CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00295/3**

TITLE: **Healthy Pennsylvania**

AWARDEE: **Pennsylvania Department of Public Welfare**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Healthy Pennsylvania section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable Pennsylvania to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of requirements under section 1902(a) of the Social Security Act (the Act), and an expenditure authority authorizing federal matching of demonstration costs not otherwise matchable. These STCs set forth in detail the nature, character and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. Enrollment activities for the new adult population will begin on November 15, 2014 for the Healthy Pennsylvania with eligibility effective January 1, 2015. The demonstration will be statewide and is approved through December 31, 2019.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Populations Affected
V. Benefits
VI. Healthy Behaviors, Premiums, and Cost Sharing
VII. Delivery System
VIII. General Reporting Requirements
IX. General Financial Requirements
X. Budget Neutrality Determination
XI. Evaluation
XII. Monitoring
XIII. Health Information Technology
XIV. T-MSIS Requirements
XV. Schedule of State Deliverables During the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Healthy Behaviors Incentives Program Protocol (reserved)
Attachment B: Premiums and Copayments Monitoring Protocol (reserved)
Attachment C: Copayments Infrastructure Operational Protocol (reserved)

Attachment D: PA Department of Public Welfare Minimum Standards for Managed Care under the Private Coverage Option
Attachment E: Demonstration Evaluation Plan (reserved)
Attachment F: Comprehensive Quality Strategy (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Commonwealth of Pennsylvania's statewide initiative, Healthy Pennsylvania, Pennsylvania is undertaking a number of changes to its Medicaid program including the creation of new benefit packages, the implementation of premiums and the establishment of an incentive structure for encouraging healthy behaviors. Some of those changes, like the creation of high-risk and low-risk benefit packages and the Private Care Option alternative benefit plan, are being implemented through the state plan. Other changes are effective through this demonstration, which authorizes the state to require that a portion of the new adult group eligible under the Affordable Care Act receive benefits through private managed care health plans, which the state refers to as Private Care Option service delivery systems, and provides authority for the charging of premiums and the implementation of healthy behavior incentives.

With this demonstration Pennsylvania proposes to further the objectives of title XIX by:

- Promoting access to health insurance through private coverage options;
- Encouraging healthy behaviors and appropriate care, including early intervention, prevention, and wellness; and
- Increasing quality of care and efficiency of the health care delivery system.

Pennsylvania proposes to demonstrate the following key features:

- Whether a private health plan option improves beneficiary access to care and health outcomes;
- Whether incentives for beneficiaries to obtain preventive services and engage in healthy behaviors will result in better health outcomes and lower overall health care costs; and
- Whether premiums in lieu of cost sharing for individuals above 100 percent of the federal poverty level (FPL) will affect utilization, increase the use of preventive services by beneficiaries, or improve beneficiary satisfaction.

Under the Healthy Pennsylvania demonstration monthly premiums may be charged for certain individuals with incomes above 100 percent of the FPL, and an incentive program will be implemented that is intended to encourage personal responsibility, improve healthy behaviors and develop cost conscious consumer behaviors among all beneficiaries. Monthly premiums for nonexempt enrollees with incomes above 100 percent of the FPL can be imposed in year 2 of the demonstration and may be reduced if enrollees complete all required healthy behaviors during year 1 of the demonstration. Individuals below 100 percent of the FPL may have their cost sharing obligations reduced for completion of healthy behaviors through the state plan. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors and to continue to have their financial contributions reduced based on those activities, i.e., healthy behaviors completed in year 1 will have reduced premiums or cost sharing in year 2. Beginning in Year 2, the healthy behavior reductions will be evaluated every six months for potential reduction on a bi-annual basis.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Federal Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

    b. Should there be changes in the FFP associated with the demonstration, the state may seek to end the demonstration (as per STC 9) or seek an amendment (as per STC7).

5. **State Plan Amendments.** If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

    Should the state amend the state plan to make any changes to eligibility for any population affected by the demonstration, upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request any necessary corresponding technical corrections to the demonstration.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-

federal share of funding, and budget neutrality must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 14, prior to submission of the requested amendment;

b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in STC44; and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9.

a. Compliance with Transparency Requirements at 42 CFR §431.412.

b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 14.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft plan to CMS. To be assured of approval, if the phase-out of the demonstration will be accompanied by the termination of coverage, the state must submit the notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with 42 CFR 431.408. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into the revised plan. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.

b. **Transition and Phase-out Plan Requirements**. The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

c. **Phase-out Procedures**. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR §435.916.

d. **Exemption from Public Notice Procedures 42.CFR §431.416(g)**. CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

e. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated

with terminating the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.

10. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report associated with the quarter in which the forum was held. The state must also include the summary in its annual report.

11. **Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

    a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

    b. **Expiration Procedures.** The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

    c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

    d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling participants.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration are proposed by the state.

    a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

    b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

    c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **Federal Financial Participation (FFP).** No federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. POPULATIONS AFFECTED

16. Eligibility Groups Affected By the Demonstration. This demonstration affects individuals ages 21 through 64 who are eligible in the new adult group under the state plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, and 42 CFR § 435.119, and who receive services described in the PCO ABP under the state plan, unless otherwise excluded as described in STC 17. These individuals are known as PCO beneficiaries, as they will receive coverage through private managed care health plans. In addition, beneficiaries with incomes above 100 percent FPL in the eligibility groups in the table below are affected by the waivers in the demonstration authorizing the collection of premiums and permitting variations in cost sharing in part to allow participation in the healthy behavior incentive program. All affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. All Medicaid eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, remain applicable.

Table 1. Medicaid State Plan Groups Affected by the Demonstration

Medicaid State Plan Group	Population Description	Funding Stream	PCO	Premiums for individuals above 100 percent FPL
VIII Group	Individuals ages 21 through 64 who are eligible in the new adult group under the state plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act.	Title XIX	Yes	Yes
Pregnant Women Who Elect to Remain in PCO	Pregnant women who were enrolled in the PCO option before becoming pregnant, and who elect to remain enrolled in the PCO option.	Title XIX	Yes	No
Extended Medicaid due to Child or Spousal Support Collections	Individuals who lose eligibility under Section 1931 due to spousal support.	Title XIX	No	Yes
Transitional Medical Assistance	12-month continued medical assistance due to increased earnings or hours of employment.	Title XIX	No	Yes

Individuals Receiving Home and Community Based Services under Institutional Rules	Special income level group, with gross income that does not exceed 300 percent of the SSI income standard; receives Long Term Services and Supports in the community.	Title XIX	No	Yes, unless otherwise exempt.

17. Excluded Populations. The following individuals are excluded from the demonstration, even if otherwise within the populations described in STC 16:

a. Individuals who are medically frail as determined pursuant to the methodology and definition set forth in the approved Alternative Benefit state plan provisions.
b. Pregnant women, with the exception that a woman who becomes pregnant while in PCO coverage may elect to stay in PCO coverage.
c. Individuals who are institutionalized.
d. Individuals who are dually eligible for Medicaid and Medicare
e. Individuals 65 years of age and older.
f. Individuals under 21 years of age.

18. Retroactive Coverage. The state must provide retroactive coverage because CMS is not granting a waiver of this provision. The state may request an amendment seeking a waiver of retroactive coverage pursuant to STC 7. Such request must include data from DY 1 on the state's performance in the real-time processing of applications for coverage and data regarding the prevalence of gaps in coverage.

V. BENEFITS

19. Private Coverage Option Benefits. Private Coverage Option beneficiaries will receive benefits described in the state plan ABP designated as the Private Coverage Option ABP.

20. Non-Emergency Medical Transportation (NEMT). In DY 1, the state is not obligated to provide NEMT to individuals enrolled in the PCO. This waiver authority shall sunset after one year. During the first year of the demonstration, the state will undertake efforts to ensure that PCO beneficiaries shall have the ability to utilize non-emergency transportation to and from providers by DY 2.

VI. HEALTHY BEHAVIORS AND PREMIUMS

This section provides an overview of the framework that will be used to further define the programmatic features of the healthy behaviors component of the Healthy Pennsylvania demonstration. Following the development and subsequent approval of the protocols outlined in STC 25, beneficiaries will be responsible for paying monthly premiums.

These beneficiaries will have the opportunity to reduce their premium and cost sharing obligations through the completion of certain healthy behaviors.

21. Healthy Pennsylvania Beneficiary Contribution Protections.

a. All Medicaid cost sharing rules apply, except to the extent of the authority to charge premiums described in STC 22.

b. Beneficiaries' cost sharing and premium contributions may not exceed 5 percent of the family's income, following rules established in 42 CFR 447.56(f).

22. Premiums.

a. **Protocols.** Authority to charge premiums is subject to the CMS approval of the protocols described in STC 25. Once approved, these protocols will be fund in Attachments A, B, and C.

b. **Individuals Subject to Premium Liability.** Individuals with incomes above 100 percent of the FPL in the groups affected by the Demonstration (listed in Table 1) may be charged a premium in an amount not to exceed 2 percent of household income beginning in DY 2. The state may not charge premiums in DY 1. No premiums will be charged for individuals with incomes at or below 100 percent of the FPL. Premiums may only be assessed on non-exempt individuals as described in 42 CFR 447.56.

c. **Healthy Behaviors.** PCO enrollees' premium amounts may be reduced for completion of healthy behaviors, as described in STC 25.

d. **Grace Period.** Enrollees will be allowed a 90 day premium grace period before disenrollment is permitted. An individual may not be denied an opportunity to re-enroll due to nonpayment of a premium for a prior period. After 90 days, unpaid premiums may be considered a collectible debt owed to the state of Pennsylvania and, at state option, subject to collection by the state.

23. Copayments.

a. In Year 1 individuals in the demonstration will be subject to cost sharing under the state plan.

b. Beginning in January 2016, the state may collect and analyze data regarding the average amount of copayments paid each month by individuals below 100 percent of the FPL. The state may submit for CMS review an amendment to the demonstration (pursuant to STC 7) seeking a premium model for individuals with incomes at or below 100 percent of the FPL.

c. Beginning in DY 2 individuals above 100 percent of the FPL who are subject to premiums must not be charged copayments except for the state plan copayment for non-emergency use of the emergency department authorized under the state plan.

24. Healthy Behaviors. Authority to implement the Healthy Behaviors component is subject to the CMS approval of the protocols described in STC 25.

a. **General Description**. All individuals who are subject to premiums under the demonstration will be eligible to receive a reduction of monthly premium contributions required in year 2 of enrollment if enrollees complete healthy behaviors during year 1 of enrollment. For each subsequent year, nonexempt enrollees will have the opportunity to complete healthy behaviors to continue to reduce financial contributions, i.e. healthy behaviors performed in year 1 will be permitted to reduce premiums for year 2. The healthy behavior reductions for each subsequent year will be evaluated every six months for potential reduction on a bi-annual basis.

b. **Healthy Behaviors Beneficiary Requirements**. In order to receive reduced monthly premiums in year 2, the individual must complete an annual wellness exam and make timely copayments during year 1.

25. Healthy Behaviors and Premiums and Copayment Protocols. The state shall establish the protocols, subject to CMS approval, described here. CMS commits to expeditious review of all protocols submitted by the state for approval.

a. **DY 1 Healthy Behaviors Incentives Protocols.** By March 31, 2015, the state must submit for approval a protocol describing the state's plan for implementing Healthy Behavior Incentives in DY 2 including, at a minimum, the following:
   i) The purpose and objectives of the Healthy Behaviors Incentive program.
   ii) The state will supply baseline data, in accordance with the protocol approved in STC 25, on the rate of healthy behavior compliance by August 1, 2015.
   iii) The criteria to be met for completing a wellness exam.
   iv) A description of the consultation process and the list of stakeholders consulted in the development of the protocol.
   v) A description of how healthy behaviors will be tracked and monitored at the enrollee and provider levels, including standards of accountability for providers.
   vi) A description of how the state will notify and educate enrollees about the Healthy Behaviors Incentives program.
   vii) The notices beneficiaries will receive regarding premiums and/or Healthy Behaviors and related appeal rights, and the schedule for such notices.
   viii) The process by which beneficiaries will be able to remit payment, including ways individuals who cannot pay by check will be accommodated.
   ix) The process by which the state will collect past due premiums including how the state proposes to collect the debt and which beneficiaries will be subject to collection.

x) Any baseline data, including access data, associated with the implementation of new healthy behavior requirements.

b. **Future Year Healthy Behaviors Incentives Standards**. Pennsylvania will further evaluate, define and refine healthy behavior requirements for subsequent years of the demonstration. Pennsylvania must obtain CMS approval before the state can introduce new healthy behaviors to enrollees. By August 31, 2015 (and succeeding years), the state will submit for approval, the protocol with the following Healthy Behaviors Incentive Program standards:
   i) A description of selected healthy behaviors to be met by an individual in year 2 (or subsequent years), whereas, an individual will be deemed compliant with healthy behaviors resulting in a reduction of premiums in year 3 (or subsequent years).
   ii) Any data, including access data, if applicable, associated with the implementation of new healthy behavior requirements and an updated monitoring protocol related to healthy behaviors to be met in year 2 (or subsequent years).

c. **Premium and Copayments Monitoring Protocols**. By August 31, 2015 the state must submit for approval, criteria by which the state will monitor premiums and copayments and thresholds for modification and/or termination of premium and copayment collection. This monitoring must include data related to premium payment/non-payment. The state must include a list of the data it will report to CMS in quarterly reports and actual data where it is available. Such data must include but is not limited to the number of:
   i) Individuals subject to premiums and copayment requirements (i.e. number of nonexempt individuals),
   ii) Individuals whose premiums and copayments have been reduced due to healthy behaviors,
   iii) Individuals with overdue premiums and copayments including those with premiums past due less than and greater than 90 days.
   iv) Information about the state's collection activities including the number of beneficiaries subject to collection, amounts due and amounts paid.
   v) The number of individuals who have premiums and copayments that have become collectible debt.

d. **Copayments Infrastructure Operational Protocol**. The state must submit a draft Copayments Infrastructure Operational Protocol to CMS describing the process to be used under the state plan for collecting copayments from beneficiaries. The protocol should include the following items:
   i) A description of how the state will collect data from the plans regarding the amount of copayments due.
   ii) The process by which the state will identify individuals who are exempt from the premium and copayment requirements.
   iii) The state's operational plan to ensure that the beneficiary will not be charged a copayment by a Medicaid healthcare provider when covered benefits are provided.

iv) The state's operational plan to ensure that copayment liability will be accurately tracked on a per visit basis, as well as quarterly and annual statements that will be provided to the beneficiary.
v) The state's implementation plan for the beneficiary education and assistance process including copies of beneficiary notices, a description of beneficiaries' rights and responsibilities, appeal rights and processes and instructions for beneficiaries about how to interact with state officials for discrepancies or other issues that arise regarding the beneficiaries' cost sharing obligations.
vi) A strategy for educating beneficiaries on how to use the statements, and understand that their health care expenditures will be covered.
vii) A strategy for educating beneficiaries on how to self-report changes in income and the importance of doing so.
viii) The state's process for acting on changes in income as it relates to the charging of premiums versus copayments.

e. **CMS Review of the Protocols.** Once approved by CMS, the Premiums and Healthy Behaviors Protocols will become Attachments A, B, and C of these STCs, and will be binding upon the state. The state may request changes to the approved Healthy Behaviors and Premiums and Copayments Monitoring Protocols, which must be approved by CMS, and which will be effective prospectively. Changes may be subject to an amendment to the STCs in accordance with STC 7, depending upon the nature of the proposed change.

VII. DELIVERY SYSTEM

26. Private Coverage Option (PCO) Delivery System. The state shall contract with Commonwealth of Pennsylvania-licensed health insurance entities that have certified to the Pennsylvania Department of Insurance (PID) that each plan through which coverage will be provided to beneficiaries under the demonstration meets all applicable federal and state laws pertaining to health insurance coverage offered in the individual market. These entities are referred to as PCOs. The state's contracts with PCOs must comply with the Medicaid managed care requirements in 42 CFR part 438 through application of state or federal insurance laws that satisfy Medicaid requirements and as established in the state's Agreement in the RFA. The applicable standards are identified in Attachment D, "DPW Minimum Standards for Managed Care under the Private Coverage Option." CMS expects that all requirements highlighted in the Agreement in Attachment D will become part of the executed PCO agreements.

27. Effect of Changes in State or Federal Insurance Laws. The following process shall occur in the event of a change in state or federal insurance laws followed under the demonstration:

a. The state shall notify CMS of any change to an applicable state statute or regulation identified in Attachment D; if the revised statute or regulation provides less beneficiary protection than the relevant requirement in 42 CFR part 438, then 42 CFR part 438 will apply.

b. In the event a change to an applicable federal law or regulation identified in Attachment D is to take place, or if a new federal law or regulation is to be promulgated that would otherwise impact the PCO delivery system, then the process described in STC 3 applies.

VIII. GENERAL REPORTING REQUIREMENTS

28. General Financial Requirements. The state must comply with all general financial requirements under Title XIX outlined in Section IX of these STCs.

29. Monthly Monitoring Calls. CMS will convene periodic conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the Private Coverage Option plan beyond December 31, 2019. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls. Areas to be addressed may include, but are not limited to:

a. Transition and implementation activities,
b. Stakeholder concerns,
c. Healthy Pennsylvania operations and performance,
d. NEMT readiness progress,
e. Enrollment,
f. Cost sharing,
g. Quality of care,
h. Access,
i. The benefit package,
j. Audits,
k. Lawsuits,
l. Financial reporting issues,
m. Progress on evaluations,
n. Legislative developments, and
o. Any demonstration amendments the state is considering submitting.

30. Quarterly Progress Reports. The state will provide quarterly reports to CMS.

a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
b. The state will report on the enrollment figures for the quarter within the quarterly reports. The state will include enrollment numbers will be for those individuals who are eligible for PCO coverage.
c. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.
d. Reports on speed of eligibility determinations for PCO eligible individuals, including

i. The average number of days between the submission of an application and an eligibility determination, and
ii. The average number of days between an eligibility determination and PCO plan enrollment.

31. NEMT Readiness Plan. The state must provide a readiness plan to CMS no later than March 31, 2015 detailing how the state will assure NEMT to the PCO population by DY 2. The plan must include plans to amend broker contracts, a beneficiary outreach strategy, and identification and mitigation of any anticipated capacity issues.

32. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the State shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

33. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The State will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the DY to CMS.

a. All items included in the quarterly report pursuant to STC 30must be summarized to reflect the operation/activities throughout the DY;
b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration); and
d. Reports related the benefit design in the state plan, including:
    i. Actual utilization data, for the number of beneficiaries whose claims have been denied because they exceeded the benefit limits in the state plan;
    ii. Numbers of requested benefit limit exceptions and number of benefit limit exceptions granted;
    iii. Numbers of appeals and outcomes;
    iv. Numbers of individuals requesting review to move from the low-risk benefit package to the high-risk benefit package;
    v. Of those who requested to move between benefit package, numbers of individuals moving from low-risk benefit package to the high-risk benefit package; and
    vi. Total number of individuals moving from low-risk benefit package to the high-risk benefit package.

34. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

35. Comprehensive State Quality Strategy. The state shall modify and update its current HealthChoices Medicaid managed care strategy, required by 42 CFR 438.202, to incorporate the Healthy Pennsylvania demonstration.

a. The Comprehensive Quality Strategy (CQS) shall meet all the requirements of 42 CFR Part 438, subparts D and E, and address the following elements:

   i) The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part aim but should be more specific in identifying specific pathways for the state to achieve these goals.

   ii) The specific quality metrics for measuring improvement in the goals and a description of planned interventions for obtaining improvement in the goals. (See November 22, 2013 CMS letter to State Health Official.)

   iii) Monitoring and evaluation. Describe specific plans for monitoring continuous quality improvement, which includes transparency of performance on metrics and structured learning, and also a rigorous and independent evaluation of the demonstration, as described in STC 44. The evaluation should reflect all the programs covered by the CQS as mentioned above.

   iv) A timeline that considers metric development and specification, contract amendments, data submission and review, incentive disbursement (if available), and the re-basing of performance data.

   v) The CQS must include state Medicaid agency and any contracted service providers' responsibilities, including managed care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.

   vi) As required by 42 CFR 438.360(b)(4), the state must identify in the CQS any standards for which the EQRO will use information from private accreditation reviews to complete the compliance review portion of EQR for participating PCOs. The state must, by means of a crosswalk included in the CQS, set forth each standard that the state deems as duplicative to those addressed under private accreditation and explain its rationale for why the standards are duplicative.

b. The first draft of this CQS is due to CMS no later than 120 days following the approval of the Healthy Pennsylvania demonstration. CMS will review this draft and provide feedback to the state. The state must revise and resubmit the CQS to CMS for approval within 45 days of receipt of CMS comment. The state must revise (and submit to CMS for review and approval) their CQS whenever significant changes are made to the associated Medicaid programs or the content of the CQS. Any further revisions must be submitted accordingly:

i) Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver renewals); and/or

ii) Changes to an existing, approved CQS due to fundamental changes to the CQS must be submitted for review and approval to CMS no later than 60 days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than 60 days following the changes.

c. The state must solicit for and obtain the input of beneficiaries, the Medical Care Advisory Committee (MCAC), and other stakeholders in the development of its CQS and make the initial CQS, as well as any significant revisions, available for public comment prior to submission to CMS for approval. Pursuant to paragraph 35 Annual Report, the state must also provide CMS with annual reports on the implementation and effectiveness of their CQS as it impacts the demonstration.

d. Upon approval by CMS, the state shall publish the CQS on its Medicaid website.

IX. GENERAL FINANCIAL REQUIREMENTS

36. Quarterly Expenditure Reports. The state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

37. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

38. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section X:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in

accordance with the approved state plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

39. Sources of Non-Federal Share. The state must certify that the matching non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

40. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to fund the non-federal share of demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

Demonstration providers must receive and retain 100 percent of the paid amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the demonstration providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

X. BUDGET NEUTRALITY DETERMINATION

41. Budget Neutrality. CMS has determined that this demonstration is budget neutral based on CMS's assessment that the waiver authorities granted for the demonstration are unlikely to result in any increase in federal Medicaid expenditures, and that no expenditure authorities are associated with the demonstration. The state will not be allowed to obtain budget neutrality "savings" from this demonstration. The demonstration will not include a budget neutrality expenditure limit, and no further test of budget neutrality will be required. CMS reserves the right to request budget neutrality worksheets and analyses from the state whenever the state seeks a change to the demonstration, per STC 7.

XI. EVALUATION

42. Submission of Draft Evaluation Design. The state must submit to CMS for approval, within 120 days of the approval date of the demonstration a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in STC 44. The design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented.

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results. Information from the EQRO may be considered for the purposes of evaluation, as appropriate.

The design must describe the state's process to contract with an independent evaluator, ensuring no conflict of interest.

The design, including the budget and adequacy of approach, to assure the evaluation meets the requirements of STC 44, is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected within STC 44.

43. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by HHS. In addition, the state shall submit the required data to HHS or its contractor in a timely manner and at no cost to CMS or the contractor, unless the state incurs a cost in which case CMS will participate in accordance with regular administrative matching rules.

44. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

a. **Domains of Focus.** The state must propose at least one research question that it will investigate within each of the domains listed below. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reduced costs. The following are among the hypotheses to be considered in the development of the evaluation and design and will be included in the design as appropriate.

   i. PCO beneficiaries will have equal or better access to provider networks than HealthChoices beneficiaries or the access Healthy PA enrollees experienced in the private Marketplace prior to enrolling in Healthy PA.
   ii. PCO beneficiaries will have equal or better access to preventative care than HealthChoices beneficiaries or the access Healthy PA enrollees experienced in the private Marketplace prior to enrolling in Healthy PA.
   iii. PCO beneficiaries will have continuous insurance coverage and fewer gaps in coverage, with specific focus on those who move from the PCO coverage to subsidized coverage (APTC) on the federal market place or employer sponsored coverage than HealthChoices beneficiaries.
   iv. PCO beneficiaries will report equal or better satisfaction in the care provided than HealthChoices beneficiaries or the access Healthy PA enrollees experienced in the private Marketplace prior to enrolling in Healthy PA.
   v. The average per capita uncompensated care costs will decrease with the implementation of PCO coverage.
   vi. Implementation of premiums for individuals above 100 percent of the FPL will not create a barrier to health care access.
   vii. Not assuring non-emergency transportation has no impact on healthy behaviors and does not pose a barrier to access to care.
   viii. Implementation of premiums and cost sharing, particularly for the HCBS population, will incentivize individuals to complete healthy behaviors and will result in physical and mental health outcomes.
   ix. The PCO commercial option provides a comparable experience in terms of coverage, service delivery, quality outcomes, and beneficiary satisfaction as

the Medicaid MCOs that provide Medicaid coverage under the HealthyChoices Demonstration, adjusting for population differences as methodologically appropriate.

b. **Measures.** The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:
    i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);
    ii. The measure steward;
    iii. The baseline value for each measure; and
    iv. The sampling methodology for assessing these outcomes.

c. **Sources of Measures**. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

d. The evaluation design must also discuss the data sources used, including, but not limited to, the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

45. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design and the draft Healthy Pennsylvania evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS's comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.

46. Interim Evaluation Report. The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration, or by June 30, 2019, if no extension request has been submitted by that date. The interim evaluation report will discuss evaluation progress and present findings to date.

47. Final Evaluation Report. The state must submit to CMS a draft of the evaluation final report by May 1, 2020. The report must include the following:

a. An executive summary;

b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;

c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;

d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);

e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and

f. Successes, challenges, and lessons learned.

48. Public Access. The state shall post the final approved Evaluation Design on the state Medicaid website within 30 days of approval by CMS.

49. Electronic Submission of Reports. The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

XII. MONITORING

50. Rapid Cycle Assessments. The state shall specify for CMS approval a set of performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under the Health and Private Coverage Option, and for monitoring and evaluation of the demonstration.

XIII. HEALTH INFORMATION TECHNOLOGY

51. Health Information Technology (HIT). The state will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

a. Pennsylvania must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (EHR) technology and the ability to exchange data through the state's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.

b. The state must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing health information exchange (HIE) infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers. The state must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.

c. All requirements must also align with Pennsylvania's State Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

XIV. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It states that all states are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Pennsylvania against which the Healthy Pennsylvania demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the SMM Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

XV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Per award letter - Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per paragraph 42	Submit Draft Evaluation Design
Per paragraph 8	Submit Demonstration Extension Application
Per paragraph 10 Within 6 months of amendment implementation	Post-award Forum Transparency deliverable

Per paragraph 25	Healthy Behaviors Protocol
Per paragraph 25	Operational Protocol for Premiums and Copayments
Per paragraph 35	Draft Comprehensive Quality Strategy
Quarterly	**Deliverable**
Per paragraph 30	Quarterly Progress Reports
Per paragraph 36	Quarterly Expenditure Reports
Annual	**Deliverable**
Per paragraph 10	Annual Forum Transparency deliverable
Per paragraph 33	Draft Annual Report
Renewal/Close Out	**Deliverable**
Per paragraph 34	Draft Final Evaluation
Per paragraph 34	Final Evaluation

ATTACHMENT A. Healthy Behaviors Incentives Protocol (*reserved)*

ATTACHMENT B. Premiums and Copayments Monitoring Protocol (*reserved)*

ATTACHMENT C. Monthly Copayments Infrastructure Operational Protocol.

ATTACHMENT D. PA Department of Public Welfare Minimum Standards for Managed Care under the Private Coverage Option

The State's contracts with PCOs and its administration of the managed care program must comply with Medicaid requirements under 42 CFR part 438. The state intends to provide assurances that such requirements are met through existing state and federal laws and insurance regulations that satisfy Medicaid requirements. Where such existing state and federal laws or regulations do not satisfy or do not address Medicaid requirements, the State will provide assurances through PCO agreement requirements or state procedures specifically instituting and complying with the requirements of 42 CFR part 438. This Attachment D cross references the state or federal laws, insurance regulations, or other mechanisms by which the state will assure compliance. The specific references to the "Agreement" are to the requirements established in Pennsylvania's RFA for the Healthy Pennsylvania program, specifically titled "Healthy Pennsylvania Private Coverage Organization Agreement" that was released in May 2014. Fields in the second column, which captures the state or federal requirements that meet 438 requirements, will be grayed out for those sections of part 438 that will be addressed via the Agreement, as identified in the third column. In that instance, there was not a comparable state or federal standard for individual issuers. If a field in the second column contains a reference to state or federal standard, the corresponding field in the third column may be blank as the reference in the second column will be in the final Agreement between the state and the PCOs. The Demonstration does not grant any waivers of 42 CFR part 438; therefore, all state responsibilities that may not be captured in this Attachment continue to apply under the Demonstration.

42 CFR part 438 Requirement (438)	**State/Federal Law Meeting 438 Requirement**	**Agreement Provision/State Procedure Meeting 438 Requirement**
Inspection and audit of financial records 42 CFR 438.6(g)		Agreement, pgs. 42-43
Advance Directives 42 CFR 438.6(i)(1) 42 CFR 438.10(g)(2) 42 CFR 422.128 42 CFR 489 (Subpart I) 42 CFR 489.100		Agreement, pg. 35
Provision of Information to Potential Enrollees and Enrollees 42 CFR. 438.10(b)(1) 42 CFR 438.10(b)(3)	40 P.S. 991.2136 31 Pa. Code 154.16	Agreement, pg. 23
Language Requirements and Cultural Considerations 42 CFR 438.10(c)(3), (4), and (5) 42 CFR 438.206(c)(2)	40 P.S. 991.2136(a)(5) 45 CFR 147.200(a)(5) (incorporating 45 CFR 147.136(e))	
Format and Alternative Format 42 CFR 438.10(d)(1)(i)		The agreement shall require that PCO plans provide written information to

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
42 CFR 438.10(d) (1)(ii) and (2)		prospective enrollees and enrollees in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
Notice of Provider Termination 42 CFR 438.10(f)(5)	40 P.S. 991.2117 31 Pa. Code 154.15(b)	
Prohibition on Plan Discrimination of Provider Participation or Reimbursement Solely on Basis of Provider Licensure or Certification 42 CFR 438.12(a)(1) 42 CFR 438.214(c) SMD letter 02/20/98	40 P.S. 1511	
Declining of Providers by the Plan 42 CFR 438.12(a)(1) 42 CFR 438.12(b)(1)	40 P.S. 991.2121(f)	
Choice of Health Professional 42 CFR 438.6(m)	45 CFR 147.138 40 P.S.991.2111 28 Pa. Code 9.671-9.685	Agreement, pg. 35
Enrollment Process 42 CFR 438.6 (d)(2)		Agreement, pg. 24
Automatic Reenrollment 42 CFR 438.56(g)		Exhibit E (including language that automatic re-enrollment of a beneficiary into the PCO if he or she loses Medicaid eligibility)
Enrollment Discrimination Prohibited; Enrollment Not Discriminatory 42 CFR 438.6 (d)(1), (d) (3) and (4)	28 Pa. Code 9.676	Agreement, pg. 24
Enrollee Disenrollment 42 CFR 438.56(b) 42 CFR 438.56(c)(1) and (c)(2) 42 CFR 438.56(d)(1), (d)(2) and (d)(4) 42 CFR 438.56(e)		The State shall ensure that enrollees are guaranteed the ability to request and receive disenrollment from a PCO pursuant to the following: During the 90 days following the date

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
42 CFR 438.56(f) Note: The State is exercising the option to retain the processing of disenrollment requests rather than delegating such authority to the PCO plans as permitted under 42 CFR 438.56(d)(ii). Therefore, 42 CFR 438.56(d)(3) and (d)(5) are not applicable. The PCO plans may request enrollee disenrollment in accordance with 42 CFR 438.56(b).		of the beneficiary's initial enrollment into a PCO as required under 42 CFR 438.56(c)(1); and At any time during the enrollment period due to a cause for disenrollment as defined in 42 CFR 438.56(d)(2) and at least once every 12 months thereafter as required under 42 CFR 438.56(c)(ii).
Enrollee Free Exercise of Rights and Compliance with Other State and Federal Laws and Regulations 42 CFR 438.100(a)(1) 42 CFR 438.100(c) 42 CFR 438.6(f)(1) 42 CFR 438.100(a)(2) 42 CFR 438.100(d)	28 Pa. Code 9.676(a) ACA 1001 (PHSA 2715) ACA 1557 45 CFR parts 160 and 164	Agreement, pg. 18
Anti-gag Clause 1932(b)(3)(D) 42 CFR 438.102(a)(1)(i), (ii), (iii) and (iv) SMD letter 2/20/98	40 P.S. 991.2113	Agreement, pg. 27
Moral or Religious Objections 1932(b)(3)(B)(i) and (ii) 42 CFR 438.102(a)(2) and (b)(1) SMD letter 2/20/98	40 P.S. 991.2113(d)(2) 40 P.S. 991.2171(b)	Agreement, pg. 19
Marketing 1932(d)(2)(A), (B), (C), (D) and (E) 42 CFR 438.104 SMD letter 12/30/97 SMD letter 2/20/98	31 Pa. Code ch. 51	In addition to the requirements set forth in 31 Pa. Code ch. 51, the PCO plans are prohibited from engaging in cold call marketing, which means any unsolicited personal contact by the PCO with a prospective enrollee for the purpose of influencing the beneficiary to enroll in that particular PCO's product or to not enroll in, or to disenroll from, another PCO's product.
Emergency Medical Condition	45 CFR 147.138(b)(4)(i)	Agreement, pg. 21

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
and Emergency Services Defined; Coverage and Payment Provisions 1932(b)(2) 42 CFR 438.114(a) and (b) 42 CFR 438.114(c)(1) 42 CFR 438.114(d)(1)(ii) 42 CFR 438.114(d)(2) SMD letter 2/20/98	40 P.S. 3041 45 CFR 147.138(b)(4)(ii) 40 P.S. 991.2102 45 CFR 147.138(b)(2) 40 P.S. 991.2116 40 P.S. 3042 28 Pa. Code 9.672(b) and (h) 31 Pa. Code 301.62(m) 31 Pa. Code 154.14	
Post-stabilization Services Defined, Coverage and Payment Provisions 1852(d)(2) 42 CFR 438.114(e) SMD letter 8/5/98		The agreement will include provisions compliant with post-stabilization requirements pursuant to 438.114(e).
Entities (Plans) May not Limit Emergency Medical Condition Based on List of Diagnoses 42 CFR 438.114(d)(1)(i)	31 Pa. Code 154.14(d) 40 P.S. 991.2101 28 Pa. Code 9.672 ACA 1001 (PHSA 2719(A))	
Family planning- The agreement must specify that enrollment in the MCO/PIHP/PAHP/PCCM does not restrict the choice of the provider from whom the person may receive family planning services and supplies. 42 CFR 431.51(b)(2)		Agreement, pg. 22
Medical Record Content 42 CFR 456.211	40 P.S. 991.2152	
Abortions 42 CFR 441.202	18 Pa. C.S. 3215 40 Pa. C.S. 3301, 3302	Agreement, pg. 22
Clinical Laboratory Improvement Act:(CLIA) 42 CFR 493.1 and 493.3	42 U.S.C. 263a 35 P.S. 2151-2165 28 Pa. Code 5.11(a)	Agreement pg. 22
Developing the Delivery Network 42 CFR 438.206	40 P.S. 991.2111	
Direct Access to Women's Health Specialist 42 CFR 438.206(b)(2)	45 CFR 147.1138(a)(3)(B) 40 P.S. 991.2111(7)	Agreement, pg. 21
Second Opinion 42 CFR 438.206(b)(3)		Agreement, pg. 35

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
Out-of-Network Providers 42 CFR 438.206(b)(4) and (b)(5)	28 Pa. Code 9.679(k)	Agreement, pgs. 40-41
Timely Access 42 CFR 438.206(c)(1)(i)	40 P.S. 991.2111(1) 28 Pa. Code 9.679(e) and (m) 28 Pa. Code 9.681 28 Pa. Code 9.678(b)	Agreement, pg. 35
Documentation and Assurances of Adequate Capacity and Services 42 CFR 438.207(b) and (c)	28 Pa Code 9.604	Agreement, pg. 35
Primary Care and Coordination of Health Care Services 42 CFR 438.208(b)(1), (2), and (3)	28 Pa. Code 9.678 45 CFR parts 160 (relating to general administrative requirements) and 164 (relating to security and privacy) are applicable to all commercial insurance entities.	Agreement, pg. 23
Enrollees with Special Health Care Needs – Assessment, Treatment Planning, and Direct Access to Specialists 42 CFR 438.208(c)(2), (c)(3), (c)(4)	Direct Access to Specialists 28 Pa. Code 9.683 40 P.S 991.2111	The agreement shall require PCO plans to assess enrollees for special or chronic health care needs. The treating provider and PCP will establish treatment plans for enrollees with such conditions. Direct Access to Specialists Agreement, pg. 21
Coverage (Amount, Duration and Scope) 42 CFR 438.210(a)(3)	45 CFR 156.125 40 P.S. 477a and 171.5(a)(7)(ii) ACA 1302	Agreement, pg. 20
Medically Necessary Services 42 CFR 438.210(a)(4)		The agreement shall require the PCO plan, its subcontractors, and network providers to adopt a definition of medical necessity in accordance with 438.210(a)(4).
Authorization of Services 42 CFR 438.210(b)	28 Pa Code 9.752	Agreement, pg. 22
Timeframe for Decisions 42 CFR 438.210(d)(1)	28 Pa. Code 9.753	
Compensation for utilization management activities. 42 CFR 438.210(e)	40 P.S. 991.2152	
Contracts with Providers (Credentialing, Selection and	40 P.S. 991.2121 28 PA Code 9.761	

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
Retention); Nondiscrimination due to Patients with Expensive Conditions 42 CFR 438.12(a)(2) 42 CFR 438.206(b)(6) 42 CFR 438.214	40 P.S. 991.2121(e)(2) ACA 1201 (PHSA 2706)	
Excluded Providers 42 CFR 438.214(d)		Agreement, pg. 30
Confidentiality 42 CFR 438.224	40 PS 991.2131 45 CFR parts 160 and 164	
Subpart E – External Quality Review		The state and its PCO plans must meet all the requirements for external quality review (EQR) found in 42 CFR Part 438, subpart E.
Subcontractual Relationships and Delegation 42 CFR 438.6(l) 42 CFR 438.230(a), (b)(1)-(3)		Agreement, pg. 15, 28
Practice Guidelines (Development, Dissemination and Application) 42 CFR 438.236		The agreement shall require the PCO plan to adopt, disseminate, and apply practice guidelines in accordance with 438.236.
Quality Assessment and Performance Improvement Program 42 CFR 438.240	28 Pa. Code 9.674	The state must ensure that each PCO is accountable for collecting and reporting on metrics related to quality, timeliness, and access to services in accordance with 438.240
Health Information Systems 42 CFR 438.242(a)		Agreement, pg. 31, 35
Health Information Systems (Encounter Data) 438.242(b)		The agreement will require the PCO plans to collect encounter data that shall be verified and screened for accuracy and made available to the State and CMS in accordance with 438.242.
Defining an Action 42 CFR 431.201 42 CFR 438.400(b) 42 CFR 438.52(b)(2)(ii) 438.56(f)(2)	45 CFR 147.136(a)(2)(i) incorporating 29 CFR 2560.503-1.m	
Notice of Adverse Action for Service Authorizations and Notice of Action; Form and	45 C.F.R. 147.136(b) incorporating 29 CFR 2560.503-1 (f)	

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
content of Notice 42 CFR 438.210(c) 42 CFR 431.200(b) 42 CFR 431.206 42 CFR 438.404(a) 42 CFR 438.404(c) 42 CFR 438.210(c)	45 CFR 147.136(e) (form and manner of notice) 29 CFR 2560.503-1 (g)	
Timeframes for notice of action: Denial of payment 42 CFR 438.404(c)(2)	29 CFR 2560.503-1 (f)(2)(iii)(B) (post-service claims)	
Timeframes for notice of action: Termination, suspension or reduction of services; Standard Service Authorization Denials 42 CFR 438.404(c) 42 CFR 431.211 42 CFR 431.213 42 CFR 431.214 42 CFR 483.12(a)(5)(ii) 42 CFR 438.210(c) 42 CFR 438.210(d)(1) 42 CFR 438.404(c)(3) and 42 CFR 438.404(c)(4)	45 C.F.R. 147.136(b)(2)(iii) incorporating 29 CFR 2560.503-1(f)	
Timeframes for notice of action: Expedited Service Authorization denial 42 CFR 438.210(d)(2) 42 CFR 438.404(c)(6)	45 CFR 147.136(b)(ii)(B) incorporating 29 CFR 2560.503-1(f)(2)(i)	
Timeframes for notice of action: Untimely Service Authorization Decisions 42 CFR 438.404(c)(5)	45 CFR 147.136(b)(2)(ii)(F)	
Appeal is Review of an Action 42 CFR 438.400(b)	45 CFR 147.136(a)(2)(ii) 29 CFR 2560.503-1 (adopting use of "adverse benefit determination" rather than "action"	
Appeal Process: Authority to File 42 CFR 438.402(b)(1)	45 CFR 147.136 incorporating 29 CFR 2560.503-1	
Appeal Process: Timing 42 CFR 438.402(b)(2)	45 CFR 147.136(b)(3) incorporating	

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
	29 CFR 2560.503-1(h) (allows for 60 days to file an appeal)	
Appeal Process: Procedures 42 CFR 438.402(b)(3)(ii) 42 CFR 438.406(b)	45 CFR 147.136(b) incorporating 29 CFR 2560.503-1	
Appeal process: Resolution and Notification 42 CFR 438.408(a), (b)(2), and (c)	45 CFR 147.136(b)(3)(ii)(E)	
Appeal Process: Format and Content of Resolution Notice 42 CFR 438.408(d)(2)(i) 42 CFR 438.408(e)	45 CFR 147.136(b)(3)	The PCOs shall render resolution notices to enrollees following the internal appeals process providing the information as specified in 45 CFR 147.136 (b)(3)(ii)(E) and include information in accordance with 42 CFR 438.408(e)(2).
Appeal and State Fair Hearing Process: Continuation of Benefits 42 CFR 438.420(b) 42 CFR 438.402(b)(2) 42 CFR 438.404(c)(1)		
Expedited Appeals Process; Resolution and Notification 42 CFR 438.406(b)(2) 42 CFR 438.408 42 CFR 438.410	45 CFR 147.136(b)(2)(ii)(B) incorporating 29 CFR 2560.503-1(f)(2)(i) and 29 CFR 2560.503-1(m)(1)	
State Fair Hearing Process 42 CFR 431.200(b) 42 CFR 431.220(5) 42 CFR 438.414 42 CFR 438.10(g)(1) 42 CFR 438.408(f)(2)	All requirements in 42 CFR part 438 related to the State Fair Hearing process apply under the Demonstration.	
Grievances: Definition; Process; Disposition and Notification 42 CFR 438.400 42 CFR 438.402(b)(3)(i) 42 CFR 438.402(b)(1)(i) 42 CFR 438.408(a), (b)(1), and (d)(1)	45 CFR 147.136 (a)45 CFR 147.136(b) 45 CFR 147.136 (d) 40 PS 991.2141 40 PS 991.2142 28 Pa. Code 9.702 28 Pa. Code 9.703 28 Pa. Code 9.704(a)(2)	
Data Certifications 42 CFR 438.604(a), (b), and (c) 42 CFR 438.604(b)	42 CFR 438.604(a), (b), and (c) 42 CFR 438.604(b) 42 CFR 438.606	

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
42 CFR 438.606		
Program Integrity – General Requirements 42 CFR 438.608.(a) and (b)		Agreement, pgs. 28-29
Prohibited affiliations with Individuals Debarred by Federal Agencies. General Requirement 42 CFR 438.610(a) 42 CFR 438.610(b) SMD letter 2/20/98		Agreement, pg. 30
Excluded Providers 42 CFR 431.55(h) and 42 CFR 438.808 1903(i)(2) SMD letter 12/30/97		Agreement, pg. 30
Physician Identifier 1932 (d)(4)		Agreement, pg. 35
Reporting Fraud and Abuse to the State 42 CFR 455.1(a)(1) 42 CFR 455.17		Agreement, pg. 31
Service Verification 42 CFR 455.1(a)(2)		Agreement, pg. 29
State Conflict of Interest Safeguards 1932(d)(3) SMD letter 12/30/97	1932(d)(3)	
Violations Subject to Sanctions and Intermediate Sanctions 1903(m)(5)(A) and (B) 1932(e)(1) and (e)(2) 42 CFR 438.700 45 CFR 92.36(i)(1) 42 CFR 438.702 42 CFR 438.704 42 CFR 422.208 42 CFR 422.210		Exhibit A to the Agreement, pgs. 2-4
Sanction by CMS: Special Rules for MCOs and Denial of Payment 1903(m)(5)(B)(ii) 42 CFR 438.726(b)		Agreement, pg. 19

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
42 CFR 438.730(e)		
Termination of a Plan Agreement 1903(m) 1905(t) 1932 42 CFR 438.708	Note: Pennsylvania terminates a plan agreement upon finding of a violation rather than imposing temporary management, which is permissible. Therefore, the guidelines for temporary management at 42 CFR 438.706 are not applicable.	Exhibit A to the Agreement, pg. 4
Due Process: Notice of Sanction and Pre-Termination Hearing 1932(e)(5) 42 CFR 438.710 42 CFR 706(c) 42 CFR 438.708 42 CFR 438.10		Exhibit A to the Agreement, pg. 2-3
Disenrollment During Termination Hearing Process 1932(e)(4) 42 CFR 438.722	Not applicable, this is at the State's option and Pennsylvania has elected not to exercise the option.	
Insolvency of the Plan (No Enrollee Financial Responsibility) 1932(b)(6) 42 CFR 438.106(a), (b) and (c) 42 CFR 438.6(l) 42 CFR 438.116(a) 42 CFR 438.230 42 CFR 438.204(a)	1932(b)(6) 42 CFR 438.106(a), (b) and (c) 42 CFR 438.6(l) 42 CFR 438.230 42 CFR 438.204(a) Agreement, pg. 37	Agreement, pg. 37
Protect Against Financial Liability for Enrollees – Subcontractors and Referral Providers 1932(b)(6) 42 CFR 438.106(c) 42 CFR 438.6(l) 42 CFR 438.230 42 CFR 438.204(a)	1932(b)(6) 42 CFR 438.106(c) 42 CFR 438.6(l) 42 CFR 438.230 42 CFR 438.204(a)	
Solvency Standards for Plans (Medicaid requirements defer to State standards for private plans) 1903(m)(1) 42 CFR 438.116(b)(1)	40 PS Chapter 1 Art. V-A and V-B 40 PS Chapter 2 Art. II and III 31 Pa. Code Chapters 21-23, 152, and 301	

42 CFR part 438 Requirement (438)	State/Federal Law Meeting 438 Requirement	Agreement Provision/State Procedure Meeting 438 Requirement
add 42 CFR 438.116(b)(2)		
Disclosure of 5% Ownership 1124(a)(2)(A) 1903(m)(2)(A)(viii) 42 CFR 455.100-104		Agreement, pg. 44
Continue Services During Insolvency SMM 2086.6.B	40 P.S. Chapter 1 Art. V 31 Pa. Code 88.41 31 Pa. Code 301.62	
Timely claims payment by MCOs. 42 CFR 447.46 42 CFR 447.45(d)(2) 42 447.45 (d)(3) 42 CFR 447.45 (d)(5) 42 CFR 447.45 (d)(6)	40 PS 991.2166 31 Pa. Code 154.18	
Physician Incentive Plans 42 CFR 438.6(h) 1903(m)(2)(A)(x) 42 CFR 422.208 and 422.210	40 PS 991.2112	

ATTACHMENT E. Demonstration Evaluation Plan (*reserved)*

ATTACHMENT F. Comprehensive Quality Strategy (*reserved)*