Copy-ID:		GRANT Number:	SAP 4100060537

PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

GRANT AGREEMENT AMENDMENT

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

AWARD TO:	NAME AND ADDRESS: Vista Health Plan, Inc. 1901 Market Street Philadelphia, PA 19103 TELEPHONE NUMBER: 215-241-2015	Mail Final Agreement to: Laura Herzog Director PA Compliance and Regulatory Affairs Keystone First, AmeriHealth Caritas, & AmeriHealth Northeast Health Plans 200 Stevens Drive Philadelphia, PA 19113 ebaumgartner@amerihealthcaritas.com Lherzog@amerihealthcaritas.com

FEDERAL I.D. NUMBER: 23-2408039

HEALTHCHOICES PHYSICAL HEALTH AGREEMENT

BETWEEN

COMMONWEALTH OF PENNSYLVANIA

AND

VISTA HEALTH PLAN, INC.

HEALTHCHOICES NEW WEST PHYSICAL HEALTH AGREEMENT
No. 4100060537 Amendment #4

THIS Amendment to Grant Agreement No. 4100060537 (the "Amendment") is made this 5th day of Dec, 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 "PH-MCO").

W I T N E S S E T H:

WHEREAS, the Department and the PH-MCO are parties to Grant Agreement No. 4100060537 effective October 1, 2012 (the "Grant Agreement");

WHEREAS, the purpose of the Grant Agreement is to provide for a mandatory managed care program, under the name HealthChoices New West Physical Health (the "HC-NW Physical Health Program") for Medical Assistance (MA) consumers in Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango and Warren Counties (the "HC-NW Counties");

WHEREAS, the Department desires to amend certain appendices and an exhibit and to add an additional appendix to the Grant Agreement; and

WHEREAS, the PH-MCO has agreed to these changes.

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

1. The Grant Agreement is amended as follows:

a. Effective January 1, 2013, Appendix 3a ACA Health Insurer Fee (dated November 20, 2013) is deleted and replaced with the attached Appendix 3a ACA Health Insurance Providers Fee (dated June 19, 2014). The Table of Contents is updated to reflect the change in the name of Appendix 3a.
b. Effective January 1, 2013, Appendix 3b Explanation of Capitation Payments (dated November 6, 2013) is replaced with the attached Appendix 3b Explanation of Capitation Rates (dated June 14, 2014).
c. For services provided on or after January 1, 2013, Appendix 3f Capitation Rates (January 1, 2013 to June 30, 2013 Capitation Rates prepared on August 28, 2012 and July 1, 2013 to December 31, 2014 Capitation Rates prepared on October 4, 2013) are replaced with the attached Exhibit 3f Capitation Rates (Prepared on June 20, 2014).
d. Effective July 1, 2014, the attached Appendix 3i Five Percent Capitation Withhold is added as an appendix to the Grant Agreement. The Table of Contents is updated to add Appendix 3i to the list of Grant Agreement appendices.

e. Effective January 1, 2013, Appendix 3j Physician Fee Increase Arrangement (dated November 4, 2013) is replaced with the attached Appendix 3j, Physician Fee Increase Arrangement (dated June 5, 2014).
f. Effective January 1, 2014, Exhibit B(3) Provider Pay for Performance Program effective July 1, 2013 is replaced with the attached Exhibit B(3) Provider Pay for Performance Program (dated August 25, 2014).

2. The attached Appendix 3a, Appendix 3b, Appendix 3f, Appendix 3i, Appendix 3j and Exhibit B(3) are incorporated and made part of this Grant Agreement.

3. Except as modified by this Amendment, all other terms and conditions of the Grant Agreement remain unchanged.

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

OCT 10 2014

COMPTROLLER OPERATIONS

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

AMOUNT	SOURCE	APPROPRIATION SYMBOL	PROGRAM
0			

Rita K Shaffer 12-5-14
SIGNATURE COMPTROLLER OPERATIONS

Approved as to Legality and Form:

OFFICE OF LEGAL COUNSEL
DEPARTMENT OF PUBLIC WELFARE
10/27/14

DEPUTY ATTORNEY GENERAL
OFFICE OF ATTORNEY GENERAL
(when required)

DEPUTY GENERAL COUNSEL
OFFICE OF GENERAL COUNSEL
(when required)

APPENDIX 3a

ACA Health Insurance Providers Fee

This Appendix provides for potential payments by the Department to the PH-MCO related to the Health Insurance Providers Fee (HIPF).

Fee Year – The year in which a HIPF payment is due from the PH-MCO to the Internal Revenue Service (IRS) is referred to as the Fee Year.

Data Year – The IRS calculates HIPF due in the Fee Year using submitted information on net premiums written for the previous calendar year, which is referred to as the Data Year.

A. If a PH-MCO is a covered entity or a member of a controlled group under Section 9010 of the Affordable Care Act that is required to file IRS Form 8963, Report of Health Insurance Provider Information (Report 8963), the PH-MCO must perform the following steps. Submission is not required if the PH-MCO is exempt from the HIPF.

1. By May 5th of each calendar year, the PH-MCO shall provide the Department with a copy of Form 8963 submitted to the IRS. The PH-MCO shall also provide, for each line on Form 8963 that reports premiums written, the amount of HealthChoices premium included on that line.

2. The PH-MCO will provide to the Department a copy of the IRS HIPF preliminary fee calculation notice within 10 business days of its receipt from the IRS.

3. If a corrected Form 8963 is submitted to the IRS during the error correction period, the PH-MCO shall provide the Department with a copy of all such reports within 10 business days of submission to the IRS. The PH-MCO shall also provide, for each line on a corrected Form 8963 that reports premiums written, the amount of HealthChoices premium that is included on that line.

4. By September 7 of each Fee Year, the PH-MCO will provide the Department with a copy of the IRS HIPF final fee calculation notice for that Fee Year.

5. If the PH-MCO's net income is subject to federal income tax and the PH-MCO desires the Department to consider this in its calculation of

the payment amount, the PH-MCO shall provide the average federal income tax rate that applies to its income for the Data Year. The PH-MCO will also provide the amount of taxable income subject to federal income tax and the amount of federal income tax paid for the most recent income tax year for which a tax filing has been made. The PH-MCO will specify the tax year and will provide the information by September 7.

6. If the PH-MCO's net income is subject to Pennsylvania corporate net income tax and the PH-MCO desires the Department to consider this in its calculation of the payment amount, the PH-MCO shall provide the average state income tax rate that applies to its Pennsylvania corporate net income for the Data Year. The PH-MCO will also provide the amount of taxable income subject to Pennsylvania corporate net income tax and the amount of Pennsylvania corporate net income tax paid for the most recent income tax year for which a tax filing has been made. The PH-MCO will specify the tax year and will provide the information by September 7.

B. The Department will:

1. Review each submitted document and notify the PH-MCO of any questions. The PH-MCO must respond to questions from the Department within five work days.

2. By September 15 of each Fee Year, the Department will pay the portion of the Data Year HIPF Withhold Amounts that covers the HealthChoices portion (specific to this Agreement) of the PH-MCO's HIPF obligation per the IRS HIPF preliminary fee calculation notice (as noted in A.2 above). This payment will be called the Initial HIPF Payment. To calculate the payment amount, the Department will:

a. Calculate the HIPF obligation rate (the "HIPF%") from information on the IRS document "Annual Fee on Health Insurance Providers for 20xx", where 20xx is the Fee Year. For a PH-MCO that is a single-person covered entity, the IRS will send this document to the PH-MCO. For a PH-MCO that is a member of controlled group, the IRS will send this document to the designated entity of the controlled group on behalf of all members of the controlled group.

Single-person covered entity or controlled group HIPF% =

$$\frac{\text{Amount labeled "Your share of fee"}}{\text{Amount labeled "Sum of total net premiums written as reported"}}$$

The amount "Sum of total net premiums written as reported" is before the reduction of 100% of the first $25 million of premium

and 50% of the next $25 million of premium. The single-person covered entity or controlled group HIPF% is unique to each entity that is subject to the HIPF. The above formula produces the HIPF% to be used in subsequent steps of the calculation in the following circumstances:

i. The PH-MCO is a single-person covered entity.
ii. The PH-MCO is a member of a controlled group and none of the controlled group's premiums are reported as "Premiums eligible for partial exclusion for certain exempt activities" (listed on Form 8963 as attributable to 501(c)3, (c)4, (c)26, or (c)29 entities).
iii. The PH-MCO is a member of a controlled group and all of the controlled group's premiums are reported as "Premiums eligible for partial exclusion for certain exempt activities" (listed on Form 8963 as attributable to 501(c)3, (c)4, (c)26, or (c)29 entities).

If the document "Annual fee on Health Insurance Providers for 20xx" has an amount for the "Premiums eligible for partial exclusion for certain exempt activities" that is not zero and not equal to the amount "Sum of total net premiums written as reported", then information from Form 8963 on the premiums attributable to 501(c)3, (c)4, (c)26, or (c)29 entities will be used to develop a non-profit HIPF% for the 501(c)3, (c)4, (c)26, or (c)29 entities that is 50% of the HIPF% for the other (for-profit) entities, where the application of the two rates to the respective premiums produces the amount "Your share of fee". The HIPF% to be used in subsequent steps of the calculations is either the non-profit or for-profit HIPF%, as determined by the status of the PH-MCO.

b. Calculate Figure A. Figure A is the total revenue for coverage in the Data Year that the Department has provided the PH-MCO for this Agreement, as known through payments made by August 1 of the Fee Year. The Figure A amount has no provision for the HIPF obligation.

c. Calculate Figure B. Figure B is the portion of Figure A that is for services subject to the HIPF. Capitation revenue for services that are excludable under Section 9010, such as long-term care services, will not be included in Figure B. The Figure B amount has no provision for the HIPF obligation.

d. Calculate Figure C. Figure C is the calculation of total revenue that incorporates provision for the HIPF and other taxes. The Department will use the following formula to calculate Figure C. If the PH-MCO has not provided satisfactory documentation of

federal income tax obligations under section A.5, then the Average Federal Income Tax Rate (AvgFIT%) in the formula will be zero. If the PH-MCO has not provided satisfactory documentation of Pennsylvania corporate net income tax obligations under section A.6, then the Average State Income Tax Rate (AvgSIT%) in the formula will be zero. The applicable Gross Receipts Tax percentage (GRT%) is inclusive of any applicable PURTA percentage. If Gross Receipts Tax does not apply, then the GRT% amount is zero.

$$\frac{\text{Figure B} \times (1 - \text{GRT\%})}{1 - \text{GRT\%} - (\text{HIPF\%} / (1 - \text{AvgSIT\%} - \text{AvgFIT\%} \times (1 - \text{AvgSIT\%})))}$$

e. Calculate Figure D. The Department will calculate Figure D by subtracting Figure B from Figure C.

f. The Department will compare Figure D with the sum of the HIPF Withhold amounts it has withheld for this Agreement for the Data Year. The lesser of these two figures will be the Initial HIPF Payment amount.

3. The Department will utilize the steps provided in B.2. above to calculate a Final HIPF Settlement Amount, with these exceptions:

   a. The Department will utilize the IRS HIPF final fee calculation notice for that Fee Year instead of the preliminary fee calculation notice.
   b. Figure A is the total revenue for coverage in the Data Year, excluding the Initial HIPF Payment under section B.2, that the Department has provided the PH-MCO for this Agreement, as known through payments made by November 1 of the Fee Year.
   c. The Final HIPF Settlement Amount will be the difference between the new Figure D and the Initial HIPF Payment Amount, except that the sum of payments may not exceed the sum of the HIPF Withhold Amounts for the Data Year.

C. The Department will perform the steps provided by this Appendix 3a for any year that a PH-MCO pays a HIPF, even if the PH-MCO is no longer providing HealthChoices services during that Fee Year.

D. The PH-MCO shall notify the Department if the HIPF actually paid is less than the amount in the IRS final fee calculation notice or if the IRS refunds any portion of the HIPF. If such changes affect the calculations provided in Appendix 3a, the Department will recalculate its obligation and the PH-MCO will refund the difference.

E. The Department will not make a payment per this Appendix 3a if the PH-MCO is not subject to the HIPF.

F. The Department will have no obligation to the PH-MCO per this Appendix 3a unless CMS has approved the Agreement that includes this appendix.

G. The dates included in this Appendix 3a will be effective beginning January 1, 2015. In the year 2014 the PH-MCO need not provide anything specified in this Appendix until the first Agreement amendment that includes this Appendix is executed. The Department will provide payment for the 2014 Fee Year by December 31, 2014.

APPENDIX 3b

EXPLANATION OF CAPITATION PAYMENTS

Effective January 1, 2013, if there are Health Insurance Providers Fee (HIPF) withholds present on Appendix 3f, then Base Capitation Rates for the purpose of this appendix are defined as Base Capitation Rates net of HIPF withholds and prior to risk adjustment.

I. Base Capitation Rates

The final schedule of Base Capitation Rates and Maternity Care Rates for the Agreement Year is found in Appendix 3f, Capitation Rates. The ACA Rate Supplements can be found in Appendix 3f-1, ACA Rate Supplements.

II. Base Capitation Rates for Subsequent Years

A. Initial Schedule of Base Capitation Rates:

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

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

B. Final Schedule of Base Capitation Rates

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

III. Capitation Payment Rates with Risk Adjusted Rates

A. Applicability of Risk Adjusted Rates

The Department will risk adjust the Base Capitation Rates for federal Recipient Groups included in this Agreement using an actuarially sound

method to adjust Base Capitation Rates to reflect differences in health status and demographics of the Members enrolled in each PH-MCO's program.

The ACA Rate Supplements, identified in Appendix 3f-1, are not subject to Risk Adjustment.

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

B. RAR MCO Plan Factors

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

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

C. Risk Adjusted Rate

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

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

D. Provider Pay-for-Performance Amount

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

E. Capitation Payment Rates

The Capitation Payment Rate is equal to the Risk Adjusted Rate. The Department will pay the sum of the applicable monthly Capitation Payment Rate plus the ACA Rate Supplement to the PH-MCO for each Member enrolled in the PH-MCO's program.

Illustrative Example of Rate Calculation, with Risk Adjusted Rates: The Base Capitation Rate for TANF in Philadelphia is $100.00. The Department has provided the PH-MCO with a RAR MCO Plan Factor of 0.9710 for TANF Members in Philadelphia. $100.00 multiplied by 0.971 equals $97.10, which is the Risk Adjusted Rate. The Risk Sharing Withhold amount for Home Nursing is $2.41, and the HCRPAA is $1.21, but these amounts are not incorporated in the calculation of the Capitation Payment Rate. The ACA Rate Supplement is $15.00. This rate of $15.00 is added to the Capitation Payment Rate of $97.10 to total $112.10, which is the final capitation payment issued for the TANF member.

This amount will be the payment for each month the MCO Plan Factor remains at 0.971. As each recalculation of the MCO Plan Factor occurs, the PH-MCO will be paid a revised Capitation Payment Rate in effect for each month that each TANF Philadelphia Member is enrolled in the PH-MCO's program. In addition, the Department will, when specified by this Agreement, pay applicable Pay For performance amounts; and the applicable Maternity Care Payments; and any amounts that are owed in accordance with the Risk Sharing provisions as defined in the Home Nursing Risk Sharing Arrangement(s) of this Agreement; and any amounts that are owed in accordance with Appendix 3k, High Cost Risk Pool, of this Agreement.

F. ACA Rate Supplement

The Department will not pay the rates included in Appendix 3f-1, ACA Rate Supplement, for any program month after December 2014.

G. Maternity Care Payment

If there are HIPF withholds present on Appendix 3f, then the Department will pay the PH-MCO a Maternity Care Payment, as identified in Section VII.B.2, that is net of the applicable HIPF withhold.

H. Capitation for April Program Months

This paragraph applies only to capitation payments for recipients whose county of eligibility is one of the 25 counties included in HealthChoices prior to July 2012. Beginning in the year 2015, capitation payments to the PH-MCO for the April program month will be due July 15 of the same year. The provisions of Section VII.B.1 of this Agreement otherwise apply.

APPENDIX 3i

Five Percent Capitation Withhold

This appendix provides for capitation withholds if the PH-MCO has not signed an annual HealthChoices Agreement amendment by a specified date.

1. Effective with capitation payments that are payable in December of each calendar year and continuing with capitation amounts that are payable in each month thereafter, the Department will withhold from each monthly capitation payment an amount equal to five percent of the capitation amount it has paid for the August program month in the same calendar year.

2. The Department will not implement this withhold if any of the following apply:

    a. The Department has received by November 20 of the same calendar year a signed HealthChoices Agreement amendment from the PH-MCO that provides financial terms for the following calendar year; or

    b. The Deputy Secretary for the Office of Medical Assistance Programs decides to waive the monthly capitation payment withhold.

3. If the Department does not withhold an amount from the capitation payment payable in December, and if by December 20 of the same calendar year the Department has not received a signed agreement amendment from the PH-MCO that provides financial terms for the following calendar year, then effective with monthly capitation payments that are payable in January of the next calendar year and continuing with capitation amounts that are payable in each month thereafter, the Department will withhold from each monthly capitation payment an amount equal to five percent of the capitation amount it has paid for the most recent August program month. The Deputy Secretary of the Office of Medical Assistance Programs may elect to waive the monthly capitation payment withhold.

4. If the Department withholds payment per this appendix, the Department will initiate a payment of the total amount that was withheld when the Department receives a signed HealthChoices Agreement amendment from the PH-MCO that provides financial terms for the applicable calendar year for this HealthChoices zone.

5. This entire appendix does not apply: (a) if the Department does not provide a detailed financial offer to the PH-MCO for the following year by August 31 or (b) the PH-MCO has terminated the HealthChoices Agreement.

APPENDIX 3j

Physician Fee Increase Arrangement

Effective January 1, 2013, this appendix establishes an arrangement (Arrangement) between the Department and the PH-MCO for revenue associated with increased expenditure for eligible Evaluation and Management (E&M) procedure codes and Vaccine Administration (VA) procedure codes in accordance with Section 1202 of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reform Act of 2010, and 42 CFR 438.6 and 42 CFR 438.804.

This Appendix 3j supersedes any previous version to define the Arrangement beginning January 1, 2013.

I. Eligible Physicians

The Department will be the sole identifier and data source to the PH-MCO of all qualifying physicians eligible for the enhanced payment for qualifying primary care codes. The Department will be the sole determiner of the effective date(s) of their eligibility for the increase.

II. Eligible Members

All Members covered by this Agreement are eligible for inclusion.

III. Eligible Services

Eligible services are limited to specific E&M procedure codes and VA codes, as approved by CMS in the Department's State Plan.

IV. Six Month Program Periods

The Department will perform separate settlements for four program periods defined by the following dates of service:

- January 1, 2013 through June 30, 2013;
- July 1, 2013 through December 31, 2013;
- January 1, 2014 through June 30, 2014; and
- July 1, 2014 through December 31, 2014.

V. E&M Rate Increments

The Department will pay ACA Rate Supplements to the PH-MCO as provided by Appendix 3b, Explanation of Capitation Payments, and Appendix 3f-1, Capitation Rates, included in this Agreement. Each ACA Rate Supplement amount is inclusive of an E&M Rate Increment amount. The E&M Rate Increments are specified in Appendix 3f-1.

VI. VA Rate Increments

The Department will pay ACA Rate Supplements to the PH-MCO as provided by Appendix

3b, Explanation of Capitation Payments, and Appendix 3f-1, Capitation Rates, included in this Agreement. Each ACA Rate Supplement amount is inclusive of a VA Rate Increment amount. The VA Rate Increments are specified in Appendix 3f-1.

VII. E&M Rate Increment Settlement Amount

A. This chart specifies certain amounts that will be used in the calculation below.

January – June 2013	TANF	Healthy Beginnings	SSI and Healthy Horizons	Breast and Cervical Cancer
E&M Procedure Fee Increment	$ 44.05	$ 40.31	$ 50.23	$ 51.01
E&M Excess Utilization Increment	$ 52.45	$ 54.43	$ 50.90	$ 49.97
100% E&M Utilization (per 1,000)	2,570	2,758	3,120	5,003

July – December 2013	TANF, Healthy Beginnings, MAGI	SSI and Healthy Horizons	Breast and Cervical Cancer
E&M Procedure Fee Increment	$ 41.58	$ 48.80	$ 51.93
E&M Excess Utilization Increment	$ 54.34	$ 52.34	$ 49.13
100% E&M Utilization (per 1,000)	2,547	3,007	4,919

January - June 2014	TANF, Healthy Beginnings, MAGI	SSI and Healthy Horizons	Breast and Cervical Cancer
E&M Procedure Fee Increment	$ 39.18	$ 46.37	$ 49.73
E&M Excess Utilization Increment	$ 54.34	$ 52.34	$ 49.13
100% E&M Utilization (per 1,000)	2,547	3,007	4,919

July - December 2014	TANF, Healthy Beginnings, MAGI	SSI and Healthy Horizons	Breast and Cervical Cancer
E&M Procedure Fee Increment	$ 38.40	$ 45.39	$ 49.19
E&M Excess Utilization Increment	$ 55.16	$ 53.32	$ 49.68

100% E&M Utilization (per 1,000)	2,562	3,041	4,969

B. The Department will perform the calculation below for each MA program or program grouping listed in the chart VII.A above and sum each program or program grouping's E&M settlement figure to determine one comprehensive E&M Settlement Amount for each applicable six month period. If the E&M Settlement Amount is a positive number, the Department will initiate payment to the PH-MCO within thirty days of notification of the settlement amount to the PH-MCO. If the E&M Settlement Amount is a negative number, then the absolute value is an obligation of the PH-MCO to the Department. The Department will reduce a subsequent payment by the amount of the obligation. As an alternative, the PH-MCO will pay the amount to the Department upon demand.

C. Calculation of the E&M Settlement:

	E&M units of service, determined by the Department from the PH-MCO's data submission
Multiplied by	E&M Procedure Fee Increment
Equals	Interim Figure A
	E&M units of service reported by the PH-MCO in excess of the Units/1000 Included in the Rates, capped at 105% of the units/1000 Included in the Rates
Multiplied by	E&M Excess Utilization Increment
Equals	Interim Figure B
	E&M Rate Increment
Multiplied by	Member Months
Equals	Interim Figure C
	Interim Figure A
Plus	Interim Figure B
Minus	Interim Figure C
Multiplied by	1.0627
Equals	E&M settlement figure.

VIII. VA Rate Increase Settlement Amount

A. This chart specifies certain amounts that will be used in the calculation below.

January – June 2013	TANF	Healthy Beginnings	SSI and Healthy Horizons	Breast and Cervical Cancer
VA Procedure Fee Increment	$ 13.10	$ 13.16	$ 12.44	$ 12.62
VA Excess Utilization Increment	$ 10.04	$ 9.98	$ 10.70	$ 10.52

100% VA Utilization (per 1,000)	1,166	1,626	328	133

July – December 2013	TANF, Healthy Beginnings, MAGI	SSI and Healthy Horizons	Breast and Cervical Cancer
VA Procedure Fee Increment	$ 12.91	$ 12.14	$ 12.80
VA Excess Utilization Increment	$ 10.23	$ 11.00	$ 10.34
100% VA Utilization (per 1,000)	1,281	317	132

January - June 2014	TANF, Healthy Beginnings, MAGI	SSI and Healthy Horizons	Breast and Cervical Cancer
VA Procedure Fee Increment	$ 12.91	$ 12.14	$ 12.80
VA Excess Utilization Increment	$ 10.23	$ 11.00	$ 10.34
100% VA Utilization (per 1,000)	1,281	317	132

July - December 2014	TANF, Healthy Beginnings, MAGI	SSI and Healthy Horizons	Breast and Cervical Cancer
VA Procedure Fee Increment	$ 12.75	$ 11.93	$ 12.69
VA Excess Utilization Increment	$ 10.39	$ 11.21	$ 10.45
100% VA Utilization (per 1,000)	1,289	320	134

B. The Department will perform the calculation below for each MA program or program grouping listed in the chart VIII.A above and sum each program or program grouping's VA settlement figure to determine one comprehensive VA Settlement Amount for each applicable six month period. If the VA Settlement Amount is a positive number, the Department will initiate payment to the PH-MCO within thirty days of notification of the settlement amount to the PH-MCO. If the VA Settlement Amount is a negative number, then the absolute value is an obligation of the PH-MCO to the Department. The Department will reduce a subsequent payment by the amount of the obligation. As an alternative, the PH-MCO will pay the amount to the Department upon demand.

C. Calculation of the VA Settlement:

VA units of service, determined by the Department from the PH-MCO's data submission
Multiplied by VA Procedure Fee Increment

Equals	Interim Figure A
	VA units of service reported by the PH-MCO in excess of the Units/1000 Included in the Rates, capped at 105% of the units/1000 Included in the Rates
Multiplied by	VA Excess Utilization Increment
Equals	Interim Figure B
	VA Rate Increment
Multiplied by	Member Months
Equals	Interim Figure C
	Interim Figure A
Plus	Interim Figure B
Minus	Interim Figure C
Multiplied by	1.0627
Equals	VA settlement figure.

IX. Claims Notification

A. The PH-MCO will provide the Department with semi-annual files as defined by the Department that include information on applicable services.

B. Each file must include all eligible procedures, including services provided by capitated providers, and must have dates of service within the applicable six month period. This file must contain all data elements as specified by the Department.

C. The PH-MCO may not include an allowance for claims that have not been paid.

D. Each file is due on or before a date specified by the Department, which will be at least six months following the end of the applicable six month period.

E. The Department will include in its calculation only services rendered by a physician who is eligible on the date of service per the Department's current file.

X. Payment to the PH-MCO

A. The Department may subsequently adjust the amount of its obligation to eliminate payment applicable to physicians determined as ineligible. The Department will recover any excess payment that it has made to the PH-MCO.

B. The Department will provide the PH-MCO with written notification and corresponding documentation prior to initiating a payment reduction. The PH-MCO will be afforded the opportunity to review the documentation and provide a written objection to the Department within 30 days from the date of the written notification. The Department will review the written objection and provide a final determination within 15 days. The final determination will be considered the final payment reduction amount, and the Department will offset a future payment in the amount of reduction. Nothing herein shall be construed as waiving the PH-MCO's right to or prohibiting the PH-MCO from further reconsideration of the final payment reduction amount pursuant to the dispute provisions set forth Section XVI of the Agreement.

C. The Department will appropriately adjust the calculations above if Gross Receipts Tax is either altered or eliminated.

XI. Audit or Review

Any payment is subject to appropriate adjustment if an audit or review demonstrates insufficient or inappropriate documentation to support a claims notification submitted to the Department.

Exhibit B (3)
Provider Pay for Performance Program

The Provider Pay-for-Performance (P4P) program described in this Exhibit B (3) is for services rendered by providers during a Calendar Year (CY) and defined in your PH-MCO specific Quality Performance Program approved by the Department

A. Provider P4P Program Requirements

All Provider P4P programs must target improvements in the quality of or access to health care services for HealthChoices members and must not limit the appropriate use of services by members.

Quality Performance Program (QPP):

a. The PH-MCO is required to develop a QPP using the following **mandatory** ten (10) HEDIS Quality Measures (per HEDIS® 2014 Technical Specifications, Vol. 2):
   i. Comprehensive Diabetes Measure: Hemoglobin A1c (HbA1c) Screening for People with Diabetes
   ii. Prenatal Care in the First Trimester
   iii. Frequency of Ongoing Prenatal Care: ≥ 81% of expected visits
   iv. Postpartum Care
   v. Adolescent Well-Care Visits
   vi. Annual Dental Visit (Ages 2 – 21 years)
   vii. Controlling High Blood Pressure (Ages 18 – 85)
   viii. Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C < 100 mg/dL
   ix. Comprehensive Diabetes Care: HbA1c Control (<8.0%)
   x. Comprehensive Diabetes Care: Cholesterol Management in People with Diabetes (LDL-C < 100mg/dL)

b. The PH-MCO has the option of including any or all of the following **optional** five (5) HEDIS Quality Measures:
   i. Breast Cancer Screening (Ages 50 – 74)
   ii. Cervical Cancer Screening (Ages 21 – 64)
   iii. Emergency Room (ER) Utilization
   iv. Lead Screening in Children
   v. Payment for electronic submission of mandatory and optional measures

c. As an additional option, the Department may approve the use of a portion of Provider P4P funds for use in Community Based Care Management activities.

d. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its QPP. PH-MCO must complete and submit proposals using Exhibit B (3)(b), the QPP Submission Template. Proposals are due no later than October 1, 2013.

    i. The QPP proposal must include:
        1. A detailed description of the program, including the mandatory HEDIS Quality Measures and any optional HEDIS Quality Measures;
        2. Targeted providers for each measure;
        3. Proposed payout amount and payout schedule to provider(s) for each specific mandatory and optional HEDIS Quality Measure;
        4. Description of the specific requirements the provider(s) must complete to receive the incentive;
        5. How Provider(s) success or compliance will be measured;
        6. How the MCO will evaluate the effectiveness of its Provider P4P program; and
        7. PH-MCO single point of contact name, email and phone number responsible for submission of Exhibit B (3)(a), Provider P4P Submission Change form; and
        8. Attestation from the Medical Director.

    ii. The PH-MCO must submit a supplemental community based care management plan, as an Addendum to the PH-MCO's QPP. The Addendum should include both a narrative explanation of each proposed community based care management activity, and a projected budget that corresponds to each activity.

A PH-MCO's approved QPP will remain in effect until December 31 of each calendar year. The PH-MCO may submit quarterly revisions only to the provider payout amounts for the Department's review and approval. The PH-MCO must complete and submit Exhibit B (3)(a), Provider P4P Submission Change Form. Payout revisions must be submitted no later than close of business on the last day of each calendar quarter. No other revisions to the QPP will be accepted.

The PH-MCO must annually evaluate the effectiveness of its approved QPP. The results of this analysis must be submitted to the Department no later than December 31st of the subsequent calendar year to PW.QualityManagement@pa.gov. The analysis must include, at a minimum, the following:

- Methodology used to notify providers of the program
- Policies, procedures or workflows used to identify providers eligible for the incentives;
- Processes used to identify and reconcile duplicate claims/encounters;

- Processes for data submission;
- Detailed explanation of the processes used to verify and audit data for accuracy and completeness from the time the claim/encounter is submitted until the provider payout is made;
- Strengths and areas of opportunities of the QPP; and
- Identify next steps.

The Department may request that PH-MCOs share QPP findings with other HealthChoices PH-MCOs to identify best practices and improve the overall HealthChoices program.

B. Provider P4P Program Funding

The Department will make quarterly payments based on a per member per month (PMPM) rate, noted in Appendix 3f. This payment is separate from the monthly capitation process, as identified in Appendix 3b, and will be made via Gross Adjustment. The Department will process a payment in the second subsequent month following the quarter end.

The Department will make these payments only to the extent that adequate funds are included for the purpose of these Exhibit B (3) payments to all PH-MCOs in the Commonwealth's enacted budget for the capitation appropriation.

If this payment is subject to the Gross Receipts Tax (GRT), the payment amount will increase by 6.27%. This increase recognizes the legitimate and marginal administrative cost to the PH-MCO of this tax. If the Department has notified the PH-MCO that the GRT is reduced or ended, upon advance written notice to the PH-MCO, the increase to the Provider P4P payment for GRT will be appropriately reduced or ended.

Payments made to the PH-MCO under the Provider P4P program are intended to fund all mandatory measures first prior to funding optional measures and/or Community Based Care Management activities, or as approved by the Department.

If the PH-MCO has unspent Provider P4P funds after all final disbursements have been made for the approved QPP above, upon advanced written notice to the PH-MCO, the Department may reduce a future Provider P4P payment by the unspent amount.

If at any time the Department determines Provider P4P funds were not disbursed in accordance with the approved QPP above, upon advanced written notice to the PH-MCO, the Department may elect to reduce a future Provider P4P payment by the amount identified.

C. Provider P4P Program Payments to Providers

All Provider P4P funds received from the Department for this HealthChoices Agreement should be paid to network providers in accordance with the approved QPP above.

The PH-MCO is required to develop and maintain a separate accounting process of the receipts and disbursements of Provider P4P funds. The PH-MCO must be able to separately identify and track each payment to a provider on a per-claim basis for each specific mandatory and optional HEDIS Quality Measure identified in the QPP. If the Department has approved the use of Provider P4P funds for Community Based Care Management in the QPP above, the PH-MCO must be able to provide acceptable source documentation that demonstrates total funds expended per selected facility and/or PCP office.

Each PH-MCO may determine the frequency of issuing payments to its providers. However, the Department recommends, at a minimum, quarterly payouts. The PH-MCO must issue Provider P4P payments to its providers for services rendered under approved terms of this Exhibit B (3) to be paid out in full no later than June 30 of the subsequent calendar year.

D. Reporting

The PH-MCO is required to meet the Department's reporting requirements relative to Annual Report #40 (Provider P4P). Instructions for completing Annual Report #40 can be found in the applicable Financial Reporting and Requirements issued separately by the Department.

E. Clinical Review

The Department may choose to perform a clinical review of the Pay-for-Performance program. The PH-MCO must reasonably cooperate with Department staff during the clinical review process.