Copy-ID:		GRANT Number:	SAP: 4100067988

PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

GRANT AGREEMENT

PURPOSE OF THE GRANT:	To provide Healthy Pennsylvania Program Private Coverage physical and behavioral health services.

AWARD TO:	I.Steven Udvarhelyi, MC President and Chief Executive Officer Vista Health Plan, Inc. 1901 Market Street Philadelphia, PA 19103 TELEPHONE NUMBER: 215-241-4106 Steven.udvarhelyi@ibx.com	Mail fully executed agreement to: Laura Herzog Director, PA Compliance and Regulatory Affairs Keystone First and AmeriHealth Caritas Health Plans 200 Stevens Drive Philadelphia, PA 19113

FEDERAL I.D. NUMBER: 23-2408039

HEALTHY PENNSYLVANIA PROGRAM

PRIVATE COVERAGE ORGANIZATION AGREEMENT

BETWEEN

COMMONWEALTH OF PENNSYLVANIA

AND

VISTA HEALTH PLAN, INC.

4100067988

HEALTHY PENNSYLVANIA PRIVATE COVERAGE ORGANIZATION AGREEMENT

THIS AGREEMENT made effective as of the 12 day of NOV, 2014 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 PCO).

W I T N E S S E T H:

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) approved the Department's demonstration waiver request under Section 1115(a) of the Social Security Act, 42 U.S.C. §1396n, under the name *Healthy Pennsylvania* to expand access to coverage of physical and behavioral health services for eligible adults up to 133% of federal poverty level in all counties of Pennsylvania; and

WHEREAS, the Department issued Request for Application Number 04-14 (the RFA) containing the participation requirements and the terms and conditions of the *Healthy Pennsylvania* Program and soliciting applications from Pennsylvania-licensed health insurance entities to participate in the program (including all technical amendments, appendices and exhibits attached thereto); and

WHEREAS, the PCO submitted an Application in response to the RFA and such Application was selected by the Department as responsive to the requirements of the RFA (the Application submitted by the PCO, including all appendices and exhibits attached thereto, shall be referred to as the "Application"); and

WHEREAS, the Department and the PCO executed an Agreement effective _____.

NOW, THEREFORE, the parties intending to be legally bound hereby agree as follows:

IN WITNESS WHEREOF, the parties hereto have caused this Grant Agreement to be executed by its duly authorized officials.

GRANTEE

SIGNATURE
PRINT OR TYPE NAME AND TITLE

I. Steven Udvarhelyi, M.D.
President & CEO

SIGNATURE
PRINT OR TYPE NAME AND TITLE

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

Program Deputy Secretary

SIGNATURE

Secretary

SIGNATURE

NOV 0 3 2014

COMPTROLLER OPERATIONS

I hereby certify that funds in the amount shown are available under the Appropriation Symbols shown

AMOUNT	SOURCE	APPROPRIATION SYMBOL	PROGRAM
1.—			

Rita K Shaffer 11-12-14
SIGNATURE COMPTROLLER OPERATIONS

Approved as to Legality and Form:

OFFICE OF LEGAL COUNSEL
DEPARTMENT OF PUBLIC WELFARE
11/5/14

DEPUTY ATTORNEY GENERAL
OFFICE OF ATTORNEY GENERAL
(when required)
11/12/14

DEPUTY GENERAL COUNSEL
OFFICE OF GENERAL COUNSEL
(when required)

HEALTHY PENNSYLVANIA
PRIVATE COVERAGE ORGANIZATION AGREEMENT

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SECTION I: INCORPORATION OF DOCUMENTS

A. Term

The term of the Agreement shall commence on January 1, 2015 and shall remain in effect for three (3) years, subject to the other provisions of this Agreement. The Department, in its sole discretion, may renew the Agreement for two (2) additional 1 year periods. The Effective Date shall be fixed after the Agreement has been fully executed by the PCO and by the Commonwealth and all approvals required by Commonwealth procurement procedures have been obtained. No agency employee has the authority to verbally direct the commencement of work. The Department, may, upon notice to the PCO, extend the term of the Agreement for up to three (3) months upon the same terms and conditions to prevent a lapse in Agreement coverage, and only for the time necessary to enter into a new Agreement.

B. Operative Documents

The PCO will provide services for the *Healthy Pennsylvania* Program in accordance with this Agreement and its attached Exhibits and Appendices. These Exhibits and Appendices are incorporated and made part of this Agreement. With regard to the governance of such documents, it is agreed that:

1. In the event that any of the terms of this Agreement conflict with, or are inconsistent with, the terms of Appendix 1, RFA # 04-14, the terms of this Agreement shall govern;

2. In the event that any of the terms of this Agreement conflict with, or are inconsistent with, the terms of Appendix 2, Application, the terms of this Agreement shall govern;

3. In the event that any of the terms of Appendix 1, RFA # 04-14 conflict with, are inconsistent with, the terms of Appendix 2, Application, the terms of Appendix 1, RFA # 04-14 shall govern.

4. In the event that any of the terms of the Agreement conflict with, or are inconsistent with, the terms of any Appendix or Exhibit to the Agreement, the terms of the Agreement shall govern.

C. Operational Updates and Department Communications

1. PCO Operations Memos (PCO OPS Memos)

The Department will issue PCO OPS Memos via the Department's Intranet Systems to provide clarification to policies and procedures for the *Healthy Pennsylvania* Programs. The PCO must comply with the Department's directions in a timely manner.

2. DPW Web Site

MA Bulletins, Program information and other Department communications are available on the DPW Web site at http://www.dpw.state.pa.us/. The PCO is responsible to monitor the site regularly for any *Healthy Pennsylvania* Program related information.

SECTION II: DEFINITIONS

Abuse — Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the *Healthy Pennsylvania* Program, or in reimbursement for services that fail to meet professionally recognized standards or Agreement obligations (including the terms of the Agreement, and the requirements of state or federal law and regulations) for health care in a managed care setting. The Abuse can be committed by the PCO, subcontractor, Provider, State employee, or a Member, among others. Abuse also includes Member practices that result in unnecessary cost to the *Healthy Pennsylvania* Program, the PCO, a subcontractor, or Provider.

Actuarially Sound Rates —

- Have been developed in accordance with generally accepted actuarial principles and practices;
- Are appropriate for the populations to be covered and the services to be furnished under the agreement;
- Have been certified by actuaries credentialed by the American Academy of Actuaries and follow practice standards established by the Actuarial Standards Board.

Adverse Benefit Determination or Adverse Action—A PCO determination that includes:

- A denial of Service
- A reduction, suspension or termination of a previously authorized service
- A denial, in whole or part, of payment for a service
- A failure to provide a service in a timely manner
- A failure to meet the required timeframes for the internal claims and appeals process.

Affiliate — Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlling, controlled by or under common control with the PCO or its parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of PCO or its parent(s), directors or subsidiaries of PCO or parent(s) shall be presumed to be Affiliates for purposes of the RFA and Agreement. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, other ownership interests, or by contract or otherwise including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

A person with an employment, consulting or other arrangement for the provision of items and services that is significant and material to the PCO's obligations under this Agreement.

Behavioral Health (BH) Services — Mental health and/or substance abuse services which are provided by the PCO.

Beneficiaries—*Healthy Pennsylvania* Program eligible adults aged 21-64 that are not medically frail and have not otherwise been determined to meet Medicaid eligibility requirements.

Business Days — A Business Day includes Monday through Friday except for those days recognized as federal holidays or Pennsylvania State holidays.

Capitation — A fee the Department pays periodically to a PCO for each Member enrolled in its health plan to provide coverage of medical services, whether or not the Member receives the services during the period covered by the fee.

Centers for Medicare and Medicaid Services (CMS) — The federal agency within the United States Department of Health and Human Services responsible for oversight of MA Programs.

Certificate of Authority — A document issued jointly by the state Departments of Health and Insurance authorizing an entity to establish, maintain and operate an HMO in Pennsylvania.

Claim — A bill from a Provider of a medical service or product that is assigned a unique identifier (i.e. Claim reference number). A Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.

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

Client Information System (CIS) — The Department's database of Recipients and Beneficiaries. The data base contains demographic and eligibility information for all Recipients and Beneficiaries.

County Assistance Offices (CAO) — The county offices of the Department that administer all benefit programs, including MA and *Healthy Pennsylvania* on the local level. Department staff in these offices perform necessary functions such as determining and maintaining Recipient and Beneficiary eligibility.

Daily Membership File — An electronic file in a HIPAA compliant 834 format using data from DPW/CIS that is transmitted to the PCO on state work days. This 834 Daily File includes TPL information and is transmitted via the Department's PROMISe™ contractor.

Deliverables — Those documents, records, reports, processes, materials and systems required to be furnished to the Department for review and/or approval pursuant to the terms of this Agreement.

Denial of Services — Any determination made by the PCO in response to a request for approval which: disapproves the request completely; or approves provision of the requested service(s), but for a lesser amount, scope or duration than requested; or disapproves provision of the requested service(s), but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service. An approval of a requested service which includes a requirement for a concurrent review by the PCO during the authorized period does not constitute a Denial of Service.

Denied Claim — An Adjudicated Claim that does not result in a payment obligation to a Provider.

Department or DPW— The Department of Public Welfare of the Commonwealth of Pennsylvania.

Disenrollment — The process by which a Member's ability to receive services from a PCO is terminated.

Eligibility Period — A period of time during which a Beneficiary is eligible to receive benefits. An Eligibility Period is indicated by the eligibility start and end

dates as communicated by the Department. A blank eligibility end date signifies an open-ended Eligibility Period.

Encounter — Any covered health care service provided to a PCO Member, regardless of whether it has an associated Claim.

Encounter Data — A record of any covered health care service provided to a PCO Member and includes Encounters reimbursed through Capitation, Fee-for-Service, or other methods of compensation regardless of whether payment is due or made.

Enrollment — The process by which a Member's coverage by a PCO is initiated.

Enrollment Assistance Program (EAP) — The program that provides Enrollment Specialists to assist Beneficiaries in selecting a PCO and in obtaining information regarding Physical and Behavioral Health Services and Network Providers.

Family Planning Services — Services which enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies. Such services are made available without regard to marital status, age, sex or parenthood.

Federally Qualified Health Center (FQHC) — An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under the above-mentioned sections of the Act.

Fraud — Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. Fraud can be committed by any person or entity, including the PCO, a subcontractor, a Provider, a State employee, or a Member, among others.

Government Liaison — The Department's primary point of contact within the PCO. This individual acts as the day to day manager of contractual and operational issues and works within the PCO and with DPW to facilitate compliance, solve problems, and implement corrective action.

Health Care Provider — Any health care professional duly licensed or certified under Commonwealth statute regulating a particular branch of health care practice, including, but not limited to, a doctor of dental surgery, doctor of medicine, doctor of optometry, doctor of osteopathy, doctor of podiatry, doctor of chiropractic, licensed physical therapist, licensed clinical social worker, licensed

occupational therapist, licensed professional counselor, certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, certified clinical nurse specialist, licensed psychologist, licensed speech-language pathologist and licensed audiologist.

Health Maintenance Organization (HMO) — A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled Members for a fixed, prepaid fee.

Information Resource Management (IRM) — A program planned, developed, implemented and managed by DPW's Bureau of Information Systems, the purpose of which is to ensure the coordinated, effective and efficient employment of information resources in support of DPW business goals and objectives.

In-Plan Services — Services which are the responsibility of the PCO under the *Healthy Pennsylvania* Program.

Master Provider Index (MPI) — A component of PROMISe™ which is a central repository of Provider profiles and demographic information that registers and identifies Providers uniquely within the Department.

Medical Assistance (MA) — The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, and 62 P.S. §441.1 et seq. and regulations at 55 PA Code Chapters 1101 et seq.

Member — An individual who is enrolled with a PCO under the *Healthy Pennsylvania* Program and for whom the PCO has agreed to arrange the provision of Physical Health and Behavioral Health Services under the provisions of the *Healthy Pennsylvania* Program.

Member Record — A record contained on the Daily Membership File or the Monthly Membership File that contains information on eligibility, PCO coverage, and other data which help establish the covered services for which a Member is eligible.

Member Restriction — If a Member is determined to be mis-utilizing or otherwise abusing services provided under the *Healthy Pennsylvania* Program, he or she can be member restricted (locked-in) to a specific Provider(s) to obtain all of his/her services in an attempt to ensure appropriately managed care.

Monthly Membership File — An electronic file in a HIPAA compliant 834 format using data from DPW/CIS that is transmitted to the PCO on a monthly basis. This 834 Monthly File does not include TPL information and is transmitted via the Department's data contractor.

Network — All contracted or employed Providers in the PCO who are available to provide covered services to Members.

Network Provider — A PCO Health Care Provider who has a written contract with and is credentialed by a PCO and who participates in the PCO's Provider Network.

Net Worth— The excess of total admitted assets over total liabilities, but not including fully subordinated debt.

Non-participating Provider — A provider, whether a person, firm, corporation or other entity, not participating in the PCO's Network.

Nursing Facility — A general, county or hospital-based nursing facility, which is licensed by the DOH, enrolled in the MA Program and certified for Medicare participation. The Provider types and specialty codes are as follows:

- General – PT 03, SC 030
- County – PT 03, SC 031
- Hospital-based – PT 03, SC 382
- Certified Rehab Agency – PT 03, SC 040

Open-ended — A period of time that has a start date but no definitive end date.

Other Resources — With regard to TPL, Other Resources include, but are not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance, and accident indemnity insurance.

Out-of-Network Provider — See "Non-participating Provider".

Physical Health (PH) Services — Those medical and other related services, provided to Members, for which the PCO has assumed coverage responsibility under this Agreement.

Primary Care Practitioner (PCP) — A specific physician, physician group or a CRNP responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of a Member.

Primary Care Practitioner (PCP) Site — The location or office of PCP(s) where Member care is delivered.

Prior Authorization or Prospective Utilization Review — A determination made by the PCO to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiation or continuation of the requested service.

Private Coverage Organization—An HMO that has an approved agreement to provide health care services consistent with the *Healthy Pennsylvania* Program.

Provider — A person, firm or corporation, enrolled in the Pennsylvania MA Program, which provides services or supplies to Beneficiaries.

Provider Agreement — Any written agreement between the PCO and a Provider to provide medical or professional services to members to fulfill the requirements of this Agreement.

Provider Reimbursement and Operations Management Information System electronic (PROMISe™) — A claims processing and management system implemented by the Department that supports the Fee-for-Service, Managed Care Medical Assistance and *Healthy Pennsylvania* delivery programs.

Quality Assurance (QA) — An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.

Region—The nine (9) separate ACA Rating Areas in Pennsylvania.

Related Parties — Any entity that is an Affiliate of the PCO or subcontracting PCO and (1) performs some of the PCO or subcontracting PCO's management functions under contract or delegation; or (2) furnishes services to Members under a written agreement; or (3) leases real property or sells materials to the PCO or subcontracting PCO at a cost of more than $2,500.00 during any year of a PCO Agreement with the Department.

Relationship-- A director, officer or partner of the PCO, a person with a beneficial ownership of five percent or more of the PCO’s equity or a person with an employment, consulting or other arrangement with the PCO for the provision of items and services that are significant and material to the PCO’s obligations under this agreement.

Start Date--The first date on which Members are eligible for medical and behavioral health services under this Agreement, and on which the PCO s are operationally responsible and financially liable for the provision of services to Members.

Subcapitation — A fixed per capita amount that is paid by the PCO to a Network Provider for each Member identified as being in their capitation group, whether or not the Member received medical services.

Subcontract — Any contract between the PCO and an individual, business, university, governmental entity, or nonprofit organization to perform all or part of the PCO's responsibilities under this Agreement. Exempt from this definition are salaried employees, utility agreements and Provider Agreements, which are not considered Subcontracts.

Substantial Financial Risk — Financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. The cost of referrals, then, must not exceed that twenty-five percent (25%) level, or else the financial arrangement is considered to put the physician or group at Substantial Financial Risk.

Third Party Liability (TPL) — The financial responsibility for all or part of a Member's health care expenses of an individual entity or program (e.g., Medicare) other than the PCO.

Third Party Resource (TPR) — Any individual, entity or program that is liable to pay all or part of the medical cost of injury, disease or disability of a Member. Examples of Third Party Resources include: government insurance programs such as Medicare or CHAMPUS (Civilian Health and Medical Program of the Uniformed Services); private insurance coverage or similar coverage, and court-ordered medical support.

Title XVIII (Medicare) — A federally-financed health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 U.S.C. §1395 et seq., covering almost all Americans sixty-five (65) years of age and older and certain individuals under sixty-five (65) who are disabled or have chronic kidney disease.

Utilization Review (UR) — An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide medically appropriate, timely and quality health care services in the most cost-effective manner.

Voided Member Record — A Member Record used by the Department to advise the PCO that a certain related Member Record previously submitted by the Department to the PCO should be voided. A Voided Member Record can be recognized by its illogical sequence of PCO membership start and end dates with the end date preceding the Start Date.

AGREEMENT ACRONYMS

ACA—The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended
CLIA—Clinical Laboratory Improvement Act
DOH—Pennsylvania Department of Health
EAP—Enrollment Assistance Program
EOB—Explanation of Benefits
HIPAA—Health Insurance Portability and Accountability Act
OB/GYN—Obstetrics/Gynecology Provider
PCO—Private Coverage Organization
PID—Pennsylvania Insurance Department
PM/PM—Per Member Per Month
RFA—Request for Application

SECTION III: RELATIONSHIP OF PARTIES

A. Basic Relationship

The PCO, its employees, servants, agents, and representatives shall not be considered and shall not hold themselves out as the employees, servants, agents or representatives of the Department or the Commonwealth of Pennsylvania. The PCO, its employees, servants, agents and representatives do not have the authority to bind the Department or the Commonwealth of Pennsylvania and they shall not make any claim or demand for any right or privilege applicable to an officer or employee of the Department or the Commonwealth of Pennsylvania, unless such right or privilege is expressly delegated to the PCO herein.

The PCO is responsible for all taxes and withholdings of all of its employees. In the event that any employee or representative of the PCO is deemed an employee of the Department by any taxing authority or other governmental agency, the PCO agrees to indemnify the Department for any taxes, penalties or interest imposed upon the Department by such taxing authority or other governmental agency.

B. Nature of Agreement

The PCO must arrange for the provision of medical, Behavioral Health and related services to Members through qualified Providers in accordance

with this Agreement, including but not limited to, the operational and financial standards, as well as any functions expressly delegated to the PCO herein.

DPW will determine the number of PCOs operating in the *Healthy Pennsylvania* Program and may qualify, during the term of this Agreement, additional HMOs through an open process.

SECTION IV: APPLICABLE LAWS AND REGULATIONS

A. Certification and Licensing

The PCO must require that each of its Network Providers complies with all certification and licensing laws and regulations applicable to the Provider's profession or entity.

B. General Laws and Regulations

1. The PCO must comply with Titles VI and VII of the Civil Rights Act of 1964, 42 U.S.C §2000d and §2000e et seq.; Title IX of the Education Amendments of 1972, 20 U.S.C. §1681 et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §701 et seq.; the Age Discrimination Act of 1975, 42 U.S.C. §6101 et seq.; the Americans with Disabilities Act, 42 U.S.C. §12101 et seq.; Title XXVII of the Public Health Service Act (requirements relating to health insurance coverage); the ACA, 42 U.S.C. §300gg et seq; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Health Information Technology for Economic and Clinical Health (HITECH) Act; the HIPAA Privacy Rule and the HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 (HIPAA Regulations); the Pennsylvania Human Relations Act of 1955, 71 P.S. §941 et seq.; and Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2102 et seq.; and Act 106 of 1989, 40 P.S. §§ 908-1—908-8 Drug and Alcohol Use and Dependency Coverage.

2. The PCO must comply with the Terms and Conditions found in Exhibit A of this Agreement, Terms and Conditions.

3. The PCO must comply with all applicable laws, regulations and policies governing the *Healthy Pennsylvania* Program, including the approved waiver and its Special Terms and Conditions located in the Waiver Approval Section at www.healthypa.com.

4. The PCO must comply with applicable Federal and State laws that pertain to Member rights and protections. The PCO and its staff must

take those rights and protections into account when furnishing services to Members. The PCO must require its Network Providers to take those rights and protections into account when furnishing services to Members. The PCO must have written policies regarding Members' rights to:

a. Receive information on available treatment options and alternatives.
b. Participate in health care decisions, including the right to refuse treatment.
c. Be free from restraint or seclusion.
d. Request and receive a copy of his or her medical records and to request that they be amended or corrected.

5. The PCO and its subcontractors must respect the conscience rights of individual Providers and Provider organizations, as long as these conscience rights are made known to the PCO in advance, and comply with the current Pennsylvania laws prohibiting discrimination on the basis of the refusal or willingness to provide health care services on moral or religious grounds as outlined in 40 P.S. §§991.2121 and 991.2171; 43 P.S. §955.2 and 18 Pa. C.S. §3213(d).

If a PCO elects not to provide or reimburse a counseling or referral service based on its moral or religious objection to the service, it must comply with the requirements of 42 C.F.R. §438.102(b) and is responsible for making alternative arrangements for these services for its Members.

6. The PCO must maintain the highest standards of integrity in the performance of this Agreement and must take no action in violation of state or federal laws, regulations, or other requirements that govern procurements with the Commonwealth.

7. Nothing in this Agreement shall be construed to permit or require the Department to pay for any services or items which are not or have ceased to be compensable under the laws, rules and regulations governing the *Healthy Pennsylvania* Program at the time such services are provided. The administration of the *Healthy Pennsylvania* Program is dependent on Federal approval of the Commonwealth's *Healthy Pennsylvania* Section 1115 Demonstration Waiver Application as well as other factors. The requirements of this Agreement may need to be changed based upon Federal approval and other requirements.

8. The PCO must comply with 42 CFR §§ 438.726 and 438.730 describing conditions under which CMS may deny payments for new enrollees.

C. Limitation on the Department's Obligations

The obligations of the Department under this Agreement are limited and subject to the availability of funds.

D. Health Care Legislation

The PCO will comply with future changes in federal and state law, federal and state regulations, and all requirements and procedures related to changes in the *Healthy Pennsylvania* Program. This includes, but is not limited to, laws, regulations, requirements, procedures, and timelines related to the extension of the prescription drug rebate, required by Section 1927 of the Social Security Act (the Federal Drug Rebate Program), to include covered outpatient drugs dispensed to individuals eligible for *Healthy Pennsylvania* Program who are enrolled in the PCO and for whom the PCO is responsible for coverage of outpatient drugs.

SECTION V: PROGRAM REQUIREMENTS

A. In-Plan Services

PCOs may only operate in Regions approved by the Department. The Deputy Secretary for the Office of Medical Assistance Programs will notify the PCO of those Regions for which it has been approved to provide services. This approval will become part of this Agreement.

1. Amount, Duration and Scope

The PCO must provide Physical and Behavioral Health Services which are, at a minimum, included in the *Healthy Pennsylvania* Program essential health benefits package designated in Exhibit B of this Agreement. If services or Beneficiaries are added to the *Healthy Pennsylvania* Program, or if covered services or Beneficiaries are expanded or eliminated, the PCO will implement on the date the PCO is notified by the Department to commence or discontinue services. If the scope of services or Members that are the responsibility of the PCO is changed, covered services or the definition of Beneficiaries is expanded or reduced, or other significant change in the *Healthy Pennsylvania* Program (as a result of legislative, regulatory or policy changes); the Department will determine whether the change is sufficient that an actuarial analysis might conclude that a rate change is appropriate. The Department then may arrange for the actuarial analysis, and the Department will determine whether a rate change is appropriate. The Department will take into account the actuarial

analysis, and will consider input from the PCO, when making this determination. At a minimum, the Department will adjust the rates as necessary to maintain actuarial soundness of the rates. If the Department makes a change, the Department will provide the analysis used to determine the rate adjustment. If the scope of services or Members that are the responsibility of the PCO is changed, upon request by the PCO, the Department will provide written information on whether the rates will be adjusted and how, along with an explanation for the Department's decision.

The PCO, its subcontractors and Network Providers must adopt a definition of "medically necessary services" in accordance with 42 C.F.R. §438.210(a)(4).

The PCO may not arbitrarily deny or reduce the amount, duration or scope of a service solely because of a Member's diagnosis, type of illness or condition.

The PCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries. If no contracted PCO rate exists or if the Provider of the service is an Out-of-Network Provider, the PCO must pay deductibles and coinsurance up to the applicable PCO fee schedule for the service.

The PCO, its subcontractors and Providers are prohibited from balance billing Members for Medicare deductibles or coinsurance. The PCO must ensure that a Member who is eligible for both the *Healthy Pennsylvania* Program and Medicare benefits can access a Medicare product or service from the Medicare Provider of his/her choice. The PCO is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the PCO's Provider Network and whether or not the Medicare Provider has complied with the authorization requirements of the PCO.

2. Self-Referral/Direct Access

PCOs must provide Members with direct access to OB/GYN services in accordance with 40 P.S. §991.2111(7) and 28 Pa. Code §9.682. The PCO must have a system in place that does not erect barriers to care for pregnant women and does not involve a time-consuming authorization process or unnecessary travel.

When a pregnant Member is receiving care from an Out-of-Network OB-GYN at the time of Enrollment, the Member may continue to receive services from that Provider throughout the pregnancy and

postpartum care related to the delivery, in accordance with 28 Pa. Code §9.684.

The PCO must comply with 40 P.S. §991.2111 and 28 Pa. Code §9.683 regarding standing referrals or specialists as PCPs for its Members with special health care needs as defined by state law.

3. Emergency Services

The PCO must comply with Sections 2102 and 2116 of the Insurance Company Law of 1921 (40 P.S. §991.2102 and 991.2116), 28 Pa. Code §9.672 and 31 Pa. Code §154.14 pertaining to coverage and payment of Emergency and Stabilization Services.

The PCO will limit the amount to be paid to Non-participating Providers for Emergency Services to no more than the amount that would have been paid for such services under the Department's Fee for Service Program.

The PCO must cover Post-Stabilization Services without requiring authorization, regardless of whether the Member obtains services within the PCO Provider Network if Post-Stabilization Services were:

- **a.** Pre-approved by the PCO.
- **b.** Administered to maintain the Member's stabilized condition within one hour of the Health Care Provider's request to the PCO for pre-approval of further Post-Stabilization Services.
- **c.** Not pre-approved by the PCO because the PCO did not respond to the Health Care Provider's request for pre-approval within one hour of the request.
- **d.** Not pre-approved by the PCO because the PCO could not be reached by the Health Care Provider to request pre-approval for the Service.
- **e.** The PCO and the treating physician cannot reach an agreement concerning the Member's care and a PCO physician is not available for consultation. In this situation, the PCO must give the treating physician an opportunity to consult with a PCO physician and the treating physician may continue care of the Member until a PCO physician is reached or one of the criterial applicable to termination of the PCO's financial responsibility as described below is met.

  The PCO's financial responsibility for Post-Stabilization Services it has not pre-approved ends when:

f. A PCO physician with privileges at the treating hospital assumes responsibility for the Member's care.
g. A PCO physician assumes responsibility for the Member's care through transfer.
h. The PCO and the treating physician reach agreement concerning the Member's care.
i. The Member is discharged.

4. Nursing Facility Services

In any plan year, the PCO is responsible for up to 120 days of nursing facility care (including hospital reserve or bed hold days). The days need not be consecutive.

5. Co-Payments

The PCO will require its Network Providers to collect co-payments in accordance with PCO OPS Memos.

6. Family Planning

The PCO may not restrict a Member's choice of provider for family planning services.

7. Abortions

The PCO may only provide for abortion in cases of rape, incest or when the life of the Member is in danger.

8. Laboratory Services

The PCO must use laboratory testing sites that have a CLIA certification along with a CLIA identification number.

9. Authorization of Services

Except for pharmacy services, to the extent that the PCO requires Prior Authorization or Prospective Utilization Review of a service, it must comply with 28 Pa. Code §§9.751-9.753, including but not limited to the requirements for written policies and procedures.

Prior Authorization or Prospective Utilization Review of pharmacy services should comply with Exhibit H, H(1) and H(2) of the Agreement.

10. Practice Guidelines

The PCO will adopt, disseminate and apply practice guidelines consistent with 42 C.F.R. §438.236.

B. Issuance of Temporary Supply of Medication

If the PCO requires Prior Authorization as a condition for payment for an outpatient prescription drug and a Member's prescription for such a drug lacks Prior Authorization when presented to a pharmacist, the PCO must instruct the pharmacist to dispense a seventy-two (72) hour supply of the medication.

On a case by case basis, the Department may waive the seventy-two (72) hour supply requirement for medications and treatments under concurrent clinical review and treatments that are outside the parameter of use approved by the FDA or accepted standards of care.

The requirement that the Member be given at least a seventy-two (72) hour supply of a medication does not apply when a pharmacist determines that the taking of the prescribed medication, either alone or along with other medication that the Member may be taking, would jeopardize the health or safety of the Member.

C. Continuity of Care

The PCO must comply with Section 2117 of the Insurance Company Law of 1921 (40 P.S. §991.2117), 28 Pa. Code §9.684 and 31 Pa. Code §154.15 regarding continuity of care requirements. For purposes of the notice requirements under 28 Pa. Code §9.684, the PCO must make a good faith effort to provide such notice within fifteen (15) days of the termination notice.

A recipient, enrollee or Beneficiary (whether currently enrolled in MA FFS, MA-MCO or in a PCO) who transfers between the DPW delivery systems will continue (at the recipient, enrollee or beneficiary's option) to receive any prior authorized service the individual was authorized to receive or is receiving. The service must be provided, as long as it is a compensable service within the receiving delivery system, and must continue from the time of the transfer and up to sixty (60) days from the effective date of the transfer or enrollment; or until the receiving delivery system conducts a concurrent clinical review to determine if continuation of the prior authorized services is clinically appropriate. The procedures for continuity of care (based on prior authorized services) by a Non-participating Provider in a PCO are provided on the Department's Intranet site that supports the *Healthy Pennsylvania* Program.

The procedures for continuity of care for services not requiring Prior Authorization when a recipient, enrollee or beneficiary transfers between delivery systems are provided on the Department's Intranet site for the *Healthy Pennsylvania* Program.

D. Coordination of Care

The PCO is responsible for coordination of care for individuals enrolled in *Healthy Pennsylvania* Program. The PCO must provide seamless and continuous coordination of care across a continuum of services for the individual Member with a focus on improving health care outcomes. To the extent possible and appropriate, the PCO will allow each Member to select his or her health care professional.

The PCO will assess Members with special needs as defined by the Department to identify ongoing special conditions requiring treatment or monitoring. If determined necessary, the PCO and the treating provider are responsible for the development of a treatment plan in accordance with the requirements of 42 C.F.R. §438.208(c)(3) and 28 Pa. Code §9.683(b)(3).

E. PCO Responsibility for Reportable Conditions

The PCO must work with DOH State and District Office Epidemiologists in partnership with the designated county/municipal health department staffs to ensure that reportable conditions are appropriately reported in accordance with 28 Pa. Code Chapter 27. The PCO must designate a single contact person to facilitate the implementation of this requirement.

F. PCO Outreach Materials

The PCO must have and use outreach materials in accordance with Section 2136 of the Insurance Company Law of 1921 (40 P.S. §991.2136) and 31 Pa. Code §154.16. Upon request by the Department, the PCO must develop or modify existing outreach materials which can be used by the EAP contractor to assist Beneficiaries in choosing a PCO and PCP. The PCO must modify or develop such materials in the form and content required by the Department.

The PCO must provide copies of all Member outreach material to the Department for review and approval thirty (30) calendar days prior to use.

The PCO will be responsible for bearing the cost of reprinting *Healthy Pennsylvania* Program PCO outreach materials, if the PCO makes a change involving content prior to the annual revision of the EAP materials.

The PCO may not engage in cold call marketing as defined in 42 U.S.C §1396u-2(d)(2)(E) and 42 C.F.R. §438.104(a).

G. Member Incentives and Encouraging Employment

The PCO should develop a Member incentives program that is related to improving Member health outcomes and encouraging employment. The Department must approve the use of the incentive program in writing prior to its use. The PCO may not offer remunerations as provided by 42 C.F.R. §1003.102(b)(13).

H. Explanation of Benefits

Except for pharmacy claims, the PCO must provide EOB information to its Members. The PCO must make the EOB information available within 45 days of payment or denial of a claim. The EOB information must specify the services paid or denied; including the description, date of service, place of service, provider name and ID, and the amount paid, and contact information for questions the Member may have about the EOB.

I. PCO Enrollment Procedures

The PCO must have written policies and procedures for coordinating Enrollment information with the Department's EAP contractor. The PCO must receive advance written approval from the Department regarding these policies and procedures. The PCO's submission of new or revised policies and procedures for review and approval by the Department does not void any existing policies and procedures which have been prior approved by the Department for operation in a *Healthy Pennsylvania* Program Region. Unless otherwise required by law, the PCO may continue to operate under such existing policies and procedures until the Department approves the new or revised version thereof.

The PCO must enroll any Beneficiary who selects or is assigned to the PCO in accordance with the Enrollment/Disenrollment dating rules that are determined and provided by the Department on the Department's Intranet site regardless of the Beneficiary's race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, grievance status, health status, pre-existing condition, physical or mental disability or anticipated need for health care.

During the first ninety days of a Member's enrollment in a PCO, a PCO may not restrict the Member from changing PCOs for any reason. The Department will determine when a Member may disenroll from a selected PCO for cause.

J. Newborn Coverage

The Department will enroll each baby born to a Member into the HealthChoices MA Managed Care Program effective on the date of birth. The PCO is responsible for coverage of the inpatient *Normal Newborn* stay for the Member's baby. The PCO is not responsible for:

1. Physician services provided for the newborn.
2. An inpatient claim other than a *Normal Newborn* stay.
3. An inpatient claim for a complex newborn.
4. A metabolic screening.
5. Any medical product or service other than an inpatient *Normal Newborn* stay.

K. Change in Status

The PCO must report to the Department on a weekly Enrollment/Alert file the following: pregnancy (not on CIS), death, newborn (not on CIS) and return mail alerts in accordance with this Agreement.

The PCO must report to the appropriate CAO using the CAO notification form any changes in the status of families or individual Members within ten (10) Business Days of their becoming known. These changes include phone number, address, pregnancy, death and family addition/deletion. The PCO must include a detailed explanation of how the information was verified on the form.

L. Membership Files

1. Monthly File

The Department will provide an 834 Monthly Membership File for each PCO on the next to the last Saturday of each month. The file contains the Eligibility Period, PCO coverage, and other Beneficiary demographic information. The PCO must reconcile this membership file against its internal membership information and notify the Department of any discrepancies found within the data on the file within thirty (30) Business Days, in order to resolve problems.

Beneficiaries without an indication of prospective coverage will not be the responsibility of the PCO unless a subsequent 834 Daily Membership File indicates otherwise. Beneficiaries with an indication of future month coverage will not be the responsibility of the PCO if an 834 Daily Membership File received by the PCO prior to the beginning of the future month indicates otherwise.

2. Daily File

The Department will provide to the PCO an 834 Daily Membership File that contains records for each PCO Member where data for that Member (contained in the 834 file layout) has changed that day. The file contains add, termination and change records, and demographic changes, eligibility changes, Enrollment changes, Members enrolled through the automatic assignment process, and TPL information. The PCO must process this file within 24 hours of receipt.

The PCO must reconcile this file against its internal membership information and notify the Department of any discrepancies within thirty (30) Business Days in order to resolve problems.

M. Enrollment and Disenrollment Updates

1. Weekly Enrollment/Alert Reconciliation File

The Department will provide, every week by electronic file transmission, information on Members enrolled or disenrolled from the PCO. This file also provides dispositions on alerts submitted by the PCO. The PCO must use this file to reconcile alerts submitted to the Department.

2. Disenrollment Effective Dates

Member Disenrollments will become effective on the date specified by the Department. The PCO must have written policies and procedures for complying with Disenrollment decisions made by the Department.

The PCO cannot disenroll Members, except as specified by the Department. Any requests for disenrollment made by Members must be referred to the Department.

N. PCO Identification Cards

The PCO must issue its own identification card to Members prior to coverage period.

O. Member Information

The PCO must provide information to its Members in a form that is easily understandable and complies with §2715 of the ACA (adding 42 U.S.C. §300gg-15 to the PHSA), 45 C.F.R. §146.20 and §2136 of the Insurance Company Law of 1921, 40 P.S. §991.2136 and 31 Pa. Code §154.16, including but not limited to language and format requirements.

The PCO will comply with 42 C.F.R. §438.10(d), including the requirements that PCO written materials be available in alternate formats and in an appropriate manner and that the PCO inform Beneficiaries of the availability and how to access such formats.

P. Internal Review and State Fair Hearing Processes

The PCO must comply with 42 C.F.R. §147.136 relating to internal claims and appeals and external review processes. The PCO must implement and maintain an internal claims and appeal process for the resolution of adverse benefit determinations in accordance with the requirements of 45 C.F.R. §147.136(b)(3) relating to internal claims and appeals process for individual health insurance insurers, including record keeping requirements. Upon resolution of the internal claims and appeals process, the PCO shall provide written notice to the Member. The PCO must include in the notice the information required by 42 C.F.R. §438.408(e) and 45 C.F.R. §147.136(b)(3)(ii)(E). The external review process of a final adverse benefit determination will occur through the Department's Fair Hearing process.

Upon the exhaustion of the PCO's internal claims and appeals process, a Member may request a Fair Hearing with the Department's Bureau of Hearings and Appeals within thirty (30) days from the mail date of the notice of adverse benefit determination. A Member may not request a Fair Hearing prior to the exhaustion of the PCO's claims and appeals process.

The PCO must have written policies and procedures approved by the Department for its internal claims and appeal and Fair Hearing request processes.

Q. Provider Relations and Provider Dispute Resolution

The PCO and its Network Providers must have written provider agreements that comply with 28 Pa. Code §9.722 requirements.

The PCO must comply with 40 P.S. §991.2113 relating to the medical gag clause prohibition.

The PCO must develop, implement, and maintain a Provider Dispute Resolution Process to ensure that resolution of all issues regarding Network Provider Agreements are handled between the PCO and the Provider and do not involve the Department.

R. Certification of Authority and County Operational Authority

The PCO must maintain a Certificate of Authority to operate as an HMO in Pennsylvania. The PCO must provide to the Department a copy of its Certificate of Authority upon request.

The PCO must also maintain operating authority in each county for each Region in which it has been approved to provide services. The PCO must provide to the Department a copy of the DOH correspondence granting operating authority for each county for each such Region upon request.

The PCO must report the loss of certification or operating authority to the Department immediately upon notification by the DOH or PID.

S. Administration

The PCO must comply with the program standards regarding PCO Administration.

1. Member Restriction Program

The PCO may implement a Member Restriction Program. The purpose of this Program is to identify Members that over-utilize or mis-utilize plan services. If implemented, the PCO will identify Members for this program through review of information such as medical and pharmacy claims data, diagnoses and other documentation such as medical records. The PCO may restrict Members to obtain services from a single designated Provider for a period of up to five (5) years. The PCO must provide written notice of the restriction to the Member and the designated Provider. The PCO must provide Members with an opportunity to change their designated Provider within thirty (30) days of the request from the Member.

2. Contracts and Subcontracts

The PCO may use subcontractors to perform and/or arrange for the performance of services to be provided to Members. Any such Subcontracts must be in writing and must specify the responsibilities and activities of the subcontractor.

The PCO must make all Subcontracts available to the Department upon request.

3. Records Retention

The PCO must retain program records, including financial records, supporting documents, statistical records and all other records relating to this Agreement for a period of five (5) years beyond expiration or termination of the Agreement, unless otherwise authorized by the Department. For records relating to litigation or the settlement of claims arising out of performance or expenditures under this Agreement, the PCO shall retain these records until such litigation, claim, or exceptions have reached final disposition. Upon twenty-one (21) calendar days' notice from the Department, the PCO must provide copies of all requested records to the Department. This twenty-one (21) days period does not apply to records requested by the state or federal government for purposes of fiscal or other audits or Fraud and/or Abuse reviews. The retention requirements in this section do not apply to DPW-generated Remittance Advices.

4. Fraud and Abuse

a. The PCO must have a written fraud and abuse compliance plan that contains, at a minimum the following elements:

- Written policies, procedures, and standards of conduct that articulate the PCO's commitment to comply with all Federal and State requirements.
- The designation of a compliance officer and a compliance committee that are accountable to senior management.
- Effective training and education for the compliance officer and PCO employees.
- Effective lines of communication between the compliance officer and PCO employees.
- Enforcement of standards through well publicized disciplinary guidelines.
- Provisions for internal monitoring and auditing.

- Provisions for prompt response to detected offenses and the development of corrective action initiatives.

b. Fraud and Abuse Unit

The PCO must maintain a Fraud and Abuse unit within the organization comprised of experienced Fraud and Abuse reviewers. This unit shall have the primary purpose of preventing, detecting, investigating, and reporting suspected Fraud and Abuse that may be committed by Network Providers, Members, employees, or other third parties with whom the PCO contracts.

c. Procedure for Identifying Fraud and Abuse

The policies, procedures and standards of conduct must also contain the following:

i. A description of the methodology and standard operating procedures used to identify and investigate Fraud and Abuse, including a method for verifying with Members whether services billed by Providers were received, and to recover overpayments or otherwise sanction Providers.

ii. A description of specific controls in place for Fraud and Abuse detection, including an explanation of the technology used to identify aberrant billing patterns, Claims edits, post processing review of Claims, and record reviews.

d. Education Plan

The PCO must create and disseminate, or require its subcontractors to create and disseminate, written materials for the purpose of educating employees, managers, Providers, subcontractors and subcontractors' employees about health care Fraud laws, the PCO's policies and procedures for preventing and detecting Fraud and Abuse and the rights of employees to act as whistleblowers.

e. Duty to Cooperate with Oversight Agencies

The PCO must cooperate fully with oversight agencies responsible for Fraud and Abuse detection and prosecution activities. Such agencies include, but are not limited to, the

Department, Office of Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, the CMS Office of Inspector General, and the United States Justice Department. Such cooperation must include providing access to all necessary case information, computer files, and appropriate staff.

f. Prohibited Affiliations

The PCO may not knowingly have a relationship with the following:

- An individual or entity who is barred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, 48 CFR Parts 1-51, or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

- An individual who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The PCO may not employ or enter into any type of contractual or provider relationship with an individual or entity who is precluded from participation in a federally funded health care program.

The PCO must immediately notify the Department, in writing, if a Provider or subcontractor with whom the PCO has entered into an agreement is subsequently suspended, terminated or voluntarily withdraws from participation in the PCO as a result of suspected or confirmed Fraud or Abuse. The PCO must also immediately notify the Department, in writing, if it terminates or suspends an employee as a result of suspected or confirmed Fraud or Abuse. The PCO must inform the Department, in writing, of the specific underlying conduct that led to the suspension, termination, or voluntary withdrawal. Provider Agreements must carry notification of the prohibition and sanctions for submission of false Claims and statements.

g. Subcontracts

i. The PCO will require that all Network Providers and subcontractors take such actions as are necessary to

permit the PCO to comply with the Fraud and Abuse requirements of this Agreement.

ii. To the extent that the PCO delegates oversight responsibilities to a third party (such as a Pharmacy Benefit Manager), the PCO must require that such third party complies with the Fraud and Abuse requirements of this Agreement.

iii. As part of its contracting or subcontracting, with the exception of Provider Agreements, the PCO must ensure that all Subcontracts meet all applicable federal and state laws, regulations and requirements identified in this Agreement.

iv. The PCO agrees that its contracts with all subcontractors must be consistent, as may be applicable, with DOH regulations governing HMO Contracting with Integrated Delivery Systems at 28 Pa. Code §§9.721-9.725 and PID regulations at 31 Pa. Code §§ 301.301-301.314.

h. Reporting Requirements

The PCO shall submit Fraud and Abuse information to the state. At a minimum, the information must include the number of fraud and abuse complaints made to the PCO that warrant preliminary investigation and for each complaint, the identity and type of the Provider, the source and nature of the complaint, the approximate dollars involved and the disposition of the complaint.

5. Management Information Systems

The PCO must have a comprehensive, automated and integrated health management information system (MIS) that is capable of meeting the requirements listed below and throughout this Agreement. The PCO must comply with Management Information System Standards provided by the Department on the Department's Intranet.

a. The PCO must have at a minimum the following components to its MIS or the capability to link to other systems containing this information: Membership, Provider, Claims processing, Authorization, reference files.

b. The PCO must have an MIS sufficient to support data reporting requirements specified in this Agreement.

c. The membership management system must have the capability to receive, update and maintain the PCO's membership files consistent with information provided by the Department. The PCO must have the capability to provide daily updates of membership information to subcontractors or Providers with responsibility for processing Claims or authorizing services based on membership information.

d. The PCO's Provider file must be maintained with detailed information on each Provider sufficient to support Provider payment and also meet the Department's reporting and Encounter Data requirements.

e. The PCO's Claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements required by law.

f. The PCO's Authorization system must be linked with the Claims processing component.

g. The PCO's MIS must be able to maintain its Claims history with sufficient detail to meet all Department reporting and Encounter requirements.

h. The PCO must have sufficient telecommunication capabilities, including secured electronic mail, to meet the requirements of this Agreement.

i. The PCO must have the capability to electronically transfer data files with the Department and the EAP contractor. The PCO must use a secure FTP product that is compatible with the Department's product.

j. The PCO's MIS must be bi-directionally linked to the other Department operational systems in order to ensure that data captured in Encounter records accurately matches data in Member, Provider, Claims and Authorization files, and in order to enable Encounter Data to be utilized for Member profiling, Provider profiling, Claims validation, Fraud and Abuse monitoring activities, and any other research and reporting purposes defined by the Department. The Encounter Data system must have a mechanism in place to receive and process the U277 and NCPDP response files; and to store the

PROMISe ICN associated with each processed Encounter Data record returned on the files.

k. The PCO must comply with all applicable information technology standards as defined in the Department's Information Resource Management (IRM) Standards. This includes compliance with the IRM Business Partner Network Connectivity Provisioning Standards for connectivity to the Commonwealth's network. The current IRM Standards are available to the PCO via a secured Internet site. The PCO's MIS must be compatible with the Department's MIS. The PCO must also comply with the Department's Se-Government Data Exchange Standards as defined in the IRM Standards. In addition, the PCO must comply with any changes made to the IRM Standards. Whenever possible, the Department will provide advance notice of at least sixty (60) days prior to the implementation of MIS or IRM changes. For more complex changes, every effort will be made to provide additional notice.

l. At the Department's request, the PCO must be able to document its ability to expand Claims processing or MIS capacity as Member enrollment increases.

m. The PCO must designate staff with appropriate skill level and experience to participate in DPW directed development and implementation activities.

n. Subcontractors must meet the same MIS requirements as the PCO and the PCO will be held responsible for MIS errors or noncompliance resulting from the action of a subcontractor. The PCO must provide its subcontractors with the appropriate files and information to meet this requirement.

o. The PCO's MIS shall be subject to review and approval during the Department's *Healthy Pennsylvania* Readiness Review process as referenced in Section VI of this Agreement, Program Outcomes and Deliverables.

p. Prior to any major modifications to the PCO's MIS, including upgrades and/or new purchases, the PCO must inform the Department in writing of the potential changes. The PCO must include a work plan detailing recovery effort and use of parallel system testing.

q. The PCO must be able to accept and generate HIPAA compliant transactions as requested by Providers or the Department.

r. The PCO must have a disaster recovery plan in place, and written policies and procedures documenting the disaster recovery plan including information on system backup and recovery in the event of a disaster.

s. The PCO shall make all collected MIS data available to the Department, and upon request, to CMS.

t. The PCO MIS shall collect Encounter Data that is verified and screened for accuracy in accordance with 42 C.F.R. §438.242(b)(2).

6. Department Access and Availability

The PCO must provide Department access to administrative policies and procedures pertaining to operations under this Agreement, including, but not limited to;

- Policies and procedures developed to ensure compliance with requirements under this Agreement.

- Operations policies and procedures.

The PCO must designate an appropriate staff member to act as the Government Liaison. The government liaison is the single point of contact with the Department.

T. Quality Assurance and Utilization Review Requirements

The PCO will comply with 28 Pa. Code §§9.654 and 9.674 regarding external quality assurance assessments. Upon submission of the annual DOH quality assurance and utilization review reports, the PCO must submit a copy to the Department for review and analysis by the Department's quality oversight personnel.

The PCO will cooperate fully with external quality evaluations and assessments of its performance as may be required by 42 C.F.R. Subpart E External Quality Review.

The PCO must submit Healthcare Effectiveness Data and Information Set (HEDIS) data for the prior year to the Department by June 15th of the current year.

The PCO must have an ongoing performance improvement program and collect performance measurement data and on an annual basis, report its measurement data to the Department in accordance with 42 C.F.R. §438.240 and 28 Pa. Code §9.674.

U. Mergers, Acquisitions, Mark, Insignia, Logo and Product Name

1. Mergers and Acquisitions

The Department must be notified at least forty-five (45) calendar days in advance of the legal effective date of a merger or acquisition of the PCO.

2. Mark, Insignia, Logo, and Product Name Changes

The PCO must submit mark, insignia, logo, and product name changes within thirty (30) calendar days of projected implementation.

V. Provider Network

All Network Providers who provide services to Members must be enrolled in the Commonwealth's MA Program and possess an active PROMIS*e*™ Provider ID Number for each location in which they provide services for the PCO. In addition, the PCO must be able to store and utilize the PROMIS*e*™ Provider ID Number and NPI stored in PROMIS*e*™ for each location.

The PCO must establish and maintain adequate Provider Networks to serve Members in the PCO Regions for which it has been approved. These Provider Networks must satisfy the requirements of 40 P.S. §991.2111 and 28 Pa. Code §§9.671-9.685 relating to availability and access to services. Provider Networks must include, but not be limited to: hospitals, specialty clinics, facilities for high-risk deliveries, specialists, physicians, pharmacies, emergency transportation services, long-term care facilities, rehabilitation facilities, home health agencies, certified hospice providers, DME suppliers, and Behavioral Health Providers in sufficient numbers to make available all services in a timely manner.

The PCO will comply with requirements at 40 P.S. §991.2121 and 28 Pa. Code §§9.761-.9.763 for Provider credentialing. Upon request, the PCO must demonstrate that its Network Providers are credentialed.

The PCO must monitor its Network Providers to verify compliance with access standards and take corrective action if it identifies non-compliance.

For services within the scope of this Agreement, the PCO must provide for a second opinion from a qualified Network Provider or arrange for the Member to obtain a second opinion outside of the Network at no cost to the Member.

The PCO will provide the Department with copies of DOH access reports including changes to its Network Providers as required by 28 Pa. Code §9.679.

The PCO must have Provider directories for all Provider types in the PCO's Network, including, but not limited to PCPs, hospitals, specialists, Providers of ancillary services, and Nursing Facilities. Provider directories must include, at a minimum, the following information:

1. PCPs

- **a.** The names, addresses, telephone numbers and hospital affiliations of Network PCPs
- **b.** Identification of whether the PCP is a Doctor of Medicine or Osteopathy
- **c.** Identification of whether PCPs are Board-certified and, if so, in what area(s)
- **d.** Identification of PCP Teams which include physicians, Certified Registered Nurse Practitioners (CRNPs), Certified Nurse Midwives and Physician Assistants
- **e.** Identification of languages spoken by Network Providers at the primary care sites
- **f.** Identification of sites which are wheelchair accessible
- **g.** Identification of the days of operation and the hours when the PCP office is available to Members

The PCO, at the request of the PCP, may include the PCP’s experience or expertise in serving individuals with particular conditions

2. Specialist and Providers of Ancillary Services

- **a.** The names, addresses and telephone numbers of Network specialists and their hospital affiliations
- **b.** Identification of the specialty area of each Network specialist's practice
- **c.** Identification of whether the specialist is Board-certified and, if so, in what area(s)

d. Experience or expertise in serving individuals with particular conditions

The PCO must develop and utilize a web-based Provider directory. The PCO must establish a process to ensure the accuracy of electronically posted content including a method to monitor and update changes in Provider information.

The PCO must submit its Provider directory to the Department for review before distribution to its Members. If there are significant format changes to the directory, the PCO must submit the directory to the Department for review prior to member distribution. The PCO also must make modifications to its Provider directory upon request by the Department.

The PCO must notify its Members annually of their right to request and obtain Provider directories. Upon request, the PCO must provide its Members with its Provider directories. Upon request from a Member, the PCO will print the most recent electronic version from their Provider file and mail it to the Member.

At a minimum, the PCO must provide the EAP contractor with an updated electronic version of its Provider directory on a weekly basis. The PCO must include information regarding terminations, additions, PCPs and specialists not accepting new assignments, and other information as determined by the Department. The PCO must utilize the file layout and format specified by the Department. The format must include, but not be limited to the following:

- Correct PROMISe™ Provider ID
- All Network Providers
- The location where Network PCPs will see Members, as well as whether the PCP has evening and/or weekend hours
- Wheel chair accessibility of Provider sites
- Language indicators including any non-English language spoken by Network Providers

W. Advance Directives

The PCO must maintain written policies and procedures with respect to advance directives as defined by 20 Pa. C.S. §5421 et seq. and must provide Members with written information concerning state law, including any limits regarding implementation as a matter of conscience. Within ninety (90) days of changes in state law, the PCO must update its information.

SECTION VI: PROGRAM OUTCOMES AND DELIVERABLES

The PCO must obtain Department's prior written approval of all systems, processes and materials prior to the operational date of the Term and throughout the duration of the Agreement unless otherwise specified by the Department.

The Department may require the PCO to resubmit for Department approval previously approved Deliverables, as needed, to conform to the Agreement or applicable law. If the PCO makes changes to previously approved Deliverables, these Deliverables must be resubmitted for Department review and approval unless otherwise specified by the Department. Unless otherwise specified by the Department, previously approved deliverables remain in effect until approval of new versions.

The Department will conduct initial on-site Readiness Reviews, to determine the PCO's ability to comply with this Agreement. Upon request by the Department, as part of the Readiness Review, the PCO must provide detailed written descriptions of how the PCO will comply with Agreement requirements and standards. The Department may require additional Readiness Reviews during the course of the Agreement if the PCO systems and processes change substantially.

SECTION VII: FINANCIAL REQUIREMENTS

A. Financial Standards

As proof of financial responsibility and adequate protection against insolvency, the PCO agrees to the following requirements.

1. Net Worth Requirements and Solvency Protection

The PCO must comply with all financial standards and requirements included in this Agreement, in addition to those of the PID.

The PCO must maintain SAP-basis Net Worth equal to the highest of the amounts determined by the following "Three (3) Part Test" as of the last day of each calendar quarter:

- $10.00 million;
- 5.5% of revenue earned by the licensed HMO during the most recent four (4) calendar quarters; or
- 5.5% of revenue earned by the licensed HMO during the current quarter multiplied by three (3).

Revenue, for the purpose of the Net Worth requirement calculation, is defined as the total gross Direct Business Premiums, for all Pennsylvania lines of business, reported in Schedule T, "Premiums and Other Considerations," of the PID report.

For the purpose of this requirement, Net Worth amounts, as of the last day of each calendar quarter, shall be determined in accordance with statutory accounting principles as specified or accepted by the PID. The Department will accept PID determinations of Net Worth amounts, and in the absence of such determination, will rely on required financial statements filed by the PCO with PID to determine Net Worth amounts.

2. Risk Based Capital (RBC)

The RBC ratio is defined as the Total Adjusted Capital figure in Column 1 from the page titled Five Year Historical Data in the Annual Statement for the most recent year filed most recently with the PID divided by the Authorized Control Level Risk-based Capital figure.

The PCO must maintain a RBC ratio of 2.0.

3. Change in Independent Actuary or Independent Auditor

The PCO must notify the Department in writing within ten (10) calendar days when its contract with an independent auditor or actuary has ended. The notification must include the date of and reason for the change or termination. If the change or termination occurred as a result of a disagreement or dispute, the nature of the disagreement or dispute must be disclosed. In addition, the name of the replacement auditor or actuary, if any, must be provided.

4. Member Liability

The PCO is prohibited from holding a Member liable for the following:

a. Debts of the PCO in the event of the PCO's insolvency.

b. Services provided to the Member in the event of the PCO failing to receive payment from the Department for such services.

c. Services provided to the Member in the event of a Health Care Provider with a contractual, referral or other arrangement with the PCO failing to receive payment from the Department or the PCO for such services.

d. Payments to a Provider that furnishes compensable services under a contractual, referral or other arrangement with the PCO in excess of the amount that would be owed by the Member if the PCO had directly provided the services.

B. Commonwealth Capitation Payments

1. Payments for Services

The obligation of the Department to make payments shall be limited to Capitation payments and any other payments provided by this Agreement.

The PCO agrees that the Commonwealth or Department may set off the amount of any state tax liability or other obligation of the PCO or its subsidiaries to the Commonwealth against any payments due the PCO under any contract or agreement with the Commonwealth or the Department.

a. Capitation Rates

i. The Department will pay the PCO based on a schedule of PMPM capitation rates.

ii. At a minimum the Department will annually propose a schedule of PMPM capitation rates to the PCO that will apply to a time period subsequent to the end date of the rate schedule in this Agreement, or that is intended to replace the schedule of rates in the Agreement. When new rates are proposed by the Department, the Department will make itself available to consider and discuss PCO input. The Department may impose strict deadlines for a PCO proposal, completion of discussions, or PCO signature on an amendment that provides updated rates or other terms.

iii. The Department will risk adjust the rates provided by Appendix 3f, Capitation Rates, beginning January 2016, or at some later date determined by the Department. The Department will share detailed information with the PCO on the risk adjusted rate methodology. The PCO will accept capitation rates that are adjusted upward or downward, using rate adjustment factors computed by the Department, consistent with the risk adjustment methodology shared by the Department with the PCO.

b. Capitation Payments

i. The Department will divide the PMPM capitation rate to determine a per diem capitated rate. By the fifteenth (15) of each month the Department will make a per diem capitated rate payment to the PCO, for each Member enrolled in the PCO, for the 1st day in the month the Member is enrolled in the PCO and for each subsequent day through and including the last day of the month. The Department will also make a payment to the PCO for each Member enrolled in the PCO on any day prior to the 1st day of the current month for which the Department has not previously made payment.

ii. The Department will not make a Capitation payment for a Member Month if the Department notifies the PCO before the first of the month that the individual's PCO eligibility or PCO Enrollment ends prior to the first of the month.

iii. The Department will recover Capitation payments made for Members who were later determined to be ineligible for the *Healthy Pennsylvania* Program for up to twelve (12) months after the service month for which payment was made. The Department will recover Capitation payments made for deceased Members for up to eighteen (18) months after the service month for which payment was made.

2. Program Changes

Amendments, revisions, or additions to state or federal regulations, laws, 1115 waiver submission, guidelines, or policies shall, insofar as they affect the scope or nature of benefits available to Beneficiaries, amend the PCO's obligations as specified herein, unless the Department notifies the PCO otherwise. The Department will inform the PCO of any changes, amendments, revisions, or additions.

The Department will appropriately adjust the rates provided by Appendix 3f, Capitation Rates, to reflect change in an Assessment, Premium Tax, Gross Receipts Tax, or similar tax.

Capitation rates and any other payments made under the Agreement year will remain the same as rates for the previous Agreement Year, unless the Agreement is amended to provide different rates.

C. No Appeals Relating to Actuarially Sound Rates

By executing the Agreement, the PCO has had an opportunity to review the rates set forth in Appendix 3f, Capitation Rates, and accepts the rates for the relevant Agreement Year.

D. Other Financial Requirements

1. Retroactive Eligibility Period

The PCO shall not be responsible for any payments owed to Providers for services that were rendered prior to the effective date of a Member's Enrollment into the PCO.

2. In-Network Services

In-network services are services obtained from a Network Provider. The PCO must make timely payment for clean claims submitted by Network Providers in accordance with 40 P.S. §991.2166 and 31 Pa. Code §154.18.

Except as required by law, the PCO is not financially liable for services rendered to treat a non-emergency condition in a hospital emergency room.

3. Payments for Out-of-Network Providers

The PCO must pay Non-Participating providers as may be required by law and regulations, including but not limited to 40 P.S. §991.2116, Pa. Code §9.672 and 31 Pa. Code §154.14 relating to emergency services, and 40 P.S. §991.2217 and 28 Pa. Code §§9.679 relating to access and 9.684 relating to continuity of care.

If the PCO chooses to cover out-of-network services, it assumes the full financial risk for these services.

4. Payments to FQHCs and Rural Health Centers (RHCs)

The PCO must provide Members access to FQHCs and RHCs within its Provider Network. The PCO must pay FQHCs and RHCs rates no less than the Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by the Department. The PCO must include in its

Provider Network every FQHC and RHC located within its Regions that are willing to accept PPS rates as payment in full.

5. Third Party Liability (TPL)

The PCO must comply with the TPL requirements.

a. Cost Avoidance Activities

i. The PCO must take measures to avoid initial payment of Claims, whenever possible, where federal or private insurance-type resources are available. The PCO must report all funds that are cost avoided to the Department via Encounter Data submissions. The use of the appropriate HIPAA 837 Loop(s) for Medicare and Other Insurance Paid (OIP) shall indicate that TPL has been pursued and the amount which has been cost-avoided.

ii. The PCO may not deny or delay approval of otherwise covered treatment or services based upon TPL considerations. The PCO may neither unreasonably delay payment nor deny payment of Claims unless the probable existence of TPL is established at the time the Claim is adjudicated.

b. Post-Payment Recoveries

i. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) Other Resources. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts. The PCO can pursue and retain recoveries of both health-related and Other resources.

ii. The PCO must pursue, collect, and may retain recoveries of (1) all personal injury or trauma-related claims, including Workers' Compensation, and will establish a trauma-related questionnaire process to identify potential personal injury cases utilizing the codes identified by the Department or (2) claims where the liable party has improperly denied payment based upon either lack of a medically necessary

determination or lack of coverage. The PCO must develop and implement cost-effective procedures to identify and pursue cases that are susceptible to collection through either legal action or traditional subrogation and collection procedures.

iii. The PCO agrees to pay, and to require that its subcontractors pay, all Clean Claims for prenatal care and then seek reimbursement from liable third parties. The PCO recognizes that cost avoidance of these Claims is prohibited with the exception of hospital delivery Claims, which may be cost-avoided.

c. Third Party Resource Identification

Third Party Resources identified by the PCO or its subcontractors, which do not appear on the Department's TPL database, must be supplied to the Department's TPL Division by the PCO. In addition to newly identified resources, coverage for other household members, addition of a coverage type, changes to existing resources, including termination of coverage and changes to coverage dates, must also be supplied to the Department's TPL Division. The method of reporting must be by electronic file or by any alternative method approved by the Department. TPL resource information must be submitted within two weeks of its receipt by the PCO.

6. Requests for Additional Data

The PCO must provide, at the Department's request, such information not included in the Encounter Data submissions that may be necessary for the administration of this Agreement.

7. Accessibility to TPL Data

The Department will provide the PCO with access to data maintained on the TPL file.

8. Audits

a. Annual Entity-Wide Financial Audit

The PCO shall provide to the Department a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in

accordance with Generally Accepted Auditing Standards. Such audit shall be submitted to the Office of Medical Assistance Programs (OMAP), Bureau of Managed Care Operations (BMCO) via email at FinancialGatekeeper@pa.gov within 30 days from the date the auditor signed the report.

b. Annual Private Coverage Financial Audit

The PCO shall bear the costs of an audit of its annual Financial Statements for its *Healthy Pennsylvania* plan. The audit must be performed by an independent, licensed Certified Public Accountant and shall be completed in accordance with Generally Accepted Government Auditing Standards. The contract audit shall be digitally submitted to OMAP, BMCO, Division of Financial Analysis via email at FinancialGatekeeper@pa.gov no later than 180 days after the Agreement year has ended.

c. Other Financial and Performance Audits

The Department and other state and federal agencies and their authorized representatives may, at reasonable times, inspect the books, documents, papers and records and perform additional financial or performance audits or other reviews of the PCO, its subcontractors or Providers.

9. Restitution

The PCO must make full and prompt restitution to the Department, as directed by the Department, for any payments received in excess of amounts due to the PCO under this Agreement whether such overpayment is discovered by the PCO, the Department, or a third party.

SECTION VIII: REPORTING REQUIREMENTS

The PCO must comply with state and federal reporting requirements that are set forth in this section and throughout the Agreement and Exhibit D.

Exhibit D to this Agreement details the reports required by the Department to enable oversight of the PCO. All specifications for reports, including but not limited to submission dates, content, data, etc. will be communicated to the PCO by the Department.

The Department may require additional ad hoc reports from the PCO as necessary to ensure compliance with federal and state laws, regulations and Department needs.

A. Encounter Data Reporting

The PCO must record for internal use and submit to the Department Encounter Data. Encounter Data consists of a separate record each time a Member has an Encounter with a Health Care Provider. The PCO must have the ability to provide separate Physical Health and Behavioral Health encounters if required by the Commonwealth. A service rendered under this Agreement is considered an Encounter regardless of whether or not it has an associated Claim. The PCO shall only submit Encounter Data for Members enrolled in its PCO on the date of service and not submit any duplicate records. The Provider's National Provider Identifier (NPI) and Master Provider Number (MPI) must be used when submitting required Encounter Data.

The PCO must maintain appropriate systems and mechanisms to obtain all necessary data from its Providers to ensure its ability to comply with the Encounter Data reporting requirements. The failure of a Provider or Subcontractor to provide the PCO with necessary Encounter Data does not excuse the PCO's noncompliance.

The PCO will be given a minimum of sixty (60) days notification of any new edits or changes that DPW intends to implement regarding Encounter Data.

1. Data Format

The PCO must submit Encounter Data to the Department using established protocols.

Encounter Data files must be provided in the following HIPAA transactions:

- 837 Professional
- 837P - Drug
- 8371 - Inpatient
- 837I – Outpatient
- 837I – LTC
- 837I – Outpatient Drug
- 837 Dental
- NCPDP batch files

2. Timing of Data Submittal

a. Provider Claims

Claims must be submitted by Providers to the PCO within one hundred eighty (180) days after the date of service.

The PCO may to include a requirement for more prompt submissions of Claims or Encounter records in Provider Agreements and Subcontracts. Claims adjudicated by a third party vendor must be provided to the PCO by the end of the month following the month of adjudication.

b. Encounter Submissions

All Encounter records except pharmacy transactions must be submitted and determined acceptable by the Department on or before the last calendar day of the third month after the payment/adjudication calendar month in which the PCO paid/adjudicated the Claim. Pharmacy transactions must be submitted and approved in PROMISe™ within 30 days following the adjudication date.

Encounter records sent to the Department are considered acceptable when they pass all Department edits.

Encounter records that deny or suspend due to Department edits are returned to the PCO and must be corrected. Denied Encounter records must be resubmitted as a "new" Encounter record if appropriate and within the timeframe referenced above.

Suspended Encounter records must be corrected and resubmitted as an adjustment within the timeframe referenced above. Corrections and resubmissions must pass all edits before they are accepted by the Department.

Failure of subcontractors to submit Encounter Data timely shall not excuse the PCO's noncompliance.

c. Encounter File Specifications

The PCO must adhere to the file size and format specifications provided by the Department. PCOs must also adhere to the Encounter file submission schedule provided by the Department.

d. Response Files

The Encounter Data system must have a mechanism in place to receive and process the U277 and NCPDP response files; and to store the PROMISe™ ICN associated with each processed Encounter Data record returned on the files.

3. Data Completeness

The PCO is responsible for submission of records each time a Member has an Encounter with a Health Care Provider. The PCO must have a data completeness monitoring program in place that:

a. Demonstrates that all Claims and Encounters submitted to the PCO by the Health Care Providers, including Subcontractors, are submitted accurately and timely as Encounters to the Department. In addition, demonstrates that denied Encounters are resolved and/or resubmitted;

b. Evaluates Health Care Provider and Subcontractor compliance with contractual reporting requirements; and

c. Demonstrates the PCO has processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with Encounter Data reporting to the Department.

The PCO must submit an annual Data Completeness Plan for review and approval. This Data Completeness Plan must include the three elements listed above.

4. Financial Assessments

The PCO must provide complete, accurate, and timely Encounter Data to the Department and must maintain complete medical service history data.

The Department may request a Corrective Action Plan from the PCO when areas of noncompliance are identified.

Based on the Department's identification of non-compliance with the standards outlined in Exhibit F Encounter Data Submission Requirements and Assessment Applications, the Department may apply an assessment as provided in Exhibit F.

5. Drug Rebate Supplemental File

The PCO is required to submit a monthly file containing supplemental data for NCPDP transactions used for the purpose of drug rebate dispute resolution.

SECTION IX: REPRESENTATIONS AND WARRANTIES OF THE PCO

A. Accuracy of the Application

The PCO warrants that the representations made to the Department in the Application are true and correct and that all of the information submitted to the Department in or with the Application is accurate and complete in all material respects. The PCO agrees that such representations are continuing ones, and that it is the PCO's obligation to notify the Department within ten (10) Business Days, of any material fact, event, or condition which arises or is discovered subsequent to the date of the PCO's submission of the Application, which affects the truth, accuracy, or completeness of such representations.

B. Disclosure of Interests

The PCO must disclose to the Department, in writing, the name of any person or entity having a direct or indirect ownership or control interest of five percent (5%) or more in the PCO. The PCO must inform the Department, in writing, of any change in or addition to the ownership or control of the PCO. Such disclosure must be made within thirty (30) days of any change or addition. The PCO agrees that failure to comply with this provision in any material respect, or making of any misrepresentation which would cause the PCO to be precluded from participation in the *Healthy Pennsylvania* Program, shall entitle the Department to recover all payments made to the PCO subsequent to the date of the misrepresentation.

C. Disclosure of Change in Circumstances

The PCO will report to the Department, as well as the DOH and PID, within ten (10) Business Days of when the PCO becomes aware of any change in circumstances that may have a material adverse effect upon financial or operational conditions of the PCO or PCO's parent(s). Such reporting must be provided upon the occurrence of, by way of example and without limitation, the following events, any of which must be presumed to be material and adverse:

1. Suspension or debarment of PCO, PCO's parent(s), or any Affiliate or Related Party of either, by any state or the federal government;

2. Knowingly having a person act as a director, officer, partner or person with beneficial ownership of more than five percent (5%) of the PCO's Equity who has been debarred from participating in federal procurement activities under federal regulations.

3. Notice of suspension or debarment or notice of an intent to suspend/debar issued by any state or the federal government to PCO, PCO's parent(s), or any Affiliate or Related Party of either; and

4. Any new or previously undisclosed lawsuits or investigations by any federal or state agency involving PCO, PCO's parent(s), or any Affiliate or Related Party of either, which would have a material impact upon the PCO's financial condition or ability to perform under this Agreement.

SECTION X: CONFIDENTIALITY

A. The PCO must comply with all applicable federal and state laws regarding the confidentiality of protected health information. The PCO must require all of its subcontractors to comply with all applicable federal and state laws regarding the confidentiality of protected health information. The PCO must comply with the Management Information System and System Performance Review (SPR) Standards, available on the Department's Intranet, regarding maintaining confidentiality of data. The federal and state laws with regard to confidentiality of protected health information include, but are not limited to: Mental Health Procedures Act, 50 P.S. 7101 et seq.; Confidentiality of HIV-Related Information Act, 35 P.S. 7601 et seq.; 45 CFR Parts 160 and 164 (HIPAA Standards for Privacy of Individually Identifiable Health Information); Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. 1690.101 et seq.; 42 U.S.C. 1396a(a)(7); 62 P.S. §404; 31 Pa. Code Ch. 146b; 55 Pa. Code §105.1 et seq.; and 42 CFR §431.300 et seq.

B. The PCO is liable for any state or federal fines, financial penalties, or damages levied upon the Department for a breach of confidentiality due to the improper release of protected health information or intentional conduct of the PCO in relation to the PCO's systems, staff, or other area of responsibility.

C. The PCO will return all data and material obtained in connection with this Agreement and the implementation thereof, including confidential data and material, at the Department's request. No material may be used by the

PCO for any purpose after the expiration or termination of this Agreement. The PCO also agrees to transfer all such information to a subsequent PCO at the direction of the Department.

D. The PCO considers the following to be confidential information; its financial reports and information, marketing plans, Provider rates, trade secrets, information or materials relating to the PCO's software, databases or technology, and information or materials licensed from, or otherwise subject to contractual nondisclosure rights of third parties, which would be harmful to the PCO's competitive position. This information shall not be disclosed by the Department to other parties except as required by law or except as may be determined by the Department to be related to the administration and operation of the *Healthy Pennsylvania* Program. The Department will notify the PCO when it determines that disclosure of information is necessary for the administration of the *Healthy Pennsylvania* Program. The PCO will be given the opportunity to respond to such a determination prior to the disclosure of the information.

The PCO is entitled to receive all information relating to the health status of its Members in accordance with applicable confidentiality laws.

E. The Department may elect from time to time to share with the PCO an internal Business Requirements Document (BRD) or an internal Business Design Document (BDD). The Department may also elect to share Fee-for-Service (FFS) inpatient hospital rates and cost-to-charge ratio information with the PCO. The PCO shall not use this information for a purpose other than support for the PCO's mission to perform its responsibilities per its Agreements with the Department and related responsibilities provided by law. The PCO may share a BRD, a BDD, or the FFS inpatient hospital rates and cost-to-charge ratio information provided by the Department with another party, provided that the other party does not use the information for a purpose other than support for the PCO's mission to perform its responsibilities per this Agreement and any other related responsibilities provided by law

SECTION XI: GENERAL

A. Rights of the Department and the PCO

The rights and remedies of the Department provided herein shall not be exclusive and are in addition to any rights and remedies provided by law.

Except as otherwise stated in Appendix A, Terms and Conditions, the rights and remedies of the PCO provided herein shall not be exclusive and are in addition to any rights and remedies provided by law.

B. Waiver

No waiver by either party of a breach or default of this Agreement shall be considered as a waiver of any other or subsequent breach or default.

C. Invalid Provisions

Any provision of this Agreement which is in violation of any state or federal law or regulation shall be deemed amended to conform with such law or regulation, pursuant to the terms of this Agreement, except that if such change would materially and substantially alter the obligations of the parties under this Agreement, any such provision shall be renegotiated by the parties. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions hereof.

D. Notice

Any written notice to any party under this Agreement shall be deemed sufficient if delivered personally, or by facsimile, telecopy, electronic or digital transmission (provided such delivery is confirmed), or by recognized overnight courier service (e.g., UPS, Federal Express, etc.), with confirmed receipt, or by certified or registered United States mail, postage prepaid, return receipt requested, sent to the address set forth below or to such other address as such party may designate by notice given pursuant to this section:

To the Department via U.S. Mail:

Department of Public Welfare
Director, Bureau of Managed Care Operations
P.O. Box 2675
Cherry Wood Building # 33, 2nd Floor
DGS Annex Complex
Harrisburg, Pennsylvania 17105

To the Department via UPS, FedEx, DHL or other delivery service:

Department of Public Welfare
Director, Bureau of Managed Care Operations
Cherry Wood Building # 33, 2nd Floor
49 Beech Drive
DGS Annex Complex
Harrisburg, Pennsylvania 17110

With a Copy to:

Department of Public Welfare
Office of General Counsel
3rd Floor West, Health and Welfare Building
Forster and 7th Street
Harrisburg, Pennsylvania 17120
Attention: Chief Counsel

To the PCO.

E. Counterparts

This Agreement may be executed in counterparts, each of which shall be deemed an original for all purposes, and all of which, when taken together shall constitute but one and the same instrument.

F. Headings

The section headings used herein are for reference and convenience only, and shall not enter into the interpretation of this Agreement.

G. No Third Party Beneficiaries

This Agreement does not, nor is it intended to, create any rights, benefits, or interest to any third party, person, or organization.

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

May 8, 2014

SUBJECT: RFA 04-14 Healthy Pennsylvania Program, Physical & Behavioral Health Services Statewide

Dear Prospective Offeror:

You are invited to submit an application for the above subject RFA for the Commonwealth of Pennsylvania, Department of Public Welfare in accordance with the attached Request for Application (RFA) 04-14.

All applications must be submitted as follows: two (2) paper copies. Applicants must also submit a complete and exact copy of the entire submittal on seven (7) separate CDs or Flash drives. All electronic documents must be submitted in Microsoft Office or Microsoft Office compatible format and sent to the Pennsylvania Department of Public Welfare, Division of Procurement, Room 402, Health and Welfare Building, 625 Forster Street, Harrisburg, PA 17120. **Applications must be received at the above address no later than twelve o'clock P.M. (12:00 P.M.) on June 10, 2014. Late Applications will not be considered regardless of the reason.**

All questions should be directed to Barry Bowman**,** Project Officer, Department of Public Welfare, Office of Medical Assistance Programs via e-mail babowman@pa.gov **no later than 5:00 p.m. on May 13, 2014.** Offerors will be provided with answers to questions asked by any one offeror.

In addition, a Pre-Proposal Conference will be held from 10:00 a.m. to 2:00 p.m. Thursday May 15, 2014 at The Pennsylvania Child Welfare Resource Center, University of Pittsburgh, School of Social Work, 403 East Winding Hill Road, Mechanicsburg, PA 17055; Meeting Room – Susquehanna A&C combined.

Applications **must** be signed by an official authorized to bind the vendor to its provisions. Also, please include your Federal Identification Number, SAP Vendor Number and the Point of Contact's email address on the cover sheet of your application. Evaluation of applications and selection of vendors will be completed as quickly as possible after receipt of application.

Sincerely,

Daniel R. Boyd
Director of Procurement

Attachments

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

REQUEST FOR APPLICATION

HEALTHY PENNSYLVANIA PROGRAM

PHYSICAL & BEHAVIORAL HEALTH SERVICES STATEWIDE.

ISSUING OFFICE

Commonwealth of Pennsylvania
Department of Public Welfare
Bureau of Financial Operations
Division of Procurement,
Room 402
Health and Welfare Building
625 Forster Street
Harrisburg, PA 17120

RFA # 04-14

DATE OF ISSUANCE

May 8, 2014

REQUEST FOR APPLICATION

RFA #04-14

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Part III—CRITERIA FOR SELECTION

Part IV—WORK STATEMENT

Attachments to the RFA

CALENDAR OF EVENTS

The Commonwealth will make every effort to adhere to the following schedule:

Activity	Responsibility	Date
Deadline to submit Questions via email to babowman@pa.gov	Potential Applicants	5/13/14 @ 5:00pm
Potential Applicants' Question & Answer Conference— The Pennsylvania Child Welfare Resource Center University of Pittsburgh, School of Social Work 403 East Winding Hill Road Mechanicsburg, PA 17055 Meeting Rooms Susquehanna A&C combined. !--Interested entities must limit the number of staff members in attendance at the Q&A Conference to four (4).	Issuing Office/Potential Applicants	5/15/14 10:00am- 2:00pm
Answers to potential applicant questions posted to the DGS & linked from the DPW Web sites no later than this date.	Issuing Office	5/28/14
Monitor website for all communications regarding the RFA.	Potential Applicants	N/A
Sealed application must be received by the Issuing Office at: Department of Public Welfare Office of Administration Bureau of Financial Operations Division of Procurement Room 402 Health and Welfare Building 625 Forster Street Harrisburg, PA 17120	Applicants	6/10/14 By 12:00 pm

PART I

GENERAL INFORMATION

I-1. Purpose.

This Request for Application ("RFA") provides to those interested in submitting applications for the subject RFA ("Applicants") sufficient information to enable them to prepare and submit applications for the Department of Public Welfare's ("Department") consideration on behalf of the Commonwealth of Pennsylvania ("Commonwealth") to satisfy a need for private market health plans to provide for Physical and Behavioral Health Services under the *Healthy Pennsylvania Program*.

I-2. Issuing Office.

The **Bureau of Financial Operations, Division of Procurement** ("Issuing Office") has issued this RFA on behalf of the Commonwealth. The sole point of contact in the Commonwealth for this RFA shall be **Barry Bowman** the Project Officer for this RFA. Please refer all inquiries to the Project Officer.

Barry Bowman, Director
Division of Program Initiatives, Contract Management and Communications
Department of Public Welfare
Bureau of Managed Care Operations
P.O. Box 2675
Cherrywood Bldg. #33, 2nd Floor/DGS Annex Complex
Harrisburg, PA 17105.
E-Mail: babowman@pa.gov

I-3. Scope.

This RFA contains instructions governing the requested applications, including the requirements for the information and material to be included; a description of the services to be provided; requirements which Applicants must meet to be eligible for consideration; general selection criteria; and other requirements specific to this RFA.

I-4. Problem Statement.

The Healthy Pennsylvania Program ("HPP") is a new Program designed to provide physical and behavioral health coverage to the approximately 500,000 plus citizens that have income that falls below 133% of the Federal Poverty Level ("FPL") under the Patient Protection and Affordable Care Act ("ACA"). The HPP will meet the Healthy Pennsylvania core priorities of improving access to care, ensuring quality and providing

affordability. The HPP is scheduled to commence operations on January 1, 2015[1] Commonwealth-wide.

This RFA has been issued to procure the services of Pennsylvania-licensed health insurance entities to provide coverage under the HPP in the nine ACA Rating Areas ("Regions") throughout the Commonwealth. Participation in the HPP will be limited to Commonwealth of Pennsylvania-licensed health insurance entities that have certified to the Pennsylvania Insurance Department ("PID") that each plan through which coverage will be provided meets all applicable federal and state laws pertaining to health insurance coverage offered in the individual market. Selected Applicants that receive Agreements to operate a plan in the HPP will be known as *Private Coverage Organizations* ("PCO").

The Primary Goals of the HPP are:

- Increase health care access for more than 500,000 Pennsylvanians.
- Promote healthy behaviors, improve health outcomes and increase personal responsibility.
- Provide essential health care benefits in accordance with federal and state laws and regulations.

The actual implementation and administration of the HPP will be dependent on Federal approval of the Commonwealth's Healthy Pennsylvania Section 1115 Demonstration Waiver Application as well as other factors. Accordingly, the requirements of this RFA and resulting agreements may need to be changed based upon Federal approval and other requirements.

Each Pennsylvania County is included in one of nine ACA Rating Areas ("Regions"). See Part II-1 for a list of these Regions. The Department is seeking PCOs to operate in all regions. An Applicant must indicate the Regions in which it requests to operate its plan.

A selected PCO must make its plan available to HPP eligible Pennsylvania beneficiaries in all counties within a selected Region.

The Department reserves the right to solicit additional Applicants in future years.

I-5. Type of Agreement.

If the Department enters into agreements with PCOs as a result of this RFA, they will be full-risk, capitated agreements containing the Agreement Terms and Conditions as shown in Attachment A. The Department will enter into agreement negotiations with all

[1] All dates stated within this RFA are subject to change based upon Federal approval and other requirements.

Applicants determined to be qualified; and in the numbers determined by the Department necessary to meet the requirements of the Program.

The Department will pay each PCO using a schedule of per member per month (PMPM) capitation rates.

The following information is included in Attachment B, [FINANCIAL TERMS]

- Draft capitation rates for calendar year 2015.
- Methodology statement for development of the draft capitation rates for calendar year 2015.
- Supporting documentation on development of the initial draft capitation rates for calendar year 2015.

The Department will provide selected Applicants with an opportunity to ask questions about the development of the proposed capitation rates and to discuss and negotiate financial rates. Applicants should be aware that implementation of the HPP initiative will require the Department to establish an end date for each negotiation. Failure to agree to terms by this date will mean that there will be no HPP Agreement with the Applicant.

The Department will timely provide proposed capitation rates and supporting documentation for each program year subsequent to calendar year 2015.

I-6. Rejection of Applications.

The Department, in its sole and complete discretion, may reject any application received as a result of this RFA.

I-7. Incurring Costs.

The Department is not liable for any costs Applicant incurs in preparation and submission of its application, in participating in the RFA and Readiness Review process or in anticipation of award of an Agreement.

I-8. Pre-Application Conference

The Department will hold a Pre-Application Conference as specified in the Calendar of Events. The purpose of this conference is to provide an opportunity for clarification of the RFA. Applicants should forward all questions to the RFA Project Officer in accordance with **Section I-9** to ensure adequate time for analysis before the Department provides an answer. Applicants may also ask questions at the conference. The pre-application conference is for information only. Any answers furnished during the conference will not be official until they have been verified, in writing, by the Department. All questions and written answers will be posted on the Department of

General Services (DGS) Web site as an addendum to, and shall become part of, this RFA. Attendance at the Pre-Application Conference is optional.

I-9. Questions and Answers.

If an Applicant has any questions regarding the RFA, the Applicant must submit the questions by E-mail (**with the subject line RFA # 04-14 Question)** to the Project Officer named in **Part I, Section I-2** of the RFA. If an Applicant has questions, they must be submitted **no later than** the date indicated on the Calendar of Events. The Applicant shall not attempt to contact the Project Officer by any other means. The Department will post the answers to the questions on the DGS Web site and linked from the Department's Web site by the date stated on the Calendar of Events.

The Department shall not be bound by any verbal information; nor shall it be bound by any written information that is not either contained within the RFA or formally issued as an addendum by the Department.

I-10. Addenda to the RFA.

If the Department deems it necessary to revise any part of this RFA before the application response date, the Department will post an addendum to the DGS Web site and linked from the Department's Web site at http://www.dgsweb.state.pa.us/RTA/Search.aspx & www.dpw.state.pa.us. Applicants are responsible for periodically checking the websites for any new information or addenda to the RFA. Answers to the questions asked during the Questions & Answers period also will be posted to the DGS Web site and linked from the DPW Web site as an addendum to the RFA.

I-11. Response Date.

To be considered for selection, applications must arrive at the Issuing Office on or before the time and date specified in the RFA Calendar of Events. The Department will **not** accept applications via email or facsimile transmission. Applicants who send applications by mail or other delivery service should allow sufficient delivery time to ensure timely receipt of their applications. If, due to inclement weather, natural disaster, or any other cause, the Commonwealth office location to which applications are to be returned is closed on the application response date, the deadline for submission will be automatically extended until the next Commonwealth business day on which the office is open, unless the Department otherwise notifies Applicants. The hour for submission of applications shall remain the same. The Department will reject unopened, any late applications.

I-12. Applications.

To be considered, Applicants should submit a complete response to this RFA to the Issuing Office, using the format provided in **Part II**, providing two (2) **paper copies of the application.** In addition, Applicants shall submit seven (7) **complete and exact** copies of the entire Application with all requested documents on CD-ROM or Flash drive in Microsoft Office or Microsoft Office-compatible format. The electronic copy must be a mirror image of the paper copy and any spreadsheets must be in Microsoft Excel. The Applicants may not lock or protect any cells or tabs. The CD or Flash drive should clearly identify the Applicant and include the name and version number of the virus scanning software that was used to scan the CD or Flash drive before it was submitted. The Applicant shall make no other distribution of its application to any other Applicant or Commonwealth official or Commonwealth consultant. Each application page should be numbered for ease of reference. An official authorized to bind the Applicant to its provisions must sign the Application. If the official signs the Application Cover Sheet (Attachment C to this RFA) and the Application Cover Sheet is attached to the Applicant's application, the requirement will be met. For this RFA, the application must remain valid for 120 days or until an agreement is fully executed. If the Department selects the Applicant's application for award, the contents of the selected Applicant's application will become, except to the extent the contents are changed through negotiations, obligations under the Agreements.

Each Applicant submitting an application specifically waives any right to withdraw or modify it, except that the Applicant may withdraw its application by written notice received at the Issuing Office's address for application delivery prior to the exact hour and date specified for application receipt. An Applicant or its authorized representative may withdraw its application in person prior to the exact hour and date set for application receipt, provided the withdrawing person provides appropriate identification and signs a receipt for the application. An Applicant may modify its submitted application prior to the exact hour and date set for application receipt only by submitting a new sealed application or sealed modification which complies with the RFA requirements.

I-13. Economy of Preparation.

Applicants should prepare applications simply and economically, providing a straightforward, concise description of the Applicant's ability to meet the requirements of the RFA.

I-14. Discussions for Clarification. Applicants may be required to make an oral or written clarification of their applications to the Issuing Office to ensure thorough mutual understanding and Applicant responsiveness to the RFA requirements. The Project Officer will initiate requests for clarification.

I.15. Private Coverage Organization Responsibilities. The Applicant is responsible for all services offered in its agreement whether it produces them itself or by subcontract. The Department will consider the selected Applicant to be the sole point of contact with regard to matters under the agreement.

I-16. Application Contents.

A. Confidential Information. The Commonwealth is not requesting, and does not require, confidential proprietary information or trade secrets to be included as part of an Applicants' submissions submitted in response to this RFA. Accordingly, except as provided herein, Applicants should not label their applications as confidential or proprietary or trade secret protected. Any Applicant who determines that it must divulge such information as part of its RFA must submit a signed written statement described in subsection C. below and must additionally provide a redacted version of its application, which removes only the confidential proprietary information and trade secrets, for required public disclosure purposes.

B. Commonwealth Use. All material submitted with the application shall be considered the property of the Commonwealth of Pennsylvania and may be returned only at the Department's option. The Commonwealth has the right to use any or all ideas not protected by intellectual property rights that are presented in any application regardless of whether the application becomes part of an agreement. Notwithstanding any Applicant copyright designations contained on applications, the Commonwealth shall have the right to make copies and distribute applications internally and to comply with public record or other disclosure requirements under the provisions of any Commonwealth or United States statute or regulation, or rule or order of any court of competent jurisdiction.

C. Public Disclosure. After the award of the agreements pursuant to this RFA, all application submissions are subject to disclosure in response to a request for public records made under the Pennsylvania Right-to-Know-Law, 65 P.S. § 67.101, et seq. If an application contains confidential proprietary information or trade secrets, a signed written statement to this effect must be provided with the application in accordance with 65 P.S. § 67.707(b) for the information to be considered exempt under 65 P.S. § 67.708(b)(11) from public records requests. Financial capability information submitted in response to Part II, Section II-7 is exempt from public records disclosure under 65 P.S. § 67.708(b)(26).

I-17. News Releases.

Applicants shall not issue news releases, Internet postings, advertisements or any other public communications pertaining to this RFA without prior written approval of the Department, and then only in coordination with the Department.

I-18. Restriction of Contact.

From the issue date of this RFA until Applications are selected for award, the Project Officer is the sole point of contact concerning this RFA. If the Department later discovers that an Applicant has engaged in any violation of this condition by sharing information contained in its application with other Commonwealth personnel or competing Applicants, the Department may reject the offending Applicant's application or rescind its agreement award.

I-19. Issuing Office Participation.

Applicants shall provide all services, supplies, facilities, and other support necessary to complete the identified work, except as otherwise provided in this **Section.**

The Department will be responsible for monitoring PCOs. The Department will designate staff to coordinate the project, provide or arrange technical assistance, and monitor for Readiness Review and compliance with Agreement requirements, as well as the approved waiver and program policies and procedures. At its discretion, the Department may commence monitoring before the effective and/or operational dates of the Agreement, and before the formal Readiness Review period.

I-20. Term of Agreement.

Subject to Federal approval and other considerations, the term of the Agreement is anticipated to begin on January 1, 2015 and will end in three (3) years with two optional one-year extensions. The selected Applicant will be required to demonstrate an ability to perform services required within the scope of this application during a readiness review period. The Department anticipates starting a readiness review period on or about August 4, 2014.

I-21. Applicant's Representations and Authorizations.

By submitting its application, each Applicant understands, represents, and acknowledges that:

A. All of the Applicant's information and representations in the application are material and important, and the Department may rely upon the contents of the application in awarding the agreement(s).

B. The Applicant has not attempted, nor will it attempt, to induce any firm or person to refrain from submitting an application.

C. The Applicant makes its application in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive application.

D. To the best knowledge of the person signing the application for the Applicant, the Applicant, its affiliates, subsidiaries, officers, directors, and employees are not currently under investigation by any governmental agency and have not in the last **four** years been convicted or found liable for any act prohibited by State or Federal law in any jurisdiction, involving conspiracy or collusion with respect to bidding or proposing on any public contract, except as the Applicant has disclosed in its application.

E. The Applicant is not currently under suspension or debarment and has not been precluded from participation in any federally funded health care program by the Commonwealth, any other state or the federal government, and if the Applicant cannot so certify, then it shall submit along with its application a written explanation of why it cannot make such certification.

F. The Applicant has not made, under separate contract or agreement with the Department, any recommendations concerning the need for the services described in its application or the specifications for the services described in the application.

G. Each Applicant, by submitting its application, authorizes Commonwealth agencies to release to the Commonwealth information concerning the Applicant's Pennsylvania taxes, unemployment compensation and workers' compensation liabilities.

H. Until the selected Applicants receive fully executed and approved written agreements from the Department, there is no legal and valid agreement, in law or in equity, and the Applicant shall not begin to perform.

I-22. Notification of Selection.

The Department will notify the selected Applicants in writing of their selection for negotiation after the Department has determined, taking into consideration all selection factors, those Applicants that qualify for participation as a PCO.

I-23. Information Technology

This RFA is subject to the Information Technology Bulletins (ITBs) issued by the Office of Administration, Office for Information Technology (OA-OIT). ITB's may be found at http://www.portal.state.pa.us/portal/server.pt?open=512&objID=416&PageID=210791&mode=2 and the Management Information System and System Performance Review Standards for MIS and Systems Performance Review (SPR) Standards provided by the Department on the Department's Intranet.

All applications must be submitted on the basis that all ITBs are applicable to this procurement. It is the responsibility of the Applicant to read and be familiar with the ITBs. Notwithstanding the foregoing, if the Applicant believes that any ITB is not applicable to this procurement, it must list all such ITBs in its application, and explain why it believes the ITB is not applicable. The Department may, in its sole discretion, accept or reject any request that an ITB not be considered to be applicable to the procurement. The Applicant's failure to list an ITB will result in its waiving its right to do so later, unless the Department, in its sole discretion, determines that it would be in the best interest of the Commonwealth to waive the pertinent ITB.

Applicants can obtain temporary access to the Department's Intranet system to review IT Systems Performance Standards by directing an email request for access to the following address: contractmonitoringunit@pa.gov.

The Department's general IT and Business standards can be reviewed at the following location: http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/busandtechstandards/appii/index.htm

Part II

APPLICATION REQUIREMENTS

Applicants must submit their application in the format, including heading descriptions, outlined below. To be considered, the application must respond to all requirements in this part of the RFA.

The Department may request additional information which, in the Department's opinion, is necessary to assure that the Applicant is qualified according to the RFA.

The Department may make investigations as deemed necessary to determine an Applicant's qualifications. The Applicant shall furnish to the Department all requested information and data. The Department may reject any application if the evidence submitted by, or investigation of, such Applicant fails to satisfy the Department that the Applicant is qualified to perform as provided in the RFA.

The Applicant must identify the PCO contact name, address and phone number of the authorized official who will participate in financial term discussions with the Department.

II-1. Regions of Operation.

Indicate the Region or Regions of operation for which the Applicant wishes to be considered as a PCO.

The Regions are based on the ACA Rating Areas located within the Commonwealth of Pennsylvania. These Regions are:

- **A.** *Region 1:* Clarion, Crawford, Erie, Forest, McKean, Mercer, Venango & Warren Counties.
- **B.** *Region 2:* Cameron, Elk & Potter Counties
- **C.** *Region 3:* Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne & Wyoming Counties.
- **D.** *Region 4:* Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington & Westmoreland Counties.
- **E.** *Region 5:* Bedford, Blair, Cambria, Clearfield, Huntingdon, Jefferson & Somerset Counties.
- **F.** *Region 6:* Centre, Columbia, Lehigh, Mifflin, Montour, Northampton, Northumberland, Schuylkill, Snyder & Union Counties.
- **G.** *Region 7:* Adams, Berks, Lancaster & York Counties
- **H.** *Region 8:* Bucks, Chester, Delaware, Montgomery & Philadelphia Counties.

I. *Region 9:* Cumberland, Dauphin, Franklin, Fulton, Juniata, Lebanon & Perry Counties.

II-2. Proposed Behavioral Health Services Coverage Model

Applicant must indicate how it intends to provide Behavioral Health Services by illustrating whether:

- The behavioral health network of providers will be included in the Applicant's own provider network; or
- The behavioral health network of providers will be part of a subcontract, and if so, the name of the behavioral health subcontractor. Applicants should provide a description of the payment process and indicate whether it includes any risk or incentive arrangements; or
- Other model—please describe and provide sufficient information regarding how the other model will be incorporated into the Applicant's service provision processes. Please also include a description of the payment process and indicate whether it includes any risk or incentive arrangements, if applicable.

II-3. Current Valid Pennsylvania HMO Certificate of Authority

Provide documentation of valid joint Department of Health ("DOH")/Pennsylvania Insurance Department ("PID") Certificate of Authority as an HMO. Applicant must be continuously certified as an HMO throughout the term of the Agreement.

II-4. County Operational Authority—DOH

Applicants for the HPP operational Regions must provide documentation of DOH Operating Authority in each county in the Region(s) for which they apply. If an Applicant does not have this authority for each county at time of application, the Applicant must provide a statement regarding its plan to have operating authority for each county in place by August 1, 2014 or such later date as may be specified by the Department. Failure to produce the appropriate documentation by the deadline will result in the Applicant's application being rejected and any offer to negotiate an Agreement rescinded. The selected Applicants must provide the Department a copy of the correspondence granting this authority from the DOH no later than August 1, 2014 or such later date as may be specified by the Department.

If an Applicant does not have current DOH Operating Authority for a Region or county areas within a Region, they must submit a Service Area Expansion ("SAE") request to DOH Bureau of Managed Care (BMC) no later than July 11, 2014. This will allow the DOH BMC adequate time to assess SAE requests and for any follow-up that must be conducted between the BMC and the Applicant.

II-5. Compliance with Insurance Requirements

An Applicant must provide documentation that each plan through which coverage will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. It may do so by submitting a copy of the certification submitted to PID with the plan form filing. For information on the certification to PID, please see http://www.pabulletin.com/secure/data/vol44/44-12/615.html. If an Applicant has not made a final certification at time of application, the Applicant must provide a statement describing its plan to have the certification in place by August 4, 2014 or such later date as may be specified by the Department. Failure to produce the appropriate documentation by the deadline, or subsequent disapproval or withdrawal of a plan such that the plan may not be sold in the individual market will result in the Applicant's application to use that plan being rejected and any offer to negotiate an Agreement using that plan to be rescinded.

II-6. ***National Committee for Quality Assurance*** (NCQA) Health Plan Accreditation.

Provide documentation of the Applicant's most recent NCQA health plan accreditation level or of New Health Plan Accreditation by NCQA's New Health Plan Accreditation Program.

II-7. Financial Condition.

The Applicant must submit information about the financial condition of the company in this section. If any information requested is not applicable or not available, provide an explanation. Applicants must submit appropriate documentation to support information provided.

The Applicant must provide the following information:

A. The identity of each entity that owns at least five percent (5%) of the Applicant.

B. For the Applicant and for each entity that owns at least five percent (5%) of the Applicant:

1. Audited financial statements for the two (2) most recent fiscal years for which statements are available. The statements must include a balance sheet, statement of revenue and expense, and a statement of cash flow. Statements must include the auditor's opinion and the notes to the financial statements submitted by the auditor to the Applicant. If audited financial statements are not available, explain why and submit unaudited financial statements.

2. Unaudited financial statements for the period between the last date covered by the audited statements through the quarter before the submission of the application.

3. Documentation about available lines of credit, including maximum credit amount and amount available thirty (30) business days prior to the submission of the application.

4. The most recent sets of quarterly and annual financial statements filed with the Insurance Department.

5. State of incorporation.

6. Type of incorporation, as profit or non-profit.

7. Bond rating.

8. A.M. Best rating for life/health.

9. Standard and Poor rating.

10. Weiss rating.

11. Confirm RBC level exceeds 200% of the authorized control level as defined in 40 P.S. §221.2-(B).

C. Explain how your response provides proof of fiscal soundness.

D. If the Applicant plans to enter into a subcontract at a cost of at least eighty percent of anticipated Agreement revenues received from the Department, and if the subcontract provides for financial risk on the part of the subcontractor, provide items listed in Section II-7.b above, as they relate to the proposed subcontractor.

E. Identify any proposed subcontractor in which the Applicant has five percent (5%) or more ownership interest.

F. The Applicant must have net worth as of December 31, 2013, or a subsequent date not later than July 31, 2014, equal to or greater than $10 million.

G. The Applicant shall explain how it will fund development and start-up costs (including readiness review), including the source of funds. Provide information and documentation to enable the Department to conclude whether sources have and are committed to providing the expected funds.

H. List any financial interest in proposed subcontractors. Copies of proposed subcontract arrangements are to be included as an appendix. The Department may approve all subcontracts used by selected Applicants.

I. The Applicant will state whether it has changed its independent actuary or independent auditor in the last two years. If it has, it must provide the date and explain the reasons for the change.

II-8 Emergency Preparedness

To support continuity of operations during an emergency, including a pandemic, the Commonwealth needs a strategy for maintaining operations for an extended period of time. One part of this strategy is to ensure that essential agreements that provide critical business services to the Commonwealth have planned for such an emergency and put contingencies in place to provide needed goods and services.

A. Describe how you anticipate such a crisis will impact your operations.

B. Describe your emergency response continuity of operations plan. Please attach a copy of your plan, or at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness:

- employee training (describe your organization's training plan, and how frequently your plan will be shared with employees)
- identified essential business functions and key employees (within your organization) necessary to carry them out
- contingency plans for:
    - How your organization will handle staffing issues when a portion of key employees are incapacitated due to illness.
    - How employees in your organization will carry out the essential functions if contagion control measures prevent them from coming to the primary workplace.
- How your organization will communicate with staff and suppliers when primary communications systems are overloaded or otherwise fail, including key contacts, chain of communications (including suppliers), etc.
- How and when your emergency plan will be tested, and if the plan will be tested by a third party.

Part III

CRITERIA FOR SELECTION

III-1. Mandatory Responsiveness Requirements

To be eligible for consideration, an application must be:

A. Timely received from an Applicant.
B. Properly signed by the Applicant.

III-2. Selection.

The Department will notify in writing Applicants who are deemed to be qualified in accordance with this RFA of selection for negotiations.

III-3. Criteria for Selection.

In order for an application to be considered for selection for negotiations, the Applicant must have the following items:

A. Applicant, or related party, must possess current and valid Pennsylvania HMO Certificate of Authority; or a detailed explanation of its Plan and Timeline to obtain such.

B. Applicant must provide documentation that each plan through which coverage will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. The Checklist may be found on-line at http//www.pabulletin.com/secure/data/vol44/44-12/615.html. If the Applicant does not possess documentation at the time of application, the Department may provisionally qualify the Applicant conditioned upon its acquiring the necessary documentation by August 4, 2014 or such later dates as may be specified by the Department.

C. Applicant must possess valid Pennsylvania DOH Operational Authority for all counties in the Regions for which the Applicant makes application. If the Applicant does not possess either the Certificate of Authority or Operational Authority for all counties in which it seeks to operate at the time of application, the Department may provisionally qualify the Applicant conditioned upon its acquiring the necessary Certificate of Authority and Operational Authority by August 4, 2014 or such later date as may be specified by the Department.

D. Applicants must have a recent NCQA health plan accreditation of *COMMENDABLE* or *EXCELLENT.*

1. The Department may consider Applicants with the NCQA Accreditation of *ACCREDITED* if their inclusion is in the best interest of the Commonwealth.

2. New Health Plan Accreditation through NCQA's New Health Plan (NHP) Accreditation will also be considered by the Department.

E. Applicants must possess the financial stability and economic capacity to perform as a PCO as required by this RFA and any resulting Agreement.

F. Acceptable Emergency Preparedness Statement as indicated in Part II-8 of this RFA.

G. A statement of net worth must be supported by a copy of a filing with the PID or a balance sheet that is attested to by an independent public accounting firm. The Department will not permit a selected Applicant to implement a PCO plan if it does not comply with this requirement. [Reference RFA II-7.f]

PART IV

WORK STATEMENT

IV-1. Objectives.

This RFA has been issued to obtain the services of health insurance entities to provide coverage through private health plans to implement the HPP on a statewide basis.

IV-2. Nature and Scope

In preparation for commencement of the HPP, the Commonwealth submitted a Section 1115 Demonstration waiver application to the U.S. Department of Health and Human Services on February 19, 2014. Applicants should review the waiver application and Healthy Pennsylvania Program information found on the Department's website at www.dpw.state.pa.us/healthypa .

The actual implementation and administration of the Healthy Pennsylvania Program will be dependent on Federal approval of the Commonwealth's Healthy Pennsylvania Section 1115 Demonstration Waiver Application as well as other factors. Accordingly, the requirements of this RFA and resulting agreements may need to be changed based upon Federal approval and other requirements.

The Primary Goals of the Healthy Pennsylvania Program are:

- Increase health care access for more than 500,000 Pennsylvanians.
- Promote healthy behaviors, improve health outcomes and increase personal responsibility.
- Provide essential health care benefits in accordance with federal and state laws and regulations

The coverage population is newly-eligible adults ages 21-64 that are not medically frail. This population has not otherwise been determined to meet current Medicaid eligibility requirements.

IV-3. Requirements.

A. A full description of the requirements for the provision of Physical and Behavioral Health services for the PCO Program in all Zones of operation is set forth in the draft Agreement (**Attachment A).**

B. Certification of Authority—joint Pennsylvania Department of Health ("DOH") and Pennsylvania Insurance Department ("PID")—must be maintained for the life of the agreements.

C. County Operational Authority—Pennsylvania Department of Health ("DOH")—must be maintained for the life of the agreements.

If the Applicant does not have current DOH Operating Authority for the selected Regions and requires submission of a Service Area Expansion ("SAE") request for DOH review and approval, that SAE must be submitted to DOH's Bureau of Managed Care no later than July 11, 2014.

D. Certification that each plan through which coverage will be provided meets all federal and state laws regulating health insurance coverage offered in the individual market. It may do so by submitting a copy of the certification submitted to PID with the plan form filing.

Commonwealth of Pennsylvania

Date:	**May 28, 2014**
Subject:	**Healthy PA**
Solicitation Number:	**RFA 04-14**
Opening Date/Time:	**June 10, 2014 2:01 PM**
Addendum Number:	**1**

To All Suppliers:

The Commonwealth of Pennsylvania defines a solicitation "Addendum"" as an addition to or amendment of the original terms, conditions, specifications, or instructions of a procurement solicitation (e.g., Invitation for Bids or Request for Proposals).

List any and all changes:

The Department of Public Welfare (Department) is issuing responses to questions received on or before May 28, 2014. Any questions submitted that do not appear in this posting remain under review. The Department intends to issue responses to all remaining questions that have not been formally addressed in this posting on May 30, 2014 and June 5, 2014.

Please note that the Department intends to close the question submission period for RFA #04-14 on June 2, 2014 at 12:00pm. Any additional questions submitted after that deadline will be considered as part of the discussions with selected applicants.

The Department is pleased with the positive response regarding the Healthy Pennsylvania Program and RFA # 04-14.

In addition the Department is providing the supporting documentation for responses contained in this addemdum. The Department is also providing the Pre-application conference PowerPoint Presentation and sign-in sheet of conference attendees.

For electronic solicitation responses via the SRM portal:

- Attach this Addendum to your solicitation response. Failure to do so may result in disqualification.
- To attach the Addendum, download the Addendum and save to your computer. Move to 'My Notes", use the "Browse" button to find the document you just saved and press "Add" to upload the document.
- Review the Attributes section of your solicitation response to ensure you have responded, as required, to any questions relevant to solicitation addenda issued subsequent to the initial advertisement of the solicitation opportunity.

For solicitations where a "hard copy" (vs. electronic) response is requested:

- Attach this Addendum to your solicitation response. Failure to do so may result in disqualification.
- If you have already submitted a response to the original solicitation, you may either submit a new response, or return this Addendum with a statement that your original response remains firm, by the due date to the following address:

  Bureau of Financial Operations
  Division of Procurement

402 Health and Welfare Building
Harrisburg, PA 17105

Except as clarified and amended by this Addendum, the terms, conditions, specifications, and instructions of the solicitation and any previous solicitation addenda, remain as originally written.

Very truly yours,

Name: Barry Bowman
Title: Project Officer-RFA #04-14
Phone:
Email: babowman@pa.gov

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

May 28, 2014

RE: *Responses to questions submitted under Request for Application (RFA) #04-14*

The Department of Public Welfare (Department) is issuing responses to questions received on or before May 28, 2014. Any questions submitted that do not appear in this posting remain under review. The Department intends to issue responses to all remaining questions that have not been formally addressed in this posting on May 30, 2014 and June 5, 2014.

Please note that the Department intends close the question submission period for RFA #04-14 on June 2, 2014 at 12:00pm. Any additional questions submitted after that deadline will be considered as part of the discussions with selected applicants.

The Department is pleased with the positive response regarding the Healthy Pennsylvania Program and RFA # 04-14.

Barry Bowman,
Project Officer—RFA #04-14
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Managed Care Operations

RFA #04-14

Questions by Topic

As of 05/28/2014

Section 1 - RFA/Draft Agreement/Participation

1. Q. We are wondering why there is no Small Diverse Business (SDB) requirement for this RFA?

   A. Given the nature of the procurement and resulting agreements, the Department was not required to, and opted not to include SDB requirements in this RFA.

2. Q. Why is a RFA treated differently than other PA procurements (RFPs, RFQs) that have a standard 20% of points awarded based on SDB Submittals?

   A.The Department determined that the Request for Application (RFA) procurement method was best suited to achieve the Department's Healthy Pennsylvania Program objectives. For this procurement, the Department will determine whether an applicant is qualified and will select for negotiations all applicants determined to meet the criteria set forth in the RFA. See Part III of the RFA.

3. Q. For Section II-5 of the RFA is DPW seeking Geisinger Health Plan's 2015 QHP self-certifications to prove compliance with state and federal laws regulating health insurance coverage? Or is DPW seeking the 2015 self-certifications? Or both?

   A. The 2015 plan form filing, with the updated Compliance Checklist and Certification, should be refiled to comprise a complete product filing with PID. The Compliance Checklist and Certification should be substantially identical to the form provided in the.

4. Q.If a plan chooses not to respond to an RFA, is there a possibility that a plan can come in at a later date?

   A. Yes. The Department may choose to issue a solicitation at a later date. See RFA Part I, Section I-4.

5. Q. When is the bid "opening" date? (there is no reference to such a date on the Healthy PA RFA home page on the general services website)

A. Applicants will not be submitting bids. An applicant can file an application up to the submission deadline of June 10, 2014 at 12:00 p.m. Please refer to the RFA "Calendar of Events" on page 4.

6. Q. What is the desired font type and font size for the submission? Also, can the submission be 2-sided?

   A. Arial 12 is the preferred font type and size for the submission; however, if not used, the font type and size must be easily readable. Double-sided submissions are acceptable, but not required.

7. Q. Is a cover letter permissible to go along with the submission? If so, is there a specified maximum length?

   A. A cover letter is permissible. If an Applicant chooses to include a cover letter, it still must submit a properly completed Attachment C, Application Cover Letter Template. See Part I, Section I-12 for these requirements. Please follow the Part I, Section I-13 of the RFA, Economy of Preparation standard.

8. Q. On page 17 of the PCO agreement, there is a reference to "qualified providers." However, in the definitions section they only have the term "providers" defined. Can you provide a definition for "qualified providers?"

   A. Qualified Providers are providers who meet all of the state and federal regulatory requirements of the specified provider type and meet the qualifications of the PCO Agreement.

9. Q. On page 40 of the PCO agreement, what is considered a non-emergency medical condition?

   A. The commercial definition of emergency services will apply to the Healthy Pennsylvania Program. Emergency services are defined at 40 P.S. §991.2102 and 28 Pa. Code §9.602.

10. Q. While we would have experience incentivizing healthy outcomes, does the Department intend to provide direction and/or support to PCOs on the Encouraging Employment requirement in the DRAFT PCO Agreement (see Section V(G)) consistent with the Healthy Pennsylvania Program as proposed by the Commonwealth?

    A. Pending Federal approval, the Department will work with PCOs to develop and implement these types of initiatives.

11. Q. Will a Health Plan be considered if the NCQA Interim Survey Accreditation is in process but not completed at the time of readiness review?

A. Applicants must meet the NCQA requirements set forth in Part III, Section III-3D by August 4, 2014. For purposes of applications, applicants should submit its most recent accreditation and the Department will consider interim survey accreditations.

12. Q. Does the Healthy Pennsylvania Program only cover the population below 133% of the Federal Poverty Level excluding Medicaid eligible, or are Medicaid eligible individuals also able to join the Healthy PA program?

    A. Medicaid eligible individuals will not be enrolled in Healthy PA, with one exception. If a Member who is enrolled in a PCO becomes pregnant while enrolled, she will become MA eligible and have the choice of enrolling in Medicaid or continuing her enrollment with the PCO.

13. Q. Will preference be given to PCOs that cover the entire state?

    A. No, the Department will select for negotiations every applicant who meets the criteria set forth in the RFA. See Part III of the RFA, "Criteria for Selection".

14. Q. Will there be a minimum and maximum number of PCOs selected for each Region?

    A. The Department intends to have at least two PCOs operating in each Region. The Department will select for negotiations every applicant who meets the criteria set forth in the RFA. There are no pre-established maximums.

15. Q. The RFA requires that applicants provide a copy of the certification submitted to the PID with the plan form filing. Are plans required to file as an on or off exchange plan? (Reference RFA)

    A. The certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. See Part II-5 of the RFA, "Compliance with Insurance Requirements." Both the Market Reform and QHP portions of the certification should be filled out and submitted with the plan form filing. An Applicant is not required to offer its PCO product on the exchange, but must specify its intentions (whether it is offering the product on or off the exchange) at the time of filing.

16. Q. Section I-6 of the Request for Application refers to the discretionary rejection of applicants. What are additional reasons that can cause the rejection of an otherwise acceptable applicant?

    A. The Department is unable to speculate as to what additional reasons may cause it to reject a submitted application.

17. Q. For 2015, will members under FPL 133/138% lose their Federal subsidies for exchange coverage?

    A. A Member who is enrolled in Healthy PA is not eligible for Federal subsidies on the exchange.

18. Q. Will a PCO need to compete with others within each region? If so, how many competitors can be anticipated?

    A. The Department intends to have at least two PCOs operating in each Region. The Department will select for negotiations every applicant who meets the criteria set forth in the RFA.

19. Q. We understand this section to be subject to Sections II-5 and III-B(3), which also state that Applicant must provide documentation that each plan through which coverage will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market, but adds that if the Applicant does not possess documentation at the time of application, the Department may provisionally qualify the Applicant conditioned upon its acquiring the necessary documentation by August 4, 2014 or such later dates as may be specified by the Department. Please confirm and clarify.

    A. Part IV, Section IV-3.D sets forth the Agreement requirement that an HMO certify that each plan for which PCO coverage will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. For purposes of its Application only, if an Applicant has not made its final certification at the time of application, it must provide a statement describing its plan to have its certification in place by August 4, 2014 or such later date as may be specified by the Department. See RFA Part II, Section II-5.

20. Q. To the extent an Applicant may not control what entities purchase shares of an ultimate parent company that is publicly traded, or therefore be able to make representations regarding such entities, would the State consider revising this sentence to clarify that Affiliate does not include institutional investors with no control over the Applicant or its parents or subsidiaries by adding the phrase ", and with control over," after the words "ownership interests of", as follows? "Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of***, and with control over,*** PCO or its parent(s), directors or subsidiaries of PCO or parent(s) shall be presumed to be Affiliates for purposes of the RFA and Agreement."

    A. The Department will not consider changing the definition because it wants to keep the definition consistent with federal regulations. The federal regulation prohibits a knowing relationship with these entities.

21. Qa. Could the state please clarify the intent of including this statement in the definition of "Affiliate"?

    Aa. The Department has defined Affiliate as a person with an employment, consulting or other arrangement for the provision of items and services that is significant and material to the PCO's obligations under this Agreement.

    Qb. Would the State consider striking or moving to the definition of subcontractor?

    Ab. No. Federal regulations at 42 C.F.R. §438.610 encompass this type of relationship. These persons may also be encompassed by the definition of Subcontractor set forth in RFA Attachment A, Draft Agreement, Section II, Definitions.

22. Q. "A PCO Health Care Provider who has a written contract with and is credentialed by a PCO and who participates in the PCO's Provider Network." We understand this to mean that Network Providers may be credentialed by a subcontractor of PCO, provided PCO maintains oversight of the subcontractor. Please confirm and clarify.

    A. A PCO's credentialing of its provider network must comply with 40 P.S. §991.2121 and 28 Pa.Code §§9.761-9.763.

23. Q. Must the PCO meet all the qualifications contained in the Insurance Department's "Affordable Care Act; Guidance for Compliance Submissions; Notice 2014-04," including the QHP requirements? Or must the PCO meet only those requirements applicable to the plans being offered? For example, would guaranteed availability and renewability apply, if this product is only offered to eligible enrollees during the term of their eligibility? If only a subset of the requirements in Notice 2014-04 apply, which ones are inapplicable?

    A. For purposes of the Compliance Checklist and Certification filed with PID, if an Applicant believes a requirement is not applicable to the PCO product, it may note that in its certification.

24. Q. Same questions submitted regarding Section II-5. (Must the PCO meet all the qualifications contained in the Insurance Department's "Affordable Care Act; Guidance for Compliance Submissions; Notice 2014-04," including the QHP requirements? Or must the PCO meet only those requirements applicable to the plans being offered? For example, would guaranteed availability and renewability apply, if this product is only offered to eligible enrollees during the term of their eligibility? If only a subset of the requirements in Notice 2014-04 apply, which ones are inapplicable?)

A. For purposes of the Compliance Checklist and Certification filed with PID, if an Applicant believes a requirement is not applicable to the PCO product, it may note that in its certification.

25. Q. In order to meet this requirement and offer the product described in this RFA, must Applicant submit a PID plan form filing, if Applicant is only submitting this certification for purposes of offering the product described in this RFA?

A. Yes, an Applicant should submit a plan form filing as well as a Compliance Checklist and Certification. The Applicant should submit its policy form via SERFF as a Form Schedule document. If assistance is needed regarding SERFF, the Applicant may contact the Insurance Department. (Please contact Ms. Tracy Bixler, Life & Health Insurance Policy Examiner Supervisor, 717.783.2112, tbixler@pa.gov.)

26. Q. Same question submitted regarding Section II-5. (In order to meet this requirement and offer the product described in this RFA, must Applicant submit a PID plan form filing, if Applicant is only submitting this certification for purposes of offering the product described in this RFA?)

A. Yes, an Applicant should submit a plan form filing as well as a Compliance Checklist and Certification. The Applicant should submit its policy form via SERFF as a Form Schedule document. If assistance is needed regarding SERFF, the Applicant may contact the Insurance Department. (Please contact Ms. Tracy Bixler, Life & Health Insurance Policy Examiner Supervisor, 717.783.2112, tbixler@pa.gov.)

27. Q. The PCO must comply with Sections 2102 and 2116 of the Insurance Company Law of 1921 40 P.S. §991.2102 and 991.2116, and 28 Pa. Code §9.672 and 31 Pa. Code §154.14 pertaining to coverage and payment of Emergency and Stabilization Services. For this population funded through title XIX, we suggest that payment for out-of-network emergency stabilization services be required at Deficit Reduction Act levels.

A. The PCO will need to comply with applicable law and regulation.

28. Q. May the Applicant modify its application by sealed written notice after the date specified for application receipt in order to remove Regions on which Applicant has bid, and without Applicant's application being rejected or its offer to negotiate an Agreement being rescinded, if rates applicable to the Regions proposed for removal are either not available for Applicant's review or are not approved by Applicant in writing?

A. After an Applicant has been selected for negotiations, it may modify its application to remove those Regions for which it is unable to reach agreement on

rates, or meet all RFA requirements for those Regions without affecting its application for other Regions.

29. Q. What rate should we expect to pay for out of network emergency services?

    A. The PCO will need to comply with applicable law and regulation.

30. Q. May we be provided with a zip code based / geographic view of the prospective Medicaid expansion eligibles?

    A. The Department does not possess a zip code-based distribution. An estimated population distribution based upon county of residence is provided as an attachment to this response document. The Department has prepared the estimate based upon the assumption that the Healthy Pennsylvania Program's beneficiary population of 500,000 will be geographically distributed similar to the population of the HealthChoices Program.

    Please note that this information represents the Department's estimate and may not reflect actual distribution following commencement of the Program.

31. Q. What actions can a PCO take prior to the August readiness review period to ensure the applicant is positioned to increase the efficiency of the readiness review period? (i.e. Will the Department readiness review include analysis of documentation on current policies and procedures, benchmarks, and/or applicable processes?)

    A. The Department will provide guidance to assist in preparation for the readiness review at a later date.

32. Q. May Applicants follow-up directly with the Pennsylvania Insurance Department (PID) contact with any questions regarding the PID filing in addition to the Project Officer for the Healthy Pennsylvania Program?

    A. Applicants may follow-up with the PID with plan-specific questions related to its PID policy form filings. (Please contact Ms. Tracy Bixler, Life & Health Insurance Policy Examiner Supervisor, 717.783.2112, tbixler@pa.gov.) Any questions related to the RFA or its Attachments should be directed to the DPW Project Officer identified in Part I, Section I-2.

33. Q. Please clarify that Applicants responding to this RFA and not intending to offer their Healthy Pennsylvania product as a qualified health plan on the Exchange need only to complete the Compliance and Checklist for the PID submission portion of the RFA.

    A. An Applicant should submit a plan form filing as well as a Compliance Checklist and Certification. The certification must certify that the coverage that

will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. See Part II-5 of the RFA, "Compliance with Insurance Requirements." Both the Market Reform and QHP portions of the certification should be filled out. An Applicant is not required to offer its PCO product on the exchange, but must specify its intentions (whether it is offering the product on or off the exchange) at the time of filing.

34. Q. If Applicant has not made a final certification at time of application, they must submit a statement describing the plan to have certification in place by August 4, 2014. Please clarify whether this pertains to those items on the PID's Compliance Checklist and Certification where Applicant has indicated "No" under "Certification of Compliance."

    A. The certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. See Part II-5 of the RFA, "Compliance with Insurance Requirements." Both the Market Reform and QHP portions of the certification should be filled out, though an applicant is not required to offer its PCO product on the exchange. A "No" answer will not prevent a certification from being final, though it may impact the final approval of the PCO plan, A Compliance Checklist and Certification should be submitted to the PID by August 4, 2014 or such later date as may be specified by the Department.

35. Q. The RFA states that "if covered services or Beneficiaries are expanded or eliminated, the PCO will implement on the date the PCO is notified by the Department to continue or discontinue services." Will the Department provide PCOs with advance notice of possible changes in order for them to effectively implement the programmatic changes?

    A. The Department will provide notice of changes and potential changes as information becomes available to the Department.

36. Q. Does the Department have any example of or specific requirements related to the member incentives program that a PCO is responsible for developing and implementing as part of the Healthy PA initiative?

    A. Pending Federal approval, the Department will work with PCOs to develop and implement these types of initiatives. Please see Section V.G.

37. Q. What is the Department's expected process or procedure for communicating the status of PCO application after the readiness review but prior to the final approval into the Healthy PA program?

    A. The Department plans to notify PCOs if they have met the qualifications on or about June 20, 2014. After selection and through implementation, the Department will communicate with selected PCOs as needed.

38. Q. Does Option A [of Healthy PA 1115 Waiver, Section5.3 Section A] require a PCO to offer the plan through the FFM?

    A. PCOs are not required to offer a plan on the FFM.

39. Q. Will CMS review the PCO plans that will be included in the Healthy PA Private Coverage option?

    A. CMS approval of each DPW/PCO agreement is required.

40. Q. Will the state publish FFM plans in addition to private and ESC plans on the Department's enrollment portal?

    A. No. Only Healthy PA PCO plans will be available through the Department's enrollment contractor.

41. Q. Is there a minimum and maximum number of PCOs in each region? The answer provided in the conference was "All successful applicants will be accepted. There is no limit or specific number of PCOs that will be accepted by region." We would like confirmation of this in the form of a written response.

    A. The Department intends to have at least two PCOs operating in each region. The Department will select for negotiations every applicant who meets the criteria set forth in the RFA. There are no pre-established maximums.

42. Q. The RFA requires that Applicant provide documentation that it has a valid Certificate of Authority as an HMO. Provided Applicant meets the other applicable submission requirements, would Applicant be precluded from applying using a Certificate of Authority that Applicant also uses for a Medicaid program?

    A. In order to qualify to offer a PCO product, an Applicant must have a Certificate of Authority jointly issued by PID and DOH pursuant to The Health Maintenance Organization Act, 40 P.S. §1551 et seq. to operate as an HMO in Pennsylvania. For the product(s) proposed to be offered, an Applicant should also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

43. Q. If Applicant already has a Certificate of Authority to operate an HMO for a Medicaid program in the counties for which Applicant submits an application, is it necessary for an Applicant to submit a modification to its HMO license?

    A. In order to qualify to offer a PCO product, an Applicant must have a Certificate of Authority jointly issued by PID and DOH pursuant to The Health Maintenance

Organization Act, 40 P.S. §1551 et seq. to operate as an HMO in Pennsylvania. For the product(s) proposed to be offered, an Applicant should also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

44. Q. At the bidder's conference, it was stated that PCO plans must satisfy PID criteria for commercial HMOs. Which PID criteria must the PCO plan satisfy?

A. The Department is not sure the context of the response that was given at the pre-application process. To the extent that the question and response refers to the criteria to be used for determining whether an Applicant is qualified, PCO entities must comply with all PID regulatory requirements. For the product(s) proposed to be offered, an Applicant should also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

45. Q. To the extent there is any conflict between the Department's responses to questions submitted by prospective Applicants regarding this RFA, does the later response always control?

A. The Department is bound only by information contained in the RFA or as issued as an addendum to the RFA. Please see Section I-9 of the RFA Part I-9.

46. Q. Regarding compliance with insurance requirements, will the form filing and compliance checklist that were submitted to PID last year be sufficient documentation for purposes of the RFA?

A. The 2015 plan form filing, with the updated Compliance Checklist and Certification, should be refiled to comprise a complete product filing with PID. The Compliance Checklist and Certification should be substantially identical to the form provided in the Pennsylvania Bulletin for use in 2015. If the plan has a 2014 self-certification, it should also submit it to the Department, as well.

47. Q. Will applicants have to do a form filing with the PID regarding Compliance with insurance requirements? We would like more clarity on the Compliance with insurance requirements section.

A. To assist DPW, for any plan (or product) through which an Applicant intends to offer the PCO, the Applicant should submit the policy form, along with a Compliance Checklist and Certification, to PID via SERFF. A form Compliance Checklist and Certification is available on the Department's website, in SERFF in the "general instructions", and in the PA Bulletin as linked in the RFA. Both the Market Reform and QHP portions should be filled out, and the Certification

executed by an authorized representative of the insurer. PID asks that these documents be submitted with the policy form via SERFF as a Form Schedule document. Also, if the policy form an Applicant intends to use for the PCO is substantially identical to a policy form the Applicant intends to use in the Marketplace, it would be helpful to note that in the submission, as it will facilitate the review process.

48. Q. Please confirm that Attachment A of RFA #04-14, Section VII (D) (4) allows a plan to provide network only services and deny coverage of services that are received from out-of-network providers except for emergency services, access and continuity requirements under Pennsylvania laws.

    A.The PCO is required to provide coverage of services received from an out-of-network provider as may be required by law, which includes but may not be limited to emergency services, and services as defined in the access and continuity of care requirements.

49. Q. Please confirm that as this program was submitted for approval as a Section 1115 demonstration project, the Healthy Pennsylvania Program qualifies as an extension of the Medicaid program and existing Medicaid network contracts can be used to support the program.

    A. The Healthy Pennsylvania Program is not an extension of the MA Program. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

50. Q. Will the PCO be responsible for performing casualty related recoveries?

    A. Yes, the PCO will perform all casualty related recoveries including but not limited to workers' compensation, motor vehicle accidents, slip and falls, medical malpractice, etc. The Draft Agreement will be changed to reflect this responsibility

51. Q. Will the PCO be required to pay for prenatal services and then chase any potential primary coverage post payment?

    A. Yes, the PCO should pay for prenatal services and pursue any recovery from a primary insurer post payment.

52. Q. In reference to paragraph II-4 of this RFA regarding County Operational Authority, the HMO's intent is to provide documentation of our existing DOH licensure, as we will use this legal entity for our proposed Healthy PA product. In terms of building our Healthy PA provider network, HMO's intent is to provide a statement indicating that we will have a provider network, specific to Healthy PA,

in place by August 1, 2014. Because we are not proposing to expand into any counties/regions outside of our current service area, we do not see the need to submit a Service Area Expansion (SAE) request as part of this RFA. Is our understanding of what is required to demonstrate DOH County Operational Authority accurate and complete?

A. Questions regarding DOH County Operational Authority should be directed to the Department of Health. Documentation of DOH County Operational Authority, or a written statement outlining the PCO's plan to have DOH County Operational Authority in place by August 4, 2014, is required for Applicant's submission on June 10, 2014.

If DOH approved a plan to operate in certain counties, the approval meets the operating authority requirement in the RFA. However, from a network adequacy standpoint, DOH will still want to review the network the company plans to use for the Healthy Pennsylvania population to ensure that there are enough providers to handle the influx of new business.

Section 2- Enrollment related

1. Q. Will Maximus be the enrollment broker utilized for Healthy PA enrollment?

   A. Maximus is the current enrollment broker engaged by the Department and the Department anticipates that it will be the enrollment broker for the implementation of the Healthy Pennsylvania Program.

2. Q. What is the expected enrollee coverage duration? Are enrollees likely to move to and from Private Coverage Organizations (PCO) to Individual Commercial Coverage throughout a calendar year period?

   A. The Department does not possess a zip code-based distribution. An estimated population distribution based upon county of residence is provided as an attachment to this response document. The Department has prepared the estimate based upon the assumption that the Healthy Pennsylvania Program's beneficiary population of 500,000 will be geographically distributed similar to the population of the HealthChoices Program.

   Please note that this information represents the Department's estimate and may not reflect actual distribution following commencement of the Program.

3. Q. Can you provide a breakdown of eligible enrollees by rating region?

   A. The Department does not possess a zip code-based distribution. An estimated population distribution based upon county of residence is attached. Please note this information represents the Department's estimate and may not reflect actual distribution.

4. Q. It's stated that any requests for enrollment and disenrollment must be referred to the Department. What types of changes would the carrier be permitted to process (i.e. address change within the same rating region, contact information)?

   A. The PCO will report information as specified in RFA Attachment A (Draft PCO Agreement) in Section V.K "Change of Status" found on page 25.

5. Q. Will enrollment and disenrollment (including Automatic Assignment) be effective only on the first of a future month? Will either take place with a retroactive effective date? If either date is other than the first of a month; is it expected that proration of the capitation payment will take place?

   A. Enrollment will be effective on either the 1st or 15th of a future month. Disenrollment is effective at the close of the applicable month. Proration of capitation will occur. The Department is still considering the issue of retroactive coverage in limited circumstances.

6. Q. Please clarify the process for eligibility determinations and enrollment. Can individuals apply through the Federally Facilitated Marketplace as well as through the State's COMPASS system (like CHIP and Medicaid today)? Will there also be paper applications for the program? Will the PCO's be responsible to enter the paper applications into COMPASS as is done today for CHIP? Will families be able to use one application and the system will determine which programs all family members are eligible for (Medicaid, CHIP, Healthy PA Program, marketplace subsidy)?

   A. The PCO will not be involved in the eligibility determination or actual enrollment process. The Department is responsible for eligibility determinations and enrollment into the Healthy Pennsylvania Program.

7. Q. Will the enrollees be equally divided among all plans in each Region?

   A. Beneficiaries are able to choose a PCO. Only those Beneficiaries who do not choose a PCO will be distributed evenly amongst the PCOs in a Region. Please see Exhibit E Automatic Assignment of Attachment A (Draft PCO Agreement) to the RFA.

8. Q. Would Healthy PA consider moving the identified medically frail enrollees mid-year, similar to the CHIP process?

   A. The Department is currently evaluating how newly identified medically frail individuals will be handled.

9. Q. What is the open enrollment period, and are there any special election periods throughout the year?

A. The initial enrollment period begins December 1, 2014, subject to Federal approval. Beneficiaries, who become eligible for this program throughout the year, have an opportunity to choose a PCO. Beneficiaries are only able to change PCOs once a year or in limited circumstances.

10. Q. Is the distribution directly with the insurance carriers?

    A. The Department does not understand this question.

11. Q. In the Agreement it states that enrollee auto-assignment will be divided equally among all PCOs in an Exchange Region. Do you envision keeping that methodology for the next several years?

    A. Any changes to the Healthy Pennsylvania Program, including changes to auto-assignment process will be communicated to and negotiated with the PCOs.

12. Q. Would DPW consider allowing PCOs to automatically transfer enrollees into a qualified HealthChoices MCO when they have been assessed as Medically Frail?

    A. The Department is currently evaluating how newly identified medically frail individuals will be handled.

13. Q. We note no mention of an enrollee's shopping experience or product pricing display. As such, it is assumed that no online tools are required. Please confirm.

    A. The Department's enrollment broker will provide the shopping experience. PCOs are to engage enrollees in better understanding the cost of health care through Explanation of Benefits (EOBs) and other paper or online tools.

14. Q. Please clarify whether there is any need to file the Healthy PA program on the marketplace.

    A. An Applicant is not required to offer its PCO product on the exchange, but must specify its intentions (whether it is offering the product on or off the exchange) at the time of filing its plan form filing and Compliance Checklist and Certification. Also, if the policy form an Applicant intends to use for the PCO is substantially identical to a policy form the Applicant intends to use in the Marketplace, it would be helpful to note that in the submission, as it will facilitate the review process.

15. Q. Does an applicant have the option to pick Healthy PA if they are deemed medically frail at the point of initial application, or will they exclusively be eligible for Medical Assistance?

A. No, if determined to be medically frail at the time of application, the individual will exclusively be eligible for MA.

16. Q. If a member is covered by Healthy PA and their health deteriorate and become medically frail, can you confirm at what point in time that member will become eligible for Medical Assistance?

    A.The Department is currently evaluating how newly identified medically frail individuals will be handled.

    Please note: A change in an individual's category of assistance at any time could qualify an individual for MA coverage

17. Q. Exhibit E Automatic Assignment describes briefly the auto-enrollment process that occurs when a beneficiary does NOT select a PCO. Are there any more details regarding how are members assigned to the PCO? How does the member choose the PCO?

    A. The initial enrollment period begins December 1, 2014, subject to Federal approval. Beneficiaries, who become eligible for this program throughout the year, have an opportunity to choose a PCO. Beneficiaries are only able to change PCOs once a year or in limited circumstances. The enrollment broker will assist Beneficiaries in their selection of a PCO.

18. Q. Is the member automatically re-enrolled each year?

    A. If this question refers to a Member's choice of a PCO, if the Member continues to be eligible for the Healthy Pennsylvania Program, the Member will be automatically re-enrolled in the same PCO, unless the Member makes a different PCO selection during the annual enrollment period.

19. Q. Is there a defined open enrollment period for this program to avoid anti-selection?

    A. Yes, there is an annual enrollment period during which Beneficiaries are able to choose or change PCOs. Beneficiaries, who become eligible for this program throughout the year, have an opportunity to choose a PCO. Beneficiaries are only able to change PCOs once a year or in limited circumstances. The target initial enrollment period will be December 1, 2014, subject to Federal approval.

20. Q. Can Healthy PA enrollees enroll through the federal exchange or through the PCO's own channels?

    A. Individuals who apply for health care coverage through the federal exchange and appear to meet the eligibility requirements for Healthy PA will be transferred

to the Department for final eligibility determination and enrollment. The Enrollment Broker will be responsible for enrollment activities.

21. Q. How are incomes determined and what are the timeframes for gathering that information?

    A. The PCO is not responsible for income determinations or compliance with timeframes related to gathering that information. The Department will be responsible for determining eligibility for the Healthy Pennsylvania Program, including determinations related to income.

22. Q. Is there a timeframe associated with this provision [Provision concerning eligibles who lose and regain eligibility in RFA Attachment A, Draft Agreement Exhibit E, Automatic Enrollment], for example, regains eligibility within 6 mos and will be enrolled in previous PCO?

    A. The 6 month period does not apply to individuals who lose and regain eligibility. Beneficiaries may only make a new PCO selection in the prescribed annual enrollment period otherwise, they will remain in the same PCO for the program year including situations where eligibility has been lost and re-gained.

23. Q. Will participant eligibility be reflected on the daily eligibility file provided by the Department to the PCO, or will there be a separate identifying file to determine participant eligibility? Since the daily eligibility file has not yet been approved by CMS as a definitive file, PCO would remain at risk for adjudicating claims for participants who would no longer be eligible.

    A. Participant eligibility will be reflected on the daily eligibility file. Please see RFA Attachment A, Draft Agreement, Section V. L.2, page 25. The Department will use a HIPAA compliant 834 format that will closely resemble the PA Medicaid file format.

24. Q. If an individual is employed and is eligible for the Healthy Pennsylvania Private Coverage option, is the individual required to choose the ESC plan option or will they be able to choose between private coverage options as well?

    A. The Department will determine the most cost effective program and the enrollee will receive coverage through that program.

25. Q. How will a consumer enroll into a plan? Will a participant enroll in a state website that includes all plan options or would they be enrolling through healthcare.gov for FFM, private issuers' consumer channels.

    A. The enrollment broker will facilitate the selection and enrollment of a Beneficiary into a PCO.

26. Q. If an individual is eligible but does not choose a plan the Department will auto-assign the participant to a private market plan. How will the department determine which private plan to choose for an individual?

    A. The initial enrollment period begins December 1, 2014, subject to Federal approval. Beneficiaries, who become eligible for this program throughout the year, have an opportunity to choose a PCO. Beneficiaries are only able to change PCOs once a year or in limited circumstances. Please refer to Exhibit E to Attachment A of the RFA, Draft Agreement.

Section 3- Network Requirements/Development

1. Q. Can we use our PA Dept. of Health adequate network approval letters, which we have received for our Medicaid line of business (by county), for this Healthy PA population?

   A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

   If DOH approved a plan to operate in certain counties, the approval meets the operating authority requirement in the RFA. However, from a network adequacy standpoint, DOH will still want to review the network the company plans to use for the Healthy Pennsylvania population to ensure that there are enough providers to handle the influx of new business.

2. Q. Do the Healthy PA participating providers also have to be Medicaid participating providers?

   A. No, Healthy PA providers do not have to be MA participating providers.

3. Q. Will this program be following the ACA network adequacy and Essential Community Providers standards?

   A. Yes. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program. Compliance with the network adequacy and essential community provider standards should also be indicated in the Compliance Checklist and Certification filed with the PID.

4. Q. Will a Health Plan be considered if the Certificate of Authority is in progress, but has not been completed by the RFA due date of June 10, 2014? In the RFA document, Section III-3 Criteria for Selection, the requirements seem to indicate

that a plan will be considered if the Certificate of Authority is completed in a timeline acceptable to DPW.

A. A PID/DOH Certificate of Authority, or written statement outlining a plan how the Certificate of Authority will be in place by August 4, 2014 or such later date as may be specified by the Department, is required for submission on June 10, 2014. See RFA Part III, Section III-3.A.

5. Q. Part II-3 and 4 of the Request for Application describe at length the requirement that the applicant have valid HMO authority in the regions it intends to provide coverage. Can a gatekeeper PPO or EPO be used to administer Health PA instead of an HMO? Is a gatekeeper/PCP required?

   A. The Department requires an HMO model and an HMO Certificate of Authority as specified in RFA Section II-3.

6. Q. Can the provider network change after the Request for Application is submitted?

   A. Yes, the provider network may change; however, the PCO must comply with applicable DOH regulations and maintain DOH Operational Authority in its Regions of participation.

7. Q. Can the PCO have backend agreements with Medicaid MCOs to subcontract the provider network?

   A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

8. Q. How is network adequacy determined? Timing – go-live vs, readiness review Documentation needed – contracted vs. letter of intent

   A. For readiness review purposes, the Department requires DOH County Operational Authority as evidence of network adequacy by August 4, 2014. Applicants must submit Service Area Expansions by July 11, 2014 to the Department of Health. Please refer to RFA Part II, Section II-4.

9. Q. The PCO and its Network Providers must have written provider agreements that comply with 28 Pa. Code §9.722 requirements. We understand this provision to mean that Provider Agreements may include existing provider agreements already contracted with one or more Applicant plans that have been amended or otherwise modified to meet the program requirements as set forth in this RFA. Please confirm and clarify.

A. PCOs must have the appropriate network contracts to obtain and maintain applicable DOH Operational Authority. Applicants may use existing provider agreements and modify them to meet the program requirements so long as the amended agreements continue to meet the regulatory requirements of 28 Pa Code §9.722 of the DOH managed care regulations.

10. Q. If the Applicant does not have operating authority from the State for those counties the Applicant intends to operate by the time they submit their application. According to the RFA the Applicant must "provide a statement regarding its plan to have operating authority for each county in place by August 1, 2014 or such later date as may be specified by the Department." Can the Department please clarify at what point in the application process they would specify any "later date" for obtaining Operating Authority?

    A. By the Application due date of June 10, 2014, an Applicant must provide either documentation of DOH County Operational Authority, or a written statement outlining its plan for having DOH County Operational Authority in place by August 4, 2014, unless the Department specifies a later date. Given that the Department is implementing a new program, we are unable to specify if and when we may extend the date for obtaining DOH Operational Authority.

11. Q. During the contracting process, if a provider wants to know what the fee schedule for the Healthy PA program is based upon, what should we tell them?

    A. The Department does not have requirements for the fee schedule to be used by PCOs to pay their providers. The PCO will have to determine what it communicates to providers during its negotiations with their providers.

12. Q. By what date will provider networks be due for approval by the state?

    A. PCOs must have the appropriate network contracts to obtain DOH County Operational Authority for the Regions in which they have applied by August 4, 2014. July 11, 2014 is the deadline to submit the SAE to DOH to expand its Operational Authority.

16. Given the short time-line, is deeming of current contracts acceptable?

    A. Contracts will not be deemed. Changes and amendments to the standard provider contracts must be submitted to the DOH for review and approval. If DOH approved a plan to operate in certain counties, the approval meets the operating authority requirement in the RFA. However, from a network adequacy standpoint, DOH will still want to review the network the company plans to use for the Healthy Pennsylvania population to ensure that there are enough providers to handle the influx of new business.

17. Q. The RFA requires Applicant to possess a valid Pennsylvania DOH Operational Authority for all counties in the Regions for which the Applicant submits an application. Provided Applicant meets the other applicable submission requirements, would Applicant be precluded from applying using DOH Operational Authority that it has received in such counties for a Medicaid program?

    A. Network adequacy for purposes of the PID Compliance Checklist and Certification depends on DOH approval of the network.

    In order to qualify to offer a PCO product, an Applicant must have a Certificate of Authority jointly issued by PID and DOH pursuant to The Health Maintenance Organization Act, 40 P.S. §1551 et seq.to operate as a HMO in Pennsylvania. For the product(s) proposed to be offered, an Applicant should also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

    In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

    If DOH approved a plan to operate in certain counties, the approval meets the operating authority requirement in the RFA. However, from a network adequacy standpoint, DOH will still want to review the network the company plans to use for the Healthy Pennsylvania population to ensure that there are enough providers to handle the influx of new business.

18. Q. Sections II-4 and IV-3.C of the RFA explain that if an Applicant does not have current DOH Operating Authority for a Region or county areas within a Region, they must submit a Service Area Expansion ("SAE") request to DOH Bureau of Managed Care (BMC) no later than July 11, 2014. Our understanding from the bidder's conference is that the deadline for having the network contracted is August 4. Would the State permit an Applicant to supplement its SAE filings on or before August 4, to reflect the extended network submission deadline?

    A. The August 4, 2014 deadline applies to the deadline for submitting documentation of DOH County Operational Authority for all counties for which the Applicant has applied to provide services. July 11, 2014 is the deadline to submit the SAE to DOH to expand its Operational Authority.

19. Q. May Applicant use existing network provider agreements that have been amended to include the applicable provider agreement requirements described in

the RFA in order to fully or partially satisfy the network adequacy requirements for this program?

A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program. Applicants may use existing provider agreements and modify them to meet the program requirements so long as the amended agreements continue to meet the regulatory requirements of 28 Pa Code §9.722 of the DOH managed care regulations.

20. Q. May Applicant do so if those existing network provider agreements also satisfy network adequacy requirements for a HealthChoices health plan offered by Applicant?

    A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

21. Q. May Applicant do so if those existing network provider agreements also satisfy network adequacy requirements for a commercial health plan offered by Applicant?

    A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

22. Q. Has DPW discussed with DOH their willingness to accept letters of intent in lieu of contracts by the August 1, 2014 to begin the process of meeting operational authority? August 1, 2014 is a challenge because of contracting, rates, amendments etc. This timeline presents a problem, especially given the fact that DOH will have a 30 day review period before granting operational authority.

    A. A letter of agreement is acceptable for the June submission date. However, a fully executed contract must be in place by July 11, 2014 when the network is submitted to the DOH for review.

23. Q. Do Healthy PA providers (physical health and behavioral health) need to have a Promise ID number?

    A. As currently designed, no, they are not required to have a PROMISe™ ID number.

24. Q. If an applicant's network is not currently contracted at this new, hybrid rate, but the applicant has or will have Department of Health Operating Authority in an applicable county, may an applicant apply on the basis of that authority while in the process of contracting providers for the Healthy PA product at the intended rate?

    A. For Application submission on June 10, 2014, DPW requires either documentation of DOH County Operational Authority, or a written statement outlining the PCO's plan to have DOH County Operational Authority in place by August 4, 2014.

Section 4- Covered/Non-Covered Services

1. Q. In regard to the recently released RFA pertaining to the Healthy Pennsylvania Program, should wrap around benefits, including non-emergency medical transportation, be included in the benefit package of applicant companies? If not, will the state provide coverage of these benefits through Pennsylvania Medicaid?

   A. As in-network covered services, the PCOs will be required to provide access to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as part of their benefit packages. PCOs must also include free choice of a Family Planning Provider and possibly Non-Emergency Transportation (still under consideration). PCOs will be required to provide benefits consistent with any changes to the Healthy Pennsylvania Program benefit package.

   The MA Program will not provide wraparound benefits to Healthy Pennsylvania Program Beneficiaries.

2. Q. The proposed Agreement makes the point about coverage for pregnant women. Why wouldn't pregnant women automatically be transitioned into HealthChoices where they will receive better benefits?

   A. A woman who becomes pregnant while enrolled in a PCO has the choice to transition into the MA Program or to remain in the Healthy Pennsylvania Program.

3. Q. The proposed Agreement states that the PCO must cover Medicare deductibles and coinsurances for any Medicare-covered services for qualified Medicare beneficiaries. Please explain when you believe that Medicare beneficiaries would be in Healthy PA.

   A. The Department does not plan to enroll individuals with Medicare coverage into a PCO. If a PCO Member becomes eligible for Medicare, the Department will prospectively disenroll the Member from the PCO and place in the MA Program. During the period of transition (the Member notice of Medicare eligibility

until the next PCO disenrollment date,) Beneficiaries will remain in a PCO. Medicare beneficiaries may also be eligible in the Healthy Pennsylvania Program and enrolled in a PCO due to the possibility of retroactive Medicare eligibility.

4. Q. The plan design provided excludes pediatric dental. How will enrollees meet the Federal individual shared responsibility requirements for their coverage? Is this Essential Health Benefit service provided through another source?

   A. Children will not be enrolled in the Healthy Pennsylvania Program. Children, if eligible, will be enrolled in MA.

5. Q. Is DPW going to be publishing a list of the specific Private Coverage Option benefits, including Behavioral Health? Health insurers need to specify for providers what services they will be contracted to provide.

   A. Please refer to Exhibit B to Attachment A Draft Agreement of the RFA. Exhibit B serves as a broad description of the minimum benefits required. An Applicant should include in each PCO product form filing Physical and Behavioral Health benefits packages that include amount, duration and scope of all benefits provided by its product. Additional details may be required to be provided to DPW.

6. Q. Please clarify if newborns will be enrolled with the related party MCO (if present) in Medicaid?

   A. All newborns are enrolled in MA. Parent of the MA newborn will have the opportunity to select a HealthChoices MCO. The MA auto-assignment rules also apply.

7. Q. Regarding compliance with insurance requirements, will the form filing and compliance checklist that were submitted to PID last year be sufficient documentation for purposes of the RFA?

   A. The 2015 plan form filing, with the updated Compliance Checklist and Certification, should be refiled to comprise a complete product filing with PID. The Compliance Checklist and Certification should be substantially identical to the form provided in the

8. Q. Will applicants have to do a form filing with the PID regarding Compliance with insurance requirements? We would like more clarity on the Compliance with insurance requirements section.

   A. In order to qualify to offer a PCO product, an Applicant must have a Certificate of Authority ~~is~~ jointly issued by PID and DOH pursuant to The Health Maintenance Organization Act, 40 P.S. §1551 et seq.to operate as a HMO in Pennsylvania. For the product(s) proposed to be offered, an Applicant should

also submit a plan form filing as well as a Compliance Checklist and Certification to the PID, and the certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market.

9. Q. Can the Department provide the expected incidence of Hepatitis C and the expected coverage population?

   A. The Department does not specifically track this condition. The Centers for Disease Control CDC) may have statistics that can assist you. Please contact the CDC for additional information. Information may be available on the CDC website.

Section 5 - Operations/Compliance/Oversight

1. Q. Will the DPW Managed Care Operational Memos, MA Bulletins and Systems Notices apply to PCOs? Will they be posted the same way and in the same place for PCOs?

   A. Please refer to RFA Part I, Section I-23, Information Technology, as well RFA Attachment A, Draft Agreement, Section V.S.5, page 31 addressing the application of information technology related bulletins and standards. PCO Operations Memos and System Notices will be issued in a similar format and using a similar process as that for the MA Program. See RFA Attachment A, Draft Agreement, Section I.C.

2. Q. Will DPW be the state department in charge of oversight for Healthy PA?

   A. Yes, but this program will be a partnership between DPW, PID, and DOH.

3. Q. When will the Department finalize their listing of additional Reports and Data requirements?

   A. The listing of reporting requirements is contained in Exhibit D of Attachment A to the RFA (Draft Agreement) and is comprehensive at the current time. There may be additions or changes to the list.

4. Q. Is there minimum incentive amount to be provided? Are there metrics by which the department will use to measure incentive effectiveness and or outcomes?

   A. PCOs are responsible for presenting ideas for Member incentives. The Department will review, approve, and work with PCOs to implement initiatives. . As part of their incentive program, PCOs should propose or define those health outcomes to be improved as well as the program design and measures. There are currently no set minimums. Measurement of effectiveness will be tailored to

the incentive proposed. Please see RFA Attachment A, Draft Agreement Section V.G.

5. Q. Can you please define health outcomes? Are incentives tied to changes in biometric measures in one period compared to the next time period? Or are these activities like Health risk assessments and online coaching that are presumed to have a positive impact on outcomes?

   A. PCOs are responsible for presenting ideas for Member incentives. The Department will review, approve, and work with PCOs to implement initiatives. As part of their incentive program, PCOs should propose or define those health outcomes to be improved as well as the program design and measures. Please see RFA Attachment A, Draft Agreement Section V.G.

6. Q. Is the program required to be available in formats other than online web-based?

   A. The Program has no specific restrictions for communication formats over and above those outlined in the Draft Agreement, and those requirements imposed by Federal and State laws and regulations. PCOs must take into consideration the population that will be served, and design a communication plan that suits the needs of that population.

7. Q. Is the program requirement just for the subscriber or all members on the contract?

   A. The Department does not understand this question.

8. Q. For incentives around employment – will the PCO be provided some type of data file or information to support employment efforts by the subscriber?

   A. The Department plans to provide guidance. Pending Federal approval, the Department will work with PCOs to develop and implement these types of initiatives.

9. Q. Are both wellness and employment incentives necessary or can the program just include incentives tied to wellness activities?

   A. See RFA Attachment A, Draft Agreement Section V.G. The PCO should propose incentive programs that meet the goals of the Healthy Pennsylvania Program.

10. Q. What is the expected turnaround for report development and delivery based on their requirements?

A. The Department will provide reporting specifications and timeframes at a later date.

11. Q. Are reports formats fixed or is there any flexibility?

    A. The Department will provide reporting specifications and timeframes at a later date.

12. Q. Can a PCO promote its products (Marketing) like any commercial plan or are there restrictions?

    A. The PCO must provide all outreach material to the Department 30 calendar days prior to its use. Please refer RFA Attachment A, Draft Agreement, Section V.F, page 23. PCOs will not be permitted to conduct "cold calls" as a marketing effort. PCOs must comply with all PID guidelines for written materials.

13. Q. Can other services (e.g. Dental, Life) be bundled with or sold with the core HPP product offering by PCO?

    A. If the question is referring to a PCO's ability to separately sell additional services to its Members at additional costs, the PCO is not prohibited from doing provided that those additional services do not include benefits required to be provided by the PCO as part of its PCO Agreement. In addition, a PCO may not deny enrollment based on a Beneficiary's purchase of the additional services or products

    If the question is referring to the PCO's ability to augment or improve the required benefit package by adding additional services at no cost, a PCO is not prohibited from doing so, provided that it provides all benefits as required by its PCO Agreement.

    In either case, the PCO is at full financial risk for any additional products and services.

    Any materials concerning additional services or products either separately sold or offered by the PCO are considered Member outreach material. As such, the PCO must provide this material to the Department thirty calendar days prior to its use. Please refer RFA Attachment A, Draft Agreement, Section V.F, page 23.

14. Q. Can members of Healthy PA automatically/compulsorily enrolled in a Care Management program of the PCO? Or would a care management program only provide an advantage for the PCO? Can this be different from the "Member incentive program" that is referred to on the RFA?

A. Care Management Programs address management of clinical Member care. Incentive Programs are not used to evaluate or provide clinical support for Members.

15. Q. “The PCO may not knowingly have a Relationship with the following….”[in RFA Attachment A, Draft Agreement, Section V.S.4.f] How is “Relationship” defined?

    A. Relationship is defined in a manner to be consistent with federal requirements set forth in 42 U.S.C. §1396u-2(d) and 42 C.F.R. §438.610. The Department will clarify this provision in a revision to the Agreement.

16. Q. The RFA states that "The PCO may not knowingly have a Relationship with … An individual who is an Affiliate." Does this preclude the PCO from subcontracting with affiliates? What does this mean in terms of subcontracting?

    A. Consistent with the requirements of 42 U.S.C. §1396u-2(d) and 42 C.F.R. §438.610, PCOs may not have relationships with individuals or entities who are debarred, suspended or otherwise excluded from participating in non-procurement activities or the affiliates of these individuals or entities. The Department will clarify this provision in a revision to the Draft Agreement.

17. Q. Can the Commonwealth provide the details of the readiness review requirements to allow plans to begin preparation? These would include, but not be limited to, any desk audit or system requirements.

    A. The Department will provide additional information concerning the readiness review process after PCO selection.

Section 6- Systems/IT

1. Q. Given that the list of required reports and files are, in general, the same for Healthy PA as HealthChoices, will DPW follow the same file layouts?

   A. The Department will use existing layouts where possible. However, final decisions and requirements may necessitate some changes.

2. Q. Please confirm that the monthly and daily 834 transmission files will follow the defined FFM 834 file format. There have and will continue to be updates to carrier’s eligibility transmission (i.e., federal Health Plan Identifier). It is assumed that the Commonwealth’s system is prepared to utilize all updated reporting fields. Please confirm.

   A. The Department will use a HIPAA compliant 834 format, but the format does not mirror the FFM 834 file format. The format will resemble the PA MA file format. The Department will comply with any future federally required changes.

3. Q. Has a timeline been established for testing of the 834 files with carriers?

   A. Not at this time.

4. Q. Noted in Attachment A, the Draft Agreement, section V.K (page 25) that Change in Status reporting will be required. Will the communication channel for reporting this information be an 834 file from the carrier to the Department? Or will another format/communication channel be defined?

   A. No. A DPW proprietary file will be used to communicate such changes.

5. Q. Request file format associated with the monthly Drug Rebate Supplemental File.

   A. Attached.

6. Q. Request file format associated with the daily/weekly Automated Provider Directory file.

   A. Attached.

7. Q. Is the encounter reporting requirement expected to be comparable to what is required by the Medicaid program?

   A. Encounter reporting will be required. Requirements are still being developed.

8. Q. A PCO is required to notify the department of any discrepancies after reconciliation of the Department's monthly membership file and a PCO's internal membership information. Does the Department have a defined or preferred method of membership discrepancy notification?

   A. Yes. Additional information will be provided during the readiness review process.

9. Q. Is the Department expecting a PCO and should the PCO expect the Department to comply with existing Management Information System SLAs specific to claim submissions, reconciliation, and reporting?

   A. Yes.

10. Q. Is a PCO permitted to submit Healthy PA claims within existing PA Medicaid claim submission files to the Department's PROMISe system or is a separate Healthy PA claims submission file required?

A. The files must be separate, and the PCO will have its own separate plan code.

11. Q. Should a PCO expect any modifications or impact to existing channels of claim processing or will the Healthy PA program require new and additional files between the Department and a PCO?

A. No new files are expected at this time.

12. Q. When will the Commonwealth expect the plans to begin system testing?

A. This will occur during readiness review, targeted to begin on August 5, 2014.

Section 7 - Premiums/Copayments/Cost Sharing

1. Q. Please advise if enrollees will be subject to premium billings. If yes, will the monthly premium be a fixed amount for all enrollees? Will enrollees make premium payment to the carrier or to the Commonwealth of Pennsylvania? Will there be any grace period for enrollees to pay premiums? For those that have to pay a premium, will there be an open enrollment period?

   A. The Department plans to implement premiums in 2016. The monthly premium will be a range, not a fixed amount. At this time, we are planning for premiums to be collected by the Commonwealth. There is no distinction between Members who do and do not pay a premium. Beneficiaries who are required to pay a premium will be subject to the same annual enrollment period as all other Beneficiaries.

2. Q. The plan design provided outlines a variety of cost-sharing components (deductibles, coinsurance, copays). Will enrollees receive any additional funding through this program to offset these cost-sharing responsibilities? If yes, please provide additional details.

   A. RFA Attachment B "Financial Terms" is for informational purposes only and reflects the assumptions and basis for Mercer's draft rates. The only cost-sharing responsibility of Members in 2015 will be the same as that contained in the DPW Medical Assistance copay schedule found at the link below: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005972.pdf

3. Q. What copay will PCOs be permitted to charge Members for the 72 hour supply of medication? … full copay vs. prorated copay?

   A. The only copays that will apply in 2015 are the same as those contained in the DPW Medical Assistance copay schedule found at the link below:

http://www.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005972.pdf

4. Q. The RFA notes the premiums in Attachment B have not yet been approved. 1. What is the approval process for these premiums? 2. What is the current status of the approval process? Is there an estimated date the Commonwealth expects to obtain approval? 3. Have there been any challenges obtaining approval to date? 4. What options are available to PCO's should the final, approved premiums be materially different than those presented? (Reference Attachment B)

   A. RFA Attachment B "Financial Terms" is for informational purposes only and reflects the assumptions and basis for Mercer's draft rates. The Department is not seeking approvals for the premiums contained in this Attachment.

5. Q. Is there a member premium? Who collects the member premium?

   A. Member premiums will begin in 2016. The Department plans to implement premiums in 2016. The monthly premium will be a range, not a fixed amount. At this time, we are planning for premiums to be collected by the Commonwealth.

6. Q. Is there any member cost sharing?

   A. In 2015, the Member cost sharing is exactly the same as the DPW Medical Assistance copay schedule found at the link below: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005972.pdf

   Member premiums are scheduled to begin in 2016.

7. Q. For Demonstration Year 1, will a participant who is enrolled in an FFM Plan be required to pay a copayment just similar to a participant enrolled in a Healthy Pennsylvania Private Coverage Option?

   A. FFM plans are not part of Healthy PA.

Section 8 - Pharmacy

1. Q. For products with smallest unbreakable package size that provides for greater than 72 hours, what copay will PCOs be permitted to render?

   A. Copays do not vary based on the amount dispensed.

2. Q. The RFA states that "On a case by case basis, the Department may waive the seventy-two (72) hour supply requirement." Can the Department outline the process for the PCO to submit potential cases?

   A. Not at this time. This will be discussed during readiness review. Please see Section V.B. of RFA Attachment A, Draft Agreement.

Section 9- Behavioral Health

1. Q. Exhibit B list services broadly for MH and SUD services. Can the Commonwealth provide a comprehensive list of behavioral health benefits, including service definitions? (Reference Attachment A, Exhibit B)

   A. Please refer to Exhibit B to Attachment A Draft Agreement of the RFA. Exhibit B serves as a general description of the minimum benefits required. PCOs should include a Physical and Behavioral Health benefits package that include amount, duration and scope of all benefits for their Healthy Pennsylvania PCO product with their application.

2. Q. Is the behavioral health network adequacy requirement equivalent to that of the physical health network, or is another standard being used?

   A. County Operational Authority is also required for and applies to the behavioral health network adequacy requirements for Healthy Pennsylvania. The same adequacy standard is used for physical and behavioral health.

Section 10 – Financial

1. Q. Will the Medicaid fee schedule be the baseline for payment for the PCOs?

   A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

2. Q. What provider reimbursement rates did DPW/Mercer assume in their capitation rates?

   A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

3. Q. Is the revenue (denominator) in the risk corridor formula subject to the Health Insurance Providers Fee (HIPF)?

   A. DPW will improve the definition in the draft Appendix 3d to make it clear that "revenue" refers to revenue net of payments by DPW for HIPF.

4. Q. Since there is no risk adjustment in Year 1, would DPW consider a more robust risk corridor design, to protect carriers who may get higher risk recipients (for example, in addition to the wider corridor, a more narrow corridor within the wider range)?

   A. DPW will review the MLR that is specified in the draft Agreement Appendix 3d. Selected applicants may propose agreement terms, but DPW might be unwilling to agree to terms that differ from its proposal.

5. Q. Could a high risk pool be implemented as well, or alternatively a reinsurance program?

   A. DPW does not plan to include High Cost Risk Pools in HPA agreements. DPW does not plan to offer reinsurance to PCOs.

6. Q. Were emerging trends (such as the impact of new Hepatitis C drugs) factored into the trend assumptions? If so, how?

   A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the updated Healthy PA Rate Methodology Narrative prepared by Mercer and provided with these questions and answers. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles.

7. Q. What benefit design and induced utilization adjustments were made to the claims costs?

   A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

8. Q. How will premiums be set in year 2+? Will carriers go through a bidding process, or will carriers need to file for a rate change, subject to DPW and/or PID approval?

   A. The process will be similar to Year One. In the spring of 2015 DPW will provide a rate offer and schedule a negotiation.

9. Q. Can you share any details on how the Risk Adjustment Methodology will work?

   A. This planning will occur in the future.

10. Q. For the Risk Corridor Calculation, will expenses for Quality Improvement Initiatives be added to medical costs, similar to the Federal Minimum MLR calculation?

    A. Yes.

11. Q. Will there be an opportunity to discuss with Mercer the pricing assumptions in more detail?

    A. No, but DPW is providing a more-thorough Healthy Pennsylvania RATE METHODOLOGY NARRATIVE with these questions and answers.

12. Q. What is the benefit plan including cost sharing to be provided by the private insurer (PCO) to the private coverage option member for the 2015 capitation rates listed in Attachment B?

a. Is it the Attachment B Appendix C AETNA Silver Plan exactly as shown with the $1500 deductible, etc.?

b. Or is it the Attachment A Exhibit B list of benefits with limits? If so, is this the same as the Low-Risk plan outlined in the Healthy PA 1115 Waiver?

   A. DPW Medical Assistance cost sharing will be utilized in 2015 in Healthy PA. Attachment A Exhibit B (Draft Agreement) applies. RFA Attachment B "Financial Terms" Appendix C within the Mercer rate documentation was prepared by Aetna and includes a lot of information that is not relevant to Healthy PA. The Low-Risk Medical Assistance benefit package is not utilized in Healthy PA.

13. Q. If the 2015 capitation is to cover only the AETNA Silver Plan, does the private coverage option member actually receive the Attachment A Exhibit B benefits? If so, are the differences in the cost sharing and coverage reconciled between the member, provider and the State only? Or is the insurer involved and if so how?

A. Attachment A Exhibit B applies to Healthy PA. DPW's capitation payments include costs that would have been borne by the individual under the Aetna benchmark plan's cost-sharing design. In year 1 the existing Medical Assistance cost-sharing rules will apply and it will be the responsibility of the providers to collect those co-payments. In year 2 and beyond there may be adjustments made to individual cost-sharing obligations and any change will be appropriately reflected in the PCO's capitation payment.

14. Q. Are the 2015 capitation rates entirely set by the State and the same for all insurers? And again, if so, for which benefit plan/cost sharing?

    A. DPW will provide each selected applicant with a rate proposal. These rate proposals vary by region but will be the same for all selected applicants within a region. The benefit plan is found in Attachment A Exhibit B. The only cost sharing in 2015 will be DPW's Medical Assistance co-pay schedule.

15. Q. Is it correct that the Risk Corridor arrangement Attachment A Appendix 3d (p. 49) only looks at claims incurred in the calendar year and paid through November 30 of following year with no completion?

    A. DPW is reviewing the settlement terms included in the draft Appendix 3d.

16. Q. Would we be able to see quantifiable data on how:

a) Rates adjusted for keeping those in HPA until redetermination that meet medically frail definition
b) How much SSI data was used in rate development?
c) What factor was used to increase expected costs for newly identified population
d) What factors were used for pent up demand
e) Details of maternity costs included
f) Adjustment considered since population has not been medically managed yet

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

17. Q. The RFA indicates that rates are set based on paying providers between Medicaid and commercial rates. Where within that range, since it is so large?

    A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

18. Q. Can you give actual trend rates used?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

19. Q. Please explain why it does not appear that any risk adjustment, like the Exchange products, is being utilized?

    A. DPW plans to implement risk adjustment in 2016. Earlier risk adjustment would be compromised by lack of data.

20. Q. How did Mercer do an adjustment to their rate reimbursement cells to include funding to pay providers above Medicaid levels?

    A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

21. Q. Would the Commonwealth consider using risk adjustment as well as risk corridors?

    A. DPW does not intend that the risk corridors will be permanent, but a decision has not been made on an end date.

22. Q. As indicated in Section I(5) of RFA # 04-14, please confirm that the Department will provide qualified Applicants an opportunity to negotiate the terms and conditions and financial rates set forth the DRAFT PCO Agreement.

    A. There will be an opportunity to negotiate, but DPW might be unwilling to agree to terms different than its proposal.

23. Q. The Capitation rate says that the Healthy PA program will not have a separate maternity payment in CY 2015. Pregnant women may stay in the program or move to HealthChoices. What happens if the pregnant woman stays in the Healthy PA program? How are maternity costs accounted for if there is no kick payment?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

24. Q. The RFA notes the premiums in Attachment B have not yet been approved. 1. What is the approval process for these premiums? 2. What is the current status

of the approval process? Is there an estimated date the Commonwealth expects to obtain approval? 3. Have there been any challenges obtaining approval to date? 4. What options are available to PCO's should the final, approved premiums be materially different than those presented? (Reference Attachment B)

A. RFA Attachment B "Financial Terms" is for informational purposes only and reflects the assumptions and basis for Mercer's draft rates. DPW's discussion with CMS about Healthy PA is continuing. DPW will manage challenges as they arise.

25. Q. How was the impact of new and emerging specialty drug therapies accounted for in the pharmacy trend development? What was the magnitude? (Reference Attachment B)

A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the detailed Healthy PA Rate Methodology Narrative provided by Mercer. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles.

26. Q. Benefit adjustments – what specific benefit adjustments were made to the base data and what were the magnitudes of the changes? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

27. Q. Maternity - document states that "Pregnant women may choose to stay in the Healthy PA program or move to HC." What assumptions, if any, were made to account for the selection into or out of Healthy PA? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

28. Q. Pent up Demand – what is the pent up demand assumption and the basis for it? Document states that "The pent-up demand factor will ultimately be reduced

to zero as the Healthy PA program matures." What is the timeframe of this normalization? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

29. Q. Reverse MCS – What specific adjustments were made? What is the magnitude? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

30. Q. Provider Pricing - What specific adjustments were made? What is the magnitude? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

31. Q. Admin Loads – What are the admin/profit/risk/contingency loads? (Reference Attachment B)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

32. Q. Section VII C of the Healthy Pennsylvania Private Coverage Organization (PCO) Agreement refers to no appeal for actuarially sound rates. Can an issuer (PCO) terminate the contract if the PCO determines the rates are unacceptable for a given year?

A. The PCO may terminate its agreement at the end of any calendar year with notice to DPW by June 30 of the same year.

33. Q. How will the capitation payments from the State of Pennsylvania be funded? Page 19 of the Healthy Pennsylvania PCO Agreement indicates a limitation based on available funds. Why would funds not be available?

A. DPW anticipates that funds will be appropriated for the Healthy PA program, and that CMS will provide federal participation as provided by law. DPW is looking for federal participation to remain at the levels currently indicated in the ACA. If there is a change in the law that reduces the federal funding commitment, DPW will evaluate options including an end to the program for this population.

34. Q. Appendix 3d of the Healthy Pennsylvania PCO Agreement describes the Risk Corridor:

    Qa.The uncertainty surrounding the ultimate cost level for this population warrants more protection on the upper end of the MLR corridor in the initial years of the program. Will the Commonwealth consider narrowing the corridor to provide reasonable protections given that the PCOs aren't developing the rate?

    Aa.DPW will review the MLR used in the draft Agreement Appendix 3d.

    Selected applicants may propose agreement terms, but DPW might unwilling to agree to terms that differ from its proposal.

    Qb.How are taxes and fees handled in the risk corridor calculation?

    Ab. DPW will improve the definition in the draft Appendix 3d to make it clear that "revenue" refers to revenue net of payments by DPW for HIPF.

    Qc.How will the risk corridor program be funded?

    Ac.There is no difference between funding for capitation payments and risk corridor payments.

35. Section VII B of the Healthy Pennsylvania PCO Agreement refers to Risk Adjustment. Given the multi-year contractual period of the RFA, additional details on the risk adjustment program are necessary. Please provide details of any existing Risk adjustment programs that PA currently utilizes that may be used to model the Healthy PA approach.

    Ad.The HealthChoices Risk Adjusted Rates manual is provided with these questions and answers.

36. Q. Can bidders obtain a copy of the detailed Mercer Actuarial analysis? After review of the Mercer Actuarial analysis will additional questions be permitted?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

37. Q. Apart from the capitation rates, is there an additional payment being contemplated to account for risk of enrollees with chronic conditions?

    A. DPW plans to implement risk adjusted rates in 2016. DPW does not anticipate making any additional payments for chronic conditions.

38. Q. The attachment provides the draft potential CY2015 capitation rates and a very general rate methodology narrative.
a. Please provide the base data that were used to develop the draft rates. The data may be de-identified to protect health plan proprietary data.

A. Base data used to develop the draft rates can be found at this link under the following bullets:
http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm

- HealthChoices Lehigh-Capital Zone/SFY 13-14 Contract Year
- HealthChoices Southeast Zone/SFY 13-14 Contract Year
- HealthChoices Southwest Zone/SFY 13-14 Contract Year
- HealthChoices Expansion Zones and BCC/SFY 13-14 Contract Year

Qb. Please provide the actual development that includes the trends, benefit adjustments, provider pricing, pent-up demand and managed care adjustments.

Ab.Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

Qc. What is the administration/Profit/Risk/Contingency Load as a percentage of developed capitation rates?

Ac.Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

Qd. Should the amounts withheld for the Health Insurance Providers Fee be insufficient to cover the payment due, will the State provide any additional amounts required?

Ad. No.

39. Q. Will the capitation rates for members who become “medically frail” after enrollment into the Healthy PA program be “risk-adjusted” to recognize the potentially higher medical costs for such members?

A. DPW plans to implement risk adjustment that will cover all HPA members in 2016.

40. Q. In addition to age and geographic differences, will capitation rates be risk-adjusted for the covered population?

A. DPW plans to implement risk adjustment that will cover all HPA members in 2016.

41. Q. Is the risk adjustment methodology shared by the Department with the PCO subject to PCO's written approval?

A. DPW will share extensive information about the risk adjustment methodology and meet with the PCOs and discuss and attempt to achieve consensus on the risk adjustment methodology, which will be the same across all PCOs. DPW will make the final decisions.

Q. If not, does this provision bind PCO to prospectively accept rates before it has the opportunity to review them?

A. Yes.

42. Q. If services or Beneficiaries are added to the Healthy Pennsylvania Program, or if covered services or Beneficiaries are expanded or eliminated, or if the Department adjusts the rates as set forth in this section, will such modifications be subject to the prior written consent of the PCO? (If the response to this question differs from the response to the same question regarding Attachment A, Section V.A(1), which controls?)

A. The most likely vehicle for a change in base capitation rates is an agreement amendment that would need a signature from the PCO.

43. Q. Are any such changes to the capitation rates, amendments and modifications subject to the prior written consent of the PCO?

A. The most likely vehicle for a change in base capitation rates is an agreement amendment that would need a signature from the PCO.

44. Q. "By executing the Agreement, the PCO has had opportunity to review the rates set forth in Appendix 3f, Capitation Rates, and accepts the rates for the relevant Agreement period." Does "relevant Agreement period" mean the initial three-year term beginning January 1, 2015? If not, how is "relevant Agreement period" defined?

A. No, this does not cover the three-year period. This refers to the period covered by the capitation rates included in the agreement as set forth in Appendix 3f.

45. Q. Due to complexity and number of material adjustments, it is critical to be transparent to ensure success of this new initiative. Please provide additional exhibits that illustrate base costs used and their source as well as explicit

adjustments for benefits, maternity-newborn adjustments, regional factors, pent up demand, managed care factors, network and admin assumptions.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

46. Q. Please confirm our understanding that TANF and Healthy Beginning rates were used as a basis for rate development of Healthy PA Rates and SSI and other populations were used as a reference only in development of pent up demand and other adjustments. Please indicate how Federal GA, CNO, CMO rate categories from current Medicaid program were used as a reference, if any.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

47. Q. Please list all program changes factored in currently proposed rates and outline mechanism of reimbursement for future program changes materially affecting this population.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

48. Q. Please provide an outline of benefit comparison between Medicaid benefit set used as an initial pricing reference and resulting benefit set used for Healthy PA population. Please outline benefit adjustment factors for each benefit with rate-cell impact.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

49. Q. Please elaborate on the regional adjustment methodology used and need to vary regions relative to current Medicaid regions set and closer alignment to initial pricing references used from Medicaid TANF/ Healthy Beginning regional rates. Please list regional rate-cell specific factors and indicate if they varied by category of service.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

50. Q. Please indicate how mental health adjustment was developed, and what was the basis for this adjustment. Please indicate if pricing for mental health

component assumed pent up demand/ managed care adjustments specific to this category of service.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

51. Q. Please indicate how adjustments for copays/ deductibles and the methodology for a member or beneficiary's responsibility to pay were factored into pricing of these benefits.

A. Member cost sharing in 2015 is the same as Medical Assistance, so little adjustment was needed.

52. Q. Please elaborate on the methodology used for the administrative load and contingency and what specific references were used to form basis of these assumptions. Please elaborate how expected membership volume by MCO and uncertainty over morbidity and high degree of outreach and initial care coordination expected were factored in admin and contingency rate development.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

53. Q. Please elaborate on the expected lag in managed care factors and what categories of service specifically are expected to be affected and by what factors (inpatient, outpatient, ER, physician, mental health, Rx.)

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

54. Q. Please elaborate your pricing expectations and mechanisms related to pharmacy benefits and ability of MCOs to manage and collect rebates and how it was adjusted in development of rates that used current Medicaid rates as a starting point.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers. The actuary assumed market share rebates similar to HealthChoices.

55. Q. Please elaborate your pricing expectations for Sovaldi and new high cost specialty pharmacy drugs that might be introduced and materially affect pricing of this program but that have limited claims data information at this point from

available references. Do you expect to establish any mechanisms to reimburse MCOs fully for cost of these uncertain and material elements currently not included in pricing for Healthy Pennsylvania?

A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the detailed Healthy PA Rate Methodology Narrative provided by Mercer. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles. DPW does not intend that PCO agreements will include provision for potential additional revenue specific to certain drugs.

56. Q. Please elaborate the process of estimating HIPF liability for each MCO, factoring in the draft and final rates and providing settlement for each MCO's actual HIF liability related to this product. Please specify expected timeframe of events from rate effective dates to settlements.

A. Please see the document titled *ACA Health Insurance Providers Fee, DPW Healthy PA Overview* and the draft agreement appendix that have been posted along with the Questions and Answers.

57. Q. Please specify assumptions about unit cost increases relative to current TANF/Healthy Beginnings rates, i.e. what were the unit cost adjustment factors by region and category of service that were factored in proposed Healthy Pennsylvania rates?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

58. Q. Please indicate how the APRDRG fee schedule and gradual APRDRG regional conversion were factored in as unit cost assumptions for Healthy Pennsylvania.

A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

59. Q. Please indicate final rate development process and rate agreement by participating PCOs;

    A. DPW plans to provide a rate offer to each selected applicant on June 20, 2014. A negotiation will be scheduled, probably during the week of June 30. Dates are subject to change.

60. Q. Please elaborate on the frequency, process and transparency of the future rate updates.

    A. DPW plans to provide a rate offer for the following year each spring. A negotiation will be scheduled.

61. Q. Please clarify if any high risk pools, quality incentives, or supplemental physician payments, similar to the current Medicaid program, will be in place for the Healthy Pennsylvania program as well and how they would operate and be defined.

    A. These elements are not included in Healthy PA.

62. Q. Would exhibits be provided that illustrate specific adjustments made and key assumptions?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

63. Q. Can you specify the blending weight between TANF & SSI in base data for rate development?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

64. Q. Can you provide more background and provide specific assumption about unit cost adjustment? What was the factor assumed relative to current unit cost structure embedded in the rate, separately, behavioral health network assumption?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

65. Q. Can you specify if unit cost assumption factor varies by category of service and or regions?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

66. Q. Can you provide specifics about expected default non-par reimbursement for emergent services?

A. The PCO will need to comply with applicable law and regulation.

Q. Was an adjustment made for any changes versus current Medicaid program?

A. No.

67. Q. Can you clarify if all benefit and program adjustment factors will be outlined?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

68. Qa. Can you clarify how member cost sharing assumption was factored in?

Aa. Member cost sharing in 2015 is the same as Medical Assistance, so little adjustment was needed.

Qb.How much was it affected by expected recoverability of member cost sharing?

Ab.No further adjustment.

Qc. Will PCOs have responsibility to collect member cost sharing or providers?

Ac.PCOs will not have this responsibility in Year One.

69. Q. Please elaborate on your pricing expectations of Sovaldi in draft rates.

A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the detailed Healthy Pennsylvania RATE METHODOLOGY NARRATIVE provided by Mercer. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW

and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles.

70. Q. Please clarify if quality incentives or supplemental payments will be incorporated in this program and rate.

    A. The initial program design does not include quality incentives.

71. Q. Please elaborate on specifics of future program and the schedule changes and adjustment of premium rates.

    A. DPW plans to provide a rate offer for the following year each spring. A negotiation will be scheduled.

72. Q. Please elaborate on expectation for PCP reimbursement level since ACA PCP rate component was not included in draft rates.

    A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

73. Q. Please specify expected admin and profit margin expectation embedded in current draft rates. How do they compare to current Medicaid program?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers. HPA is a different program with different expectations and medical costs.

74. Q. Please elaborate how target MLR was used for risk corridor and if there is any flexibility in setting it lower given risk and uncertainty of this new program?

    A. DPW will review the MLR used in the draft Agreement Appendix 3d. Selected applicants may propose agreement terms, but DPW might unwilling to agree to terms that differ from its proposal.

75. Q. Can you elaborate on pent-up demand and morbidity adjustment for this population? Does it vary by age and or region?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

76. Q. Can you clarify your expectation of long term morbidity difference of this population versus current Medicaid for similar age bands?

    A. No.

77. Q. Can you specify magnitude of managed care adjustment and indicate if it varies by region or category of service?

    A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

78. Q. Please clarify if risk corridor settlement is expected to be based on encounter data or supplemental reports that reconcile to financial statements.

    A. This decision has not been made.

79. Q. Please clarify how requirement to pay PPS to FQHCs/RHCs was factored in draft rate development?

    A. This is under review by Mercer.

80. Q. Please clarify if any settlements are expected between PCOs and FQHCs/RHCs.

    A. If DPW changes the PPS rate, for dates of service after January 1, 2015 and forward, PCOs may be required to conduct settlements.

81. Qa. Please clarify if specific payment requirements apply to Critical Access Hospitals?

    Aa. No.

    Qb. Please specify if any settlements are expected?

    Ab. No.

    How are these requirements factored in draft rates?

    N/A

82. Q. What was the assumed rate to providers in the rate development, more specific provider payment assumption rather than the broad range indicated in rate methodology narrative?

A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

83. Q. What was the behavioral health adjustment added to the MAGI/SSI 2014 rates?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

84. Q. In your use of 2014 rates, were adjustments made to compensate for current abnormal pharmacy trends?

A. Additional information related to the trends utilized in the Healthy PA rate development can be found in the May 21st detailed Healthy PA Rate Methodology Narrative provided by Mercer. Mercer leveraged available information to develop appropriate trends for this population. Due to the uncertainty surrounding this newly eligible adult population, and the uncertainty of the prevalence of the populations' existing disease conditions (taking into consideration that medically frail adults upon application will not be enrolled in Healthy PA), Mercer was not able to make additional, prospective changes beyond the adjustments found in the more detailed documentation for any specific disease condition. As data becomes available for this population, DPW and its actuary will monitor the program's performance, risk and expenditure patterns for consideration in future rate-setting cycles.

85. Q. For Healthy PA population is there an adverse risk for Hepatitis-C?

A. DPW doesn't have data specific to the Healthy PA population.

86. Q. Can you provide examples of the risk corridor in years 1-3?

A. The potential applicant should be able to develop examples using the draft agreement language.

87. Q. It appears that no payment will be made in year 1 if the MLR > 95%.

A. The risk corridor will apply in Year One. If a risk corridor payment is owed, it will be made later.

88. Q. Is there any expectation of retroactivity and PCO responsibility for this period? How was this factored in rates?

A. DPW will provide details once there is an agreement on the standard terms and conditions of the waiver with CMS. If the PCO enrollment date is after the hospital admission date, the PCO is not responsible for the stay.

89. Q. Can you elaborate on expected provider payment process for members admitted to hospital while being enrolled?

A. DPW will provide details once there is an agreement on the standard terms and conditions of the waiver with CMS. If the PCO enrollment date is after the hospital admission date, the PCO is not responsible for the stay.
.

90. Q. Is documentation required to be submitted for any FQHC/RHC that would not accept rate, and thus is not contracted?

A. DPW encourages full inclusion of FQHCs and RHCs in PCO networks. DPW has not decided on a requirement for documentation when an FQHC or RHC is not in a PCO's network.

91. Q. Does the PCO need to reimburse the FQHCs and RHCs at the Medicaid prospective Rate at time of processing or is a monthly or quarterly reconciliation acceptable?

A. The PCO must pay the PPS rate when the claim is processed.

92. Q. Will risk adjustment in 2016 be CDPS or the HCC methodology under the current FFM regulations vs. Medicare regulations?

A. This decision has not been made.

93. Q. Please clarify requirement to contract and pay PPS prospective rates for FQHCs/ RHCs and if it was reflected in presented draft rates. Please clarify is this was a separate base data adjustment or was included in overall unit cost adjustment factor. Please elaborate how the unit cost impact from this requirement was evaluated at the regional level and quantified.

A. This is under review by Mercer.

94. Q. Please provide additional information about current FQHC/ RHC listing by region and their current PPS rates and effective dates as well as prior PPS rates to allow for cost impact and trend evaluation of this new component relative to current Medicaid program.

A. A list of FQHCs and RHCs by region is provided with these responses, along with current PPS rates.

95. Qa. Please elaborate if MCOs are expected to provide settlements to FQHCs/ RHCs on top of the PPS rates and if this settlement can be both negative (i.e. FQHC/ RHC owing MCO funds) and positive (MCO owes additional funds to FQHC/ RHC).

    Aa. Yes.

    Qb. Please elaborate logistical and timing aspects of the settlement process, if applicable.

    Ab. We don't have additional information at this time.

    Qc. Please clarify if expected or historical settlement components on top of the PPS rates were already reflected in draft rates as presented and quantify regional adjustments for this component.

    Ac. This is under review by Mercer.

96. Q. Please clarify if similar contracting and / or payment requirements apply to CAHs (Critical Access Hospitals) with or without settlement components and how it was or will be reflected in premium rates. Please clarify regional consideration as well in rate development.

    A. There is no requirement specific to Critical Access Hospitals.

97. Q. Please clarify if prospective FQHC/ RHC PPS rate changes and settlement liability will be tracked from the cost and trend perspective and factored in future rate-settings given that this is a consistent cost increase item that will be completely outside of control of contracting PCOs.

    A. DPW will track PPS rate changes for the purpose of future HPA rate-setting.

98. Q. Please specify how APRDRG fee schedule changes that are partially reflected in some regions but are fully reflected in others, were factored in unit cost benchmarking (since APRDRG changes affect the level of Medicaid assumed versus currently paid or factored in Medicaid premium rates).

    A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage.

99. Q. Please clarify if the program will be marketed through hospitals as it affects expected morbidity of the population.

A. DPW doesn't plan marketing through hospitals, but a provider application taken by a hospital could lead to PCO coverage for an eligible individual.

100. Q. Please clarify why risk corridor target was setup at 90% MLR target given considerable additional risk and uncertainty of this new population and that draft rate structure does not control for such risks as difference in FPL level of membership assigned to any given MCO nor lack of risk scores in the first year. Other states recognize additional risk and uncertainty of this new population in setting target MLR lower to allow for additional risk contingency as well as additional administrative and outreach costs for new challenging populations.

A. DPW will review the MLR used in the draft Agreement Appendix 3d.

101. Q. Could the Department provide the assumptions used in estimating the percentage of pregnant women that will choose to go to Medicaid?

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

102. Q. Could the Department provide the Mercer Data Books used in the actuarial calculations?

A. Base data used to develop the draft rates can be found at this link under the following bullets:
http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/index.htm

- HealthChoices Lehigh-Capital Zone/SFY 13-14 Contract Year
- HealthChoices Southeast Zone/SFY 13-14 Contract Year
- HealthChoices Southwest Zone/SFY 13-14 Contract Year
- HealthChoices Expansion Zones and BCC/SFY 13-14 Contract Year

103. Q. A Healthy PA agreement with DPW may increase our HMO's capital requirement for RBC as administered by PID or for DPW's net worth requirement. Will the Commonwealth provide relief or assistance?

A. Risk-based capital requirements are set by statute; the Commonwealth does not have the flexibility to provide relief.

104. Q. Please provide additional information on the assumption to blend TANF and SSI/Disabled rates in development of the base data for the Healthy PA population. Given the significant difference between the two rate subgroups, it is critical to know how these population blocks were weighted during the blending step of rate development. Please provide specific details of this assumption as it materially affects results in expected cost.

A. Information that addresses your question is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

105. Q. It is our understanding that rates should be submitted solely through the application process. Please confirm if the Commonwealth wants rates submitted through the QHP SERF process as well.

A. There is no rate submission required for Applicant's in this program.

106. Q. According to section D.4 located on page 41 of the RFA entitled "Other Financial Requirements," the PCO must provide Members access to FQHCs and RHCs within its Provider Network. The PCO must pay FQHCs and RHCs rates no less than the Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by the Department. When will the Department publish the PPS rates that should be used as reimbursement?

A. A list of FQHCs and RHCs by region is provided with these responses, along with current PPS rates.

107. Q. How will the premium payment be issued and communicated to the issuer?

A. Payment will be made via ACH transaction. In the event bank account information has not been set up in the system, a paper check will be issued. An 820 Capitation File (monthly) and 36 month summary file will provide each Health Plan with payment data.

108. Q. Is the Healthy PA program considered a government program (like Health Choices) for the purposes of the meeting the 80% threshold for exemption from the ACA tax?

A. Please consult with a tax specialist or attorney for this determination.

109. Q. What percentage of Medicaid FFS reimbursement is Mercer assuming for provider reimbursement in their capitation rate development, and does is differ between Medical and Rx benefits?

A. Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage. The question has less significance with pharmacy benefits.

Automated Provider Directory File
File Layout

NAME: PROV_XX_YYYYMMDD.dat (XX = two character PCO Code)

DESCRIPTION: This file will be supplied to the EAC. The file will contain all updates to the plan's provider network.

FORMAT: ASCII

RECORD LENGTH: 386

Field Name	*Record Position*	*Field Length*	*Alpha/ Numeric*	*Special Instructions*
PCO Code	01-02	02	A/N	
Provider Type	03	01	A	See Provider Type Definitions
Plan Provider Number	04-18	15	A/N	
MA Provider Number	19-31	13	N	Default will fill with 1's when null
NPI Number	32-41	10	A/N	Default will fill with 9's when null
Zip Code	42-50	09	N	Populate 0000 at the end if last 4 digits are unknown
Provider Last Name	51-100	50	A	See Data Entry Standards
Provider First Name	101-130	30	A	
Address Line 1	131-160	30	A	See USPS Address Standards
Address Line 2	161-190	30	A	
City	191-220	30	A	
Filler	221-225	05	N	Leave blank
County Code	226-227	02	N	
Phone Area Code	228-230	03	N	
Phone Number	231-237	07	N	
Phone Extension	238-241	04	N	
Evening Hours	242	01	A	Defaults to N
Weekend Hours	243	01	A	Defaults to N
Restrictions	244-263	20	A/N	
Specialty 1	264-265	02	N	In order to be selected as a PCP, at least one code must be 24, 34, 14 or 17
Specialty 2	266-267	02	N	
Specialty 3	268-269	02	N	

Language 1	270-271	02	N	
Language 2	272-273	02	N	
Language 3	274-275	02	N	
Hospital Affiliation 1	276-278	03	N	
Hospital Affiliation 2	279-281	03	N	
Hospital Affiliation 3	282-284	03	N	
Wheelchair Accessible	285	01	A	Defaults to null for unknown
Group Affiliation	286-335	50	N	
AKA or Common name	336-385	50	A	Defaults to Provider Last name
Male or Female	386	01	A	Valid values are M=Male, F=Female, U=Undefined. Defaults to U - Undefined
Low Age Limit	387-389	03	N	Lowest age provider will serve, defaults to 0
High Age Limit	390-392	03	N	Highest age provider will serve, defaults to 120
Gender Served	393	01	A	Gender service restrictions, M=Male only, F=Female only, B=Both genders served, defaults to B

Drug Rebate Supplemental File Record Format

NAME: The file naming convention for the supplemental file is as follows:

xx_supplemental_ccyymmdd.txt
xx=plan code
cc=century
yy=year
mm=month
dd=day

RECORD LENGTH: 254 (Fixed)

Field Name	Field Length	Starting Position	Ending Position	Alpha/ Numeric	Special Instructions
PROMISe ICN:	13	1	13	CHAR	PCO will use ICN sent on NCPDP Response.
Billing Provider NPI	10	14	23	CHAR	PCO will use NPI sent on NCPDP Response.
Billing Provider Name	50	24	73	CHAR	PCO will indicate Billing Provider Name identified by NPI.
Billing Provider Address Line 1	30	74	103	CHAR	PCO will indicate first line of Billing Provider Address
Billing Provider Address Line 2	30	104	133	CHAR	PCO will indicate second line of Billing provider Address
Billing Provider City	18	134	151	CHAR	PCO will indicate first line of Billing Provider City
Billing Provider State	2	152	153	CHAR	PCO will indicate first line of Billing Provider 2 Character State Code
Billing Provider Zip	5	154	158	CHAR	PCO will indicate first line of Billing Provider Zip Code
Billing Provider Telephone Number	10	159	168	CHAR	Format: AAAEEENNNN *(AAA-Area Code EEE-Exchange Code NNNN-Number)*
NDC	11	169	179	CHAR	This is the NDC billed on the claim.
Allowed Amount	9,2	180	188	NUMERIC	PCO to indicate computed allowable amount for the drug dispensed. *(Two (2) decimal positions are implied)*Per unit amount.
AWP	10,5	189	198	NUMERIC	PCO to indicate Average Wholesaler Price used to determine reimbursement paid to the billing provider. *(Five (5) decimal positions are implied)* Per unit amount.
Generic/Brand Indicator	1	199	199	CHAR	0 – Non-Drug Item such as medical supplies 1 – Generic

					2 – Brand
Multi-source code	1	200	200	CHAR	Product Multi-source indicator values on DOS: M-Multi-source Branded Product O-Brand Originator N-Single-source Branded Product Y-Generic Product
EAC	10,5	201	210	NUMERIC	PCO to indicate Estimated Acquisition Cost used to determine reimbursement paid to the billing provider. *(Five (5) decimal positions are implied)* Per unit amount
MAC	10,5	211	220	NUMERIC	PCO to indicate Maximum Allowable Cost used to determine reimbursement paid to the billing provider. *(Five (5) decimal positions are implied)* Per unit amount
WAC	10,5	221	230	NUMERIC	PCO to indicate Wholesale Acquisition Cost used to determine reimbursement paid to the billing provider. *(Five (5) decimal positions are implied)* Per unit amount
FUL	10,5	231	240	NUMERIC	PCO to indicate Federal Upper Limit Cost used to determine reimbursement paid to the billing provider. *(Five (5) decimal positions are implied)* Per unit amount
Pricing Indicator	3	241	243	CHAR	Indicates the method used to price the drug. AFD = First DataBank AWP AMS = Medi-Span AWP AMX = Micromedex AWP FUL = FUL MAC = MAC WFD = First DataBank WAC WMS = Medi-Span WAC WMX = Micromedex WAC SPE = Specialty OTH = Other
PCO Code	2	244	245	CHAR	2 character PCO Code
Recipient ID	9	246	254	CHAR	9 digit Recipient MAID

TRAILER RECORD - ONE RECORD PER FILE

Field Name	Field Length	Starting Position	Ending Position	Alpha/ Numeric	Special Instructions
Record Count	10	1	10	NUMERIC	
Filler	244	11	254	CHAR	

This file provides active service provider locations enrolled in Medical Assistance Program as FQHC or RHC and
There are 285 active locations listed: 217 FQHCs and 82 RHCs. 14 locations are enrolled as both FQHC and RH
The FQHC list includes 10 out-of-state locations.
The U9 modifier indicates the payment rate for dental services provided by FQHC/RHC.
Prepared by DPW/OMAP/BMCO/DFA, May 2014

d current MA payment rates as of May 2014.
IC.

Medical Assistance Program Enrolled Federally Qualified Health Centers (FQHCs) and Payment Rate, May 2014

FFM	County	Provider Name	MPI Provider ID	Location	City, State and Zip Code	Procedure Code	Modifier	Rate	Effective Date	End Date
	Out-of-State	TRI STATE COMMUNITY HEALTH CENTER	100728880	0002	HANCOCK, MD 21750-1199	T1015		$112.00	10/1/2013	12/31/2299
	Out-of-State	TRI STATE COMMUNITY HEALTH CENTER	100728880	0007	CUMBERLAND, MD 21502-2878	T1015		$112.00	10/1/2013	12/31/2299
	Out-of-State	TRI STATE COMMUNITY HEALTH CENTER	100728880	0008	CUMBERLAND, MD 21502-6393	T1015		$112.00	10/1/2013	12/31/2299
	Out-of-State	KINSMAN HEALTH CENTER	100757846	0083	KINSMAN, OH 44428-9514	T1015		$152.24	10/1/2013	12/31/2299
	Out-of-State	PRIMARY HEALTH NETWORK/ANDOVER PRIMARY CARE	100757846	0103	ANDOVER, OH 44003-9490	T1015		$152.24	10/1/2013	12/31/2299
	Out-of-State	ASHTABULA COMMUNITY HEALTH CENTER	100757846	0106	ROME, OH 44085	T1015		$152.24	10/1/2013	12/31/2299
	Out-of-State	CLAY BATTELLE HEALTH SVCS ASSOC INC	100770534	0005	BLACKSVILLE, WV 26521-6521	T1015		$99.38	10/1/2013	12/31/2299
	Out-of-State	CLAY BATTELLE HEALTH SVCS ASSOC INC	100770534	0005	BLACKSVILLE, WV 26521-6521	T1015	U9	$81.47	10/1/2013	12/31/2299
	Out-of-State	FAMILY MEDICAL CARE COMMUNITY HEALTH CENTER	101885199	0001	WEIRTON, WV 26062-4637	T1015		$201.15	10/1/2013	12/31/2299
	Out-of-State	CHANGE INC FAMILY MEDICAL CARE COMMUNITY HEALTH CT	101885199	0002	WEIRTON, WV 26062-5053	T1015		$201.15	10/1/2013	12/31/2299
	Out-of-State	WEST CECIL HEALTH CENTER INC	102582794	0001	CONOWINGO, MD 21918-1519	T1015		$155.87	10/1/2013	12/31/2299
1	CLARION	PRIMARY HLTH NTWK/EAST BRADY	100757846	0023	EAST BRADY, PA 16028	T1015		$152.24	10/1/2013	12/31/2299
1	CLARION	CLARION COMMUNITY HEALTH CENTER	100757846	0107	CLARION, PA 16214-3876	T1015		$152.24	10/1/2013	12/31/2299
1	CLARION	CLARION COMMUNITY HEALTH CENTER	100757846	0107	CLARION, PA 16214-3876	T1015	U9	$130.62	10/1/2013	12/31/2299
1	CRAWFORD	PRIMARY HLTH NTWK/LINESVILLE	100757846	0021	LINESVILLE, PA 16424-9214	T1015		$152.24	10/1/2013	12/31/2299
1	CRAWFORD	PRIMARY HEALTH NETWORK	100757846	0102	TITUSVILLE, PA 16354-2169	T1015		$152.24	10/1/2013	12/31/2299
1	ERIE	COMMUNITY HEALTH NET	100754307	0013	ERIE, PA 16501-1914	T1015		$159.88	10/1/2013	12/31/2299
1	ERIE	COMMUNITY HEALTH NET	100754307	0016	ERIE, PA 16506-3599	T1015		$159.88	10/1/2013	12/31/2299
1	ERIE	COMMUNITY HEALTH NET-STAIRWAYS DENTAL OFFICE	100754307	0048	ERIE, PA 16508-1832	T1015	U9	$112.07	10/1/2013	12/31/2299
1	ERIE	COMMUNITY HEALTH NET	100754307	0051	ERIE, PA 16501-2109	T1015	U9	$112.07	10/1/2013	12/31/2299
1	ERIE	HARBORCREEK HEALTH CENTER	100754307	0052	ERIE, PA 16511-2219	T1015		$159.88	10/1/2013	12/31/2299
1	ERIE	JOHN E HORAN GARDEN APARTMENTS DENTAL OFFICE	100754307	0053	ERIE, PA 16511	T1015	U9	$112.07	10/1/2013	12/31/2299
1	MERCER	SHARON COMMUNITY HEALTH CENTER	100729879	0004	SHARON, PA 16146-1754	T1015		$141.61	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/SHARON MED GRP	100757846	0017	SHARON, PA 16146-2186	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/FARRELL MEDICAL	100757846	0022	FARRELL, PA 16121-1902	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/HEALTH SHOPPE	100757846	0025	FARRELL, PA 16121-1754	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/HEALTH SHOPPE	100757846	0025	FARRELL, PA 16121-1754	T1015	U9	$130.62	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/MERCER	100757846	0027	MERCER, PA 16137-5023	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HEALTH NTWK/GREEN STREET CLINIC	100757846	0069	FARRELL, PA 16121-1307	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	ELM AVENUE HEALTH CTR/PRIMARY HLTH NTWK SHENANGO	100757846	0072	SHARON, PA 16146-2338	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK	100757846	0073	HERMITAGE, PA 16148-1718	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HEALTH NETWORK	100757846	0075	FARRELL, PA 16121-1576	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HEALTH NETWORK	100757846	0075	FARRELL, PA 16121-1576	T1015	U9	$130.62	10/1/2013	12/31/2299
1	MERCER	TRANSFER HEALTH CENTER	100757846	0080	TRANSFER, PA 16154-2225	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	JAMESTOWN HEALTH CENTER	100757846	0081	JAMESTOWN, PA 16134-9505	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	CENTER FOR COMPLIMENTARY & INTEGRATIVE MEDICINE	100757846	0084	FARRELL, PA 16121-2304	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	GREENVILLE COMMUNITY HEALTH CENTER	100757846	0096	GREENVILLE, PA 16125-2608	T1015		$152.24	10/1/2013	12/31/2299
1	VENANGO	PRIMARY HEALTH NETWK/MOBILE/HEALTH CENTER	100757846	0090	SENECA, PA 16346	T1015		$152.24	10/1/2013	12/31/2299
2	CAMERON	KEYSTONE RURAL HEALTH CONSORTIA INC	100776396	0007	EMPORIUM, PA 15834-1399	T1015		$128.45	10/1/2013	12/31/2299
2	CAMERON	KEYSTONE RURAL HEALTH CONSORTIA INC	100776396	0007	EMPORIUM, PA 15834-1399	T1015	U9	$118.56	10/1/2013	12/31/2299
2	ELK	JOHNSONBURG DENTAL	100776396	0017	JOHNSONBURG, PA 15845-1656	T1015	U9	$118.56	10/1/2013	12/31/2299
3	LACKAWANNA	SCRANTON PRIMARY HEALTH CARE CENTER	100728871	0003	SCRANTON, PA 18509-3023	T1015		$105.73	10/1/2013	12/31/2299
3	LACKAWANNA	SCRANTON PRIMARY HEALTH CARE CENTER	100728871	0003	SCRANTON, PA 18509-3023	T1015	U9	$74.54	10/1/2013	12/31/2299
3	LACKAWANNA	MCANDREW FAMILY HEALTH CENTER	100776556	0020	VANDLING, PA 18421-1711	T1015		$146.18	10/1/2013	12/31/2299
3	LACKAWANNA	WAYNE MEMORIAL COMMUNITY HEALTH CENTERS - CARBONDA	100776556	0021	CARBONDALE, PA 18407-2574	T1015		$146.18	10/1/2013	12/31/2299
3	LUZERNE	RURAL HEALTH CORP OF NORTHEAST PA	100729609	0012	SHICKSHINNY, PA 18655-1302	T1015		$116.04	10/1/2013	12/31/2299
3	LUZERNE	RURAL HEALTH CORP OF NORTHEAST PA	100729609	0013	FREELAND, PA 18224-1805	T1015		$116.04	10/1/2013	12/31/2299
3	LUZERNE	RURAL HEALTH CORP OF NORTHEAST PA	100729609	0013	FREELAND, PA 18224-1805	T1015	U9	$141.09	10/1/2013	12/31/2299
3	LUZERNE	RURAL HEALTH CORP OF NORTHEAST PA	100729609	0016	KINGSTON, PA 18704	T1015		$116.04	10/1/2013	12/31/2299
3	LYCOMING	SUSQUEHANNA COMMUNITY HEALTH AND DENTAL CLINIC INC	102441606	0003	WILLIAMSPORT, PA 17701-6122	T1015		$165.61	10/1/2013	12/31/2299
3	LYCOMING	SUSQUEHANNA COMMUNITY HEALTH AND DENTAL CLINIC INC	102441606	0003	WILLIAMSPORT, PA 17701-6122	T1015	U9	$105.48	10/1/2013	12/31/2299
3	PIKE	PIKE COUNTY BEHAVIORAL HEALTH & DENTAL CLINIC	100776556	0022	LORDS VALLEY, PA 18428-6071	T1015	U9	$166.36	1/1/2014	12/31/2299
3	SUSQUEHANNA	B-K HEALTH CENTER INC	100770131	0006	HALLSTEAD, PA 18822-8816	T1015		$103.53	10/1/2013	12/31/2299

Medical Assistance Program Enrolled Federally Qualified Health Centers (FQHCs) and Payment Rate, May 2014

FFM	County	Provider Name	MPI Provider ID	Location	City, State and Zip Code	Procedure Code	Modifier	Rate	Effective Date	End Date
3	SUSQUEHANNA	NEPA COMMUNITY HEALTH CARE	100770131	0043	SUSQUEHANNA, PA 18847	T1015		$103.53	10/1/2013	12/31/2299
3	TIOGA	LAUREL HLTH SYSTM/NRTH PENN COMP HL	100001172	0035	BLOSSBURG, PA 16912-1137	T1015		$95.03	10/1/2013	12/31/2299
3	TIOGA	LAUREL HLTH SYSTM/NRTH PENN COMP HL	100001172	0036	ELKLAND, PA 16920	T1015		$95.03	10/1/2013	12/31/2299
3	TIOGA	LAUREL HLTH SYSTM/NRTH PENN COMP HL	100001172	0038	MANSFIELD, PA 16933-1411	T1015		$95.03	10/1/2013	12/31/2299
3	TIOGA	LAUREL HLTH SYSTM/NRTH PENN COMP HL	100001172	0039	LAWRENCEVILLE, PA 16929	T1015		$95.03	10/1/2013	12/31/2299
3	TIOGA	LAUREL HLTH SYSTM/NRTH PENN COMP HL	100001172	0040	WESTFIELD, PA 16950-1607	T1015		$95.03	10/1/2013	12/31/2299
3	TIOGA	NORTH PENN COMPREHENSIVE HEALTH SERVICES WELLSBORO	100001172	0141	WELLSBORO, PA 16901-1126	T1015		$95.03	10/1/2013	12/31/2299
3	WAYNE	HONESDALE FAMILY HEALTH CENTER	100776556	0011	HONESDALE, PA 18431-1436	T1015		$146.18	10/1/2013	12/31/2299
3	WAYNE	PIKE COUNTY FAMILY HEALTH CENTER	100776556	0013	HAWLEY, PA 18428-6071	T1015		$146.18	10/1/2013	12/31/2299
3	WAYNE	TOGETHER FOR HEALTH DENTAL CENTER	100776556	0014	HONESDALE, PA 18431-1459	T1015	U9	$166.36	10/1/2013	12/31/2299
3	WAYNE	WOMENS HEALTH DIVISION	100776556	0015	HONESDALE, PA 18431-2023	T1015		$146.18	10/1/2013	12/31/2299
3	WAYNE	HAMLIN FAMILY HEALTH CENTER	100776556	0016	HAMLIN, PA 18427	T1015		$146.18	10/1/2013	12/31/2299
3	WAYNE	WAYNE MEMORIAL COMMUNITY HEALTH CENTERS WAYMART	100776556	0017	WAYMART, PA 18472-9999	T1015		$146.18	10/1/2013	12/31/2299
3	WAYNE	WAYNE MEMORIAL COMMUNITY HEALTH CNTR NORTHER WAYNE	100776556	0018	LAKE COMO, PA 18437-1020	T1015		$146.18	10/1/2013	12/31/2299
3	WYOMING	RURAL HEALTH CORP OF NORTHEAST PA	100729609	0011	NOXEN, PA 18636	T1015		$116.04	10/1/2013	12/31/2299
3	WYOMING	RURAL HEALTH CORP OF NORTHEAST PA	100729609	0011	NOXEN, PA 18636	T1015	U9	$141.09	10/1/2013	12/31/2299
3	WYOMING	RURAL HEALTH CORP OF NORTHEAST PA	100729609	0015	FALLS, PA 18615-7949	T1015		$116.04	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HLTH SVCS ALMA ILLERY	100134339	0023	PITTSBURGH, PA 15208-1899	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HLTH SVCS ALMA ILLERY	100134339	0023	PITTSBURGH, PA 15208-1899	T1015	U9	$92.74	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0025	PITTSBURGH, PA 15212	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0025	PITTSBURGH, PA 15212	T1015	U9	$92.74	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0026	BRADDOCK, PA 15104-1066	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0026	BRADDOCK, PA 15104-1066	T1015	U9	$92.74	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0027	PITTSBURGH, PA 15220-5540	T1015	U9	$92.74	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0029	PITTSBURGH, PA 15208	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0031	WILKINSBURG, PA 15221-2312	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0033	PITTSBURGH, PA 15207-1623	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0034	BRADDOCK, PA 15104-1804	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0035	DUQUESNE, PA 15110	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0036	PITTSBURGH, PA 15219-4396	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES INC	100134339	0036	PITTSBURGH, PA 15219-4396	T1015	U9	$92.74	10/1/2013	12/31/2299
4	ALLEGHENY	EAST END COMMUNITY HEALTH CENTER	100134339	0048	PITTSBURGH, PA 15206-3518	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES WEST END	100134339	0049	PITTSBURGH, PA 15220-5516	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES STEEL VALLEY	100134339	0050	HOMESTEAD, PA 15120-2563	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES MCKEESPORT	100134339	0051	MCKEESPORT, PA 15132-2524	T1015		$137.62	10/1/2013	12/31/2299
4	ALLEGHENY	PRIMARY CARE HEALTH SERVICES MCKEESPORT	100134339	0051	MCKEESPORT, PA 15132-2524	T1015	U9	$92.74	10/1/2013	12/31/2299
4	ALLEGHENY	METRO FAMILY PRACTICE INC	100728002	0006	PITTSBURGH, PA 15221-2833	T1015		$133.69	10/1/2013	12/31/2299
4	ALLEGHENY	NORTH SIDE CHRISTIAN HEALTH CNTR NORTH VIEW HEIGHT	100747115	0006	PITTSBURGH, PA 15214-2427	T1015		$87.77	10/1/2013	12/31/2299
4	ALLEGHENY	NORTH SIDE CHRISTIAN HEALTH CARE	100747115	0007	PITTSBURGH, PA 15212-4915	T1015		$87.77	10/1/2013	12/31/2299
4	ALLEGHENY	EAST LIBERTY FAMILY HEALTH CARE CTR	100752492	0001	PITTSBURGH, PA 15206-3015	T1015		$160.05	10/1/2013	12/31/2299
4	ALLEGHENY	EAST LIBERTY FAMILY HEALTH CARE CTR	100752492	0002	PITTSBURGH, PA 15206-1217	T1015		$160.05	10/1/2013	12/31/2299
4	ALLEGHENY	EAST LIBERTY FAMILY HEALTH CARE CTR	100752492	0002	PITTSBURGH, PA 15206-1217	T1015	U9	$89.67	10/1/2013	12/31/2299
4	ALLEGHENY	EAST LIBERTY FAMILY HEALTH CARE	100752492	0015	PITTSBURGH, PA 15221-2312	T1015	U9	$89.67	10/1/2013	12/31/2299
4	ALLEGHENY	STO ROX NEIGHBORHOOD HEALTH COUN	100777811	0002	MC KEES ROCKS, PA 15136-3808	T1015		$130.22	10/1/2013	12/31/2299
4	ALLEGHENY	STO ROX NEIGHBORHOOD HEALTH COUN	100777811	0002	MC KEES ROCKS, PA 15136-3808	T1015	U9	$70.91	10/1/2013	12/31/2299
4	ALLEGHENY	HILLTOP COMMUNITY HEALTHCARE CENTER	100777811	0007	PITTSBURGH, PA 15210-1347	T1015		$130.22	10/1/2013	12/31/2299
4	ALLEGHENY	HILLTOP COMMUNITY HEALTHCARE CENTER	100777811	0007	PITTSBURGH, PA 15210-1347	T1015	U9	$70.91	10/1/2013	12/31/2299
4	ALLEGHENY	SQUIRREL HILL HEALTH CENTER	101799500	0002	PITTSBURGH, PA 15217-2917	T1015		$156.48	10/1/2013	12/31/2299
4	ALLEGHENY	SQUIRREL HILL HEALTH CENTER	101799500	0002	PITTSBURGH, PA 15217-2917	T1015	U9	$147.33	10/1/2013	12/31/2299
4	BEAVER	PRIMARY HLTH NTWK/BEAVER FALLS	100757846	0029	BEAVER FALLS, PA 15010-4217	T1015		$152.24	10/1/2013	12/31/2299
4	BEAVER	PRIMARY HLTH NTWK/BEAVER FALLS	100757846	0029	BEAVER FALLS, PA 15010-4217	T1015	U9	$130.62	10/1/2013	12/31/2299
4	BEAVER	AUTUMN STREET HEALTH CENTER/BEHAVIORAL HEALTH	100757846	0104	ALIQUIPPA, PA 15001-1301	T1015		$152.24	10/1/2013	12/31/2299
4	BUTLER	PRIMARY HLTH NTWK/PETROLIA	100757846	0028	PETROLIA, PA 16050	T1015		$152.24	10/1/2013	12/31/2299
4	FAYETTE	CENTERVILLE CLINICS INC	100728844	0031	FAIRCHANCE, PA 15436-1039	T1015		$144.73	10/1/2013	12/31/2299

Medical Assistance Program Enrolled Federally Qualified Health Centers (FQHCs) and Payment Rate, May 2014

FFM	County	Provider Name	MPI Provider ID	Location	City, State and Zip Code	Procedure Code	Modifier	Rate	Effective Date	End Date
4	FAYETTE	CENTERVILLE CLINICS INC	100728844	0032	REPUBLIC, PA 15475-0786	T1015		$144.73	10/1/2013	12/31/2299
4	FAYETTE	CENTERVILLE CLINICS INC	100728844	0032	REPUBLIC, PA 15475-0786	T1015	U9	$94.46	10/1/2013	12/31/2299
4	FAYETTE	CENTERVILLE CLINICS INC	100728844	0033	UNIONTOWN, PA 15401-5527	T1015		$144.73	10/1/2013	12/31/2299
4	FAYETTE	CENTERVILLE CLINICS INC	100728844	0037	CONNELLSVILLE, PA 15425-3519	T1015		$144.73	10/1/2013	12/31/2299
4	FAYETTE	CENTERVILLE CLINICS INC	100728844	0037	CONNELLSVILLE, PA 15425-3519	T1015	U9	$94.46	10/1/2013	12/31/2299
4	FAYETTE	CORNERSTONE CARE/VALLEY WOMENS HEALTH	100772557	0018	BELLE VERNON, PA 15012-4019	T1015		$116.27	10/1/2013	12/31/2299
4	FAYETTE	CORNERSTONE CARE UNIONTOWN OFFICE	100772557	0022	UNIONTOWN, PA 15401-7401	T1015		$116.27	10/1/2013	12/31/2299
4	FAYETTE	CORNERSTONE CARE UNIONTOWN OFFICE	100772557	0022	UNIONTOWN, PA 15401-7401	T1015	U9	$105.95	10/1/2013	12/31/2299
4	GREENE	CENTERVILLE CLINICS INC	100728844	0028	CARMICHAELS, PA 15320-1325	T1015		$144.73	10/1/2013	12/31/2299
4	GREENE	CENTERVILLE CLINICS INC	100728844	0036	WAYNESBURG, PA 15370-1660	T1015		$144.73	10/1/2013	12/31/2299
4	GREENE	CENTERVILLE CLINICS INC	100728844	0088	WAYNESBURG, PA 15370-1604	T1015		$144.73	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE	100772557	0003	GREENSBORO, PA 15338-9507	T1015		$116.27	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE	100772557	0003	GREENSBORO, PA 15338-9507	T1015	U9	$105.95	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE	100772557	0004	ROGERSVILLE, PA 15359-1001	T1015		$116.27	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE	100772557	0020	WAYNESBURG, PA 15370-8269	T1015		$116.27	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE	100772557	0021	WAYNESBURG, PA 15370-7209	T1015		$116.27	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE	100772557	0021	WAYNESBURG, PA 15370-7209	T1015	U9	$105.95	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE MOUNT MORRIS CENTR	100772557	0024	MOUNT MORRIS, PA 15349	T1015		$116.27	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE MOUNT MORRIS CENTR	100772557	0024	MOUNT MORRIS, PA 15349	T1015	U9	$105.95	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE INC MOBILE VAN I	100772557	0025	GREENSBORO, PA 15338-9507	T1015		$116.27	10/1/2013	12/31/2299
4	GREENE	CORNERSTONE CARE INC MOBILE VAN I	100772557	0025	GREENSBORO, PA 15338-9507	T1015	U9	$105.95	10/1/2013	12/31/2299
4	INDIANA	PRIMARY HEALTH NETWORK/JACKSONVILLE FAM MEDICINE	100757846	0071	CLARKSBURG, PA 15725-7400	T1015		$152.24	10/1/2013	12/31/2299
4	INDIANA	INDIANA DENTAL CENTER	100757846	0097	INDIANA, PA 15701-3600	T1015	U9	$130.62	10/1/2013	12/31/2299
4	LAWRENCE	PRIMARY HLTH NTWK/NEW CASTLE MEDICAL	100757846	0018	NEW CASTLE, PA 16101-4629	T1015		$152.24	10/1/2013	12/31/2299
4	LAWRENCE	PRIMARY HLTH NTWK/NEW CASTLE MEDICAL	100757846	0018	NEW CASTLE, PA 16101-4629	T1015	U9	$130.62	10/1/2013	12/31/2299
4	LAWRENCE	PRIMARY HLTH NTWK/SHEAKLEYVILLE	100757846	0019	SHEAKLEYVILLE, PA 16151	T1015		$152.24	10/1/2013	12/31/2299
4	LAWRENCE	PRIMARY HLTH NTWK/NEW CASTLE WALK-IN	100757846	0033	NEW CASTLE, PA 16101-4672	T1015		$152.24	10/1/2013	12/31/2299
4	LAWRENCE	NEW CASTLE DENTAL PRIMARY HEALTH NETWORK	100757846	0100	NEW CASTLE, PA 16105-1263	T1015	U9	$130.62	10/1/2013	12/31/2299
4	WASHINGTON	CENTERVILLE CLINICS INC	100728844	0027	FREDERICKTOWN, PA 15333-2114	T1015		$144.73	10/1/2013	12/31/2299
4	WASHINGTON	CENTERVILLE CLINICS INC	100728844	0027	FREDERICKTOWN, PA 15333-2114	T1015	U9	$94.46	10/1/2013	12/31/2299
4	WASHINGTON	CENTERVILLE CLINICS INC	100728844	0030	BENTLEYVILLE, PA 15314-1028	T1015		$144.73	10/1/2013	12/31/2299
4	WASHINGTON	CENTERVILLE CLINICS INC	100728844	0095	CALIFORNIA, PA 15419-1260	T1015		$144.73	10/1/2013	12/31/2299
4	WASHINGTON	CENTERVILLE CLINICS INC	100728844	0104	WASHINGTON, PA 15301-4062	T1015		$144.73	10/1/2013	12/31/2299
4	WASHINGTON	CENTERVILLE CLINICS INC	100728844	0104	WASHINGTON, PA 15301-4062	T1015	U9	$94.46	10/1/2013	12/31/2299
4	WASHINGTON	CENTERVILLE CLINICS INC	100728844	0105	CHARLEROI, PA 15022-1605	T1015		$144.73	10/1/2013	12/31/2299
4	WASHINGTON	CENTERVILLE CLINICS INC	100728844	0105	CHARLEROI, PA 15022-1605	T1015	U9	$94.46	10/1/2013	12/31/2299
4	WASHINGTON	CORNERSTONE CARE	100772557	0005	BURGETTSTOWN, PA 15021	T1015		$116.27	10/1/2013	12/31/2299
4	WASHINGTON	CORNERSTONE CARE	100772557	0005	BURGETTSTOWN, PA 15021	T1015	U9	$105.95	10/1/2013	12/31/2299
4	WASHINGTON	CORNERSTONE CARE	100772557	0016	WASHINGTON, PA 15301-4261	T1015		$116.27	10/1/2013	12/31/2299
4	WASHINGTON	CORNERSTONE CARE	100772557	0017	MONONGAHELA, PA 15063	T1015		$116.27	10/1/2013	12/31/2299
4	WESTMORELAND	MON VALLEY COMMUNITY HEALTH SERVICES INC	100728521	0019	MONESSEN, PA 15062-1388	T1015		$124.70	10/1/2013	12/31/2299
4	WESTMORELAND	SEWARD MEDICAL CENTER PRIMARY HEALTH NETWORK	100757846	0098	SEWARD, PA 15954-2053	T1015		$152.24	10/1/2013	12/31/2299
4	WESTMORELAND	COMMUNITY HEALTH CLINIC INC	101267643	0003	NEW KENSINGTON, PA 15068-6409	T1015		$162.23	10/1/2013	12/31/2299
4	WESTMORELAND	COMMUNITY HEALTH CLINIC INC	101267643	0004	NEW KENSINGTON, PA 15068	T1015	U9	$81.53	10/1/2013	12/31/2299
5	BEDFORD	HYNDMAN HEALTH CENTER	100733281	0003	HYNDMAN, PA 15545-0706	T1015		$80.75	10/1/2013	12/31/2299
5	BEDFORD	HYNDMAN HEALTH CENTER	100733281	0003	HYNDMAN, PA 15545-0706	T1015	U9	$77.26	10/1/2013	12/31/2299
5	BEDFORD	BEDFORD HEALTH CENTER	100733281	0008	BEDFORD, PA 15522-1760	T1015		$80.75	10/1/2013	12/31/2299
5	BEDFORD	BEDFORD HEALTH CENTER	100733281	0008	BEDFORD, PA 15522-1760	T1015	U9	$77.26	10/1/2013	12/31/2299
5	BLAIR	ALTOONA COMMUNITY HEALTH CENTER	100757846	0082	ALTOONA, PA 16601-3100	T1015		$152.24	10/1/2013	12/31/2299
5	BLAIR	ALTOONA BEHAVIORAL HEALTH	100757846	0095	ALTOONA, PA 16601-4804	T1015		$152.24	10/1/2013	12/31/2299
5	CAMBRIA	TRI COUNTY COMMUNITY HEALTH CENTER	100757846	0108	CHERRY TREE, PA 15724-9003	T1015		$152.24	10/1/2013	12/31/2299
5	CLEARFIELD	GLENDALE AREA MEDICAL ASSOC INC	100771184	0004	COALPORT, PA 16627	T1015		$87.75	10/1/2013	12/31/2299
5	CLEARFIELD	GLENDALE AREA MEDICAL ASSOC INC	100771184	0004	COALPORT, PA 16627	T1015	U9	$140.46	10/1/2013	12/31/2299
5	HUNTINGDON	SOUTHERN HUNTINGDON COUNTY MED CTR	000843478	0002	ORBISONIA, PA 17243-9424	T1015		$73.26	10/1/2013	12/31/2299

Medical Assistance Program Enrolled Federally Qualified Health Centers (FQHCs) and Payment Rate, May 2014

FFM	County	Provider Name	MPI Provider ID	Location	City, State and Zip Code	Procedure Code	Modifier	Rate	Effective Date	End Date
5	HUNTINGDON	SOUTHERN HUNTINGDON COUNTY MED CTR	000843478	0002	ORBISONIA, PA 17243-9424	T1015	U9	$159.01	10/1/2013	12/31/2299
5	HUNTINGDON	BROADTOP AREA MEDICAL CENTER	100749693	0006	BROAD TOP, PA 16621-9001	T1015		$101.40	10/1/2013	12/31/2299
5	HUNTINGDON	BROAD TOP AREA MEDICAL CENTER AT HUNTINGDON	100749693	0017	HUNTINGDON, PA 16652-1836	T1015		$101.40	10/1/2013	12/31/2299
5	JEFFERSON	PUNXSUTAWNEY COMMUNITY HEALTH CENTER	100757846	0105	PUNXSUTAWNEY, PA 15767-2605	T1015		$152.24	10/1/2013	12/31/2299
5	JEFFERSON	PRIMARY HEALTH NETWORK PUNXSUTAWNEY COMMUNITY HEAL	100757846	0110	PUNXSUTAWNEY, PA 15767-2343	T1015		$152.24	3/31/2013	12/31/2299
6	CENTRE	MOUNTAINTOP AREA MEDICAL CENTER	100776396	0018	SNOW SHOE, PA 16874-8832	T1015		$128.45	10/1/2013	12/31/2299
6	LEHIGH	THE NEIGHBORHOOD HEALTH CENTERS OFTHE LEHIGH VALLE	102323513	0004	ALLENTOWN, PA 18102-3508	T1015		$47.15	10/1/2013	12/31/2299
6	MIFFLIN	LEWISTOWN COMMUNITY HEALTH CENTER	100757846	0109	LEWISTOWN, PA 17044-8126	T1015		$152.24	1/13/2014	12/31/2299
6	SCHUYLKILL	RURAL HLTH CORP OF NE PA/BLACK CREEK CTR	100729609	0014	NUREMBERG, PA 18241	T1015		$116.04	10/1/2013	12/31/2299
6	SCHUYLKILL	RURAL HLTH CORP OF NE PA/BLACK CREEK CTR	100729609	0014	NUREMBERG, PA 18241	T1015	U9	$141.09	10/1/2013	12/31/2299
7	ADAMS	FAMILY FIRST HEALTH (GETTYSBURG CENTER)	100754853	0021	GETTYSBURG, PA 17325	T1015		$130.92	10/1/2013	12/31/2299
7	ADAMS	FAMILY FIRST HEALTH (GETTYSBURG CENTER)	100754853	0021	GETTYSBURG, PA 17325	T1015	U9	$186.88	10/1/2013	12/31/2299
7	BERKS	BERKS COMMUNITY HEALTH CENTER	102691224	0002	READING, PA 19602-1108	T1015		$163.52	1/1/2013	12/31/2299
7	BERKS	BERKS COMMUNITY HEALTH CENTER	102691224	0002	READING, PA 19602-1108	T1015	U9	$103.47	1/1/2013	12/31/2299
7	LANCASTER	SOUTHEAST LANCASTER HEALTH SVCS INC	100729912	0005	LANCASTER, PA 17602-4509	T1015		$112.13	10/1/2013	12/31/2299
7	LANCASTER	SOUTHEAST LANCASTER HEALTH SVCS INC	100729912	0005	LANCASTER, PA 17602-4509	T1015	U9	$117.16	10/1/2013	12/31/2299
7	LANCASTER	SOUTHEAST LANCASTER HEALTH SERVICES AT BRIGHTSIDE	100729912	0007	LANCASTER, PA 17603	T1015		$112.13	10/1/2013	12/31/2299
7	LANCASTER	SOUTHEAST LANCASTER HEALTH SVCS INC	100729912	0009	LANCASTER, PA 17603-2928	T1015		$112.13	10/1/2013	12/31/2299
7	LANCASTER	WELSH MOUNTAIN MEDICAL & DENTAL CTR	100761419	0002	NEW HOLLAND, PA 17557-9565	T1015		$110.21	10/1/2013	12/31/2299
7	LANCASTER	WELSH MOUNTAIN MEDICAL & DENTAL CTR	100761419	0002	NEW HOLLAND, PA 17557-9565	T1015	U9	$96.46	10/1/2013	12/31/2299
7	LANCASTER	WELSH MT / MEADOW CREEK FAMILY PRACTICE	100761419	0005	NEW HOLLAND, PA 17557-8706	T1015		$110.21	10/1/2013	12/31/2299
7	LANCASTER	WELSH MT / MEADOW CREEK FAMILY PRACTICE	100761419	0005	NEW HOLLAND, PA 17557-8706	T1015	U9	$96.46	10/1/2013	12/31/2299
7	YORK	EAST SIDE HEALTH CENTER	100001708	0655	YORK, PA 17403-2515	T1015		$224.98	10/1/2013	12/31/2299
7	YORK	FAMILY FIRST HEALTH	100754853	0004	YORK, PA 17403-2811	T1015		$130.92	10/1/2013	12/31/2299
7	YORK	FAMILY FIRST HEALTH	100754853	0004	YORK, PA 17403-2811	T1015	U9	$186.88	10/1/2013	12/31/2299
7	YORK	FAMILY FIRST HEALTH	100754853	0006	LEWISBERRY, PA 17339-9257	T1015		$130.92	10/1/2013	12/31/2299
7	YORK	FAMILY FIRST HEALTH	100754853	0018	YORK, PA 17401-1443	T1015		$130.92	10/1/2013	12/31/2299
7	YORK	FAMILY FIRST HEALTH	100754853	0018	YORK, PA 17401-1443	T1015	U9	$186.88	10/1/2013	12/31/2299
7	YORK	FAMILY FIRST HEALTH	100754853	0020	HANOVER, PA 17331-1127	T1015		$130.92	10/1/2013	12/31/2299
7	YORK	FAMILY FIRST HEALTH	100754853	0020	HANOVER, PA 17331-1127	T1015	U9	$186.88	10/1/2013	12/31/2299
8	CHESTER	CHESSPENN HEALTH SERVICES INC	100728281	0016	COATESVILLE, PA 19320-3590	T1015		$151.45	10/1/2013	12/31/2299
8	CHESTER	LA COMUNIDAD HISPANA INC	100752680	0007	KENNETT SQUARE, PA 19348-2419	T1015		$151.42	1/1/2013	12/31/2299
8	DELAWARE	CHESPENN HEALTH SERVICES	100728281	0006	CHESTER, PA 19013-2040	T1015		$151.45	10/1/2013	12/31/2299
8	DELAWARE	CHESPENN HEALTH SERVICES	100728281	0006	CHESTER, PA 19013-2040	T1015	U9	$138.82	10/1/2013	12/31/2299
8	DELAWARE	CHESPENN HEALTH SERVICES	100728281	0015	CHESTER, PA 19013-6019	T1015		$151.45	10/1/2013	12/31/2299
8	DELAWARE	CHESPENN HEALTH SERVICES	100728281	0015	CHESTER, PA 19013-6019	T1015	U9	$138.82	10/1/2013	12/31/2299
8	DELAWARE	CHESPENN HEALTH SERVICES-CENTER FOR FAMILY HEALTH	100728281	0019	UPPER DARBY, PA 19082-2013	T1015		$151.45	10/1/2013	12/31/2299
8	MONTGOMERY	NORRISTOWN REGIONAL HEALTH CENTER	100772996	0024	NORRISTOWN, PA 19401-3426	T1015		$126.46	10/1/2013	12/31/2299
8	MONTGOMERY	NORRISTOWN REGIONAL HEALTH CENTER	100772996	0024	NORRISTOWN, PA 19401-3426	T1015	U9	$118.15	10/1/2013	12/31/2299
8	MONTGOMERY	COMMUNITY HEALTH AND DENTAL CARE INC	102207819	0004	POTTSTOWN, PA 19464-6421	T1015		$175.24	10/1/2013	12/31/2299
8	MONTGOMERY	COMMUNITY HEALTH AND DENTAL CARE INC	102207819	0004	POTTSTOWN, PA 19464-6421	T1015	U9	$171.74	10/1/2013	12/31/2299
8	PHILADELPHIA	PUBLIC HEALTH MANAGEMENT CORPORATION	100001664	0030	PHILADELPHIA, PA 19107-5125	T1015		$181.88	10/1/2013	12/31/2299
8	PHILADELPHIA	PUBLIC HEALTH MANAGEMENT CORPORATION	100001664	0054	PHILADELPHIA, PA 19123	T1015		$181.88	10/1/2013	12/31/2299
8	PHILADELPHIA	CONGRESO HEALTH CENTER	100001664	0060	PHILADELPHIA, PA 19133-3534	T1015		$181.88	10/1/2013	12/31/2299
8	PHILADELPHIA	PUBLIC HEALTH MANAGEMENT CORPORATION RISING SUN HE	100001664	0061	PHILADELPHIA, PA 19120-2719	T1015		$181.88	10/1/2013	12/31/2299
8	PHILADELPHIA	PHMC HEALTH CONNECTION	100001664	0062	PHILADELPHIA, PA 19122-2024	T1015		$181.88	1/20/2014	12/31/2299
8	PHILADELPHIA	RESOURCES FOR HUMAN DEVELOPMENT	100001708	0175	PHILADELPHIA, PA 19123-1957	T1015		$224.98	10/1/2013	12/31/2299
8	PHILADELPHIA	RESOURCES FOR HUMAN DEVELOPMENT	100001708	0175	PHILADELPHIA, PA 19123-1957	T1015	U9	$231.85	10/1/2013	12/31/2299
8	PHILADELPHIA	ABBOTTSFORD-FALLS FAMILY PRACTICE AND COUNSELING	100001708	0503	PHILADELPHIA, PA 19144-4248	T1015		$224.98	10/1/2013	12/31/2299
8	PHILADELPHIA	ABBOTTSFORD-FALLS FAMILY PRACTICE AND COUNSELING	100001708	0503	PHILADELPHIA, PA 19144-4248	T1015	U9	$231.85	10/1/2013	12/31/2299
8	PHILADELPHIA	HEALTH ANNEX	100001708	0506	PHILADELPHIA, PA 19142-3224	T1015		$224.98	10/1/2013	12/31/2299
8	PHILADELPHIA	HEALTH ANNEX	100001708	0506	PHILADELPHIA, PA 19142-3224	T1015	U9	$231.85	10/1/2013	12/31/2299
8	PHILADELPHIA	ROCHELLE CENTER FOR CHILDREN'S SERVICES	100001708	0656	PHILADELPHIA, PA 19128-3808	T1015		$224.98	10/1/2013	12/31/2299
8	PHILADELPHIA	QCARE	100001708	0716	PHILADELPHIA, PA 19129	T1015		$224.98	1/15/2014	12/31/2299

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FFM	County	Provider Name	MPI Provider ID	Location	City, State and Zip Code	Procedure Code	Modifier	Rate	Effective Date	End Date
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0008	PHILADELPHIA, PA 19145-2383	T1015		$191.08	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0008	PHILADELPHIA, PA 19145-2383	T1015	U9	$145.94	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0009	PHILADELPHIA, PA 19104-4489	T1015		$191.08	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0009	PHILADELPHIA, PA 19104-4489	T1015	U9	$145.94	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0010	PHILADELPHIA, PA 19104-1361	T1015		$191.08	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0010	PHILADELPHIA, PA 19104-1361	T1015	U9	$145.94	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0011	PHILADELPHIA, PA 19121-2217	T1015		$191.08	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0011	PHILADELPHIA, PA 19121-2217	T1015	U9	$145.94	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0012	PHILADELPHIA, PA 19123-1531	T1015		$191.08	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0012	PHILADELPHIA, PA 19123-1531	T1015	U9	$145.94	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0013	PHILADELPHIA, PA 19144-2153	T1015		$191.08	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0013	PHILADELPHIA, PA 19144-2153	T1015	U9	$145.94	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0014	PHILADELPHIA, PA 19149-1298	T1015		$191.08	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0014	PHILADELPHIA, PA 19149-1298	T1015	U9	$145.94	10/1/2013	12/31/2299
8	PHILADELPHIA	PHILA DEPT PUBLIC HLTH/HLTH CARE CR	100007695	0015	PHILADELPHIA, PA 19132-4627	T1015		$191.08	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILA HEALTH ACTION INC	100137448	0016	PHILADELPHIA, PA 19147-3840	T1015		$144.33	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILA HEALTH ACTION INC	100137448	0016	PHILADELPHIA, PA 19147-3840	T1015	U9	$156.49	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILA HEALTH ACTION INC	100137448	0017	PHILADELPHIA, PA 19145-3101	T1015		$144.33	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILA HEALTH ACTION INC	100137448	0017	PHILADELPHIA, PA 19145-3101	T1015	U9	$156.49	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILA HEALTH ACTION INC	100137448	0018	PHILADELPHIA, PA 19124-3602	T1015		$144.33	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILA HEALTH ACTION INC	100137448	0018	PHILADELPHIA, PA 19124-3602	T1015	U9	$156.49	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILA HEALTH ACTION INC	100137448	0020	PHILADELPHIA, PA 19140-2828	T1015		$144.33	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILA HEALTH ACTION INC	100137448	0020	PHILADELPHIA, PA 19140-2828	T1015	U9	$156.49	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILA HEALTH ACTION INC	100137448	0022	PHILADELPHIA, PA 19147-5907	T1015		$144.33	10/1/2013	12/31/2299
8	PHILADELPHIA	GPHA SOUTHEAST HEALTH CENTER	100137448	0051	PHILADELPHIA, PA 19147-4717	T1015		$144.33	10/1/2013	12/31/2299
8	PHILADELPHIA	GPHA WOODLAND AVE HEALTH CENTER	100137448	0052	PHILADELPHIA, PA 19143-5137	T1015		$144.33	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILADELPHIA HEALTH ACTION INCE	100137448	0055	PHILADELPHIA, PA 19148-2419	T1015	U9	$156.49	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILADELPHIA HEATH ACTION, INC. DENTAL AND	100137448	0056	PHILADELPHIA, PA 19143-5607	T1015		$144.33	10/1/2013	12/31/2299
8	PHILADELPHIA	GREATER PHILADELPHIA HEATH ACTION, INC. DENTAL AND	100137448	0056	PHILADELPHIA, PA 19143-5607	T1015	U9	$156.49	10/1/2013	12/31/2299
8	PHILADELPHIA	SPECTRUM HEALTH SVCS INC/HADDINGTON	100728826	0005	PHILADELPHIA, PA 19122-3323	T1015		$172.61	10/1/2013	12/31/2299
8	PHILADELPHIA	SPECTRUM HEALTH SERVICES INC	100728826	0014	PHILADELPHIA, PA 19139-1401	T1015		$172.61	10/1/2013	12/31/2299
8	PHILADELPHIA	SPECTRUM HEALTH SERVICES INC	100728826	0014	PHILADELPHIA, PA 19139-1401	T1015	U9	$110.17	10/1/2013	12/31/2299
8	PHILADELPHIA	COVENANT HOUSE HEALTH SERVICES	100756446	0003	PHILADELPHIA, PA 19144-1799	T1015		$160.08	10/1/2013	12/31/2299
8	PHILADELPHIA	MT PLEASANT MEDICAL CENTER	100756446	0006	PHILADELPHIA, PA 19150-3530	T1015		$160.08	10/1/2013	12/31/2299
8	PHILADELPHIA	QUALITY COMMUNITY HEALTH CARE INC	100758807	0001	PHILADELPHIA, PA 19132-3207	T1015		$135.59	10/1/2013	12/31/2299
8	PHILADELPHIA	QUALITY COMMUNITY HEALTH CARE INC	100758807	0001	PHILADELPHIA, PA 19132-3207	T1015	U9	$161.96	10/1/2013	12/31/2299
8	PHILADELPHIA	QUALITY COMMUNITY HEALTH CARE INC	100758807	0002	PHILADELPHIA, PA 19121-1207	T1015		$135.59	10/1/2013	12/31/2299
8	PHILADELPHIA	QUALITY COMMUNITY HEALTH CARE INC	100758807	0003	PHILADELPHIA, PA 19121-3232	T1015		$135.59	10/1/2013	12/31/2299
8	PHILADELPHIA	QUALITY COMMUNITY HEALTH CARE INC	100758807	0004	PHILADELPHIA, PA 19121	T1015		$135.59	10/1/2013	12/31/2299
8	PHILADELPHIA	QUALITY COMMUNITY HEALTH CARE INC	100758807	0004	PHILADELPHIA, PA 19121	T1015	U9	$161.96	10/1/2013	12/31/2299
8	PHILADELPHIA	COOKE FAMILY HEALTH CENTER	100758807	0011	PHILADELPHIA, PA 19141-2603	T1015		$135.59	10/1/2013	12/31/2299
8	PHILADELPHIA	DELAWARE VALLEY COMMUNITY HEALTH	100772996	0006	PHILADELPHIA, PA 19130-2908	T1015		$126.46	10/1/2013	12/31/2299
8	PHILADELPHIA	DELAWARE VALLEY COMMUNITY HEALTH	100772996	0006	PHILADELPHIA, PA 19130-2908	T1015	U9	$118.15	10/1/2013	12/31/2299
8	PHILADELPHIA	MARIA DE LOS SANTOS HEALTH CENTER	100772996	0022	PHILADELPHIA, PA 19133	T1015		$126.46	10/1/2013	12/31/2299
8	PHILADELPHIA	MARIA DE LOS SANTOS HEALTH CENTER	100772996	0022	PHILADELPHIA, PA 19133	T1015	U9	$118.15	10/1/2013	12/31/2299
8	PHILADELPHIA	PARKVIEW - OB/GYN	100772996	0023	PHILADELPHIA, PA 19124-4800	T1015		$126.46	10/1/2013	12/31/2299
8	PHILADELPHIA	FAIRMOUNT PRIMARY CARE CENTER AT HORIZON HOUSE	100772996	0025	PHILADELPHIA, PA 19104-3403	T1015		$126.46	10/1/2013	12/31/2299
8	PHILADELPHIA	FAIRMOUNT PRIMARY CARE CENTER AT ST JOSEPHS HOSPIT	100772996	0027	PHILADELPHIA, PA 19130-1615	T1015		$126.46	10/1/2013	12/31/2299
8	PHILADELPHIA	ESPERANZA HEALTH CENTER INC	100773456	0007	PHILADELPHIA, PA 19133-2801	T1015		$192.41	10/1/2013	12/31/2299
8	PHILADELPHIA	ESPERANZA HEALTH CENTER INC	100773456	0008	PHILADELPHIA, PA 19134-2400	T1015		$192.41	10/1/2013	12/31/2299
8	PHILADELPHIA	ESPERANZA HEALTH CENTER INC	100773456	0008	PHILADELPHIA, PA 19134-2400	T1015	U9	$154.85	10/1/2013	12/31/2299
8	PHILADELPHIA	ESPERANZA HEALTH CENTER INC	100773456	0009	PHILADELPHIA, PA 19140-2319	T1015		$192.41	10/1/2013	12/31/2299
8	PHILADELPHIA	SAYRE HEALTH CENTER	101970440	0001	PHILADELPHIA, PA 19139-3836	T1015		$186.72	10/1/2013	12/31/2299
8	PHILADELPHIA	URBAN HEALTH INITIATIVES INC	102562648	0003	PHILADELPHIA, PA 19146-4808	T1015		$117.04	10/1/2013	12/31/2299

Medical Assistance Program Enrolled Federally Qualified Health Centers (FQHCs) and Payment Rate, May 2014

FFM	County	Provider Name	MPI Provider ID	Location	City, State and Zip Code	Procedure Code	Modifier	Rate	Effective Date	End Date
9	CUMBERLAND	SADLER HEALTH CENTER CORPORATION	001944537	0003	CARLISLE, PA 17013-2421	T1015		$166.91	10/1/2013	12/31/2299
9	CUMBERLAND	SADLER HEALTH CENTER CORPORATION	001944537	0003	CARLISLE, PA 17013-2421	T1015	U9	$132.87	10/1/2013	12/31/2299
9	DAUPHIN	HAMILTON HEALTH CENTER INC	100748079	0010	HARRISBURG, PA 17104-3410	T1015		$128.40	10/1/2013	12/31/2299
9	DAUPHIN	HAMILTON HEALTH CENTER @ DOWNEY ELEMENTARY	100748079	0022	HARRISBURG, PA 17103-1139	T1015		$128.40	10/1/2013	12/31/2299
9	DAUPHIN	HAMILTON HEALTH CENTER @ DOWNEY ELEMENTARY	100748079	0022	HARRISBURG, PA 17103-1139	T1015	U9	$116.68	10/1/2013	12/31/2299
9	DAUPHIN	HAMILTON HEALTH CENTER INC	100748079	0023	HARRISBURG, PA 17102-1249	T1015		$128.40	10/1/2013	12/31/2299
9	DAUPHIN	HAMILTON HEALTH CENTER INC	100748079	0024	HARRISBURG, PA 17104-1123	T1015		$128.40	10/1/2013	12/31/2299
9	DAUPHIN	HAMILTON HEALTH CENTER INC	100748079	0024	HARRISBURG, PA 17104-1123	T1015	U9	$116.68	10/1/2013	12/31/2299
9	FRANKLIN	KEYSTONE RURAL HEALTH CENTER	100776233	0005	CHAMBERSBURG, PA 17201-4219	T1015		$165.47	10/1/2013	12/31/2299
9	FRANKLIN	KEYSTONE DENTAL CARE	100776233	0035	CHAMBERSBURG, PA 17201-4207	T1015	U9	$122.32	10/1/2013	12/31/2299
9	FRANKLIN	KEYSTON RURAL HEALTH CENTER KEYSTONE CARDIOLOGY	100776233	0039	CHAMBERSBURG, PA 17201-4223	T1015		$165.47	10/1/2013	12/31/2299
9	FRANKLIN	KEYSTONE WOMENS CARE	100776233	0040	CHAMBERSBURG, PA 17201-4219	T1015		$165.47	10/1/2013	12/31/2299
9	FRANKLIN	KEYSTONE PEDIATRICS	100776233	0041	CHAMBERSBURG, PA 17201-4219	T1015		$165.47	10/1/2013	12/31/2299
9	FRANKLIN	KEYSTONE INTERNAL MEDICINE	100776233	0042	CHAMBERSBURG, PA 17201-4219	T1015		$165.47	10/1/2013	12/31/2299
9	FRANKLIN	KEYSTONE URGENT MEDICAL CARE	100776233	0043	CHAMBERSBURG, PA 17201-4219	T1015		$165.47	10/1/2013	12/31/2299
9	FRANKLIN	KEYSTONE CRISIS INTERVENTION PROGRAM	100776233	0045	CHAMBERSBURG, PA 17201-1720	T1015		$165.47	10/1/2013	12/31/2299
9	FULTON	TRI STATE COMMUNITY HEALTH CENTER	100728880	0006	MC CONNELLSBURG, PA 17233	T1015		$112.00	10/1/2013	12/31/2299
9	LEBANON	WELSH MOUNTAIN HEALTH CENTER	100761419	0007	LEBANON, PA 17042-7444	T1015		$110.21	10/1/2013	12/31/2299
9	LEBANON	LEBANON RIDGE ORAL HEALTH	100761419	0008	LEBANON, PA 17042-5108	T1015	U9	$96.46	4/15/2014	12/31/2299
9	PERRY	SADLER HEALTH CENTER CORPORATION	001944537	0005	LOYSVILLE, PA 17047-9200	T1015	U9	$132.87	10/1/2013	12/31/2299

Medical Assistance Program Enrolled Rural Health Clinics (RHCs) and Payment Rate, May 2014

FFM	County	Provider Name	MPI Provider ID	Location	City, State and Zip Code	Procedure Code	Modifier	Rate	Effective Date	End Date
1	CLARION	SEMEYN FAMILY PRACTICE NB RHC	001970804	0008	FAIRMOUNT CITY, PA 16224-1502	T1015		$82.95	10/1/2013	12/31/2299
1	CLARION	RIMERSBURG MED CTR RHC	001970804	0009	RIMERSBURG, PA 16248	T1015		$82.95	10/1/2013	12/31/2299
1	CLARION	A C VALLEY MEDICAL CENTER RHC	001970804	0012	PARKER, PA 16049-7029	T1015		$82.95	10/1/2013	12/31/2299
1	CLARION	PRIMARY HLTH NTWK/EAST BRADY	100757846	0023	EAST BRADY, PA 16028	T1015		$152.24	10/1/2013	12/31/2299
1	CLARION	BROOKVILLE HOSPITAL	100773376	0047	FAIRMOUNT CITY, PA 16224-1139	T1015		$82.00	12/14/2012	12/31/2299
1	CLARION	BJ SNYDER MD & ASSOC LLC	101513059	0001	FAIRMOUNT CITY, PA 16224-1101	T1015		$72.94	10/1/2013	12/31/2299
1	CRAWFORD	CONNEAUT VALLEY HLTH CTR	000723003	0001	CONNEAUTVILLE, PA 16406-7138	T1015		$103.50	10/1/2013	12/31/2299
1	CRAWFORD	CONNEAUT LAKE HEALTH CENTER	000723003	0012	CONNEAUT LAKE, PA 16316-3526	T1015		$102.68	10/1/2013	12/31/2299
1	CRAWFORD	CONNEAUT VALLEY HEALTH CENTER INC	000723003	0015	MEADVILLE, PA 16335-1737	T1015		$128.18	10/1/2013	12/31/2299
1	CRAWFORD	CAMBRIDGE SPRINGS HEALTH CENTER	000723003	0017	CAMBRIDGE SPRINGS, PA 16403-1060	T1015		$89.38	10/1/2013	12/31/2299
1	CRAWFORD	SPARTANSBURG MEDICAL CENTER	001511070	0007	SPARTANSBURG, PA 16434-1026	T1015		$92.50	10/1/2013	12/31/2299
1	CRAWFORD	PRIMARY HLTH NTWK/LINESVILLE	100757846	0021	LINESVILLE, PA 16424-9214	T1015		$152.24	10/1/2013	12/31/2299
1	ERIE	MEDICAL GROUP OF CORRY	000647260	0016	CORRY, PA 16407-1496	T1015		$75.91	10/1/2013	12/31/2299
1	ERIE	CANADOHTA LAKE HEALTH CENTER	001511070	0006	UNION CITY, PA 16438-2919	T1015		$92.50	10/1/2013	12/31/2299
1	FOREST	BROOKVILLE HOSPITAL-MARIENVILLE FAMILY HEALTH RHC	100773376	0048	MARIENVILLE, PA 16239	T1015		$129.00	11/1/2013	12/31/2299
1	MCKEAN	UPPER ALLEGHENY MEDICAL CTR	001403288	0001	PORT ALLEGANY, PA 16743-1332	T1015		$83.36	10/1/2013	12/31/2299
1	MCKEAN	ELDRED HEALTH CTR OF CCMH	100001127	0040	ELDRED, PA 16731-4515	T1015		$139.60	10/1/2013	12/31/2299
1	MCKEAN	PORT ALLEGANY HLTH CTR OF CCMH	100001127	0072	PORT ALLEGANY, PA 16743	T1015		$170.52	10/1/2013	12/31/2299
1	MCKEAN	BOWMAN HEALTH CENTER	100001127	0125	SMETHPORT, PA 16749-2031	T1015		$122.00	10/1/2013	12/31/2299
1	MCKEAN	FOOTHILLS MEDICAL GROUP AT BRMC RHC	100750765	0058	SMETHPORT, PA 16749	T1015		$79.00	4/4/2013	12/31/2299
1	MCKEAN	FOOTHILLS MEDICAL GROUP AT BRMC RHC	100750765	0059	BRADFORD, PA 16701	T1015		$79.00	4/4/2013	12/31/2299
1	MERCER	SHARON REGIONAL HLTH SYS/MERCER RHC	100000059	0051	MERCER, PA 16137-5019	T1015		$95.85	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/SHARON MED GRP	100757846	0017	SHARON, PA 16146-2186	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/FARRELL MEDICAL	100757846	0022	FARRELL, PA 16121-1902	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/HEALTH SHOPPE	100757846	0025	FARRELL, PA 16121-1754	T1015		$152.24	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/HEALTH SHOPPE	100757846	0025	FARRELL, PA 16121-1754	T1015	U9	$130.62	10/1/2013	12/31/2299
1	MERCER	PRIMARY HLTH NTWK/MERCER	100757846	0027	MERCER, PA 16137-5023	T1015		$152.24	10/1/2013	12/31/2299
1	VENANGO	CLINTONVILLE COMMUNITY HEALTH CENTER	100776547	0026	CLINTONVILLE, PA 16372	T1015		$108.19	10/1/2013	12/31/2299
2	CAMERON	EMPORIUM HEALTH CTR OF CCMH	100001127	0029	EMPORIUM, PA 15834-3944	T1015		$138.67	10/1/2013	12/31/2299
2	POTTER	SHINGLEHOUSE HC OF CCMH	100001127	0057	SHINGLEHOUSE, PA 16748	T1015		$109.81	10/1/2013	12/31/2299
2	POTTER	NORTHERN POTTER HEALTH CTR OF CCMH	100001127	0060	ULYSSES, PA 16948	T1015		$121.28	10/1/2013	12/31/2299
2	POTTER	COUDERSPORT PED HLTH CTR OF CCMH	100001127	0069	COUDERSPORT, PA 16915-8161	T1015		$140.04	10/1/2013	12/31/2299
2	POTTER	COUDERSPORT PED HLTH CTR OF CCMH	100001127	0069	COUDERSPORT, PA 16915-8161	T1015	U9	$160.42	5/15/2014	12/31/2299
2	POTTER	GALETON HEALTH CENTER OF CCMH	100001127	0091	GALETON, PA 16922-1203	T1015		$109.97	10/1/2013	12/31/2299
2	POTTER	CENTRAL POTTER HEALTH CENTER	100001127	0126	COUDERSPORT, PA 16915-9601	T1015		$148.18	10/1/2013	12/31/2299
3	CARBON	ST LUKES MINERS HEALTH CENTER	100745470	0034	NESQUEHONING, PA 18240-1511	T1015		$96.22	10/1/2013	12/31/2299
3	CLINTON	CLINTON HOSPITAL CORPORATION DBA HAVEN MEDICAL CEN	100755091	0020	LOCK HAVEN, PA 17745-2025	T1015		$134.89	5/6/2013	12/31/2299
3	PIKE	PINNACLE HEALTH PARTNERS	101320802	0002	TAFTON, PA 18464-7829	T1015		$70.95	10/1/2013	12/31/2299
3	SUSQUEHANNA	FAMILY HEALTH CLINIC OF BARNES KASSON HOSPITAL	100727622	0025	SUSQUEHANNA, PA 18847-1615	T1015		$121.50	10/1/2013	12/31/2299
3	SUSQUEHANNA	FAMILY HEALTH CLINIC OF BARNESKASSON HOSPITAL SUSQ	100727622	0031	SUSQUEHANNA, PA 18847-2771	T1015		$145.91	10/25/2013	12/31/2299
3	SUSQUEHANNA	FAMILY HEALTH CLINIC OF BARNES KASSON NEW MILFORD	100727622	0032	NEW MILFORD, PA 18834	T1015		$148.44	10/25/2013	12/31/2299
3	TIOGA	WESTFIELD HEALTH CENTER OF CCMH	100001127	0063	WESTFIELD, PA 16950-1538	T1015		$123.53	10/1/2013	12/31/2299
3	WAYNE	PEDIATRIC PRACTICE	100742226	0015	HONESDALE, PA 18431-2121	T1015		$79.20	10/1/2013	12/31/2299
3	WAYNE	PEDIATRIC PRACTICES OF NE PA RHC LAKE ARIEL	100742226	0016	LAKE ARIEL, PA 18436-5606	T1015		$79.20	10/1/2013	12/31/2299
3	WAYNE	PEDIATRIC PRACTICES OF NE PA LLP	100742226	0018	WAYMART, PA 18472-9366	T1015		$79.20	10/1/2013	12/31/2299
3	WAYNE	HIGHLAND PHYSICIANS LTD	100773652	0029	HONESDALE, PA 18431-2121	T1015		$110.29	10/1/2013	12/31/2299
4	ARMSTRONG	ARMSTRONG PRIMARY CARE CLINC	100745907	0009	LEECHBURG, PA 15656-1333	T1015		$138.96	10/1/2013	12/31/2299
4	ARMSTRONG	ARMSTRONG COUNTY MEMORIAL HOSPITAL	100745907	0026	ELDERTON, PA 15736	T1015		$107.35	10/1/2013	12/31/2299
4	ARMSTRONG	ARMSTRONG COUNTY MEMORIAL HOSPITAL	100745907	0035	KITTANNING, PA 16201-8165	T1015		$94.73	1/25/2014	12/31/2299
4	ARMSTRONG	ARMSTRONG PRIMARY CARE CENTER-SOUTH BETHLEHEM	100745907	0036	NEW BETHLEHEM, PA 16242-8107	T1015		$89.16	10/1/2013	12/31/2299
4	BEAVER	PRIMARY HLTH NTWK/BEAVER FALLS	100757846	0029	BEAVER FALLS, PA 15010-4217	T1015		$152.24	10/1/2013	12/31/2299
4	BEAVER	PRIMARY HLTH NTWK/BEAVER FALLS	100757846	0029	BEAVER FALLS, PA 15010-4217	T1015	U9	$130.62	10/1/2013	12/31/2299
4	BUTLER	PRIMARY HLTH NTWK/PETROLIA	100757846	0028	PETROLIA, PA 16050	T1015		$152.24	10/1/2013	12/31/2299
4	FAYETTE	LAUREL HIGHLANDS OB/GYN PC	100732462	0017	HOPWOOD, PA 15445-2250	T1015		$80.08	10/1/2013	12/31/2299

Medical Assistance Program Enrolled Rural Health Clinics (RHCs) and Payment Rate, May 2014

FFM	County	Provider Name	MPI Provider ID	Location	City, State and Zip Code	Procedure Code	Modifier	Rate	Effective Date	End Date
4	GREENE	WASHINGTON PHYSICIAN SERVICES ORGANIZATION	001591849	0028	WAYNESBURG, PA 15370	T1015		$99.39	10/1/2013	12/31/2299
4	LAWRENCE	PRIMARY HLTH NTWK/NEW CASTLE MEDICAL	100757846	0018	NEW CASTLE, PA 16101-4629	T1015		$152.24	10/1/2013	12/31/2299
4	LAWRENCE	PRIMARY HLTH NTWK/NEW CASTLE MEDICAL	100757846	0018	NEW CASTLE, PA 16101-4629	T1015	U9	$130.62	10/1/2013	12/31/2299
4	LAWRENCE	PRIMARY HLTH NTWK/SHEAKLEYVILLE	100757846	0019	SHEAKLEYVILLE, PA 16151	T1015		$152.24	10/1/2013	12/31/2299
4	LAWRENCE	PRIMARY HLTH NTWK/NEW CASTLE WALK-IN	100757846	0033	NEW CASTLE, PA 16101-4672	T1015		$152.24	10/1/2013	12/31/2299
4	WASHINGTON	WASHINGTON PHYSICIAN SERVICES ORGANIZATION	001591849	0030	MC DONALD, PA 15057-2285	T1015		$108.47	10/1/2012	12/31/2299
5	BEDFORD	NEW PARIS HEALTH CLINIC	100735811	0148	NEW PARIS, PA 15554-7706	T1015		$74.37	10/1/2013	12/31/2299
5	BEDFORD	ALUM BANK COMMUNITY HEALTH CENTER	100770374	0029	ALUM BANK, PA 15521-8264	T1015		$81.88	10/1/2013	12/31/2299
5	CAMBRIA	CRESSON FAMILY PRACTICE RHC	100735811	0153	CRESSON, PA 16630-1214	T1015		$99.70	10/1/2013	12/31/2299
5	CAMBRIA	PORTAGE HEALTH CENTER	100735811	0154	PORTAGE, PA 15946-6546	T1015		$83.39	10/1/2013	12/31/2299
5	CAMBRIA	ST BENEDICT RURAL HEALTH CLINIC	100735811	0167	CAROLLTOWN, PA 15722-7702	T1015		$85.14	10/1/2013	12/31/2299
5	CLEARFIELD	GLENDALE AREA MEDICAL ASSOC INC	100771184	0004	COALPORT, PA 16627	T1015		$87.75	10/1/2013	12/31/2299
5	CLEARFIELD	GLENDALE AREA MEDICAL ASSOC INC	100771184	0004	COALPORT, PA 16627	T1015	U9	$140.46	10/1/2013	12/31/2299
5	HUNTINGDON	MT UNION AREA MED CENTER	000543210	0002	MOUNT UNION, PA 17066-1334	T1015		$85.19	10/1/2013	12/31/2299
5	HUNTINGDON	SOUTHERN HUNTINGDON COUNTY MED CTR	000843478	0002	ORBISONIA, PA 17243-9424	T1015		$73.26	10/1/2013	12/31/2299
5	HUNTINGDON	SOUTHERN HUNTINGDON COUNTY MED CTR	000843478	0002	ORBISONIA, PA 17243-9424	T1015	U9	$159.01	10/1/2013	12/31/2299
5	HUNTINGDON	HUNTINGDON HEALTHCARE INC	001890759	0006	HUNTINGDON, PA 16652-1726	T1015		$62.56	10/1/2013	12/31/2299
5	HUNTINGDON	JUNIATA VALLEY MEDICAL CENTER	001890759	0007	ALEXANDRIA, PA 16611-2936	T1015		$68.83	10/1/2013	12/31/2299
5	HUNTINGDON	BROADTOP AREA MEDICAL CENTER	100749693	0006	BROAD TOP, PA 16621-9001	T1015		$101.40	10/1/2013	12/31/2299
5	JEFFERSON	ALLEGHENY HEALTH CENTER	100773376	0043	BROOKVILLE, PA 15825-7228	T1015		$157.43	11/16/2013	12/31/2299
5	JEFFERSON	STATES, PHILIP J	101925786	0003	PUNXSUTAWNEY, PA 15767-2605	T1015		$94.14	10/1/2013	12/31/2299
5	SOMERSET	HIGHLANDS FAMILY MEDICINE RURAL HEALTH CLINIC	100735811	0150	SOMERSET, PA 15501-1143	T1015		$105.42	10/1/2013	12/31/2299
5	SOMERSET	CONEMAUGH PHYSICIAN GROUP FAMILY MEDICINE JENNERST	100735811	0164	JENNERSTOWN, PA 15547	T1015		$79.00	3/1/2013	12/31/2299
5	SOMERSET	CONEMAUGH PHYSICIAN GRP -FAMILY MED DAVIDSVILLE RH	100735811	0166	HOLSOPPLE, PA 15935-7119	T1015		$79.00	3/1/2013	12/31/2299
5	SOMERSET	MED ASSOCS BOSWELL/STOYSTOWN	100769838	0001	STOYSTOWN, PA 15563-6002	T1015		$79.62	10/1/2013	12/31/2299
5	SOMERSET	MED ASSOCS BOSWELL/STOYSTOWN	100769838	0002	BOSWELL, PA 15531-1024	T1015		$79.62	10/1/2013	12/31/2299
5	SOMERSET	MEYERSDALE MEDICAL CENTER	100770507	0014	MEYERSDALE, PA 15552-1220	T1015		$136.47	10/1/2013	12/31/2299
5	SOMERSET	MEYERSDALE MEDICAL CENTER	100770507	0015	SALISBURY, PA 15558	T1015		$113.95	10/1/2013	12/31/2299
6	CENTRE	CARING HEALTHCARE NETWORK	102642598	0001	PHILIPSBURG, PA 16866-2303	T1015		$184.69	5/3/2014	12/31/2299
6	NORTHUMBERLAND	COMMUNITY HEALTH CARE RHC	001630900	0001	SHAMOKIN, PA 17872-5231	T1015		$83.53	10/1/2013	12/31/2299
6	NORTHUMBERLAND	MILLER DONMOYER FAMILY HEALTH CENTER	102769784	0001	SHAMOKIN, PA 17872-5811	T1015		$95.79	10/1/2013	12/31/2299
6	SCHUYLKILL	ST LUKES MINERS HEALTH CENTER HOMETOWN	100745470	0036	TAMAQUA, PA 18252-4302	T1015		$86.19	10/19/2013	12/31/2299
6	SCHUYLKILL	ST LUKES MINERS HEALTHCENTER MCADOO	100745470	0038	MCADOO, PA 18237-1908	T1015		$145.15	10/1/2013	12/31/2299
6	SCHUYLKILL	CORNERSTONE COORDINATED HEALTH CARE	102788780	0001	FRACKVILLE, PA 17931	T1015		$79.00	1/1/2013	12/31/2299

Health Pennsylvania Program Estimated Population Distribution

SOUTHEAST			
County	**Health-Choices Enrollment**	**% of Statewide Total**	**HealthyPA Estimate**
Bucks	42,286	2.56%	12,807
Chester	30,081	1.82%	9,111
Delaware	65,898	3.99%	19,959
Montgomery	56,109	3.40%	16,994
Philadelphia	410,560	24.87%	124,348
TOTAL	**604,934**	**36.64%**	**183,219**

SOUTHWEST			
County	**Health-Choices Enrollment**	**% of Statewide Total**	**HealthyPA Estimate**
Allegheny	140,819	8.53%	42,651
Armstrong	9,185	0.56%	2,782
Beaver	21,329	1.29%	6,460
Bedford	6,140	0.37%	1,860
Blair	18,928	1.15%	5,733
Butler	14,712	0.89%	4,456
Cambria	18,903	1.15%	18,903
Fayette	25,476	1.54%	7,716
Greene	5,707	0.35%	1,729
Indiana	9,295	0.56%	2,815
Lawrence	13,034	0.79%	3,948
Somerset	8,191	0.50%	8,191
Washington	21,512	1.30%	6,515
Westmoreland	38,292	2.32%	11,598
TOTAL	**351,523**	**21.29%**	**106,467**

Health Pennsylvania Program Estimated Population Distribution

LEHIGH/CAPITAL			
County	**Health-Choices Enrollment**	**% of Statewide Total**	**HealthyPA Estimate**
Adams	8,567	0.52%	2,595
Berks	57,880	3.51%	17,530
Cumberland	16,877	1.02%	5,112
Dauphin	37,821	2.29%	11,455
Franklin	15,095	0.91%	4,572
Fulton	1,886	0.11%	571
Huntingdon	5,777	0.35%	1,750
Lancaster	56,780	3.44%	17,197
Lebanon	15,818	0.96%	4,791
Lehigh	48,284	2.92%	14,624
Northampton	30,007	1.82%	9,088
Perry	4,393	0.27%	1,331
York	49,997	3.03%	15,143
TOTAL	**349,182**	**21.15%**	**105,758**

Health Pennsylvania Program Estimated Population Distribution

NEW WEST			
County	**Health-Choices Enrollment**	**% of Statewide Total**	**HealthyPA Estimate**
Cameron	766	0.05%	232
Clarion	4,595	0.28%	4,595
Clearfield	11,461	0.69%	3,471
Crawford	12,115	0.73%	3,669
Elk	3,531	0.21%	1,069
Erie	47,090	2.85%	14,262
Forest	553	0.03%	167
Jefferson	6,261	0.38%	1,896
McKean	6,398	0.39%	1,938
Mercer	16,857	1.02%	5,106
Potter	2,335	0.14%	707
Venango	7,730	0.47%	2,341
Warren	4,727	0.29%	1,432
TOTAL	**124,419**	**7.54%**	**37,683**

Health Pennsylvania Program Estimated Population Distribution

NEW EAST			
County	**Health-Choices Enrollment**	**% of Statewide Total**	**HealthyPA Estimate**
Bradford	7,498	0.45%	2,271
Carbon	7,259	0.44%	2,199
Centre	8,274	0.50%	2,506
Clinton	5,235	0.32%	1,586
Columbia	6,986	0.42%	2,116
Juniata	2,286	0.14%	692
Lackawanna	29,453	1.78%	8,921
Luzerne	46,805	2.84%	14,176
Lycoming	14,997	0.91%	4,542
Mifflin	6,412	0.39%	1,942
Monroe	21,469	1.30%	6,502
Montour	1,643	0.10%	498
Northumberland	11,607	0.70%	3,515
Pike	6,102	0.37%	1,848
Schuylkill	18,608	1.13%	5,636
Snyder	4,053	0.25%	1,228
Sullivan	564	0.03%	171
Susquehanna	4,292	0.26%	1,300
Tioga	4,862	0.29%	1,473
Union	3,514	0.21%	1,064
Wayne	5,751	0.35%	1,742
Wyoming	3,120	0.19%	3,120
TOTAL	**220,790**	**13.37%**	66,872

ACA Health Insurance Providers Fee

DPW Healthy PA Overview

This document is provided by the Pennsylvania Department of Public Welfare (Department) as explanation of the Department's plan for paying for the Medical Assistance impact of the ACA Section 9010 Health Insurance Providers Fee (HIPF).

For those Private Coverage Organizations (PCOs) with a liability for payment of this fee, the Department's actuary intends to recognize the costs associated with this fee as "reasonable, appropriate and attainable costs" to be considered in actuarially sound payments to the plans. The HIPF due each year (the "fee year") is calculated by the IRS from information on net premiums written for the prior calendar year (the "data year") filed by the insurers on Form 8963.

ACA Health Insurance Providers Fee Capitation Rate Withhold

The Department seeks to make payments to each PCO that are appropriate for the specific level of this tax expense. The amount of HIPF incurred by PCOs will vary as a percentage of their data year premium revenue because HIPF rates are not identical and corporate income tax impact may vary by plan. To accommodate both situations, for the appropriate data year the Department's actuary will provide two sets of actuarially sound capitation rate ranges, one set applicable to PCOs not subject to the HIPF and one set applicable to PCOs that are subject to the HIPF. The only difference between the two sets of capitation rate ranges will be an allowance for the HIPF, which will be withheld by the Department until payment is due by the PCOs in the fee year. The allowance for the HIPF incorporated in the rate range will be the maximum anticipated such allowance needed for any of the PCOs. Because the HIPF percentage tax rate varies by PCO and effective corporate income tax rates vary by PCO, the entire withhold amount will not be paid to every PCO that is subject to the HIPF.

A summary of the Department's plan is as follows:

- The Department will negotiate rates with the participating PCOs net of the HIPF withhold amounts. The final agreement with each PCO will include the withhold amounts equal to the HIPF portion of the rates (this may not be applicable to those PCOs not subject to the HIPF, but will still be included in the agreements). The Department will initially pay rates net of the HIPF withhold amounts.
- Each PCO will provide the Department with a copy of Form 8963, along with HPA-specific amounts included on that form and necessary income tax information. PCOs will also be required to provide the preliminary fee calculation notice from the IRS.
- By September 15 of the fee year the Department will pay (preliminary payment) the portion of the data year withhold amounts that covers the HPA portion, as

determined by the Department, of each PCO's obligation per the preliminary fee notice.

- The PCOs will provide the final IRS bill, and the Department will calculate its final obligation to each PCO, reconciling any differences against the preliminary payment through a settlement.

This plan:

- Accomplishes the revenue objective of providing additional funds to the PCOs affected by the HIPF.
- Uses the premiums from the same data year that the IRS uses to calculate the HIPF due in the fee year, thereby readily providing the means to make payments to any PCO that ceases to have an HPA agreement during the data year.
- Minimizes the budget burden on the Commonwealth and CMS by paying only what is needed and no more.
- Makes payments for the HIPF via actuarially sound capitation rates.

To ensure PCOs receive appropriate revenue to cover their HIPF obligation, including necessary tax-related gross-ups, and to ensure the Department recognizes its fair share of the related IRS deductions, the accompanying draft agreement language includes detailed steps and calculations to determine the Department's obligation to each PCO.

Updated May 7, 2014

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Healthy PA

ACCESS • AFFORDABILITY • QUALITY

Private Coverage Organization (PCO)

Physical and Behavioral Health Services
RFA 04-14 Statewide Pre-Application Conference

May 15, 2014

10:00-2:00pm

Welcome/Opening Remarks

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Leesa Allen

Office of the Secretary

Executive Medical Assistance Director

Program/Process Overview

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Jolene Calla

Office of Medical Assistance Programs

Director

Bureau of Managed Care Operations

Conference Agenda

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Welcome/Opening Remarks

- Leesa Allen, Executive Medical Assistance Director, Office of the Secretary

Presentations

- Program/Process Overview
  Jolene Calla, Director, Bureau of Managed Care Operations
- Solicitation Overview
  Barry Bowman, Bureau of Managed Care Operations
- Pennsylvania Insurance Department
  Peter Camacci, Director of Life, Accident and Health Insurance
- Financial Overview
  Allen Fisher, Bureau of Managed Care Operations
- Data Overview
  Scott Brady, Bureau of Data and Claims Management
- Behavioral Health Overview
  Dennis Marion, Deputy Secretary, Office of Mental Health and Substance Abuse Services

Applicant Questions

Closing Remarks

- Matthew O'Donnell, Deputy Director of Policy and Planning, Office of the Governor

PCO Timeline

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May 08: Solicitation (RFA 04-14) Posted

May 13: Initial Deadline for Written Questions

May 15: Pre-Application Conference

May 28: Answers Posted for all Questions Received

June 10: Applications Due

June 11-19: Application Review

June 20: Acceptance/Rejection Letters

June 30-July 11: Negotiations

July 14-16: Final Agreements

August 1: PCO Signs Agreement

PCO Timeline

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August 4: PCO Certificates of Authority and County Operational Authority for Applicable Regions Due

August 5: PCO information is sent to Maximus

August 5-November 30: Readiness Review

August 6-September 26: Agreement Approval/Full Commonwealth Signature Process

December 1: Formal Open Enrollment Begins

January 1: PCO GO-LIVE

Enrollment Broker

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- Maximus will help beneficiaries select a PCO.
- Two-way connectivity is required.
- Files will be transmitted to PCOs in a format and frequency specified by the Department.

Questions

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Process to submit questions from applicants:

HealthyPA-PCO@pa.gov

Solicitation Overview

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Barry Bowman

Bureau of Managed Care Operations

Division of Program Initiatives,
Contract Management, and Communications

Financial Overview

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Peter Camacci

Pennsylvania Insurance Department

Director of Life, Accident and Health Insurance

Financial Overview

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Allen Fisher

Bureau of Managed Care Operations

Financial Analysis Division

Healthy PA Regions

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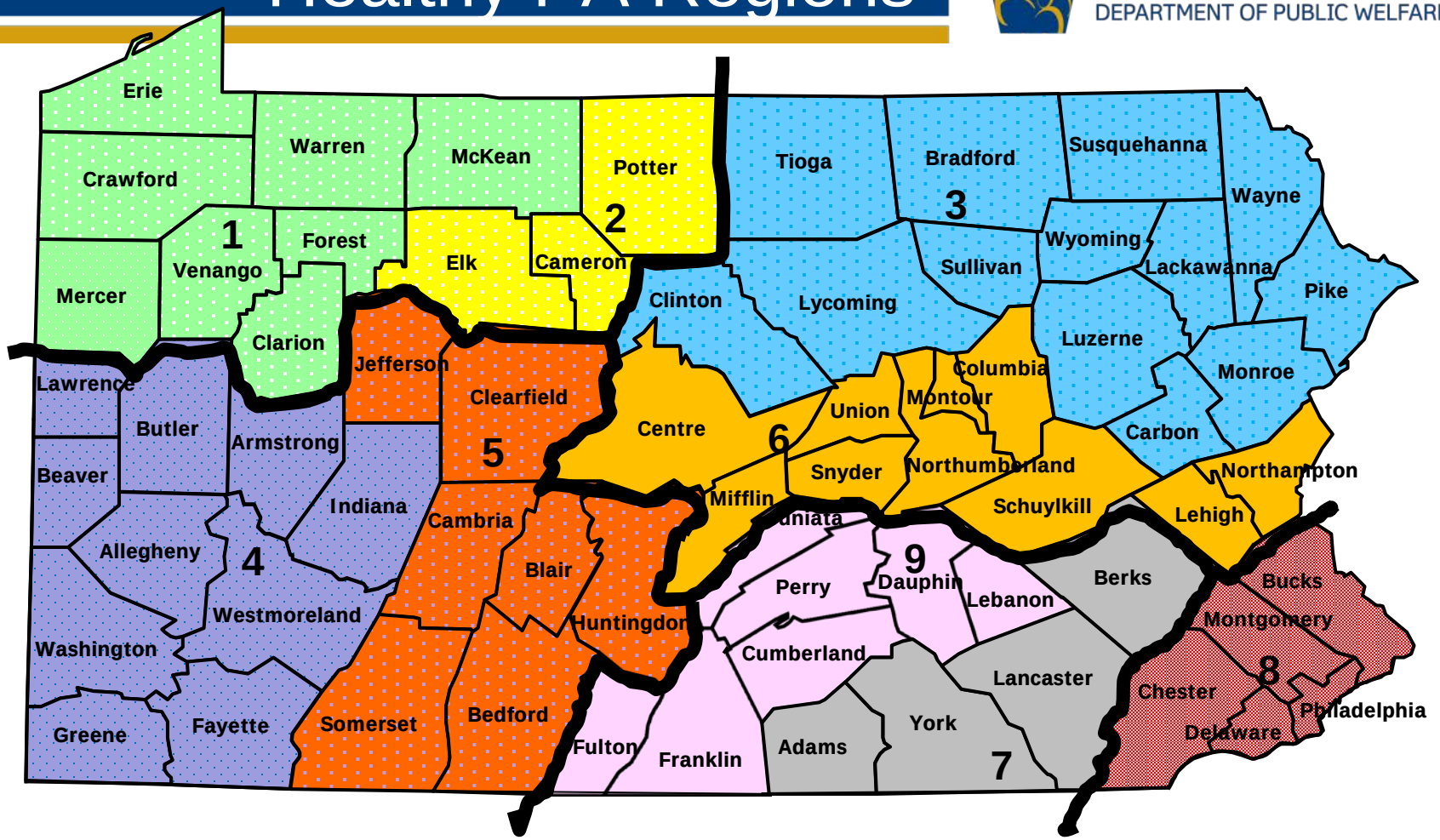

ACA Rating Region 1
ACA Rating Region 2
ACA Rating Region 3
ACA Rating Region 4
ACA Rating Region 5
ACA Rating Region 6
ACA Rating Region 7
ACA Rating Region 8
ACA Rating Region 9

Financial Overview

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- Potential Rates
- Risk Adjustment
- Risk Corridor
- Reinsurance
- Health Insurance Providers Fee (HIPF)

Financial Overview

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- Payment of Capitation
- Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
- Net Worth
- Schedule for Negotiations and Signed Agreements

Data Overview

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Scott Brady

Bureau of Data and Claims Management

Division of Managed Care Systems Support

Data Files

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- **Data Files are transferred via secure FTP; PCO must use a product that is compatible with DPW's product**
- **X12 HIPAA Transactions**:
  - 834 Daily and Monthly Files – The daily file reflects changes that were applied to the Client Information System (CIS) that day for their beneficiaries; the monthly file will contain one record (the most recent) for each beneficiary who is eligible at some point in the following month.
  - 820 Capitation File (Monthly) - provides each Health Plan with payment data sufficient to reconcile their PCO membership to their accounts receivable file
    - Capitation Payment 36 Month Summary File (Monthly/Proprietary) - a summary of all capitation payments and adjustments for the most recent 36 months.

Data Files

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- **X12 HIPAA Transactions (continued)**:
  - 837 Encounters by Claim Type
    - 837 Institutional (Inpatient, Outpatient, and LTC)
    - 837 Professional
    - 837 Dental
    - 837 Professional Drug
    - 837 Institutional Outpatient Drug
    - NCPDP
  - Encounter Response Files
    - U277 - (Unsolicited) Batch Claim/Encounter Status
    - NCPDP response
    - Translator Files:
      - ZZZ Full File Reject Report
      - 999 Formatting Reject Report
      - TXN Record Accept/Reject Report
      - EXT Record Accept/ Reject flat file

Data Files

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- **Examples of Proprietary Files:**
  - Alert File (Weekly) – File sent by the PCO containing newborns, returned mail, pregnancy and death alerts.
  - Weekly Reconciliation File – File returned to the PCO on with the disposition of each alert, and enrollments from Maximus.
  - Service History Files (Weekly) – Four separate files (Inpatient, Revenue, Medical, and Pharmacy) containing 12 months of service history for beneficiaries.
  - PCP File (Weekly) – File sent to DPW of PCP assignment information for each beneficiary.
  - TPL File (Monthly) – File sent to the PCO containing TPL information for each beneficiary.

Data Files

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- **Examples of Enrollment Broker Files**:
  - Automated Provider Directory File (Weekly) – File sent by the PCO to Maximus containing a complete snapshot of the plan's current provider directory.
  - Weekly Pending Enrollment File – File sent by Maximus to the PCO containing all enrollments that were submitted to DPW in the Enrollment Broker's Weekly Enrollment/Disenrollment File.

Behavioral Health Overview

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Dennis Marion

Office of Mental Health and Substance Abuse Services

Deputy Secretary

Behavioral Health Overview

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- The applicant HMO must indicate how it intends to provide Behavioral Health Services by illustrating whether the behavioral health network of providers will be included in the Applicant's own provider network, be part of a subcontract approach, or be part of some other model to deliver behavioral health services.

- The PCO and its Network Providers must comply with applicable Federal and State laws that pertain to Member/Beneficiary rights and protections.

Behavioral Health Overview

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- The PCO is responsible for coordination of care for individuals enrolled in the Healthy PA Program. The PCO must provide effective coordination of care across a continuum of behavioral health and physical health care with a focus on improving individual health outcomes.

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----------BREAK----------

(30 minutes)

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Applicant Questions

Closing Remarks

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Matthew O’Donnell

Office of the Governor

Deputy Director of Policy and Planning

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Thank you!

Commonwealth of Pennsylvania

Date: **May 30, 2014**
Subject: **Healthy Pennsylvania Program**
Solicitation Number: **RFA 04-14**
Opening Date/Time: **June 10, 2014 12:00 PM**
Addendum Number: **2**

To All Suppliers:

The Commonwealth of Pennsylvania defines a solicitation "Addendum"" as an addition to or amendment of the original terms, conditions, specifications, or instructions of a procurement solicitation (e.g., Invitation for Bids or Request for Proposals).

List any and all changes:

Complete response to Question #3 and additional questions and answers posted.

For electronic solicitation responses via the SRM portal:

- Attach this Addendum to your solicitation response. Failure to do so may result in disqualification.
- To attach the Addendum, download the Addendum and save to your computer. Move to 'My Notes", use the "Browse" button to find the document you just saved and press "Add" to upload the document.
- Review the Attributes section of your solicitation response to ensure you have responded, as required, to any questions relevant to solicitation addenda issued subsequent to the initial advertisement of the solicitation opportunity.

For solicitations where a "hard copy" (vs. electronic) response is requested:

- Attach this Addendum to your solicitation response. Failure to do so may result in disqualification.
- If you have already submitted a response to the original solicitation, you may either submit a new response, or return this Addendum with a statement that your original response remains firm, by the due date to the following address:

  Pennsylvania Department of Public Welfare
  Division of Procurement
  Room 402 Health and Welfare Building
  625 Forster Street, Harrisburg, PA 17120

Except as clarified and amended by this Addendum, the terms, conditions, specifications, and instructions of the solicitation and any previous solicitation addenda, remain as originally written.

Very truly yours,

Name: Barry Bowman
Title: Project Officer-RFA #04-14
Phone:
Email: babowman@pa.gov

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DEPARTMENT OF PUBLIC WELFARE

May 30, 2014

RE: *Responses to questions submitted under Request for Application (RFA) #04-14*

The Department of Public Welfare (Department) is issuing responses to questions received on or before May 30, 2014. Any questions submitted that do not appear in this posting remain under review. The Department intends to issue responses to all remaining questions that have not been formally addressed in this posting on June 5, 2014.

Please note that the Department intends to *close* the question submission period for RFA #04-14 on June 2, 2014 at 12:00pm. Any additional questions submitted after that deadline will be considered as part of the discussions with selected applicants.

The Department is pleased with the positive response regarding the Healthy Pennsylvania Program and RFA # 04-14.

Barry Bowman,
Project Officer—RFA #04-14
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Managed Care Operations

RFA #04-14

Questions by Topic

As of 05/30/2014

Section 1 - RFA/Draft Agreement/Participation

The Department's complete response to the following question (previously Question 3 in this section) was not included in the Addendum posted on Wednesday, May 28, 2014. The question and the complete response are as follows:

3. Q. For Section II-5 of the RFA is DPW seeking Geisinger Health Plan's 2015 QHP self-certifications to prove compliance with state and federal laws regulating health insurance coverage? Or is DPW seeking the 2015 self-certifications? Or both?

   A. The 2015 plan form filing, with the updated Compliance Checklist and Certification, should be refiled to comprise a complete product filing with PID. The Compliance Checklist and Certification should be substantially identical to the form provided in the Pennsylvania Bulletin for use in 2015.

Section 2- Enrollment Related

No additional questions at this time.

Section 3- Network Requirements/Development

1. Q. In follow up to a question asked and responded to verbally at the bidder's conference, please confirm that the Commonwealth will accept an NCQA "Accredited" rating as meeting the NCQA requirement. This differs from what appears in the RFA at Part III, Section III-3D and we are seeking written confirmation of this change.

   A. Applicants must have a recent NCQA health plan accreditation of *COMMENDABLE* or *EXCELLENT.* The Department may consider Applicants with the NCQA Accreditation of *ACCREDITED* if their inclusion is in the best interest of the Commonwealth. New Health Plan Accreditation through NCQA's New Health Plan (NHP) Accreditation will also be considered by the Department. Please see Section III-3 of the RFA.

2. Q. Please confirm that the physical and behavioral health benefits package is not a required submission for the application but that it should be submitted as part of the plan form filing with PID in accordance with II-5 of the RFA, "Compliance

with Insurance Requirements." It is our understanding that to pass this required element the Applicant must, at a minimum, provide a statement at the time of application describing its plan to have the certification in place by August 4, 2014. Please clarify as this seems to conflict with the response provided to the first question listed under Section 9, "Behavioral Health," on page 32 of the Responses to questions issued by DPW on May 28, 2014.

A. The Department's response to Question 1, Section 9, Behavioral Health should have been:
Please refer to Exhibit B to Attachment A Draft Agreement of the RFA. Exhibit B serves as a broad description of the minimum benefits required. An Applicant should include in each PCO product form filing Physical and Behavioral Health benefits packages that include amount, duration and scope of all benefits provided by its product. Additional details may be required to be provided to DPW.

Section 4- Covered/Non-Covered Services

The Department's complete response to the following question (previously Question 7 in this section) was not included in the Addendum posted on Wednesday, May 28, 2014. The question and the complete response are as follows:

7. Q. Regarding compliance with insurance requirements, will the form filing and compliance checklist that were submitted to PID last year be sufficient documentation for purposes of the RFA?

   A. The 2015 plan form filing, with the updated Compliance Checklist and Certification, should be refiled to comprise a complete product filing with PID. The Compliance Checklist and Certification should be substantially identical to the form provided in the Pennsylvania Bulletin for use in 2015.

Section 5 - Operations/Compliance/Oversight

No additional questions at this time.

Section 6- Systems/IT

No additional questions at this time.

Section 7 - Premiums/Copayments/Cost Sharing

No additional questions at this time.

Section 8 - Pharmacy

1. Q. Is retail supply limited to 30 days or is the intent to allow 31 to 90 day supply to be dispensed at retail pharmacy? If 31 to 90 day supply procured at retail pharmacy, will stepped copay apply (i.e., 2 copays for 31 to 60 days, 3 copays for 61 to 90 days)?

   A. Copays do not vary based on the amount dispensed. Retail supply is not limited to 30 days. The intent is to allow the use of mail order or retail for prescription fills from 31 to 90 days. The only cost-sharing responsibility of members in 2015 will be the DPW Medical Assistance copay schedule found at the link below: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005972.pdf

2. Q. Please clarify whether the intent is for all "infused" drugs to be covered under the pharmacy benefit? What is generally covered under pharmacy is only "infused medications that can be self-administered" such as therapy like factor products (for hemophilia), while infused therapies that are administered in a physician office or a facility clinic are covered under the medical benefit?

   A. Route of administration does not dictate how the drug is covered. If the drug is dispensed or administered outside of the inpatient setting, it is covered under the PCO Pharmacy benefit.

Section 9- Behavioral Health

No additional questions at this time.

Section 10 – Financial

1. Q. Please clarify if the difference in non-participating provider reimbursement regulations for emergent services in Healthy PA program (relative to current A. Medicaid) was reflected in draft rates as presented. Please specify key assumptions and quantify impact of that difference. Please further clarify if the expected non-participating provider reimbursement for emergent services is expected to revert to Medicaid methodology and level or follow commercial regulations and level of reimbursement. Please further clarify, if non-participating reimbursement reverts to commercial rates, how this disincentive to contract at lower than commercial rates was reflected in Healthy PA unit cost assumption.

   Based on available information, DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft potential 2015 HPA rates. DPW wants to increase access and provider capacity in this program and to lay the groundwork for a seamless transition by members to employer sponsored or exchange market coverage. The actuary did not differentiate between participating and non-participating providers in the pricing assumption.

2. Q. Could the Department provide all cost sharing anticipated including the specific co-payments for specific services that will apply to the program?

   A. This is provided in a document that is posted with these questions and answers.

   http://www.dpw.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005972.pdf

3. Q. What is the Commonwealth's standard for determination of what constitutes reasonably necessary costs? How was that factored in to the rates?

   Healthy PA rates were developed based on available information. More information on how the Healthy PA rates were developed is found in the updated Healthy Pennsylvania RATE METHODOLOGY NARRATIVE prepared by Mercer and provided with these questions and answers.

4. Q. Please confirm retroactivity should be assumed and apply to this program and how retroactivity for the Healthy PA program differs in process relative to the current Medicaid program. Please indicate if any adjustments in the draft rates have been made for these variances, if any.

   A. DPW will provide details once there is an agreement on the standard terms and conditions of the waiver with CMS. If the PCO enrollment date is after the hospital admission date, the PCO is not responsible for the stay.

Commonwealth of Pennsylvania

Date: **June 5, 3014**
Subject: **Healthy Pennsylvania Program**
Solicitation Number: **RFA 04-14**
Opening Date/Time: **June 10, 2014 12:00 PM**
Addendum Number: **3**

To All Suppliers:

The Commonwealth of Pennsylvania defines a solicitation "Addendum"" as an addition to or amendment of the original terms, conditions, specifications, or instructions of a procurement solicitation (e.g., Invitation for Bids or Request for Proposals).

List any and all changes:

Please find attached to the solicitation the final question-and-response document pertaining to the formal inquiries posed through June 2, 2014. In additon, please find attached an updated Exhibit B of Attachment A that contains additional detail for the Behavioral Health service coverage.

For electronic solicitation responses via the SRM portal:

- Attach this Addendum to your solicitation response. Failure to do so may result in disqualification.
- To attach the Addendum, download the Addendum and save to your computer. Move to 'My Notes", use the "Browse" button to find the document you just saved and press "Add" to upload the document.
- Review the Attributes section of your solicitation response to ensure you have responded, as required, to any questions relevant to solicitation addenda issued subsequent to the initial advertisement of the solicitation opportunity.

For solicitations where a "hard copy" (vs. electronic) response is requested:

- Attach this Addendum to your solicitation response. Failure to do so may result in disqualification.
- If you have already submitted a response to the original solicitation, you may either submit a new response, or return this Addendum with a statement that your original response remains firm, by the due date to the following address:

  Pennsylvania Department of Public Welfare
  Division of Procurement
  Room 402 Health and Welfare Building
  625 Forster Street, Harrisburg, PA 17120

Except as clarified and amended by this Addendum, the terms, conditions, specifications, and instructions of the solicitation and any previous solicitation addenda, remain as originally written.

Very truly yours,

Name: Barry Bowman
Title: Project Officer-RFA #04-14

Phone:
Email: babowman@pa.gov

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

June 05, 2014

RE: *Responses to questions submitted under Request for Application (RFA) #04-14*

This is the final response to all remaining questions regarding the Healthy Pennsylvania Program RFA # 04-14.

In addition to responses to formal questions posed through June 2, 2014, the Department is issuing an update to the RFA Attachment A draft Agreement Exhibit B. Specific elements related to Behavioral Health Coverage have been added.

Any additional questions submitted after noon on June 2, 2014 will be considered as part of the discussions with selected applicants.

The Department is pleased with the positive response regarding the Healthy Pennsylvania Program and RFA # 04-14.

Barry Bowman,
Project Officer—RFA #04-14
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Managed Care Operations

RFA #04-14

Questions by Topic

As of 06/05/2014

Section 1 - RFA/Draft Agreement/Participation

1. Q. May a PCO amend existing approved HealthChoices provider agreements for purposes of the Healthy PA program?

   A. In terms of the provider network, the applicant must ensure that its network of providers will meet the DOH adequacy standards and have the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program. From a network adequacy standpoint, DOH will still need to review the network the company plans to use for the Healthy Pennsylvania population to ensure that there are enough providers to handle the influx of new business.

2. Q. If a qualified PCO intends to subcontract risk and program management to an affiliated entity, will the affiliated entity's NCQA accreditation satisfy the accreditation requirements outlined in the RFA or does the accreditation need to reside at the PCO level?

   A. The Department will consider an affiliated entity's accreditation to satisfy this requirement.

3. Q. If the PCO intends to delegate risk and program management to an affiliated entity, can the PCO also delegate the appeals and grievances function to said affiliated entity?

   A. The entity providing the coverage must assure that there is an appeal process that satisfies the requirements of the Affordable Care Act, whether it does so itself or through an affiliate. In the event a PCO generally delegates its functions, DOH will need to review the contract.

4. Q. Due to scheduling constraints with NCQA, would the Department consider accepting plans for interim NCQA accreditation by January 1, 2015 in lieu of August 4, 2014?

   A. No. Applicants must meet the NCQA requirements set forth in Part III, Section III-3D by August 4, 2014 or such later date as specified by the Department. For purposes of applications, applicants should submit its most recent accreditation.

The Department will consider interim survey accreditations and New Health Plan accreditations.

5. Q. Given that the Healthy PA program and benefit design are defined by the State, may we submit the draft Healthy PA PCO Agreement in lieu of a form filing for PID certification and as the form filing submitted in response to the Request for Application to DPW?

   A. No, Applicants must submit the information as required by Parts II and III of the RFA.

Section 2- Enrollment related

None

Section 3- Network Requirements/Development

1. Q. In terms of provider networking, do applicants need to have signed letters of intent or fully executed contracts by the RFA response due date?

   A. Questions regarding DOH County Operational Authority should be directed to the Department of Health. Documentation of DOH County Operational Authority, or the PCO's written plan to have DOH County Operational Authority in place by August 4, 2014 or such later date as specified by the Department, is required for Applicant's submission on June 10, 2014. For purposes of the Application submittal, Applicants do not need to have fully executed contracts; however, Applicants must include a detailed statement describing their plan to have such contracts in place.
   .

2. Q. How is network adequacy determined? Does it differ based on the timing (i.e. readiness review versus go-live)?

   A. In terms of provider network, the Applicant must ensure that its network of providers meets the DOH adequacy standards and has the capacity to serve the numbers and demographics of the population to be served through the Healthy Pennsylvania Program.

   For the submittal of the Application, an Applicant need only submit its documentation of DOH County Operational Authority for each county for which it wishes to provide services, or the PCO's written plan to have DOH County Operational Authority in place.
   For purposes of readiness review, the Applicant must demonstrate that it has met DOH's network adequacy standards.

3. Q. What documentation is needed for determining network adequacy (i.e. Provider contract versus letter of intent)?

   A. Questions regarding DOH County Operational Authority should be directed to the Department of Health. Documentation of DOH County Operational Authority, or a written statement outlining the PCO's plan to have DOH County Operational Authority in place by August 4, 2014 or such later date as specified by the Department, is required for Applicant's submission on June 10, 2014. For purposes of the Application submittal, Applicants do not need to have fully executed contracts; however, Applicants must describe their plan to have DOH County Operational Authority, including its plan to have such contracts in place.

   For purposes of readiness review, the Applicant must demonstrate that it has met DOH's adequacy standards. In order to establish network adequacy, a selected Applicant must have contracts in place when the network is submitted for DOH review.

4. Q. We have concerns regarding the ability to have DOH operational authority in place by August 1, 2014. As it stands today, there is a limited amount of time to prepare contract amendments, contracts, and to negotiate provider rates—including for both physical health and behavioral health. Furthermore, guidance from DPW on where bidders are to reasonably set provider rates has not been released yet. Can you gather information regarding how DPW, DOH, PID will be working with bidders to help us meeting this tight deadline?

   A. The Department recognizes the time frames for obtaining DOH operational authority provided in the RFA may be difficult to meet. Although the optimal solution is to have this DOH authority in place by August 4, 2014, the Department will consider extending the time frames for obtaining the necessary DOH authority. The Department, DOH and PID all are committed to ensuring that selected Applicants are able to meet the tight deadlines required for the implementation of Healthy Pennsylvania. The requirement that an Applicant's submission include a description of its plan to have County Operational Authority in place is not modified.

5. Q. In the Final Draft RFA Questions Answers By Topic PDF, Question 22 of Section 3 Network Requirements/Development of the responses to Applicant questions. Please clarify if the July 11, 2014 review date applies to SAE applications only, as discussed in RFA Section II-4? In addition, please confirm that networks will be reviewed on August 1, 2014 or such later date as may be specified by the Department.

   A. Please see the Department's response to Question Number 4 of this section. The same time frames for obtaining DOH operational authority will apply to the submission to DOH of the networks to be used by a selected Applicant for the

Healthy Pennsylvania population by those selected Applicants that have existing DOH County Operational Authority.

6. Q. Will the Department be adding a requirement for “Related Party Hospitals” to negotiate in good faith with other PCOs, similar to the provision that is in the HealthChoices Standard Agreement at Section (V)(S)(5)? This section reads: The Department requires that a hospital that is a Related Party to a PH-MCO must be willing to negotiate in good faith with other PH-MCOs regarding the provision of services to Recipients. The Department reserves the right to terminate this Agreement with the PH-MCO if it determines that a hospital related to the PH-MCO has refused to negotiate in good faith with other PH-MCOs.

   A. The Department does not plan to include this provision in Healthy Pennsylvania PCO Agreements.

7. Q. Is it appropriate to choose "No" on the Compliance Checklist for those items that don't apply such as Group policy related questions?

   A. For purposes of the Compliance Checklist and Certification filed with PID, if an Applicant believes a requirement is not applicable to the PCO product, it may note that in its certification.

8. Q. If the PCO does not intend to market Healthy PA on the Exchange, does the PCO have to comply with the following QHP requirements in the Compliance Checklist: "Definition of Qualified Health Plan", "Exchange Functions: Certification of QHP Regulations" and/or "Exchange Health Insurance Issuers Standard Regulations"?

   A. An Applicant should submit a plan form filing as well as a Compliance Checklist and Certification. The certification must certify that the coverage that will be provided meets all applicable federal and state laws regulating health insurance coverage offered in the individual market. See Part II-5 of the RFA, “Compliance with Insurance Requirements.” Both the Market Reform and QHP portions of the certification should be filled out. An Applicant is not required to offer its PCO product on the exchange, but must specify its intentions (whether it is offering the product on or off the exchange) at the time of filing.

9. Q. Does Section 6085 of the DRA which created a new section 1932(b)(2)(D) of the Social Security Act (the Act) -apply to Healthy PA as currently constructed? That is, is the payment of non-par providers for emergency services limited to payment rates established by the State's Medicaid FFS program given the source of HealthyPA funding through federal and state Medicaid dollars?

   A. The PCO applicant should discuss applicability of federal and state laws with its counsel.

10. Q. If we are not planning on a Service Area Expansion, are there any other submission requirements to DOH due on July 11, 2014?

    A. Please see response to Question Number 5 of this section. Even if an Applicant does not need Service Area Expansion approval, DOH needs to review the network that is going to be used with this product, and that network should be submitted on July 11 or such later date as specified by the Department.

11. Q. If there are any submission requirements to DOH due on July 11, 2014, may we submit Letters of Intent in lieu of provider agreements with the intent of updating these LOIs with executed agreements as they are received?

    A. Please see response to Question 4 of this section.

Section 4- Covered/Non-Covered Services

1. Q. Can you provide some clarity on the benefit plan when a newborn goes to the NICU?

   A. PCOs do not have responsibility for a newborn except for a normal -baby hospital stay.

2. Q. Is a PCO required to comply with providing Coverage for Participating in Approved Clinical Trials?

   A. Please refer to Exhibit B of Attachment A of the RFA. Experimental and investigative services are not covered with the exception of medically necessary routine patient costs for Members participating in a cancer clinical trial.

3. Q. Would the PCO be compliant if they stipulated that they will cover the benefit to the extent it is included in the Essential Health Benefits Package?

   A. At a minimum, PCOs are required to provide the benefits outlined in the PCO Agreement.

4. Q. Do we need to comply with the Compliance Checklist item "Uniform Explanations of Coverage and Standardized Definitions" if eligibility is through Maximus?

   A. For purposes of the Compliance Checklist and Certification filed with PID, if an Applicant believes a requirement is not applicable to the PCO product, it may note that in its certification. However, if the requirement is applicable to the PCO product, the PCO must assure compliance, whether delivered directly or delegated, including ongoing compliance.

5. Q. Does an attestation form need to be included for each checklist item or is the Certification one page document requesting Name/Title of Authorized Representative of the Company sufficient?

   A. If this question refers to Attachment C to the RFA, the attachment must be completed by an individual or individuals that have the authority to bind the Applicant to the provisions of its Application. We are not sure what is meant by the checklist.

6. Q. How/Where do you upload the Compliance Checklist in SERFF? Where do you upload supporting documentation and is there a required format?

   A. The Compliance Checklist should be uploaded into the Form Schedule Tab. Any supporting documentation should be uploaded to the Supporting Documentation tab. All documents must be submitted in pdf format.)If assistance is needed regarding SERFF, the Applicant may contact the Insurance Department.

Section 5 - Operations/Compliance/Oversight

None

Section 6- Systems/IT

1. Q. Will the 834 form need to be broken out and sent by county?

   A. The Department will be communicating file specifications and other instructions during Readiness Review.

2. Q. Do reports have to be broken out by county?

   A. The Department will be communicating file specifications and other instructions during Readiness Review.

Section 7 - Premiums/Copayments/Cost Sharing

None

Section 8 - Pharmacy

1. Q. Will PCOs maintain independence in formulary management and their own rebate contracting or will PCOs' formularies need to conform to formulary listing as it relates to the Federal Drug Rebate Program (Section 1927 of the Social Security Act)?

A. PCOs will be permitted to enter into their own market share rebate agreements with drug manufacturers.

The Department is currently evaluating how the Federal Drug Rebate Program will be handled in the Healthy Pennsylvania Program.

2. Q. Please confirm objective is to provide essential health benefits defined by PPACA. If so, then need to request clarification for exceptions to benefit parameters and exclusions and limitations.

   For example: a) Only covered formulary generic contraceptives? Or based on PPACA, extend coverage to some brand contraceptives due to formulation not yet available generically. b) Exclude all OTC medications? Or based on PPACA, extend coverage to mandated select OTC products.

   A. The objective is to cover the services in Attachment A to the RFA, Draft Agreement.

   a) The PCO is not required to cover Over-the-Counter medications t unless they are supplied while a beneficiary is admitted to the hospital. Please refer to Exhibit B of Attachment A to the RFA, Draft Agreement.

   b) The Department requires formulary, generic FDA approved, women's contraceptives to be covered. If a PCO wants to include other pharmaceuticals as an additional benefit (including alternatives to oral contraception), they may do so at their discretion, and at their own financial risk.

Section 9- Behavioral Health

None

Section 10 – Financial

1. Q. Is the HealthyPA program subject to Gross Receipts Tax and if so, do the PCO capitation rates include a provision for this tax?

   A. The Department intends that the PCO capitation rates will include appropriate provision for Gross Receipts Tax if this tax applies to PCO revenue.

2. Q. Can you provide information on any changes we can expect in the rates DPW will send to selected applicants vs. the draft rates that were provided with the RFA?

A. DPW provided draft 2015 HPA rates with the RFA that reflected information and decisions available to the actuary when they were developed. The final 2015 HPA rates may reflect different information and decisions, based in part on CMS approval.

DPW's actuary targeted a mid-point between Medicaid and commercial pricing when developing the draft 2015 HPA rates. This rate development decision point is under review. Potential applicants should be aware that the pricing assumptions utilized to develop the final rates might be different. At this writing, there is no decision to make a change.