under any of the following:

(1) Section 630.
(2) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."
(3) The act of December 14, 1992 (P.L.835, No.134), known as the "Fraternal Benefit Societies Code."
(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).
(5) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

The term includes an entity, including a municipality, whether licensed or unlicensed, that contracts with or functions as a managed care plan to provide health care services to enrollees. The term does not include ancillary service plans or an indemnity arrangement which is primarily fee for service.

"Plan." A managed care plan.

"Primary care provider." A health care provider who, within the scope of the provider's practice, supervises, coordinates, prescribes or otherwise provides or proposes to provide health care services to an enrollee, initiates enrollee referral for specialist care and maintains continuity of enrollee care.

"Prospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information that occurs prior to the delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

"Provider network." The health care providers designated by a managed care plan to provide health care services.

"Referral." A prior authorization from a managed care plan or a participating health care provider that allows an enrollee to have one or more appointments with a health care provider for a health care service.

"Retrospective utilization review." A review by a utilization review entity of all reasonably necessary supporting information which occurs following delivery or provision of a health care service and results in a decision to approve or deny payment for the health care service.

"Service area." The geographic area for which the managed care plan is licensed or has been issued a certificate of authority.

"Specialist" A health care provider whose practice is not limited to primary health care services and who has additional postgraduate or specialized training, has board certification or practices

in a licensed specialized area of health care. The term includes a health care provider who is not classified by a plan solely as a primary care provider.

"Utilization review." A system of prospective, concurrent or retrospective utilization review performed by a utilization review entity of the medical necessity and appropriateness of health care services prescribed, provided or proposed to be provided to an enrollee. The term does not include any of the following:

(1) Requests for clarification of coverage, eligibility or health care service verification.
(2) A health care provider's internal quality assurance or utilization review process unless the review results in denial of payment for a health care service.

"Utilization review entity." Any entity certified pursuant to subdivision (h) that performs utilization review on behalf of a managed care plan.

Section 2111. Responsibilities of Managed Care Plans.

A managed care plan shall do all of the following:

(1) Assure availability and accessibility of adequate health care providers in a timely manner, which enables enrollees to have access to quality care and continuity of health care services.
(2) Consult with health care providers in active clinical practice regarding professional qualifications and necessary specialist to be included in the plan.
(3) Adopt and maintain a definition of medical necessity used by the plan in determining health care services.
(4) Ensure that emergency services are provided twenty-four (24) hours a day, seven (7) days a week and provide reasonable payment or reimbursement for emergency services.
(5) Adopt and maintain procedures by which an enrollee can obtain health care services outside the plan's service area.

Section 2116. Emergency Services.

If an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. When processing a reimbursement claim for emergency services,

a managed care plan shall consider both the presenting symptoms and the services provided. The emergency health care provider shall notify the enrollee's managed care plan of the provisions of emergency services and the condition of the enrollee. If an enrollee's condition has stabilized and the enrollee can be transported with suffering detrimental consequences or aggravating the enrollee's condition, the enrollee may be relocated to another facility to receive continued care and treatment as necessary.

Section 2117. Continuity of Care.

(a) Except as provided under subsection (b), if a managed care plan initiates termination of its contract with a participating health care provider, an enrollee may continue an ongoing course of treatment with that health care provider at the enrollee's option for a transitional period of up to six (60) days from the date the enrollee was notified by the plan of the termination or pending termination. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transition period if determined to be clinically appropriate. In the case of an enrollee in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers.

(b) If the plan terminates the contract of a participating health care provider for cause, including breach of contract, fraud, criminal activity or posing a danger to an enrollee or the health, safety or welfare of the public as determined by the plan, the plan shall not be responsible for health care services provided to the enrollee following the date of termination.

(c) If the plan terminates the contract of a participating primary care provider, the plan shall notify every enrollee served by that provider of the plan's termination of its contract and shall request that the enrollee select another primary care provider.

(d) A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider for a transition period of up to sixty (60) days from the effective date of enrollment in a managed care plan. The managed care plan, in consultation with the enrollee and the health care provider, may extend this transitional period if determined to be clinically appropriate. In the case of a new enrollee in the second or third trimester of pregnancy on the effective date of enrollment, the transitional period shall extend through postpartum care related the delivery. Any health care service provided under this section

shall be covered by the managed care plan under the same terms and conditions as applicable for a participating health care provider.

(e) A plan may require a nonparticipating health care provider whose health care services are covered under this section to meet the same terms and conditions as a participating health care provider.

(f) Nothing in this section shall require a managed care plan to provide health care services that are not otherwise covered under the terms and conditions of the plan.

Section 2121. Procedures.

(a) A managed care plan shall establish a credentialing process to enroll qualified health care providers and create an adequate provider network. The process shall be approved by the department and shall include written criteria and procedures for initial enrollment, renewal, restrictions and termination of credentials for health care providers.

(b) The department shall establish credentialing standards for managed care plans. The department may adopt nationally recognized accrediting standards to establish the credentialing standards for managed care plans.

(c) A managed care plan shall submit a report to the department regarding its credentialing process at least every two (2) years or as may otherwise be required by the department.

(d) A managed care plan shall disclose relevant credentialing criteria and procedures to health care providers that apply to participate or that are participating in the plan's provider network. A managed care plan shall also disclose relevant credentialing criteria and procedures pursuant to a court order or rule. Any individual providing information during the credentialing process of a managed care plan shall have the protections set forth in the act of July 20, 1974 (P.L.564, No.193), known as the "Peer Review Protection Act."

(e) No managed care plan shall exclude or terminate a health care provider from participation in the plan due to any of the following:

(1) The health care provider engaged in any of the activities set forth in section 2113(c).

(2) The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.

(3) The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds.

(f) If a managed care plan denies enrollment or renewal of credentials to a health care provider, the managed care plan shall provide the health care provider with written notice of the decision. The notice shall include a clear rationale for the decision.

Section 2141. Internal Complaint Process.

(g) A managed care plan shall establish and maintain an internal complaint process with two levels of review by which an enrollee shall be able to file a complaint regarding a participating health care provider or the coverage, operations or management policies of the managed care plan.

(h) The complaint process shall consist of an initial review to include all of the following:

(1) A review by an initial review committee consisting of one or more employees of the managed care plan.
(2) The allowance of a written or oral complaint
(3) The allowance of written data or other information.
(4) A review or investigation of the complaint which shall be completed within thirty (30) days of receipt of the complaint.
(5) A written notification to the enrollee regarding the decision of the Initial review committee within five (5) business days of the decision. Notice shall include the basis for the decision and the procedure to file a request for a second level review of the decision of the initial review committee.

(i) The complaint process shall include a second level review that includes all of the following:

(1) A review of the decision of the initial review committee by a second level review committee consisting of three or more individuals who did not participate in the initial review. At least one third of the second level review committee shall not be employed by the managed care plan.
(2) A written notification to the enrollee of the right to appear before the second level review committee.
(3) A requirement that the second level review be completed within forty-five (45) days of receipt of a request for such review.
(4) A written notification to the enrollee regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis for the decision and the procedure for appealing the decision to the department or the Insurance Department.

(6) Adopt and maintain procedure by which an enrollee with a life-threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation and, if the plan's established standard are net, be permitted to receive:

(i) A standing referral to a specialist with clinical expertise in treating the disease or condition; or

(ii) The designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

The referral to or designation of a specialist shall be pursuant to a treatment plan approved by the managed care plan in consultation with the primary care provider, the enrollee and, as appropriate, the specialist. When possible, the specialist must be a health care provider participating in the plan.

(7) Provide direct access to obstetrical and gynecological services by permitting an enrollee to select a health care provider participating in the plan to obtain maternity and gynecological care, including medically necessary and appropriate follow-up care and referrals for diagnostic testing related to maternity and gynecological a=care, without prior approval from a primary care provider. The health care services shall be within the scope of practice of the selected health care provider. The selected health care provider shall inform the enrollee's primary care provider of all health care services provided.

(8) Adopt and maintain a complaint process as set forth in subdivision (g).

(9) Adopt and maintain a grievance process as set forth I subdivision (i).

(10) Adopt and maintain credentialing standards for health care providers as set forth in subdivision (d).

(11) Ensure that there are participating health care providers that are physically accessible to people with disabilities and can communicate with individuals with sensory disabilities in accordance with Title III of the Americans with Disabilities Act of 1990 (Public Law 101-336, 42 U.S.C. § 12181 et seq.).

(12) Provide a list of health care providers participating in the plan to the department every two (2) years or as may otherwise be required by the department. The list shall include the extent to which health care providers in the plan are accepting new enrollees.

(13) Report to the department and the Insurance Department in accordance with the requirements of this article. Such information shall include the number, type and disposition of all complaints and grievances filed with the plan.

Section 2142. Appeal of Complaint.

(a) An enrollee shall have fifteen (15) days from receipt of the notice of the decision from the second level review committee to appeal the decision to the department or the Insurance Department, as appropriate.

(b) All records from the initial review and second level review shall be transmitted to the appropriate department in the manner prescribed. The enrollee, the health care provider or the managed care plan may submit additional materials related to the complaint.

(c) The enrollee may be represented by an attorney or other individual before the appropriate department

(d) The appropriate department shall determine whether a violation of this article has occurred and may impose any penalties authorized by this article.

Section 2143. Complaint Resolution.

Nothing in this subdivision shall prevent the department or the Insurance Department from communicating with the enrollee, the health care provider or the managed care plan as appropriate to assist in the resolution of a complaint. Such communication may occur at any time during the complaint process.

(i) Grievances.

Section 2161. Internal Grievance Process.

(a) A managed care plan shall establish and maintain an internal grievance process with two levels of review and an expedited internal grievance process by which an enrollee or a health care provider, with the written consent of the enrollee, shall be able to file a written grievance regarding the denial of payment for a health care service. An enrollee who consents to the filing of a grievance by a health care provider under this section may not file a separate grievance.

(b) The internal grievance process shall consist of an initial review that includes all of the following:

(1) A review by one or more persons selected by the managed care plan who did not previously participate in the decision to deny payment for the health care service.
(2) The completion of the review within thirty (30) days of receipt of the grievance.
(3) A written notification to the enrollee and health care provider regarding the decision within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure to file a request for a second level review of the decision.

(c) The grievance process shall include a second level review that includes all of the following:

(1) A review of the decision issued pursuant to subsection (b) by a second level review committee consisting of three or more persons who did not previously participate in any decision to deny payment for the health care service.

(2) A written notification to the enrollee or the health care provider of the right to appear before the second level review committee.

(3) The completion of the second level review within forty-five (45)-days of receipt of a request for such review.

(4) A written notification to the enrollee and health care provider regarding the decision of the second level review committee within five (5) business days of the decision. The notice shall include the basis and clinical rationale for the decision and the procedure for appealing the decision.

(d) Any initial review or second level review conducted under this section shall include a licensed physician, or, where appropriate, an approved licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service.

(e) Should the enrollee's life, health or ability to regain maximum function be in jeopardy, an expedited internal grievance process shall be available which shall include a requirement that a decision with appropriate notification to the enrollee and health care provider be made within forty-eight (48) hours of the filing of the expedited grievance.

Section 2162. External Grievance Process.

(a) A managed care plan shall establish and maintain an external grievance process by which an enrollee or a health care provider with the written consent of the enrollee may appeal the denial of a grievance following completion of the internal grievance process. The external grievance process shall be conducted by an independent utilization review entity not directly affiliated with the managed care plan.

(b) To conduct external grievances filed under this section

(1) The department shall randomly assign a utilization review entity on a rotational basis from the list maintained under subsection (d) and notify the assigned utilization review entity and the managed care plan within two (2)

business days of receiving the request. If the department fails to select a utilization review entity under this subsection, the managed care plan shall designate shall designate and notify a certified utilization review entity to conduct the external grievance.

(2) The managed care plan shall notify the enrollee or health care provider of the name, address and telephone number of the utilization review entity assigned under this subsection within two (2) business days.

(c) The external grievance process shall meet all of the following requirements:

(1) Any external grievance shall be filed with the managed care plan within fifteen (15) days of receipt of a notice of denial resulting from the internal grievance process. The filing of the external grievance shall include any material justification and all reasonably necessary supporting information. Within five (5) business days of the filing of an external grievance, the managed care plan shall notify the enrollee or the health care provider, the utilization review entity that conducted the internal grievance and the department that an external grievance has been filed.

(2) The utilization review entity that conducted the internal grievance shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision, to the utilization review entity conducting the external grievance within fifteen (15) days of receipt of notice that the external grievance was filed. Any additional written information may be submitted by the enrollee or the health care provider within fifteen (15) days of receipt of notice that the external grievance was filed.

(3) The utilization review entity conducting the external grievance-shall review all information considered in reaching any prior decisions to deny payment for the health care service and any other written submission by the enrollee or the health care provider.

(4) An external grievance decision shall be made by:

(i) one or more licensed physicians or approved licensed psychologists in active clinical practice or in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed; or

(ii) one or more physicians currently certified by a board approved by the American Board of Medical Specialists or the American Board of Osteopathic Specialties in the same or similar specialty that typically manages or recommends treatment for the health care service being reviewed.

(5) Within sixty (60) days of the filing of the external grievance, the utilization review entity conducting the external grievance shall issue a written decision to the managed care plan, the enrollee and the health care provider, including the basis and clinical rationale for the decision. The standard of review shall be whether the health care service denied by the internal grievance process was medically necessary and appropriate under the terms of the plan. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the external grievance decision. There shall be a rebuttable presumption in favor of the decision of the utilization review entity conducting the external grievance.

(6) The managed care plan shall authorize any health care service or pay a claim determined to be medically necessary and appropriate under paragraph (5) pursuant to section 2166 whether or not an appeal to a court of competent jurisdiction has been filed.

(7) All fees and costs related to an external grievance shall be paid by the non-prevailing party if the external grievance was filed by the health care provider. The health care provider and the utilization review entity or managed care plan shall each place in escrow an amount equal to one-half of the estimated costs of the external grievance process. If the external grievance was filed by the enrollee, all fees and costs related thereto shall be paid by the managed care plan. For purposes of this paragraph, fees and costs shall not include attorney fees.

(d) The department shall compile and maintain a list of certified utilization review entities that meet the requirements of this article. The department may remove a utilization review entity from the list if such an entity is incapable of performing its responsibilities in a reasonable manner, charges excessive fees or violates this article.

(e) A fee may be imposed by a managed care plan for filing an external grievance pursuant to this article which shall not exceed twenty-five ($25) dollars.

Section 2163. Records.

Records regarding grievances filed under this subdivision that result in decisions adverse to enrollees shall-be-maintained by the plan for not less than three (3) years. These records shall be provided to the department, if requested.