# PENNSYLVANIA
## DEPARTMENT OF PUBLIC WELFARE

## GRANT AGREEMENT

<table>
<thead>
<tr>
<th>PURPOSE OF THE GRANT:</th>
<th>To provide Mandatory Managed Care Services to Medicaid consumers in the following counties: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>AWARD TO:</th>
<th>NAME AND ADDRESS: Vista Health Plan, Inc. 1901 Market Street Philadelphia, PA 19103</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TELEPHONE NUMBER: 215-241-2015</td>
</tr>
<tr>
<td>Mail Final Agreement to:</td>
<td>Laura Herzog  Director  PA Compliance and Regulatory Affairs  Keystone Mercy and AmeriHealth Mercy Health Plans 200 Stevens Drive Philadelphia, PA 19113</td>
</tr>
<tr>
<td>FEDERAL I.D. NUMBER:</td>
<td>23-2408039</td>
</tr>
</tbody>
</table>
HEALTHCHOICES PHYSICAL HEALTH AGREEMENT

BETWEEN

COMMONWEALTH OF PENNSYLVANIA

AND

VISTA HEALTH PLAN, INC.
HEALTHCHOICES NEW WEST PHYSICAL HEALTH AGREEMENT

THIS AGREEMENT made this _________ day of ___________, 2012 by and between the Commonwealth of Pennsylvania, acting through its Department of Public Welfare (the "Department") and Vista Health Plan, Inc., a Pennsylvania corporation with its principal place of business at 1901 Market Street, Philadelphia, Pennsylvania 19103 (the "PH-MCO").

WITNESSETH:

WHEREAS, the Pennsylvania Medical Assistance Program ("MA Program") is organized under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq. and under the Public Welfare Code, 62 P.S. §101 et seq. to provide payment for medical services to persons eligible for medical assistance; and

WHEREAS, Section 443.5 of the Public Welfare Code (62 P.S. §443.5) authorizes the Department to provide prepaid capitation payments for services provided under contracts with Physical Health Maintenance Organizations; and

WHEREAS, the Centers for Medicare and Medicaid Services ("CMS") approved the Department's waiver request under Section 1915(b) of the Social Security Act, 42 U.S.C.A. §1396n, to implement a mandatory managed care program, under the name HealthChoices New West Physical Health (the "HC-NW Physical Health Program") for Medical Assistance (MA) consumers in Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren Counties (the "HC-NW Counties"); and

WHEREAS, the Department issued Request for Proposals Number 20-11 (the "RFP") containing the participation requirements and the terms and conditions of the HC-NW Physical Health Program and soliciting proposals from Physical Health Managed Care Organizations (PH-MCOs) to participate in the program (including all technical amendments, appendices and exhibits attached thereto); and

WHEREAS, the PH-MCO submitted a proposal in response to the RFP and such Proposal was selected by the Department as responsive to the requirements of the RFP (the proposal submitted by the PH-MCO, including all appendices and exhibits attached thereto, shall be referred to as the "Proposal"); and

WHEREAS, the Department and the PH-MCO desire to execute an Agreement with a term beginning October 1, 2012 (SAP # 4100060537); and

NOW, THEREFORE, the parties intending to be legally bound hereby agree to the attached terms and conditions as follows:
APPENDIX 3b
EXPLANATION OF CAPITATION PAYMENTS

I. Base Capitation Rates

The final schedule of Base Capitation Rates and Maternity Care Rates for the Agreement Year is found in Appendix 3f, Capitation Rates.

II. Base Capitation Rates for Subsequent Years

A. Initial Schedule of Base Capitation Rates:

Annually, the Department will provide an initial schedule of Base Capitation Rates and Maternity Care Rates. The Department will provide the PH-MCO with information on methodology and data used to develop the initial schedule of Base Capitation Rates.

The Department will provide the PH-MCO with the opportunity for a meeting, in which the Department will consider and respond to questions from the PH-MCO on development of the initial schedule of Base Capitation Rates and Maternity Care Rates.

B. Final Schedule of Base Capitation Rates

The Department will provide the PH-MCO with a final schedule of Base Capitation Rates and Maternity Care Rates. The rates in Appendix 3f, Capitation Rates, included with this Agreement will remain in effect until agreement is reached on new rates and their effective date. The PH-MCO must conclude discussion about the rates timely for the purposes of execution of an amendment and the Department’s need to obtain prior approval of the rates from the Centers for Medicare and Medicaid Services (CMS).

III. Capitation Payment Rates with Risk Adjusted Rates

A. Applicability of Risk Adjusted Rates

The Department will risk adjust the Base Capitation Rates for federal Recipient Groups included in this Agreement using an actuarially sound method to adjust Base Capitation Rates to reflect the different health status of the Members enrolled in each PH-MCO’s program.

The Department may elect to terminate the risk adjustment of any or all Base Capitation Rates. If the Department makes this election, the Department will
notify the PH-MCO and will provide an effective date for this change. If the Department makes this election, the Department will enter into negotiations with the PH-MCO on the subject of Base Capitation Rates that will apply on and after the effective date of the change.

B. **RAR MCO Plan Factors**

If Base Capitation Rates are risk adjusted, the Department and its actuarial consultant will develop each RAR MCO Plan Factor to reflect the health status of Members enrolled in the PH-MCO’s program within one Recipient Group and one County Group.

The Department and its actuaries will recalculate the RAR MCO Plan Factors monthly, or every six (6) months effective January 1 and July 1 of each year, or in accordance with another periodicity schedule determined by the Department.

C. **Risk Adjusted Rate**

The Department will multiply the Base Capitation Rate by a RAR MCO Plan Factor, as provided to the PH-MCO, to compute a Risk Adjusted Rate.

If Base Capitation Rates are not risk adjusted, the Base Capitation Rate is the Risk Adjusted Rate.

D. **Provider Pay-for-Performance Amount**

If this Agreement provides for Provider Pay-for-Performance payments, the Department will provide the PH-MCO with the Provider Pay-for-Performance Amount in Appendix 3f, Capitation Rates. The Department will pay the Provider Pay-for-Performance Amount to the PH-MCO for each Member enrolled in the PH-MCO’s program, in accordance with this Agreement. These amounts are not subject to risk adjustment and will be paid separately from other capitation.

E. **Capitation Payment Rates**

The Capitation Payment Rate is equal to the Risk Adjusted Rate. The Department will pay the applicable monthly Capitation Payment Rate to the PH-MCO for each Member enrolled in the PH-MCO’s program.

**Illustrative Example of Rate Calculation, with Risk Adjusted Rates:** The Base Capitation Rate for TANF in Philadelphia is $100.00. The Department has provided the PH-MCO with a RAR MCO Plan Factor of 0.9710 for TANF Members in Philadelphia. $100.00 multiplied by 0.971 equals $97.10, which is the Risk Adjusted Rate. The Risk Sharing Withhold amount for Home Nursing is $2.41, and the HCRPAA is $1.21, but these amounts are not incorporated in the calculation of the Capitation Payment Rate. The
Capitation Payment Rate equals the Risk Adjusted Rate of $97.10. This will be paid for each month the MCO Plan Factor of 0.971 is in effect. As each recalculation of the MCO Plan Factor occurs, the PH-MCO will be paid the revised Capitation Payment Rate in effect for each month that each TANF Philadelphia Member is enrolled in the PH-MCO's program. In addition, the Department will, when specified by this Agreement, pay applicable Pay For Performance amounts; and the applicable Maternity Care Payments; and any amounts that are owed in accordance with the Risk Sharing provisions as defined in the Home Nursing Risk Sharing Arrangement(s) of this Agreement; and any amounts that are owed in accordance with Appendix 3k, High Cost Risk Pool, of this Agreement.
This Appendix 3c supersedes any previous version to define the Arrangement for the Arrangement Year beginning January 1, 2013 and subsequent Arrangement Years.

I. Arrangement Years

A. Arrangement Years are equivalent to calendar years. Each Arrangement Year serves as an accumulation period for incurring costs for Covered Services.

B. An Arrangement Year includes all portions of a calendar year that the PH-MCO operated a HealthChoices program in this zone under this Agreement or another Agreement. If there is more than one Agreement in the calendar year, the terms for the Department’s payments included in the more recent Agreement apply.

C. If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously contracted with the Department to operate a HealthChoices program in the same zone (“Previous PH-MCO”); or if the Department transferred the Recipients enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will allow the PH-MCO to include claims paid by the Previous PH-MCO with dates of service in the current Arrangement Year, provided the Previous PH-MCO relinquishes any claims to revenue under the Home Nursing Risk Sharing appendix in their Agreement, for dates of service that overlap with the current Arrangement Year.

II. Covered Services and Members

A. This Arrangement covers services provided by a Licensed Practical Nurse, Registered Nurse, Home Health Aide, or Personal Care Provider in a home or home-like setting paid by the PH-MCO for a HealthChoices Member enrolled with the PH-MCO with a date of service during the Arrangement Year (Covered Services). This Arrangement only covers members under age twenty-one (21), who do not reside in any of the following types of facility:
- State Mental Retardation Center
- Intermediate Care Facility for the Mentally Retarded
- South Mountain Restoration Center
- County Nursing Facility
- General Nursing Facility
- Hospice
- Intermediate Care Facility for Persons with Other Related Conditions
- Residential Skilled Pediatric Facility

B. Covered Services include only Medically Necessary services. Administrative services, as defined in the HealthChoices Financial Reporting Requirements, are not covered by this Arrangement.

C. Pediatric Extended Care Centers are an acceptable venue for services included in this Home Nursing Risk Sharing Arrangement. All requirements apply, including the type of provider and the Covered Services.

III. Risk Sharing

In each Arrangement Year that is equivalent to a calendar year, the PH-MCO is responsible for the first $15,000 (Threshold Amount) in paid amounts of Covered Services provided to each Member as identified in Section II above. The Department will reimburse the PH-MCO 75.0 percent (75.0%) of Covered Services (net of third party liability/other insurance) submitted by the PH-MCO that are greater than $15,000.

If the Arrangement Year begins after January 31, the Department will provide the PH-MCO with a Threshold Amount that will apply in lieu of $15,000. The Department will provide documentation that its actuarial consultant has determined that the Threshold Amount is actuarially appropriate for the terms of the Home Nursing Risk Sharing Agreement inclusive of the applicable Withhold Amounts.

IV. Home Nursing Risk Sharing Withhold Amounts

The Home Nursing Risk Sharing Withhold Amounts are specified in Appendix 3f, Capitation Rates, of this Agreement. These amounts are an obligation of the PH-MCO to the Department.

Each Home Nursing Risk Sharing payment paid by the Department will be net of the PH-MCO’s uncollected Home Nursing Risk Sharing Withhold Amount obligation through the same quarter. If the PH-MCO’s uncollected Home Nursing Risk Sharing Withhold Amount obligation exceeds the Department’s Home Nursing Risk Sharing obligation, the Department will reduce a subsequent payment to the PH-MCO by the amount of the difference.

If the Department notifies the PH-MCO of cancellation of this HealthChoices Agreement; OR if the PH-MCO notifies the Department of cancellation of this
HealthChoices Agreement; OR if this Agreement expires within four months; OR if a PH-MCO fails to submit a required report or file to support the administration of a risk pool or risk sharing arrangement within fifteen work days of the final due date:

- The Department may elect to reduce a subsequent monthly capitation payment by the total amount of the outstanding Home Nursing Risk Sharing Withhold Amount obligation for current and previous program months; AND

- The Department may reduce each subsequent monthly capitation payment by the PH-MCO's Home Nursing Risk Sharing Withhold Amount obligation for the same month.

V. **Claims Notification**

A. The PH-MCO will provide the Department with a quarterly file that includes information on each Covered Member for whom a payment for a Covered Service has been made. Each quarterly file will provide cumulative information on payments made for dates of service within one Arrangement Year. The file will include data elements specified by the Department.

B. The PH-MCO will not include an allowance for claims that have not been paid.

C. If a provider payment is subsequently reduced or taken back by the PH-MCO, the PH-MCO will report this information on the quarterly file.

D. Each quarterly file is due on or before the date indicated in a submission schedule issued by the Department. The PH-MCO will submit a quarterly file for the current Arrangement Year, plus any file that is due for a previous Arrangement Year.

E. The submission schedule includes quarterly submissions which are optional, those which are required, and instances where there should be no submission. For an optional submission, if the PH-MCO elects not to submit a file, it will notify the Department by the due date of the submission.

F. The Department may elect to use encounter data in lieu of PH-MCO file submissions.

VI. **Payment to the PH-MCO**

The Department will notify the PH-MCO of the amount of a risk sharing payment not later than forty-five days after receipt of an acceptable file provided by the PH-MCO. Within fifteen days of the notice date, the Department will initiate the payment to the PH-MCO.
VII. **Gross Receipts Tax**

In recognition of the cost to the PH-MCO of the Gross Receipts Tax, the Department will make certain additional payments, called GRT HNRS Payments, that recognize the legitimate and marginal administrative cost to the MCO of this tax. The Department will make a GRT HNRS Payment only in accordance with the following criteria:

A. The amount of the GRT HNRS Payment will equal 6.27 percent of the Department’s Home Nursing Risk Sharing obligation to date for this Arrangement Year, net of Home Nursing Risk Sharing Withhold Amounts for this Arrangement Year, less any GRT HNRS Payments the Department has already paid for this Arrangement Year.

B. The Department will make a GRT HNRS Payment, per this Section VII, on the same date it makes any Home Nursing Risk Sharing payment.

C. The Department’s determination of an obligation to make a GRT HNRS Payment will be zone-specific and will apply collectively to all agreements the PH-MCO has with the Department to operate a HealthChoices program in the same zone.

D. If the Department has notified the PH-MCO that the Gross Receipts Tax is reduced or ended, GRT HNRS Payments will be appropriately reduced or ended.

VIII. **Audit or Review**

Any payment is subject to appropriate adjustment if an audit or review demonstrates insufficient or inappropriate documentation to support a claims notification submitted to the Department.
OVERVIEW OF METHODOLOGIES FOR RATE SETTING AND DETERMINATION OF RISK SHARING WITHHOLD AMOUNTS

I. Rate Setting Methodology #1 – Use of Historical Fee-For-Service Data

To develop capitation rates on an actuarially sound basis for the HealthChoices program using historical fee-for-service (FFS) data, the following general steps are performed:

- Summarize the FFS Claims and Eligibility Data
- Combine the Multiple Years of FFS Data Together
- Project the FFS Base Data Forward
- Include the Effect of Program/Policy Changes
- Adjust the FFS Data to Reflect Managed Care Principles
- Add an Appropriate Administration/Profit Load

Summarize the FFS Claims and Eligibility Data — The Commonwealth provides summarized FFS claims and eligibility data for the recipients and services to be covered under the HealthChoices program. Normally, three years of FFS data are made available for rate-setting purposes. This data is then adjusted to account for items not included in the initial FFS data collection process. These adjustments (positive and negative) generally include, but are not limited to: completion factors, legal settlements, gross adjustments, graduate medical education payments, pharmacy rebates, and other adjustments needed to improve the accuracy of the data.

Combine the Multiple Years of FFS Data Together — To arrive at a single year of FFS data to serve as the basis for rate setting, the multiple years of FFS data are combined together. Through this process, the older data is projected forward to be comparable to the most recent information. All the data is then blended together to form a single set of base data (with the most recent year of data receiving more weight).

Project the FFS Base Data Forward — The blended base data is then projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the FFS program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — The Commonwealth occasionally changes the services or populations covered under the HealthChoices program (e.g., expands dental care, restricts enrollment). These changes are included in the
capitation rates by either increasing or decreasing the FFS data by a certain percentage amount.

Adjust the FFS Data to Reflect Managed Care Principles — Since HealthChoices is a managed care program and not FFS, the projected FFS data needs to be adjusted to reflect the typical changes that occur when changing from an FFS program to a managed care program. This generally involves increasing the cost/use of preventative services, and decreasing hospital and emergency room cost/use.

Add an Appropriate Administration/Profit Load - After the base data has been trended to the appropriate time period, and adjusted for program/policy changes, an administration/profit load will be added to the medical claim cost component to determine the overall capitation rates applicable to each population group. The administration/profit load is applied as a percentage of the total capitation rate (e.g., percent of premium) and does not vary by population group and includes all administrative liabilities expected for the average health plan in Pennsylvania operating the program in an efficient manner.

Add an amount for Gross Receipts Tax - The final capitation rate, after all other components have been completed, is further adjusted to reflect the legislatively mandated gross receipts tax. This tax is applied as a percent of final premium and is added to the original final capitation rate.

II. Rate Setting Methodology #2 – Use of Managed Care Data

To develop capitation rates on an actuarially sound basis for the HealthChoices program using actual managed care data, the following general steps are performed:

- Summarize, Analyze, and Adjust the Managed Care Data,
- Project the Managed Care Base Data Forward,
- Include the Effect of Program/Policy Changes, and
- Add an Appropriate Administration/Profit Load.

Summarize, Analyze, and Adjust the Managed Care Data — The Commonwealth collects data from each of the managed care organizations (MCOs) participating in the HealthChoices program. This data is summarized, analyzed, and adjustments (positive and negative) are applied as needed to account for underlying differences between each MCO’s management of the HealthChoices program. These adjustments can account for items such as collection of TPL/COB, over- or under-reserving of unpaid claims, management efficiency, and provider contracting relations. After adjusting each MCO’s data, each plan’s specific medical claim costs is aggregated together to arrive at a set of base data for each population group.

Project the Managed Care Base Data Forward — The aggregate base of managed care data is projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the managed care program. These trend factors normally vary by service and/or population group.
Include the Effect of Program/Policy Changes — The Commonwealth occasionally changes the services or populations covered under the HealthChoices program (e.g., expands dental care, restricts enrollment). Any new program/policy changes that were not already reflected in the managed care data are included in the capitation rates by either increasing or decreasing the managed care data by a certain percentage amount.

Add an Appropriate Administration/Profit Load - After the base data has been trended to the appropriate time period, and adjusted for program/policy changes, an administration/profit load will be added to the medical claim cost component to determine the overall capitation rates applicable to each population group. The administration/profit load is applied as a percentage of the total capitation rate (e.g., percent of premium) and does not vary by population group and includes all administrative liabilities expected for the average health plan in Pennsylvania operating the program in an efficient manner.

Add an amount for Gross Receipts Tax - The final capitation rate, after all other components have been completed, is further adjusted to reflect the legislatively mandated gross receipts tax. This tax is applied as a percent of final premium and is added to the original final capitation rate.

III. Rate Setting Methodology #3 – Blending of Fee-For-Service and Managed Care Data

When updated fee-for-service (FFS) data is unavailable and actual managed care experience first becomes available, capitation rates for the HealthChoices program can be developed on an actuarially sound basis using a blending of both data sources using the following two track approach:

- Project the prior year's rates forward (Track 1),
- Summarize and adjust the managed care data (Track 2),
- Include the effect of new program/policy changes and trend (Track 1 and Track 2), and
- Apply credibility factors to each track and blend together.

Project the Prior Year’s Rates Forward (Track 1) — The first step of Track 1 is to begin with the previous year’s capitation rates that were originally developed using historical FFS claims and eligibility data. This data is projected forward to the time period for which the new capitation rates are to be paid. Trend factors are used to estimate the future costs of the services the covered population would generate under managed care. These trend factors normally vary by service and/or population group.

Include the Effect of New Program/Policy Changes (Track 1) — In Track 1, any new program/policy changes implemented by the Commonwealth, that were not already accounted for in the previous year’s rates, are included in the new capitation rates by either increasing or decreasing the rates by a certain percentage amount. An
additional administration/profit amount is added to arrive at the final capitation rates under Track 1.

Summarize and Adjust the Managed Care Data (Track 2) — The more recent managed care data is collected from the managed care organizations (MCOs), summarized, and analyzed to support rate setting. Adjustments (positive and negative) are applied to the managed care data as needed to account for underlying differences between each MCO’s management of the HealthChoices program. These adjustments can account for items such as collection of TPL/COB, over-or under-reserving of unpaid claims, management efficiency, and provider contracting relations.

Include the Effect of Trend and New Program/Policy Changes (Track 2) — In Track 2, the managed care data is projected forward to the time period the capitation rates are to be paid. Trend factors may vary by service and/or population group, and are used to estimate the future costs of the services that the covered population would generate under managed care. Any new program/policy changes that were not already reflected in the managed care data are included in the rates by either increasing or decreasing the data by a certain percentage amount. An additional administration/profit amount is added to arrive at the final capitation rates under Track 2.

Apply Credibility Factors to Each Track and Blend Together — After separately developing capitation rates using Track 1 and Track 2, the two (2) sets of rates are combined together. This blending involves applying a credibility weight to each track and adding the two (2) components together. The credibility weights may vary between the population groups.

Add an Appropriate Administration/Profit Load - After the base data has been trended to the appropriate time period, and adjusted for program/policy changes, an administration/profit load will be added to the medical claim cost component to determine the overall capitation rates applicable to each population group. The administration/profit load is applied as a percentage of the total capitation rate (e.g., percent of premium) and does not vary by population group and includes all administrative liabilities expected for the average health plan in Pennsylvania operating the program in an efficient manner.

Add an amount for Gross Receipts Tax - The final capitation rate, after all other components have been completed, is further adjusted to reflect the legislatively mandated gross receipts tax. This tax is applied as a percent of final premium and is added to the original final capitation rate.

IV. Additional Information on Rate Development

The reimbursement provided under this contract is intended for Medically Necessary services covered under the Commonwealth's State Plan. The MCO has the option to utilize this reimbursement to provide alternatives to the Medically Necessary services covered under the State Plan in order to meet the needs of the individual enrollee in the most efficient manner. However, since the capitation rates cannot
include these cost-effective, alternative services, an adjustment may be required in the rate development process to incorporate only the cost of state plan services which would have been provided in the absence of alternative services.

DPW will provide the Contractor, upon request, with a letter from an actuary that addresses the actuarial soundness of the rates.

V. Methodology to Determine Risk Sharing Withhold Amounts

The amount that is withheld from the capitation rates to fund the risk sharing program is based on an analysis of data (fee-for-service or managed care) from the population and services covered by the risk sharing program. This data is considered the primary source of information for developing the withhold amounts. Since any one year may reflect unusual occurrences, when available, multiple years of information are reviewed and combined together. Because the data is generally historical in nature and the withholds are applicable to the future capitation rates, the data must be trended and adjusted as necessary to coincide with the time period in which the rates will be paid. These trends are estimates of the future costs of services provided. Given the programs' narrow specificity of risk and high per recipient cost, total risk sharing costs may fluctuate substantially from year to year. However, over a period of several years, the amount withheld from the rates is expected to be equivalent to the amount paid by the Commonwealth in risk sharing claims (i.e., budget neutral).

VI. Information Sharing with MCOs

The Commonwealth will annually provide the MCO with certain information on the development of capitation rates, maternity care rates and risk pool premiums. This information will include the pieces of information listed below, exclusive of the underlying data used to develop the information. The majority of the numerical data provided will take the form of rating exhibits, detailed by geographic rating area, by rating group, and by service group. The Commonwealth’s commitment to provide data does not extend to data to which it is not legally entitled. The accuracy of data furnished by the Commonwealth is in some cases dependent on the integrity of data supplied by MCOs. The following items pertain where applicable to all three types of rates indicated above:

- Maternity and non-maternity historical utilization, unit costs and PMPMs reported to the Commonwealth by MCOs, summarized by geographic rating area, by rating group, and by service group.

- The cost base detailed by utilization, unit costs and PMPMs, by rating group and by service group, for each geographic rating area that is utilized by our actuaries, after adjustments to underlying data, with the maternity data used to develop case rates provided separately from the remaining non-maternity costs used to produce the capitation rates. The Commonwealth will also provide a text explanation of the adjustments applied to underlying data to develop the cost base.
• Information on, and the value of, program-wide adjustments.

• A review of the method employed by the Commonwealth’s actuaries to produce the final “midpoint” rates, along with a text explanation of how the ends of the actuarially sound rate range were determined.

• Information on, and the value of, adjustments to capitation rates specific to changes in the HealthChoices program or the Commonwealth’s Medicaid program, by category of aid and service category.

• Historic and projected member counts, by geographic rating area and rating group that have been used for purposes of rate development and comparison of rates.

• Average utilization, unit cost and PMPM trend rates by rating group and by service group used by the actuaries in each HealthChoices zone to project future costs.

• The amount of each rate that is intended to provide funding for administrative costs and profit collectively.

• The lower end, “midpoint,” and upper end of the range of actuarially sound rates determined by the Commonwealth’s actuaries for each rating group.

• A description of non-HealthChoices data sources considered in the course of rate development, along with comment on the applicability to HealthChoices.

The Commonwealth will provide this information in advance of discussions with the MCOs. The Department will provide the MCO, upon request, with a letter from an actuary that addresses the actuarial soundness of the rates.

The Commonwealth may elect to not provide information, as it deems appropriate, in advance of any HealthChoices rate bids that might be required from MCOs, should the Commonwealth resume the use of a rate bidding process for the HealthChoices program.

VII. Methodology to Determine High Cost Risk Pool Withholds (Where Applicable)

The amount that is withheld from the capitation rates to fund the High Cost Risk Pool (HCRP) is based on an analysis of data (FFS or managed care) from the population and services covered, as well as the design of the HCRP (e.g., threshold levels). This data is considered the primary source of information for developing the withhold amounts. Since any one (1) year may reflect unusual occurrences, when available,
multiple years of information are reviewed and combined together. Because the data is generally historical in nature and the withhold is applicable to the future capitation rates, the data must be trended and adjusted as necessary to coincide with the time period in which the rates will be paid. These trends are estimates of the future costs of services provided. Given the programs' narrow specificity of risk and high per recipient cost, total risk pool costs may fluctuate substantially from year to year.
APPENDIX 3k

HIGH COST RISK POOL

Overview

The Department will establish, administer, and distribute funds from a quarterly High Cost Risk Pool (HCRP). This Appendix 3k applies beginning October 1, 2012 and supersedes any previous version to define the HCRP for the October-December 2012 quarter and each subsequent quarter.

Each quarterly risk pool will be funded through High Cost Risk Pool Allocation Amounts (HCRPAA). After each quarter has ended, each PH-MCO will send the Department a file with information on high cost recipients during a twelve month period defined below. After repricing each inpatient claim to the amount the Department would have paid for the same admission, the Department will sum the amount spent by each PH-MCO in excess of the HCRP Threshold on each recipient for the Defined Twelve Month Period. The Department will distribute the funds in the HCRP in proportion to each PH-MCO’s adjusted expenditures in excess of the HCRP Threshold on all recipients for the Defined Twelve Month Period. The Department’s payment to each PH-MCO will be net of the PH-MCO’s HCRPAA obligation for the quarter. If the PH-MCO’s HCRPAA obligation exceeds its share of the HCRP, the Department will reduce a subsequent payment to the PH-MCO by the amount of the difference. The Department may elect to use PH-MCO encounter data in lieu of HCRP-specific files submitted by the MCOs, in whole or in part.

PH-MCO Inclusion/exclusion

The HCRP Threshold is $80,000.

A PH-MCO will participate in a quarterly high cost risk pool if both of the criteria below are met:

- The Department has made or will make Capitation payments to the PH-MCO for this HealthChoices zone for all three months during the quarter; and

- The Department has made or will make Capitation payments to the PH-MCO under this Agreement or any other HealthChoices Agreement for this HealthChoices zone for all three months of each of the four previous quarters.

The Department will deem this criterion to have been met if it was met by the PH-MCO or by a PH-MCO that operated in the same HealthChoices zone (“Previous PH-MCO”) if one of the following criteria are met:
• The current PH-MCO purchased the assets or liabilities of the Previous PH-MCO; or

• The Department transferred substantially all of the Recipients enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO.

If the PH-MCO does not meet the criteria for inclusion in a quarterly HCRP, then:

– The PH-MCO has no HCRPAA obligation for that quarter; and

– The PH-MCO has no opportunity to receive a distribution from that quarter’s HCRP; and

– The PH-MCO will not be required to contribute to that quarterly HCRP through a reduction to a subsequent payment.

The Department will determine each quarter which PH-MCOs meet the criteria for inclusion in that quarter’s HCRP.

The Department will administer only one HCRP specific to the HealthChoices zone for each calendar quarter, even if HealthChoices agreements begin and end during the quarter.

**DPW Calculation of Quarterly Funds in the Risk Pool**

After each quarter has ended, the Department will determine the sum of the PH-MCO’s HCRPAA obligation for the quarter, by multiplying the HCRPAA by the number of member months included in the PH-MCO during the quarter. The Department will use membership data compiled as of one date, for the purpose of determining each PH-MCO’s HCRPAA obligation for the quarter. The Department will provide documentation to the PH-MCO and will consider any issues the PH-MCO brings to the Department’s attention.

The sum of the HCRPAA obligation of every PH-MCO in the zone will be the total amount allocated to the HCRP for that quarter.

**Covered Services**

All medical claims paid by the PH-MCO for a medical product or service received by an enrolled recipient during the Defined Twelve Month Period may be included on files submitted to the Department, with the following exceptions:

– For recipients under the age of 21, no product or service that is a Covered Service under the Home Nursing Risk Sharing Arrangement is a Covered Service for the HCRP.
– The PH-MCO will not include any claim it has paid for a recipient who was a state-only General Assistance recipient.

The Department will apply the same criteria if it elects to use PH-MCO encounter data in lieu of HCRP-specific files submitted by the PH-MCOs.

**Defined Twelve Month Period**

The Defined Twelve Month Period is the twelve months that ended the day before the quarter for which HCRPAAAs are allocated to the quarterly risk pool.

Example: The Defined Twelve Month Period for the January-March 2012 HCRP is January-December 2011.

The Defined Twelve Month Period defines the dates that products and services are provided to recipients, not the dates claims are paid.

The Defined Twelve Month Period may include months that are covered by a different PH-MCO agreement that applies to the same HealthChoices zone.

Effective with the January-March 2011 HCRP, the discharge date on an inpatient claim determines eligibility for inclusion in a Defined Twelve Month Period.

**File Submission**

If required by the Department, the PH-MCO will provide the Department with a quarterly file that includes information on each Covered Service provided during the Defined Twelve Month Period. The Department may elect to use PROMISe-approved encounter data in lieu of MCO file submissions in whole or in part. The Department will use a consistent data source for all PH-MCOs in one zone.

For purposes of risk pool allocation, the Department will utilize information on recipients whose costs exceed the HCRP Threshold during the Defined Twelve Month Period, after repricing and other adjustments.

The Department will specify the fields that must be included on the file, as part of instructions on the files that will be issued to the PH-MCOs.

The PH-MCO will not include an allowance for Incurred But Not Reported claims.

Each quarterly file is due on or before the date indicated in a submission schedule issued by the Department.
Inpatient Hospital Repricing

The Department will reprice each acute inpatient hospital claim to the amount the Department would have paid for the admission. As the Department has implemented APR-DRGs and a new schedule of inpatient hospital rates into the Fee-for-Service program, the Department will also incorporate these changes in the repricing methodology effective with a quarterly HCRP to be determined by the Department.

The Department will send the PH-MCO a file that shows the repriced amount for each inpatient hospital claim.

Quarterly Distributions

The Department will review each file upon submission for compliance with requirements. The Department may make adjustments to each file as needed to achieve compliance with requirements.

The Department will utilize each file or PROMISe-approved encounter data or both, and administer the steps outlined in this appendix, to determine the adjusted amount each PH-MCO paid in excess of the HCRP Threshold for each recipient for products and services provided during the Defined Twelve Month period. The PH-MCO-specific sum will be the numerator in the calculation for the risk pool distribution. The denominator will be the applicable sum for all PH-MCOs in the HealthChoices zone. The resulting percentage figure will be multiplied by the amount in the risk pool. The PH-MCO’s uncollected HCRPAA obligation for the quarter will be subtracted from this amount. If the result is a positive number, the Department will pay the amount to the PH-MCO. If the result is a negative number, the Department will reduce a subsequent payment to the PH-MCO by this amount.

Gross Receipts Tax and High Cost Risk Pool

In recognition of the cost to the MCO of the Gross Receipts Tax, the Department will make certain additional payments, called GRT HCRP Payments, that recognize the legitimate and marginal administrative cost to the MCO of this tax. The Department will make a GRT HCRP Payment only in accordance with the following criteria:

A. The Department will have an obligation to make GRT HCRP Payment at the time that it makes any quarterly High Cost Risk Pool payment, in accordance with the following formula:

\[
\text{The sum of the Department’s gross High Cost Risk Pool obligation for every quarter from the October-December 2012 quarter forward}
\]

\[\text{MINUS} \quad \text{The PH-MCO’s HCRPAA obligation for the same quarters}\]
MULTIPLIED BY 6.27 percent

MINUS All GRT HCRP Payments paid by the Department to the PH-MCO for any quarter under any Agreement for this HealthChoices zone

EQUALS The Department’s GRT HCRP Payment obligation for this quarter.

If the result is negative, The Department has no GRT HCRP Payment obligation to the PH-MCO for this quarter, and the PH-MCO has no payment obligation to the Department.

B. The Department will make a GRT HCRP Payment on the same date it makes any High Cost Risk Pool payment.

C. The Department’s determination of an obligation to make a GRT HCRP Payment will be zone-specific and will apply collectively to all agreements the MCO has with the Department to operate a HealthChoices program in the same zone.

D. If the Department has notified the PH-MCO that the Gross Receipts Tax is reduced or ended, GRT HCRP Payments will be appropriately reduced or ended.

Subsequent Adjustments

If the Department determines that a PH-MCO has included data on a file submission that is incorrect or not adequately documented, the Department will retroactively adjust the final payment amounts applicable to each PH-MCO for the period in question. In this event, the PH-MCO will repay any excess final payment amount determined by the Department within thirty (30) days of a demand by the Department. The Department will apply such recovered funds toward payment of revised final payment amounts applicable to one or more other PH-MCOs.

If a PH-MCO determines it has submitted a quarterly file that contains an error, the PH-MCO must notify the Department as soon as possible. The Department will determine whether the PH-MCO must submit a revised quarterly file. If the Department notifies the PH-MCO that it must submit a revised quarterly file, the PH-MCO must submit said file within thirty (30) calendar days. The Department will process appropriate adjustments applicable to each PH-MCO for that quarter.

Early Payment of a PH-MCO’s HCRPAA Obligation

If the Department notifies the PH-MCO of termination of this HealthChoices Agreement; OR if the PH-MCO notifies the Department of termination of this HealthChoices Agreement; OR if this Agreement expires within four months; OR if an PH-MCO fails to submit a required
report or file to support the administration of a risk pool or risk sharing arrangement within fifteen work days of the final due date:

- The Department may elect to reduce a subsequent monthly capitation payment by the total amount of the outstanding HCRPAA obligation for current and previous program months; AND

- The Department may reduce each subsequent monthly capitation payment by the PH-MCO’s HCRPAA obligation for the same month.
APPENDIX 4

PH-MCO INFORMATION

Use the following PH-MCO address for sending information regarding notices and/or disputes, with the exception of the initial level disputes.

PH-MCO NAME AND ADDRESS
Vista Health Plan, Inc.
1901 Market Street
Philadelphia, PA 19103
Attention: Senior Vice President
Managed Care Products

With a copy to:

AmeriHealth Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113
Attention: Chief Executive Officer
APPENDIX 8

DURATION OF AGREEMENT AND RENEWAL

Initial Term

This Agreement, commencing on October 1, 2012, shall have an initial term of three (3) years, the "Initial Term", unless sooner terminated in accordance with Section XI of this Agreement, Termination and Default; provided that no court order, administrative decision, or action by any other instrumentality of the United States Government or the Commonwealth of Pennsylvania is outstanding which prevents commencement of this Agreement.

Renewal

The Department shall have the option to renew this Agreement for an additional two (2) year period after the expiration of the Initial Term. The Department shall give written notice to the Contractor one hundred twenty (120) days prior to the expiration of the Initial Term as to whether it wishes to renew this Agreement. If the Department exercises its option to renew this Agreement, rate discussions shall commence promptly after notice of the same.

Upon expiration of the Initial Term, the Agreement currently in effect will continue to be effective for a period of one hundred twenty (120) days if the Contractor and the Department agree to a renewal term, but cannot reach resolution of renewal contract terms, or if the parties have not proceeded to terminate the Agreement in accordance with Section XI of this Agreement, Termination and Default.
I. HealthChoices Rating Groups

Capitation Rates and Maternity Care Rates for the Agreement Year are found in Appendix 3f, Capitation Rates, for the following Rating groups:

- TANF and Healthy Beginnings Under Age 2 Months
- TANF and Healthy Beginnings Age 2 Months to Under Age 1
- TANF Age 1+
- Healthy Beginnings Age 1+
- SSI and Healthy Horizons
- Federal GA
- Maternity Care

The above rating groups are defined in Appendix 1, RFP, of the HealthChoices Agreement.