Copy-ID:		GRANT Number:	SAP 4000014647

PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

GRANT AGREEMENT AMENDMENT #8

PURPOSE OF THE GRANT:	To provide Mandatory Managed Care Services to Medicaid consumers in the following counties: Bucks, Chester, Delaware, Montgomery and Philadelphia.

AWARD TO:

NAME AND ADDRESS:	Mail fully executed agreement to:
Jason Rottman, CEO Aetna Better Health, Inc. 2000 Market Street, Suite 850 Philadelphia, PA 19103 Rottmanj@Aetna.com TELEPHONE NUMBER: 207-272-3608	Nancy Hardy, Senior Director Of Medicaid Operations Aetna Better Health, Inc. 1425 Union Meeting Road Blue Bell, PA 19440 nlhardy@Aetna.com TELEPHONE NUMBER: 215-282-3503

FEDERAL I.D. NUMBER: 27-0563973

HEALTHCHOICES SOUTHEAST PHYSICAL HEALTH AGREEMENT
No. 4000014647 Amendment # 8

THIS Amendment to Grant Agreement No. 4000014647 (the "Amendment") is made this 28th day of July 2015 by and between the Commonwealth of Pennsylvania, acting through its Department of Public Welfare (the "Department") and Aetna Better Health Inc., a Pennsylvania corporation, with its principal place of business at 2000 Market Street, Suite 850, Philadelphia, PA 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. 4000014647 effective April 1, 2010 (the "Grant Agreement");

WHEREAS, the purpose of the Grant Agreement is to provide for a mandatory managed care program, under the name HealthChoices Southeast Physical Health Program (the "HC-SE Physical Health Program") for Medical Assistance (MA) consumers in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties (the "HC-SE Counties");

WHEREAS, the Department desires to amend the Grant Agreement and certain appendices and exhibits; 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 replaced in its entirety with the amended and restated Grant Agreement attached hereto, which includes:

a. Effective January 1, 2015, Appendix 3b Explanation of Capitation Payments (dated August 18, 2014) is replaced with the attached Appendix 3b Explanation of Capitation Rates (dated April 6, 2015).
b. Effective January 1, 2015, Appendix 3d Risk Corridor (dated December 12, 2014) is replaced with the attached Appendix 3d Risk Corridor (dated April 12, 2015).
c. For services provided on or after January 1, 2015, Appendix 3f Capitation Rates (Prepared on February 13, 2015) is replaced with the attached Exhibit 3f Capitation Rates (Prepared on March 30, 2015).
d. For services provided on or after January 1, 2015, Appendix 3f-1 (Prepared on December 2, 2013) is removed from the Grant Agreement.
e. Effective January 1, 2015, Appendix 3k, High Cost Risk Pool (dated December 12, 2014) is replaced with the attached Appendix 3k, High Cost Risk Pool (dated May 7, 2015).

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

GRANTEE

SIGNATURE
Pamela S. Sedmak, CEO and President

SIGNATURE
Debra J. Bacon, Assistant Treasurer

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

Program Deputy Secretary

SIGNATURE

Secretary

SIGNATURE

MAY 2 8 2015

COMPTROLLER OPERATIONS

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

AMOUNT	SOURCE	APPROPRIATION SYMBOL	PROGRAM

SIGNATURE COMPTROLLER OPERATIONS 7/28/15

Approved as to Legality and Form:

OFFICE OF LEGAL COUNSEL
DEPARTMENT OF PUBLIC WELFARE
6/23/15

DEPUTY ATTORNEY GENERAL
OFFICE OF ATTORNEY GENERAL
(when required) 7/16/15

DEPUTY GENERAL COUNSEL
OFFICE OF GENERAL COUNSEL
(when required)

f. Effective January 1, 2015, Appendix 14, APR/DRG Adjustment Inpatient Acute Care Services (dated February 17, 2015) is replaced with the attached Appendix 14, APR/DRG Adjustment Inpatient Acute Care Services (dated March 17, 2015).
g. Effective January 1, 2015, the following exhibits are replaced: Exhibit A and Exhibit Z.

2. The attached Appendix 3b, Appendix 3d, Appendix 3f, Appendix 3k, Appendix 14, Exhibit A and Exhibit Z 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.

HEALTHCHOICES PHYSICAL HEALTH AGREEMENT

BETWEEN

COMMONWEALTH OF PENNSYLVANIA

AND

AETNA BETTER HEALTH, INC.

HEALTHCHOICES AGREEMENT

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SECTION I: INCORPORATION OF DOCUMENTS

A. Operative Documents

The RFP, a copy of which is attached hereto as Appendix 1, and the Proposal, a copy of which is attached hereto as Appendix 2, are incorporated herein and are made a 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, are inconsistent with, or are in addition to the terms of the RFP, the terms of this Agreement shall govern;

2. In the event that any of the terms of this Agreement conflict with, are inconsistent with, or are in addition to the terms of the Proposal, the terms of this Agreement shall govern;

3. In the event that any of the terms of the RFP conflict with, are inconsistent with, or are in addition to the terms of the Proposal, the terms of the RFP 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.

B. Operational Updates and Department Communications

1. Managed Care Operations Memos (MC OPS Memos)

In addition to normal correspondence between the Department and the PH-MCO, the Department will issue MC OPS Memos via the

HealthChoices Intranet. These MC OPS Memos will be issued to provide clarifications to requirements pertaining to HealthChoices.

2. HealthChoices Intranet

MC OPS Memos are available on the HealthChoices Intranet at http://healthchoices.dpw.state.pa.us. Access to the site is gained from a POSNet Personal Computer with Windows 95 and an active web browser, preferably Internet Explorer. To access the HealthChoices Intranet, Internet connectivity is not required.

Additionally, the HealthChoices Intranet Systems site contains current information on managed care systems policies and procedures, which include but are not limited to, information on eligibility, Enrollment and reimbursement procedures, and Encounter Data submission requirements. It also contains information on pending changes.

PH-MCOs must routinely check the HealthChoices Intranet. OPS Memos and Intranet notices are vehicles to clarify operational policies and procedures and are not intended to amend the terms of the Agreement.

3. DPW Web Site

MA Bulletins, RFPs, Program information and other Department communications are available on the DPW Web site at http://www.dpw.state.pa.us/.

SECTION II: DEFINITIONS

Abuse — Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the MA Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Agreement, and the requirements of state or federal regulations) for health care in a managed care setting. The Abuse can be committed by the PH-MCO, subcontractor, Provider, State employee, or a Member, among others. Abuse also includes Member practices that result in unnecessary cost to the MA Program, the PH-MCO, a subcontractor, or Provider.

ACCESS Card — An identification card issued by the Department to each MA Recipient. The card must be used by MA-enrolled Health Care Providers to access the Department's EVS and verify the Recipient's MA eligibility and specific covered benefits.

Actuarially Sound Rates — Rates that reflect, among other elements:

- the populations and benefits to be covered;
- the rating groups;
- the projected member months for each category of aid;
- the historical and projected future medical costs expected to be incurred by an efficiently and effectively operated Medicaid managed care program in the respective county/zone;
- program changes to the extent they impact actuarial soundness of the rates;
- trend levels for each type of service;
- administrative costs expected to be incurred by an efficiently and effectively operated Medicaid managed care program, including assessment costs and profit consideration.

Actuarially sound rates are developed using sound methods and assumptions, that are reasonably attainable by the Medicaid Managed Care Organizations in the relevant Agreement year and meet the standards of the Actuarial Standards Board.

Adjudicated Claim — A Claim that has been processed to payment or denial.

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 PH-MCO 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 PH-MCO or its parent(s), directors or subsidiaries of PH-MCO or parent(s) shall be presumed to be Affiliates for purposes of the RFP 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.

Alternate Payment Name — The person to whom benefits are issued on behalf of a Recipient.

Amended Claim — A Provider request to adjust the payment of a previously Adjudicated Claim. A Provider Appeal is not an Amended Claim.

Area Agency on Aging (AAA) — The single local agency designated by the Pennsylvania Department of Aging within each planning and service area to administer the delivery of a comprehensive and coordinated plan of social and other services and activities.

Behavioral Health Managed Care Organization (BH-MCO) — An entity, operated by county government or licensed by the Commonwealth as a risk-bearing Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), which manages the purchase and provision of Behavioral Health Services under an agreement with the Department.

Behavioral Health Rehabilitation Services (BHRS) for Children and Adolescents (formerly EPSDT "Wraparound") — Individualized, therapeutic mental health, substance abuse or behavioral interventions/services developed and recommended by an interagency team and prescribed by a physician or licensed psychologist.

Behavioral Health (BH) Services — Mental health and/or drug and alcohol services which are provided by the BH-MCO.

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

Capitation — A fee the Department pays periodically to a PH-MCO for each Recipient enrolled in its managed care plan to provide coverage of medical services, whether or not the Recipient receives the services during the period covered by the fee.

Case Management Services — Services which will assist individuals in gaining access to necessary medical, social, educational and other services.

Case Payment Name — The person in whose name benefits are issued.

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

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

Certified Nurse Midwife — An individual licensed under the laws within the scope of Chapter 6 of Professions & Occupations, 63 P.S. 171-176.

Certified Registered Nurse Practitioner (CRNP) — A registered nurse licensed in the Commonwealth of Pennsylvania who is certified by the boards in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania.

Children in Substitute Care — Children who have been adjudicated dependent or delinquent and who are in the legal custody of a public agency and/or under the jurisdiction of the juvenile court and are living outside their homes, in any of the following settings: shelter homes, foster homes, group homes, supervised independent living, and Residential Treatment Facilities for Children (RTFs).

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 that can be processed without obtaining additional information from the Provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in the PH-MCO's Claims system. Claims under investigation for Fraud or Abuse or under review to determine if they are Medically Necessary are not Clean Claims.

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

Community Provider — Private and public service organizations, that are not part of the PH-MCO's Provider Network, with which the PH-MCO coordinates Out-of-Plan Services for their Members.

Complaint — A dispute or objection regarding a participating Health Care Provider or the coverage, operations, or management policies of a Physical Health Managed Care Organization (PH-MCO), which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with the Department of Health or the Pennsylvania Insurance Department of the Commonwealth, including but not limited to:

- a denial because the requested service/item is not a covered benefit; or
- a failure of the PH-MCO to meet the required time frames for providing a service/item; or
- a failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames; or
- a denial of payment by the PH-MCO after a service has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or

- a denial of payment by the PH-MCO after a service has been delivered because the service/item provided is not a covered service/item for the Member.

The term does not include a Grievance.

Concurrent Review — A review conducted by the PH-MCO during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether any service, a different service or lesser level of service is Medically Necessary.

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

Cultural Competency — The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

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

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

Denial of Services — Any determination made by the PH-MCO 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 PH-MCO 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 — The Department of Public Welfare (DPW) of the Commonwealth of Pennsylvania.

Deprivation Qualifying Code — The code specifying the condition which determines a Recipient to be eligible in nonfinancial criteria.

Developmental Disability — A severe, chronic disability of an individual that is:

- Attributable to a mental or physical impairment or combination of mental or physical impairments.

- Manifested before the individual attains age twenty-two (22).

- Likely to continue indefinitely.

- Manifested in substantial functional limitations in three or more of the following areas of life activity:
  - Self care;
  - Receptive and expressive language;
  - Learning;
  - Mobility;
  - Capacity for independent living; and
  - Economic self-sufficiency.

- Reflective of the individual's need for special, interdisciplinary or generic services, supports, or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in Developmental Disabilities if services are not provided.

Disease Management — An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

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

DPW Fair Hearing — A hearing conducted by the Department of Public Welfare, Bureau of Hearings and Appeals.

Drug Efficacy Study Implementation (DESI) — Drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA).

Dual Eligibles — An individual who is eligible to receive services through both Medicare and the MA Program (Medicaid). Dual Eligibles age 21 and older and who have Medicare, Part D, will no longer participate in HealthChoices.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) — Items and services which must be made available to persons under the age of twenty-one (21) upon a determination of medical necessity and required by federal law at 42 U.S.C. §1396d(r).

Early Intervention Program — The provision of specialized services through family-centered intervention for a child, birth to age three (3), who has been determined to have a developmental delay of twenty-five percent (25%) of the child's chronological age or has documented test performance of 1.5 standard deviation below the mean in standardized tests in one or more areas: cognitive development; physical development, including vision and hearing; language and speech development; psycho-social development; or self-help skills or has a diagnosed condition which may result in developmental delay.

Eligibility Period — A period of time during which a consumer is eligible to receive MA benefits. An Eligibility Period is indicated by the eligibility start and end dates on CIS. A blank eligibility end date signifies an open-ended Eligibility Period.

Eligibility Verification System (EVS) — An automated system available to MA Providers and other specified organizations for automated verification of MA Recipients' current and past (up to three hundred sixty-five [365] days) MA eligibility, PH-MCO Enrollment, PCP assignment, Third Party Resources, and scope of benefits.

Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

Emergency Member Issue — A problem of a PH-MCO Member (including problems related to whether an individual is a Member), the resolution of which should occur immediately or before the beginning of the next Business Day in order to prevent a denial or significant delay in care to the Member that could precipitate an Emergency Medical Condition or need for urgent care.

Emergency Services — Covered inpatient and outpatient services that: (a) are furnished by a Provider that is qualified to furnish such service under Title XIX of

the Social Security Act and (b) are needed to evaluate or stabilize an Emergency Medical Condition.

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

Encounter Data — A record of any covered health care service provided to a PH-MCO 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 PH-MCO is initiated.

Enrollment Assistance Program (EAP) — The program that provides Enrollment Specialists to assist Recipients in selecting the PH-MCO and Primary Care Practitioner (PCP) and in obtaining information regarding HealthChoices Physical and Behavioral Health Services and service Providers.

Enrollment Specialist — The individual responsible to assist Recipients with selecting a PH-MCO and PCP as well as providing information regarding Physical and Behavioral Health Services and service Providers under the HealthChoices Program.

Expanded Services — Any Medically Necessary service, covered under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., but not included in the State's Medicaid Plan, which is provided to Members.

Experimental Treatment — A course of treatment, procedure, device or other medical intervention that is not yet recognized by the professional medical community as an effective, safe and proven treatment for the condition for which it is being used.

External Quality Review (EQR) — A requirement under Section 1902(a)(30)(C) of Title XIX of the Social Security Act, 42 U.S.C. 1396u-2(c)(2) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations, including the evaluation of quality outcomes, timeliness and access to services.

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.

Fee-for-Service (FFS) — Payment by the Department to Providers on a per-service basis for health care services provided to Recipients.

Formulary — An exclusive list of drug products for which the Contractor must provide coverage to its Members, as approved by the Department.

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. The Fraud can be committed by many entities, including the PH-MCO, a subcontractor, a Provider, a State employee, or a Member, among others.

Generally Accepted Accounting Principles (GAAP) — A technical term in financial accounting. It encompasses the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time.

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

Grievance — A request to have a PH-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding a PH-MCO decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item. 5) deny a request for a benefit limit exception (BLE).
The term does not include a Complaint.

Health Care-Associated Infection — A localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that:

1) occurs in a patient in a health care setting; and
2) was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting; and

3) if occurring in a hospital setting, meets the criteria for a specific infection site as defined by the Centers for Disease Control and Prevention and its National Healthcare Safety Network.

Health Care Provider — A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist or an individual accredited or certified to provide behavioral health services.

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.

HealthChoices Disenrollment — Action taken by the Department to remove a Member's name from the monthly Enrollment Report following the Department's receipt of a determination that the Member is no longer eligible for Enrollment in HealthChoices.

HealthChoices Program — The name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to Recipients.

HealthChoices Zone (HC Zone) — A multiple-county area in which the HealthChoices Program has been implemented to provide mandatory managed care to Medicaid Recipients in Pennsylvania.

HIV/AIDS Waiver Program — A Home and Community Based Waiver Program that provides for Expanded Services to Recipients who are diagnosed with Acquired Immunodeficiency Syndrome (AIDS) or symptomatic Human Immunodeficiency Virus (HIV) as a cost-effective alternative to inpatient care.

Home and Community Based Waiver Program — Necessary and cost effective services, not otherwise furnished under the State's Medicaid Plan, or services already furnished under the State's Medicaid Plan but in expanded amount, duration, or scope which are furnished to an individual in his/her home or community in order to prevent institutionalization. Such services must be authorized under the provisions of 42 U.S.C. 1396n.

Immediate Need — A situation in which, in the professional judgment of the dispensing registered pharmacist and/or prescriber, the dispensing of the drug at the time when the prescription is presented is necessary to reduce or prevent the occurrence or persistence of a serious adverse health condition.

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 payment responsibility of the PH-MCO under the HealthChoices Program.

Inquiry — Any Member's request for administrative service, information or to express an opinion.

Intellectual Disability — An impairment in intellectual functioning which is lifelong and originates during the developmental period (birth to twenty-two (22) years). It results in substantial limitations in three or more of the following areas: learning, self-direction; self care; expressive and/or receptive language; mobility; capacity for independent living; and economic self-sufficiency.

Interagency Team for Adults — A multi-system planning team consisting of the individual, family member(s), legal guardian, advocate(s), county mental health/Mental Retardation and/or drug and alcohol case manager(s), PCP, treating specialist(s), residential and/or day service Provider(s) and any other participant(s) necessary and appropriate to assess the needs and strengths of the individual, formulate treatment and service goals, approaches and methods, recommend and monitor services and develop discharge plans. Representation on the team is based on expertise necessary to determine and meet each individual's needs and, therefore, is developed on a case-by-case basis.

Interagency Team for Individuals Under the Age of Twenty-One (21) — A multi-system planning team comprised of the child, when appropriate, at least one (1) accountable family member, a representative of the County Mental Health and/or Drug and Alcohol Program, the case manager, the prescribing physician or psychologist, and as applicable, the County Children and Youth, Juvenile Probation, Mental Retardation, and Drug and Alcohol agencies, a representative of the school district, BH-MCO, PH-MCO and/or PCP, other agencies that are providing services to the child, and other community resource persons identified by the family. The purpose of the interagency team is to collaboratively assess the needs and strengths of the child and family, formulate the measurable goals for treatment, recommend the services, treatment approaches and methods, intensity and frequency of interventions and develop the discharge goals and plans.

Intermediate Care Facility for the Intellectually Disabled and Other Related Conditions (ICF/ ID/ORC) — An institution (or distinct part of an institution) that 1) is primarily for the diagnosis, treatment or rehabilitation for persons with Intellectually Disabilities or persons with Other Related Conditions; and 2)

provides, in a residential setting, ongoing evaluation, planning, twenty-four (24) hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his/her maximum capacity.

Issuing Office — The Department's Division of Procurement.

Juvenile Detention Center (JDC) — A publicly or privately administered, secure residential facility for:

- Children alleged to have committed delinquent acts who are awaiting a court hearing;

- Children who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and

- Children who have been returned from some other form of disposition and are awaiting a new disposition (i.e., court order regarding custody of child, placement of child, or services to be provided to the child upon discharge from the Juvenile Detention Center).

Lock-In — If a Recipient is involved in fraudulent activities or is identified as abusing services provided under the MA Program, they are restricted (locked-in) to a specific Provider(s) to obtain all of his/her services in an attempt to ensure appropriately managed care.

Managed Care Organization (MCO) — An entity which manages the purchase and provision of Physical or Behavioral Health Services under the HealthChoices Program.

Market Share — The percentage of Members enrolled with a particular PH-MCO when compared to the total of Members enrolled in all the PH-MCOs within a HealthChoices Zone.

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 of Public Welfare.

Medicaid Eligibility Determination Automation (MEDA) — Part of the Client Information System (CIS) that automates the determination of Medicaid eligibility.

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.

Medical Assistance Transportation Program (MATP) — A non-emergency medical transportation service provided to eligible persons who need to make trips to/from a MA reimbursable service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

Medically Necessary — A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member's family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

Member — An individual who is enrolled with a PH-MCO under the HealthChoices Program and for whom the PH-MCO has agreed to arrange the provision of Physical Health Services under the provisions of the HealthChoices Program.

Member Record — A record contained on the Daily Membership File or the Monthly Membership File that contains information on MA eligibility, managed care coverage, and the category of assistance, which help establish the covered services for which a Recipient is eligible.

Midwifery Practice — Management of the care of essentially healthy women and their healthy neonates (initial twenty-eight [28] day period). This includes intrapartum, postpartum and gynecological care.

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

Network — All contracted or employed Providers in the PH-MCO who are providing covered services to Members.

Network Provider — A Medical Assistance enrolled Health Care Provider who has a written Provider Agreement with and is credentialed by a HealthChoices PH-MCO and who participates in the PH-MCO's Provider Network to serve HealthChoices Members.

Net Worth (Equity) — The residual interest in the assets of an entity that remains after deducting its liabilities.

Non-participating Provider — A provider, whether a person, firm, corporation or other entity, either not enrolled in the Pennsylvania MA Program or not participating in the PH-MCO's Network, which provides medical services or supplies to PH-MCO Members.

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

OMAP Hotlines — The PH-MCO will cooperate with the functions of OMAP's Hotlines, which are designed to address clinically-related systems issues encountered by Recipients and their advocates or Providers. The OMAP Hotlines facilitate resolution according to PH-MCO policies and procedures and do not impose additional obligations on the PH-MCO.

Ongoing Medication — A medication that has been previously dispensed to the Member for the treatment of an illness that is chronic in nature or for an illness for which the medication is required for a length of time to complete a course of

treatment, until the medication is no longer considered necessary by the physician/prescriber, and that has been used by the Member without a gap in treatment. If the current prescription is for a higher dosage than previously prescribed, the prescription is for an Ongoing Medication at least to the extent of the previous dosage. When payment is authorized due to the obligation to cover pre-existing services while a Grievance or DPW Fair Hearing is pending, a request to refill that prescription, made after the Grievance or DPW Fair Hearing has been finally concluded in favor of the MCO, is not an Ongoing Medication.

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

OPTIONS — The long-term care pre-admission assessment program administered by the Department of Aging.

Other Related Conditions (ORC) — A physical disability such as cerebral palsy, epilepsy, spina bifida or similar conditions which occur before the age of twenty-two (22), is likely to continue indefinitely and results in three (3) or more substantial functional limitations.

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-Area Covered Services — Medical services provided to Recipients under one (1) or more of the following circumstances:

- An Emergency Medical Condition that occurs while outside the HealthChoices Zone covered by this Agreement;

- The health of the Recipient would be endangered if the Recipient returned to the HealthChoices Zone covered by this Agreement for needed services;

- The Provider is located outside the HealthChoices Zone, but nonetheless regularly provides medical services to Recipients at the request of the PH-MCO; or

- The needed medical services are not available in the HealthChoices Zone.

Out-of-Network Provider — A Health Care Provider who has not been credentialed by and does not have a signed Provider Agreement with a HealthChoices PH-MCO.

Out-of-Plan Services — Services which are non-plan, non-capitated and are not the responsibility of the PH-MCO under the HealthChoices Program comprehensive benefit package.

Pennsylvania Open Systems Network (POSNet) — A peer-to-peer network based on open systems products and protocols that was previously used for the transfer of information between the Department and the MCOs. The Department is currently using Information Resource Management (IRM) Standards.

Physical Health Managed Care Organization (PH-MCO) — A risk bearing entity which has an agreement with the Department to manage the purchase and provision of Physical Health Services under the HealthChoices Program.

PH-MCO Coverage Period — A period of time during which an individual is eligible for MA coverage and enrolled with a PH-MCO and which exists on CIS.

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

Physician Incentive Plan — Any compensation arrangement between an MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid Recipients enrolled in the MCO.

Post-Stabilization Services — Medically Necessary non-emergency services furnished to a Member after the Member is stabilized following an Emergency Medical Condition.

Preferred Provider Organization (PPO) — A Commonwealth licensed person, partnership, association or corporation which establishes, operates, maintains or underwrites in whole or in part a preferred provider arrangement as defined in 31 Pa. Code 152.2.

Primary Care Case Management (PCCM) — A program under which the Primary Care Practitioners agree to be responsible for the provision and/or coordination of medical services to Recipients under their care.

Primary Care Practitioner (PCP) — A specific physician, physician group or a CRNP operating under the scope of his/her licensure, and who is 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 Recipient.

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

Prior Authorization — A determination made by the PH-MCO 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.

Prior Authorization Review Panel (PARP) — A panel of representatives from within the Department who have been assigned organizational responsibility for the review, approval and denial of all PH-MCO Prior Authorization policies and procedures.

Prior Authorized Services — In-Plan Services, the utilization of which the PH-MCO manages in accordance with Department-approved Prior Authorization policies and procedures.

PROMISe™ Provider ID — A 13-digit number consisting of a combination of the 9-digit base MPI Provider Number and a 4-digit service location.

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

Provider Agreement — Any Department-approved written agreement between the PH-MCO and a Provider to provide medical or professional services to Recipients to fulfill the requirements of this Agreement.

Provider Appeal — A request from a Provider for reversal of a denial by the PH-MCO, with regard to the three (3) major types of issues that are to be addressed in a Provider Appeal system as outlined in this Agreement at Section V.K, Provider Dispute Resolution System. The three (3) types of Provider Appeals issues are:

- Provider credentialing denial by the PH-MCO;
- Claims denied by the PH-MCO for Providers participating in the PH-MCO's Network. This includes payment denied for services already rendered by the Provider to the Member; and
- Provider Agreement termination by the PH-MCO.

Provider Dispute — A written communication to a PH-MCO, made by a Provider, expressing dissatisfaction with a PH-MCO decision that directly impacts the Provider. This does not include decisions concerning medical necessity.

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

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

Recipient — A person eligible to receive Physical and/or Behavioral Health Services under the MA Program of the Commonwealth of Pennsylvania.

Recipient Month — One Recipient covered by the HealthChoices Program for one (1) calendar month.

Rejected Claim — A non-claim that has erroneously been assigned a unique identifier and is removed from the claims processing system prior to adjudication.

Related Parties — Any entity that is an Affiliate of the PH-MCO or subcontracting PH-MCO and (1) performs some of the PH-MCO or subcontracting PH-MCO'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 PH-MCO or subcontracting PH-MCO at a cost of more than $2,500.00 during any year of a HealthChoices physical health contract with the Department.

Residential Treatment Facility (RTF) — A facility licensed by the Department of Public Welfare that provides twenty-four (24) hour out-of-home care, supervision and Medically Necessary mental health services for individuals under twenty-one (21) years of age with a diagnosed mental illness or severe emotional disorder.

Retrospective Review — A review conducted by the PH-MCO to determine whether services were delivered as prescribed and consistent with the PH-MCO’s payment policies and procedures.

Routine Care — Care for conditions that generally do not need immediate attention and minor episodic illnesses that are not deemed urgent. This care may lead to prevention or early detection and treatment of conditions. Examples of preventive and routine care include immunizations, screenings and physical exams.

School-Based Health Center — A health care site located on school building premises which provides, at a minimum, on-site, age-appropriate primary and preventive health services with parental consent, to children in need of primary health care and which participates in the MA Program and adheres to EPSDT standards and periodicity schedule.

School-Based Health Services — An array of Medically Necessary health services performed by licensed professionals that may include, but are not

limited to, immunization, well child care and screening examinations in a school-based setting.

Special Needs — The circumstances for which a Member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of physical, developmental, emotional or behavioral conditions, as determined by DPW and as described in this Agreement at Section V.P, Special Needs Unit (SNU) and Exhibit NN, Special Needs Unit.

Special Needs Unit — A special dedicated unit within the PH-MCO's and the EAP contractor's organizational structure established to deal with issues related to Members with Special Needs.

Start Date — The first date on which Recipients are eligible for medical services under this Agreement, and on which the PH-MCOs are operationally responsible and financially liable for the provision of Medically Necessary services to Recipients.

Step Therapy — A form of automated Prior Authorization whereby one or more prerequisite medications, which may or may not be in the same drug class, must be tried first before a Step Therapy medication will be approved

Stop-Loss Protection — Coverage designed to limit the amount of financial loss experienced by a Health Care Provider.

Subcapitation — A fixed per capita amount that is paid by the PH-MCO 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 PH-MCO and an individual, business, university, governmental entity, or nonprofit organization to perform part or all of the PH-MCO's responsibilities under this Agreement. Exempt from this definition are salaried employees, utility agreements and Provider Agreements, which are not considered Subcontracts for the purpose of this Agreement and, unless otherwise specified herein, are not subject to the provisions governing Subcontracts.

Sustained Improvement — Improvement in performance documented through continued measurement of quality indicators after the performance project/study/quality initiative is completed.

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.

Targeted Case Management (TCM) Program — A case management program for Recipients who are diagnosed with AIDS or symptomatic HIV.

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 PH-MCO.

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 Recipient. Examples of Third Party Resources include: government insurance programs such as Medicare or CHAMPUS (Civilian Health and Medical Program of the Uniformed Services); private health insurance companies, or carriers; liability or casualty insurance; 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.

Transitional Care Home — A tertiary care center which provides medical and personal care services to children upon discharge from the hospital who require intensive medical care for an extended period of time. This transition allows for the caregiver to be trained in the care of the child, so that the child can eventually be placed in the caregiver's home.

Urgent Medical Condition — Any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The term also includes situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

Utilization Management (UM) — An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.

Utilization Review Criteria — Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but

not limited to, level of care, place of service, scope of service, and duration of service.

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

AGREEMENT and RFP ACRONYMS

For the purpose of this Agreement and RFP, the acronyms set forth shall apply.

AAA — Area Agency on Aging.
ACA — Affordable Care Act
AIDS — Acquired Immunodeficiency Syndrome.
ADA — Americans with Disabilities Act.
BBS — Bulletin Board System.
BH — Behavioral Health.
BHA — Bureau of Hearings and Appeals.
BH-MCO — Behavioral Health Managed Care Organization.
BMWBO — Bureau of Minority and Women Business Opportunities.
CAHPS — Consumer Assessment of Healthcare Providers and Systems.
CAO — County Assistance Office.
CASSP — Children and Adolescent Support Services Program.
CD --- Compact disc
CDC — Centers for Disease Control (and Prevention).
CFO — Chief Financial Officer.
CFR — Code of Federal Regulations.
CHAMPUS — Civilian Health and Medical Program of the Uniformed Services.
CIS — Client Information System.
CLIA — Clinical Laboratory Improvement Amendment.
CLPPP — Childhood Lead Poisoning Prevention Project.
CME — Continuing Medical Education.
CMN — Certificate of Medical Necessity.
CMS — Centers for Medicare and Medicaid Services.
CNM — Certified Nurse Midwife.
COB — Coordination of Benefits.
CSP — Community Support Program.
CRNP — Certified Registered Nurse Practitioner.
CRR — Community Residential Rehabilitation.
DEA — Drug Enforcement Agency.
DESI —Drug Efficacy Study Implementation.
DME — Durable Medical Equipment.
DOH — Department of Health (of the Commonwealth of Pennsylvania).
DPW — Department of Public Welfare.
DRA — Deficit Reduction Act.
DRG — Diagnosis Related Group.
DSH — Disproportionate Share Hospital.
DUR — Drug Utilization Review.
EAP — Enrollment Assistance Program.
EMS — Emergency Medical Services.
EOB — Explanation of Benefits.
EQR — External Quality Review.
EQRO — External Quality Review Organization.

EVS — Eligibility Verification System.
EPSDT — Early and Periodic Screening, Diagnosis and Treatment.
ER — Emergency Room.
ERISA — Employees Retirement Income Security Act of 1974.
FDA — Food and Drug Administration.
FFP — Federal Financial Participation.
FFS — Fee-for-Service.
FQHC — Federally Qualified Health Center.
FTE — Full Time Equivalent.
FTP — File Transfer Protocol.
GA — General Assistance.
GAAP — Generally Accepted Accounting Principles.
GME — Graduate Medical Education.
HBP — Healthy Beginnings Plus.
HCRP — High Cost Risk Pool.
HCRPAA — High Cost Risk Pool Allocation Amount.
HEDIS — Healthcare Effectiveness Data and Information Set.
HIPAA — Health Insurance Portability and Accountability Act.
HIPP — Health Insurance Premium Payment.
HIV — Human Immunodeficiency Virus.
HMO — Health Maintenance Organization.
IBNR — Incurred But Not Reported.
ICF/ID — Intermediate Care Facility for the Intellectually Disabled.
ICF/ORC — Intermediate Care Facility/Other Related Conditions.
IGC — Initial Grievance Committee.
IRM — Information Resource Management
JCAHO — Joint Commission for the Accreditation of Healthcare Organizations.
JDC — Juvenile Detention Center.
LTCCAP — Long Term Care Capitation.
MA — Medical Assistance.
MAAC — Medical Assistance Advisory Committee.
MAGI — Modified Adjusted Gross Income
MATP — Medical Assistance Transportation Program.
MBE — Minority Business Enterprise.
MCO — Managed Care Organization.
MEDA — Medicaid Eligibility Determination Automation.
MH/ID — Mental Health/Intellectual Disabilities.
MIS — Management Information System.
MPI — Master Provider Index.
NCPDP — National Council for Prescription Drug Programs.
NCQA — National Committee for Quality Assurance.
NPDB — National Practitioner Data Bank.
NPI — National Provider Identifier
OBRA — Omnibus Budget Reconciliation Act.
OCDEL — Office of Child Development and Early Learning
OCYF — Office of Children, Youth and Families.

ODP — Office of Developmental Programs.
OIP — Other Insurance Paid.
OLTL – Office of Long Term Living
OMAP — Office of Medical Assistance Programs.
OMHSAS — Office of Mental Health and Substance Abuse Services.
ORC — Other Related Conditions.
OTC — Over-the-Counter.
PARP — Prior Authorization Review Panel.
PBM — Pharmacy Benefit Manager.
PCP — Primary Care Practitioner.
PDA — Pennsylvania Department of Aging.
PERT — Program Evaluation and Review Technique.
PH — Physical Health.
PH-MCO — Physical Health Managed Care Organization.
PID — Pennsylvania Insurance Department.
PIP — Physician Incentive Plan.
PMPM — Per Member, Per Month.
POSNet — Pennsylvania Open Systems Network.
PROMISe™ — Provider Reimbursement (and) Operations Management Information System electronic (format).
QA — Quality Assurance.
QARI — Quality Assurance Reform Initiative.
QM — Quality Management.
QMC — Quality Management Committee.
QM/UMP — Quality Management and Utilization Management Program.
RBUC — Reported But Unpaid Claim.
RFP — Request for Proposal.
RHC — Rural Health Clinic.
RPAA — Risk Pool Allocation Amount.
RTF — Residential Treatment Facility.
SAP — Statutory Accounting Principles.
S-CHIP — State Children's Health Insurance Program
SNU — Special Needs Unit.
SPR — Systems Performance Review.
SSA — Social Security Act.
SSI — Supplemental Security Income.
STD — Sexually Transmitted Disease.
TANF — Temporary Assistance for Needy Families.
TCM — Targeted Case Management.
TPL — Third Party Liability.
TTY — Text Telephone Typewriter.
UM — Utilization Management.
URCAP — Utilization Review Criteria Assessment Process.
U.S. DHHS — United States Department of Health and Human Services.
WBE — Women's Business Enterprise.
WIC — Women's, Infants' and Children (Program).

SECTION III: RELATIONSHIP OF PARTIES

A. Basic Relationship

The PH-MCO, 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 PH-MCO, 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 PH-MCO herein. In furtherance of the foregoing, the PH-MCO acknowledges that no workers' compensation or unemployment insurance coverage shall be provided by the Department to the PH-MCO's employees, servants, agents and representatives. The PH-MCO shall be responsible for maintaining for its employees, and for requiring of its agents and representatives, malpractice, workers' compensation and unemployment compensation insurance in such amounts as required by law.

The PH-MCO acknowledges and agrees that it shall have full responsibility for all taxes and withholdings of all of its employees. In the event that any employee or representative of the PH-MCO is deemed an employee of the Department by any taxing authority or other governmental agency, the PH-MCO 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 Contract

Pursuant to this Agreement, the PH-MCO must arrange for the provision of medical and related services to Recipients through qualified Providers in accordance with the terms and conditions of this Agreement. In administering the HealthChoices Program, the PH-MCO must comply fully with the terms and conditions set forth in this Agreement, including but not limited to, the operational and financial standards, as well as any functions expressly delegated to the PH-MCO herein.

The Secretary for DPW will determine the number of Managed Care Organizations (MCOs) operating in the HealthChoices Program and may contract, during the term of this Agreement, with additional qualified MCOs who meet all established contractual, licensing and readiness review requirements.

C. Chronic Care Initiative

The PH-MCO may choose to participate in the Chronic Care Initiative.

SECTION IV: APPLICABLE LAWS AND REGULATIONS

A. Certification and Licensing

During the term of this Agreement, the PH-MCO must require that each of its Network Providers complies with all certification and licensing laws and regulations applicable to the profession or entity. The PH-MCO agrees not to employ or enter into a contractual relationship with a Health Care Provider who is precluded from participation in the MA Program or other federal health care program.

B. Specific to MA Program

The PH-MCO agrees to participate in the MA Program and to arrange for the provision of those medical and related services essential to the medical care of those individuals being served, and to comply with all federal and Pennsylvania laws generally and specifically governing participation in the MA Program. The PH-MCO agrees that all services provided hereunder must be provided in the manner prescribed by 42 U.S.C. 300e(b), and warrants that the organization and operation of the PH-MCO is in compliance with 42 U.S.C. 300e(c). The PH-MCO agrees to comply with all applicable rules, regulations, and Bulletins promulgated under such laws including, but not limited to, 42 U.S.C. 300e; 42 U.S.C. 1396 et seq.; 62 P.S. 101 et. seq.; 42 CFR Parts 431 through 481 and 45 CFR Parts 74, 80, and 84, and the Department of Public Welfare regulations as specified in Exhibit A of this Agreement, Managed Care Regulatory Compliance Guidelines.

C. General Laws and Regulations

1. The PH-MCO must comply with Titles VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, 42 U.S.C. Section 2000d et seq. and 2000e et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 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.; 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.

2. The PH-MCO must comply with the Commonwealth's Contract Compliance Regulations that are set forth at 16 Pa. Code 49.101 and on file with the PH-MCO.

3. Except for the definition of Effective Date in Section 1, the PH-MCO must comply with the Standard Grant Terms and Conditions found in Exhibit D of this Agreement, Standard Grant Terms and Conditions for Services.

4. The PH-MCO must comply with all applicable laws, regulations, and policies of the Pennsylvania Department of Health and the Pennsylvania Insurance Department.

   The PH-MCO must comply with applicable Federal and State laws that pertain to Member rights and protections. The PH-MCO must ensure that its staff take those rights and protections into account when furnishing services to Members. Also, the PH-MCO must require its Providers to take those rights and protections into account when furnishing services to Members.

5. In addition, the PH-MCO and its subcontractors must respect the conscience rights of individual Providers and Provider organizations, as long as said conscience rights are made known to the PH-MCO in advance, and comply with the current Pennsylvania laws prohibiting discrimination on the basis of the refusal or willingness to participate in certain abortion and sterilization-related activities as outlined in 43 P.S. 955.2 and 18 Pa. C.S. 3213(d).

   If the PH-MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the PH-MCO must furnish information about the services not covered in accordance with the provisions of 42 CFR 438.102(b)

   - To the Department
   - With its Proposal in response to the RFP
   - Whenever it adopts the policy during the term of the Agreement.

   The PH-MCO must provide this information to potential Members before and during Enrollment. This information must be provided to Members within thirty (30) days after adopting the policy with respect to any particular service.

6. The PH-MCO 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 contracting with the Commonwealth. The requirements regarding PH-MCO Integrity Provisions, are contained in Exhibit D of this Agreement, Standard Grant Terms and Conditions for Services.

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 MA Program at the time such services are provided.

8. The PH-MCO must comply with all applicable Federal regulations, including those regulations that prohibit affiliations with individuals debarred by Federal Agencies as described in 42 CFR Part 438, Section 438.610. Additionally, PH-MCOs must comply with 42 CFR 438, Sections 438.726 and 438.730 describing conditions under which CMS may deny payments for new enrollees.

D. Limitation on the Department's Obligations

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

E. Health Care Legislation

The PH-MCO agrees to comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in the Medicaid program resulting from Health Care Reform. 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 medical assistance who are enrolled in the PH-MCO and for whom the PH-MCO is responsible for coverage of outpatient drugs.

F. Health Information Technology and the American Recovery and Reinvestment Act of 2009 (ARRA)

The PH-MCO agrees to comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in the Medicaid program resulting from the Department's Health Information Technology (HIT) initiatives or requirements under the State Medicaid Health IT Plan (SMHP) as approved by CMS. This includes, but is not limited to, requirements under Public Law 111-5, known as the

American Recovery and Reinvestment Act of 2009, and specifically sections:

- 42 U.S.C. section 1396b(a)(3)
- 42 U.S.C. section 1396b(t)

as amended and as it meets the requirements of 42 U.S.C. section 1395w-4(o) and Title XIII, section 13001, known as the Health Information Technology for Economic and Clinical Health Act (HITECH) of Public Law 111-5, known as the American Recovery and Reinvestment Act of 2009.

Should the Department provide funding to the PH-MCO to support the HIT initiative or to meet the requirements under the State Medicaid Health IT Plan (SMHP) as approved by CMS, the PH-MCO shall at a minimum and with approval from the Department use these funds to:

- Pursue initiatives that encourage the adoption of certified Electronic Health Record technology to promote health care quality and the exchange of health care information;
- Track the meaningful use of certified Electronic Health Record technology by providers;
- Provide oversight of the initiative including, but not limited to, attesting to qualifications of providers to participate in the initiative, tracking meaningful use attestations, and other reporting mechanisms as necessary.

SECTION V: PROGRAM REQUIREMENTS

A. In-Plan Services

The PH-MCO must ensure that all services provided are Medically Necessary.

1. Amount, Duration and Scope

At a minimum, In-Plan Services must be provided in the amount, duration and scope set forth in the MA Fee-for-Service (FFS) Program and be based on the Recipient's benefit package, unless otherwise specified by the Department. The PH-MCO must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. If services or eligible consumers are added to the Pennsylvania MA Program or the HealthChoices Program, or if covered services or eligible consumers are expanded or eliminated, implementation by the PH-MCO must be on the same

day as the Department's, unless the PH-MCO is notified by the Department of an alternative implementation date. If the scope of services or consumers that are the responsibility of the PH-MCO is changed, covered services or the definition of eligible consumers is expanded or reduced; the Department will determine whether the change is sufficient that an actuarial analysis might conclude that a rate change is appropriate. If yes, the Department will 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 the Department will consider input from the PH-MCO, 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 consumers that are the responsibility of the PH-MCO is changed, upon request by the PH-MCO, 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 Department has established benefit packages based on category of assistance, program status code, age, and, for some packages, the existence of Medicare coverage or a Deprivation Qualifying Code. In cases where the Member benefits are determined by the benefit package, the most comprehensive package remains in effect during the month the Consumer's category of assistance changes.

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

2. In-Home and Community Services

The Pennsylvania Medicaid State Plan requires personal care services coverage for individuals under age 21. Personal care services may not be denied based on the member's diagnosis or because the need for assistance is the result of a cognitive impairment. The assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self.

A request for medically necessary in-home nursing services, home health aide services, or personal care services for a member under the age of 21 may not be denied on the basis that a live-in caregiver can perform the task, unless there is a determination that

the live-in caregiver is actually able and available to provide the level or extent of care that the member needs, given the caregiver's work schedule or other responsibilities, including other responsibilities in the home.

3. Program Exceptions

The PH-MCO is also required to establish a process, reviewed and approved by the Department, whereby a Provider may request coverage for items or services, which while included under the Recipient's benefit package, are not currently listed on the MA Program Fee Schedule. In addition to requests for items or services that are not on the MA fee schedule, the program exception process must be applied to requests to exceed limits for items or services that are on the fee schedule if the limits are not based in statute or regulation. These requests are recognized by the Department as a Program Exception and described in 55 Pa. Code 1150.63.

4. Expanded Benefits

The PH-MCO may provide expanded benefits subject to advance written approval by the Department. These must be benefits that are generally considered to have a direct relationship to the maintenance or enhancement of a Member's health status. Examples of potentially approvable benefits include various seminars and educational programs promoting healthy living or illness prevention, memberships in health clubs and/or facilities promoting physical fitness and expanded eyeglass or eye care benefits. These benefits must be generally available to all Members and must be made available at all appropriate PH-MCO Network Providers. Such benefits cannot be tied to specific Member performance. However, the Department may grant exceptions in areas where it believes that such tie-ins shall produce significant health improvements for Members. Previously approved tie-ins will continue to remain in effect under this Agreement, unless the PH-MCO is notified, in writing, by the Department, to discontinue the expanded benefit.

In order for information about expanded benefits to be included in any Member information provided by the PH-MCO, the expanded benefits must apply for a minimum of one full year or until the Member information is revised, whichever is later. Upon sixty (60) days advance notice to the Department, the PH-MCO may modify

or eliminate any expanded benefits, which exceed the benefits provided for under the MA FFS Program. Such benefit(s) as modified or eliminated shall supersede those specified in the Proposal. The PH-MCO must send written notice to Members and affected Providers at least thirty (30) days prior to the effective date of the change in covered benefits and must simultaneously amend all written materials describing its covered benefit or Provider Network. A change in covered benefits includes any reduction in benefits or a substantial change to the Provider Network.

For information to be included in materials to be used by the Enrollment Assistance Program (EAP), the expanded benefits must be in effect for the full calendar year for which the EAP information applies. EAP information will be updated annually on a calendar year basis.

5. Referrals

The PH-MCO is required to establish and maintain a referral process to effectively utilize and manage the care of its Members. The PH-MCO may require a referral for any medical services, which cannot be provided by the PCP except where specifically provided for in this Agreement.

6. Self Referral/Direct Access

There are some services which can be accessed without a referral from the PCP. Vision, dental care, obstetrical and gynecological (OB/GYN) services may be self-referred, providing the Member obtains the services from the PH-MCO's Provider Network. Chiropractic services may be accessed in accordance with the process set forth in Medical Assistance Bulletin 15-07-01. In addition, physical therapy services may be accessed in accordance with the amended Physical Therapy Act (63 P.S. 1301 et seq.)

The PH-MCO may not use either the referral process or the Prior Authorization process to manage the utilization of Family Planning Services. The right of the Member to choose a Health Care Provider for Family Planning Services must not be restricted. Members may access at a minimum, health education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures as described in Exhibit F of this

Agreement, Family Planning Services Procedures. The PH-MCO must pay for the Out-of-Network Services.

Under Section 2111(7) of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2111(7), Members are to be provided direct access to OB/GYN services. The PH-MCO 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.

Members must be permitted to select a Health Care Provider, including nurse midwives participating in the PH-MCO's Network, to obtain maternity and gynecological care without prior approval from a PCP. This includes selecting a Health Care Provider to provide an annual well-woman gynecological visit, primary and preventive gynecology care, including a PAP smear and referrals for diagnostic testing related to maternity and gynecological care, and Medically Necessary follow-up care.

In situations where a new (and pregnant) Member is already receiving care from an Out-of-Network OB-GYN specialist at the time of Enrollment, the Member may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery, pursuant to 28 Pa. Code 9.684.

7. Behavioral Health Services

The PH-MCO is not responsible to provide any services as set forth in the agreements between the Department and the Behavioral Health Managed Care Organizations (BH-MCOs) in effect at the same time as this Agreement, as outlined in Exhibit U of this Agreement, Behavioral Health Services.

8. Pharmacy Services

The PH-MCO must comply with the Department's pharmacy services standards and requirements described in**:**

- Exhibit BBB Pharmacy Services
- Exhibit BBB (1) Drug Formulary Requirements
- Exhibit BBB (2) Drug Utilization Review Requirements

- Exhibit BBB (3) Pharmacy Denial Notice - Complete Denial
- Exhibit BBB (4) Pharmacy Denial Notice– Partial Approval
- Exhibit BBB (5) Pharmacy Denial Notice – Approval of Different Medication
- Exhibit BBB (6) Requirements Covering Medications Prescribed by PH-MCOs and BH-MCOs

9. EPSDT Services

The PH-MCO must comply with the requirements regarding EPSDT services as set forth in Exhibit J of this Agreement, EPSDT Guidelines.

The PH-MCO must also adhere to specific Department regulations at 55 Pa. Code Chapters 3700 and 3800 as they relate to EPSDT examination for individuals under the age of 21 and entering substitute care or a child residential facility placement.

10. Emergency Services

The PH-MCO agrees to comply with the program standards regarding Emergency Services that are set forth in Exhibit K of this Agreement, Emergency Services.

The PH-MCO must comply with the provisions of 42 U.S.C. 1396u-2(b)(2)(D), 28 PA Code Ch. 9, and Sections 2102 and 2116 of the Insurance Company Law of 1921 as amended, 40 P.S. 991.2102 and 991.2116, pertaining to coverage and payment of Medically Necessary Emergency Services.

Consistent with the provisions of 42 U.S.C. 1396u-2(b)(2)(D), the PH-MCO must limit the amount to be paid to Non-participating Providers of 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 Department will determine the amount of payment after consideration of the payment proposed by the PH-MCO, the amount sought by the Non-participating Provider, the payment rates established by the Department for equivalent services under the Department's Fee-for-Service program, and the assumptions used to develop the Department's Actuarially Sound Rates paid to

the PH-MCO, along with supporting documentation submitted by the parties and information otherwise available to the Department.

In addition:

- Health Care Providers may initiate the necessary intervention to stabilize an Emergency Medical Condition of the patient without seeking or receiving prospective authorization by the PH-MCO. The attending physician or the Provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the PH-MCO.

- The PH-MCO must be responsible for all Emergency Services including those categorized as mental health or drug and alcohol except for emergency room evaluations for voluntary and involuntary commitments pursuant to 50 P.S. 7101 et seq. which shall be the responsibility of the BH-MCO.

Nothing in the above section shall be construed to imply that the PH-MCO must not:

- track, trend and profile emergency room utilization;

- retrospectively review and where appropriate, deny payment for inappropriate emergency room use;

- use all appropriate methods to encourage Members to use PCPs rather than emergency rooms for symptoms that do not qualify as an Emergency Medical Condition; or

- use a Recipient restriction methodology for Members with a history of significant inappropriate emergency room usage.

11. Post-Stabilization Services

The PH-MCO must cover Post-Stabilization Services, pursuant to 42 CFR 438.114(b).

The PH-MCO must limit charges to Members for Post-Stabilization Services to an amount no greater than what the PH-MCO would charge the Member if he or she had obtained the services through the PH-MCO.

The PH-MCO must cover Post-Stabilization Services without requiring authorization, and regardless of whether the Member

obtains the services within or outside the PH-MCO Provider Network if any of the following situations exist:

a. The Post-Stabilization Services were pre-approved by the PH-MCO.

b. The Post-Stabilization Services were administered to maintain the Member's stabilized condition within one hour of Provider's request to the PH-MCO for pre-approval of further Post-Stabilization Services.

c. The Post-Stabilization Services were not pre-approved by the PH-MCO because the PH-MCO did not respond to the Provider's request for pre-approval of these Post-Stabilization Services within one (1) hour of the request.

d The Post-Stabilization Services were not pre-approved by the PH-MCO because the PH-MCO could not be reached by the Provider to request pre-approval for these Post-Stabilization Services.

e The PH-MCO and the treating physician cannot reach an agreement concerning the Member's care and a PH-MCO physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a PH-MCO physician and the treating physician may continue with care of the patient until a PH-MCO physician is reached or one of the criteria applicable to termination of PH-MCO's financial responsibility described below is met.

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

a. A PH-MCO physician with privileges at the treating hospital assumes responsibility for the Member's care;

b. A PH-MCO physician assumes responsibility for the Member's care through transfer;

c. The PH-MCO and the treating physician reach an agreement concerning the Member's care; or

d. The Member is discharged.

12. Examinations to Determine Abuse or Neglect

a. Upon notification by the County Children and Youth Agency system, the PH-MCO must ensure that HealthChoices Members under evaluation as possible victims of child abuse and/or neglect and who present for physical examinations for determination of abuse or neglect, must receive such services. These services must be performed by trained examiners in a timely manner according to the Child Protective Services Law, 23 Pa. C.S. 6301 et seq. and Department regulations.

b. The PH-MCO must ensure that ER staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for the county. This requirement must be included in all applicable Provider Agreements.

c. Should a PCP determine that a mental health assessment is needed, the PCP must inform the Recipient or the County Children and Youth Agency representative how to access these mental health services and coordinate access to these services, when necessary.

13. Hospice Services

The PH-MCO must provide hospice care and use certified hospice Providers in accordance with the provisions outlined at 42 CFR 418.1 et seq.

Recipients who are enrolled in the Department's Hospice Program and were not previously enrolled in the HealthChoices Program will not be enrolled in HealthChoices. However, if a PH-MCO Member is determined eligible for the Department's Hospice Program after being enrolled in the PH-MCO, the Member will remain the responsibility of the PH-MCO and will not be disenrolled from HealthChoices.

14. Organ Transplants

The PH-MCO is responsible to pay for transplants to the extent that the MA FFS Program pays for such transplants. When Medically Necessary, the following transplants are the responsibility of the PH-MCO: Kidney (cadaver and living donor), kidney/pancreas, cornea, heart, heart/lung, single lung, double lung, liver (cadaver and living donor), liver/pancreas, small bowel, pancreas/small

bowel, bone marrow, stem cell, pancreas, liver/small bowel transplants, and multivisceral transplants.

15. Transportation

The PH-MCO is financially responsible for all Medically Necessary emergency ambulance transportation and all Medically Necessary non-emergency ambulance transportation.

Any non-emergency transportation (excluding Medically Necessary non-emergency transportation) for Members to and from MA compensable services must be arranged through the Medical Assistance Transportation Program (MATP). A complete description of MATP responsibilities can be found in Exhibit L of this Agreement, Medical Assistance Transportation Program.

16. Waiver Services/State Plan Amendments

a. HIV/AIDS Waiver Program

The PH-MCO must arrange for and provide services to persons with AIDS or symptomatic HIV the same as those provided under the Department's AIDS Waiver Program. Individuals enrolled in the Department's AIDS Waiver Program who would not otherwise be eligible for MA, are included in HealthChoices. The PH-MCO must track these Members in accordance with federal reporting requirements.

b. HIV/AIDS Targeted Case Management (TCM) Program

The PH-MCO must ensure the provision of TCM services for persons with AIDS or symptomatic HIV, including access to needed medical and social services using the existing TCM program standards of practice followed by the Department or comparable standards approved by the Department. In addition, individuals within the PH-MCO who provide the TCM services must meet the same qualifications as those under the Department's TCM Program.

c. Healthy Beginnings Plus (HBP) Program

The PH-MCO must provide services that meet or exceed HBP standards in effect as defined in current MA Bulletins. The PH-MCO must also assure that the coordinated prenatal

activities of the HBP Program continue by utilizing enrolled HBP Providers or developing comparable resources. Such comparable programs will be subject to review and approval by the Department based on the likelihood that such programs will be of greater effectiveness in meeting the goals of the HBP Program. The PH-MCO must provide a full description of its plan to provide prenatal care for pregnant women and infants in fulfillment of the HBP Program objectives for review and advance written approval by the Department. This plan must include comprehensive postpartum care.

d. Pennsylvania Department of Aging (PDA) Waivers

The Department may expand the scope of services to include Recipients in the PDA Waiver in HealthChoices. Please refer to Section VII.B.3 of this Agreement for further information on program changes.

17. Nursing Facility Services

The PH-MCO is responsible for payment for up to thirty (30) days of nursing home care (including hospital reserve or bed hold days) if a Member is admitted to a Nursing Facility in accordance with Exhibit BB, Rule F.1 of this Agreement.. Members are disenrolled from HealthChoices thirty (30) days following the admission date to the Nursing Facility as long as the Member has not been discharged from the Nursing Facility.

A PH-MCO may not deny or otherwise limit Medically Necessary services, such as home health services, on the grounds that the Member needs, but is not receiving, a higher level of care. A PH-MCO may not offer financial or other incentives to obtain or expedite a Member's admission to a Nursing Facility except as short-term nursing care, not to exceed thirty (30) days.

The PH-MCO must abide by the decision of the OPTIONS assessment process determination letter related to the need for Nursing Facility services.

Recipients who are placed into a Nursing Facility from a hospital and who were not previously enrolled in the HealthChoices Program or individuals who enter a Nursing Facility from a hospital and are then determined eligible for MA will not be enrolled in HealthChoices. However, should an individual leave the Nursing Facility to reside in the HealthChoices Zone covered by this

Agreement and then be determined eligible for Enrollment into HealthChoices, they will then be required to enroll into the HealthChoices Program.

Individuals who are residing in Nursing Facilities and are subsequently found eligible for MA will not be enrolled in the HealthChoices Program. Individuals eligible for MA, but not mandated into the HealthChoices Program when they enter Nursing Facilities, or Recipients who are placed in Nursing Facilities inside the HealthChoices Zone covered by this Agreement, who previously resided outside the HealthChoices Zone covered by this agreement, will not be enrolled in the HealthChoices Program.

18. Benefit Limits and Benefit Limit Exceptions (BLEs)

The PH-MCO has the option to impose the same benefit limits or lesser benefit limits as the Department. For those services that are covered in a Member's benefit package only with an approved BLE, the PH-MCO must use the same criteria as the Department or may use criteria that are less restrictive for its review of BLE requests.

The PH-MCO must establish and maintain written policies and procedures for its BLE process. The PH-MCO must receive advance written approval from the Department of these policies and procedures. The policies and procedures must comply with guidance issued by the Department. The PH-MCO's submission of revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department for operation in a HC Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof. The Department may periodically request ad hoc information related to PH-MCO operations surrounding these BLE requests.

If the PH-MCO imposes benefit limits, the PH-MCO must issue notices to its members and notify network providers at least thirty (30) days in advance of the changes. The member notices must receive advance Department approval prior to being sent to Members.

The time frames for notices of decisions for prior authorization set forth at Section V.B.2 and V.B.3. apply to requests for BLEs. If the PH-MCO denies a BLE request, the PH-MCO must issue a written

denial notice, using the appropriate template in Exhibit N(4), N(5) and N(6) of this Agreement.

If the Member is currently receiving a service or item that is subject to a benefit limit and the request for a BLE is denied, and the recipient files a complaint, grievance or request for a Fair Hearing that is postmarked or hand-delivered within 10 days of the date of the notice, the PH-MCO must continue to provide the service until a decision is made.

Recipients with approved BLE's are in a course of treatment. As such, the requirements for Continuity of Care for Course of Treatment Services Not Requiring Prior Authorization for Adults Age 21 and Older and Children Under the Age of 21, set forth in MA Bulletin 99-03-13, Attachment D, apply. PH-MCOs are required to honor all approved BLE requests issued by the Fee-for-Service (FFS) program or by another PH-MCO. The FFS delivery system will also honor all approved BLE requests issued by PH-MCOs.

B. Prior Authorization of Services

1. General Prior Authorization Requirements

The PH-MCO is financially responsible for the provision of Emergency Services without regard to Prior Authorization or the emergency care Provider's contractual relationship with the PH-MCO.

If the PH-MCO wishes to require Prior Authorization of any services which are not required to be prior authorized under the MA FFS Program, the PH-MCO must establish and maintain written policies and procedures which must have advance written approval by the Department. In addition, the PH-MCO must include a list and scope of services for referral and Prior Authorization, which must be included in the PH-MCO's Provider manual and Member handbook. PH-MCOs must receive advance written approval of the list and scope of services to be referred or prior authorized by the Department as outlined in Exhibit H of this Agreement, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and Exhibit M(1) of this Agreement, Quality Management and Utilization Management Program Requirements. Prior Authorization policies and procedures approved under previous HealthChoices contracts will be considered approved under this Agreement. The PH-MCO's submission of new or revised policies and procedures for Prior

Authorization Review Panel (PARP) review and approval shall not act to void any existing policies and procedures that were already prior approved for operation in a HealthChoices Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the PARP approves the new or revised version thereof.

The PH-MCO must not implement Prior Authorization policies without having sought and obtained advance written approval by the Department. Denials issued under unapproved Prior Authorization policies may be subject to Retrospective Review and reversal at the Department's sole discretion. The Department may, at its discretion, impose sanctions and/or corrective action plans in the event that the PH-MCO improperly implements any Prior Authorization policy or procedure.

When the PH-MCO denies a request for services, the PH-MCO must issue a written notice of denial using the appropriate notice outlined in Exhibits N(1), N(2), (N)3, and N(7) of this Agreement. In addition, the notice must be available in accessible formats for individuals with visual impairments and for persons with limited English proficiency. If, pursuant to the required taglines in all notices of denial, the PH-MCO receives a request from the Member, prior to the end of the required period of advance notice, for a translated and/or accessible alternate version of the notice of denial, the required period of advance notice will begin anew as of the date that PH-MCO mails the translated and/or accessible alternate notice of denial to the Member.

For Children in Substitute Care, notices must be sent to the County Children and Youth Agency with legal custody of a child or to the court-authorized juvenile probation office with primary supervision of a juvenile provided the PH-MCO knows that the child is in substitute care and the address of the custodian of the child.

The Department will use its best efforts to review and provide feedback to the PH-MCO (e.g., written approval, request for corrective action plan, denial, etc.) within sixty (60) days from the date the Department receives the request for review from the PH-MCO. For minor updates to existing approved Prior Authorization plans, the Department will use its best efforts to review updates within forty-five (45) days from the date the Department receives the request for review from the PH-MCO.

The PH-MCO may waive the Prior Authorization requirements for services which are required by the Department to be Prior Authorized.

2. Time Frames for Notice of Decisions

a. The PH-MCO is required to process each request for Prior Authorization (prospective utilization review) of a service and ensure that the Member is notified of the decision as expeditiously as the Member's health condition requires, or at least orally, within two (2) Business Days of receiving the request, unless additional information is needed. If no additional information is needed, the PH-MCO must mail written notice of the decision to the Member, the Member's PCP, and the prescribing Provider within two Business Days after the decision is made. Notification of coverage approvals may also be made via electronic notices permitted under 28 Pa. Code 9.753(b). If additional information is needed to make a decision, the PH-MCO must request such information from the appropriate Provider within forty-eight (48) hours of receiving the request and allow fourteen (14) days for the Provider to submit the additional information. If the PH-MCO requests additional information, the PH-MCO must notify the Member on the date the additional information is requested, using the template supplied by the Department in Exhibit N(7), Request for Additional Information Letter.

b. If the requested information is provided within fourteen (14) days, the PH-MCO must make the decision to approve or deny the service, and notify the Member orally, within two (2) Business Days of receipt of the additional information. The PH-MCO must mail written notice of the decision to the Member, the Member's PCP, and the prescribing Provider within two (2) Business Days after the decision is made.

c. If the requested information is not received within fourteen (14) days, the decision to approve or deny the service must be made based upon the available information and the Member notified orally within two (2) Business Days after the additional information was to have been received. The PH-MCO must mail written notice of the decision to the Member, the Member's PCP, and the prescribing Provider within two (2) Business Days after the decision is made.

d. In all cases, the decision to approve or deny a covered service or item must be made and the Member must receive written

notification of the decision no later than twenty-one (21) days from the date the PH-MCO received the request, or the service or item is automatically approved. To satisfy the twenty-one (21) day time period, the PH-MCO may mail written notice to the Member, the Member's PCP, and the prescribing Provider on or before the eighteenth (18th) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, then the PH-MCO must hand deliver the notice to the Member, or the request is automatically authorized (i.e., deemed approved).

e. If the Member is currently receiving a requested service and the PH-MCO decides to deny the prior authorization request, the written notice of denial must be mailed to the Member at least ten (10) days prior to the effective date of the denial of authorization for continued services. If probable Member fraud has been verified, the period of advance notice is shortened to five (5) days. Advance notice is not required when the PH-MCO has factual information on the following:

- confirmation of the death of a Member;
- receipt of a clear written statement signed by a Member that s/he no longer wishes services or gives information that requires termination or reduction of services and indicates that s/he understands that this must be the result of supplying that information;
- the Member has been admitted to an institution where s/he is ineligible under the PH-MCO for further services;
- the Member's whereabouts are unknown and the post office returns PH-MCO mail directed to him/her indicating no forwarding address;
- the PH-MCO established the fact that the Member has been accepted for Medicaid services by another State; or
- a change in the level of medical care is prescribed by the Member's physician.

3. Prior Authorization for Outpatient Prescription Drugs

The PH-MCO may require Prior Authorization as a condition of coverage or payment for an outpatient prescription drug provided that 1) the PH-MCO provides a response to the request for prior authorization by telephone or other telecommunication device indicating approval or denial of the prescription within twenty-four

(24) hours of the request, and 2) if a Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the PH-MCO must instruct the pharmacist to dispense either a fifteen (15) day supply if the prescription qualifies as an Ongoing Medication, or a seventy-two (72) hour supply of a new medication.

If the PH-MCO denies the request for prior authorization, the PH-MCO must issue a written denial notice, using the appropriate template in Exhibits BBB(3) through BBB(5) of this Agreement, Pharmacy Denial Notices, within twenty-four (24) hours of receiving the request for prior authorization.

In the event that the PH-MCO requires prior authorization of a medication, the PH-MCO must have procedures in place to permit the Member to receive a supply of the new medication such that the supply will not be exhausted prior to receipt of the notice. For drugs not able to be divided and dispensed into individual doses, the PH-MCO must instruct the pharmacist to dispense the smallest amount that will provide at least a seventy-two (72) hour or fifteen (15) day supply, whichever is applicable.
The PH-MCO must have procedures in place to assure that if a prescription for an Ongoing Medication is not authorized when presented at the pharmacy, the pharmacist shall dispense a fifteen (15) day supply of the prescription, unless the PH-MCO or its designated subcontractor issued a proper written notice of benefit reduction or termination at least ten (10) days prior to the end of the period for which the medication was previously authorized and a Grievance or DPW Fair Hearing request has not been filed. If the Member files a Grievance or DPW Fair Hearing request from a denial of an Ongoing Medication, the PH-MCO must authorize the medication until the Grievance or DPW Fair Hearing request is resolved. When medication is authorized due to the PH-MCO's obligation to continue services while a Member's Grievance or Fair Hearing is pending, and the final binding decision is in favor of the PH-MCO, a request for subsequent refill of the prescribed medication does not constitute an Ongoing Medication.

The requirement that the Member be given at least a seventy-two (72) hour supply for a new medication or a fifteen (15) day supply for an Ongoing 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. In such event, the PH-MCO and/or its subcontractor must require that its participating pharmacist make good faith efforts to contact the

prescriber. In such instances, however, the requirement that the PH-MCO issue a written denial notice within twenty-four (24) hours still applies.

C. Continuity of Care

The PH-MCO must comply with the procedures outlined in MA Bulletin #99-96-01, Continuity of Prior Authorized Services Between FFS and Managed Care Plans and Between Managed Care Plans for Individuals Under Twenty-One (21), to ensure continuity of Prior Authorized Services whenever an individual under the age of twenty-one (21) transfers from one PH-MCO to another, from a PH-MCO to the MA FFS Program, or from the MA FFS Program to a PH-MCO.

The PH-MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2117 regarding continuity of care requirements and 28 PA Code Ch. 9. The PH-MCO must comply with the procedures outlined in MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations, to ensure continuity of Prior Authorized Services for individuals age twenty-one (21) and older and continuity of non-prior authorized services for all Members.

D. Coordination of Care

The PH-MCO is responsible for coordination of care for individuals enrolled in HealthChoices. The PH-MCO must ensure seamless and continuous coordination of care across a continuum of services for the individual Member with a focus on improving health care outcomes. The continuum of services may include the in-plan comprehensive benefits package, out-of-plan benefits, and non-MA covered services provided by other community resources such as:

- Nursing Facility Care
- Intermediate Care Facility for the Intellectually Disabled/Other Related Conditions (ICF/ ID/ORC)
- Residential Treatment Facility (RTF)
- Acute Psychiatric Facilities
- Extended and/or Extended Acute Psychiatric Facilities

- Non-Hospital Residential Detoxification, Rehabilitation, and Half-Way House Facilities for Drug/Alcohol Dependence/ Addiction

- Area Agencies on Aging (AAA)/OPTIONS Assessment and Pre-admission Screening Requirements

- Pennsylvania Department of Aging (PDA) Waiver

- Juvenile Detention Centers (JDCs)

- Children in Substitute Care Transition

- Adoption Assistance Children/Adolescents

- Services to Dual Eligibles Under the Age of Twenty-one

- Transitional Care Homes

- Medical Foster Care Services

- Early Intervention Services (note that the PH-MCO must refer for Early Intervention Services any of its members who are children from birth to age three (3) who are living in residential facilities. "Children living in residential facilities" describes children who are in a 24-hour living setting in which care is provided for one or more children.)

- Home and Community Based Waiver Program for Nursing Facility Residents with Other Related Conditions (OLTL/OBRA Waiver)

- Home and Community Based Waiver Program for Nursing Facility Applicants with Other Related Conditions (OLTL/Independence Waiver)

- Home and Community Based Waiver for Attendant Care Services (OLTL/AC Waiver)

- Home and Community Based Waiver for Persons with Intellectual Disabilities

- COMMCARE Waiver for Persons with a Primary Diagnosis of Traumatic Brain Injury

The HealthChoices Program requirements covering special services are outlined in Exhibit O of this Agreement, Description of Facilities and Related Services. Out-of-Plan Services are described in Exhibit P of this Agreement, Out-of-Plan Services. Recipient coverage rules are outlined in Exhibit BB, MCO Recipient Coverage Document.

1. Coordination of Care/Letters of Agreement

The PH-MCO must coordinate the comprehensive in-plan package of services with entities providing Out-of-Plan Services. To clearly define the roles of the entities involved in the coordination of services, the PH-MCO must enter into coordination of care letters of agreement with County Children and Youth Agencies (CCYAs) and Juvenile Probation Offices (refer to Sample Model Agreement, Exhibit Q of this Agreement), and the BH-MCOs (refer to Exhibit R of this Agreement, Coordination with BH-MCOs). The Department encourages the PH-MCO to make a good faith effort to enter into coordination of care letters of agreement with school districts and other public, governmental, county, and community-based service providers.

Should the PH-MCO be unable to enter into coordination of care letters of agreement as required under this Agreement, the PH-MCO must submit written justification to the Department. Justification must include all the steps taken by the PH-MCO to secure coordination of care letters of agreement, or must demonstrate an existing, ongoing, and cooperative relationship with the entity. The Department will then determine whether or not this requirement will be deemed met.

All written coordination documents developed and maintained by the PH-MCO must have advance written approval by the Department and must be reviewed/revised at least annually by the PH-MCO. Coordination documents must be available for review by the Department upon request. All written coordination documents entered into between a service provider and the PH-MCO must also be approved by the Department. These written coordination documents, including the operational procedures, must be submitted for final review and approval at least thirty (30) days prior to the operational date of the Initial Term of the Contract.

Any written coordination documents entered into between the PH-MCO and service Providers must contain, but are not limited to, the provisions outlined in Exhibit S of this Agreement, Written Coordination Agreements Between PH-MCO and Service

Providers. Under no circumstances may these coordination documents contain any definition of Medically Necessary other than the definition found in this Agreement.

2. PH-MCO and BH-MCO Coordination

The HealthChoices PH-MCOs and the BH-MCOs are required to develop and implement written agreements regarding the interaction and coordination of services provided to Recipients enrolled in the HealthChoices Program. These agreements must be submitted and approved by the Department. The PH-MCOs and BH-MCOs in the HealthChoices Zone covered by this Agreement are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services.

The HealthChoices Program requirements covering Behavioral Health Services requirements are outlined in Exhibit U of this Agreement, Behavioral Health Services.

The PH-MCO will comply with the requirements regarding coordination of care, which are set forth in Section V.D, Coordination of Care of this Agreement, including those pertaining to behavioral health.

a. The PH-MCO agrees, and the Department will require HealthChoices BH-MCOs to agree, to submit to a binding independent arbitration process in the event of a dispute between the PH-MCO and any such BH-MCOs concerning their respective obligations pursuant to this Agreement and a Behavioral HealthChoices contract. The mutual agreement of the PH-MCO and a BH-MCO to such an arbitration process must be evidenced by and included in the written agreement between the PH-MCO and the BH-MCO.

b. All outpatient pharmacy services, except those otherwise assigned, are the payment responsibility of the Member's PH-MCO. The only exception is that the BH-MCO is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO service Providers. All prescribed medications are to be dispensed through the PH-MCO's Network pharmacies. This includes drugs prescribed by both the PH-MCO and the BH-MCO Providers. Payment for inpatient pharmaceuticals during a BH admission is the responsibility of the BH-MCO and is included in the hospital charges. The PH-MCO must follow

the PH/BH Pharmacy Services guidelines in Exhibit BBB(6) of this Agreement, Requirements Covering Medications Prescribed by PH-MCOs and BH-MCOs. The Department will issue a list of BH-MCO Providers to the PH-MCO prior to the effective date of this Agreement. Should the PH-MCO receive a request to dispense medication from a BH Provider not listed on the BH-MCO's Provider file, the PH-MCO must work through the appropriate BH-MCO to identify the Provider. The PH-MCO is prohibited from denying prescribed medications solely on the basis that the BH-MCO Provider is not clearly identified on the BH-MCO Provider file.

c. The PH-MCO must send data files, via DPW's file transfer protocol (FTP), containing records of detailed pharmacy services as provided to individual enrollees of the BH-MCOs contracted with DPW. The PH-MCO must adhere to the file delivery schedule established at the implementation of the data exchange process, or notify the Department in advance of schedule changes. Files must be sent directly to the Department for distribution by the Department.

3. Disability Advocacy Program

The MCO is required to cooperate with the Department's Disability Advocacy Program that provides assistance to members in applying for Supplemental Security Income or Social Security Disability benefits by sharing member specific information and performing coordination activities as requested by the Department, on a case by case basis.

E. PH-MCO Responsibility for Reportable Conditions

The PH-MCO must work with Department of Health (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 27.1 et seq. The PH-MCO must designate a single contact person to facilitate the implementation of this requirement.

F. Member Enrollment and Disenrollment

1. General

The PH-MCO is prohibited from restricting its Members from changing PH-MCOs for any reason. The MA Consumer has the right to initiate a change in PH-MCOs at any time.

The PH-MCO is prohibited from offering or exchanging financial payments, incentives, commissions, etc., to any other PH-MCO (not receiving an agreement to operate under the HealthChoices Program or not choosing to continue a relationship with the Department) for the exchange of information on the terminating PH-MCO's membership. This includes offering incentives to a terminating PH-MCO to recommend that its membership join the PH-MCO offering the incentives. This section would not prohibit making a payment in connection with a transfer, which has received the Department's prior written approval, of the rights and obligations to another entity.

The Department will disenroll Members from a PH-MCO when there is a change in residence which places the Member outside the HC Zone covered by this Agreement, as indicated on the individual county file maintained by the Department's Office of Income Maintenance.

The Department has implemented a process to enroll HC Members transferring from one HC Zone to another with the same PH-MCO, provided that the PH-MCO operates in both HC Zones.

2. PH-MCO Outreach Materials

Upon request by the Department, the PH-MCO must develop outreach materials such as pamphlets and brochures which can be used by the EAP contractor to assist Recipients in choosing a PH-MCO and PCP. Such materials to be used for the PH-MCO's Pennsylvania HealthChoices program must be developed in the form and context required by the Department. The Department must approve such materials in writing prior to their use. The Department's review will be conducted within thirty (30) calendar days and approval will not be unreasonably withheld.

The PH-MCO is prohibited from distributing directly or through any agent or independent contractor, outreach materials without advance written approval of the Department. In addition, the PH-MCO must comply with the following guidelines and/or restrictions.

a. The PH-MCO may not seek to influence an individual's Enrollment with the PH-MCO in conjunction with the sale of any other insurance.

b. The PH-MCO must comply with the Enrollment procedures established by the Department in order to ensure that, before the individual is enrolled with the PH-MCO, the individual is provided accurate oral and written information sufficient to make an informed decision on whether to enroll.

c. In accordance with the federal Balanced Budget Act of 1997, Section 1932(d)(2)(E), the PH-MCO must not directly or indirectly conduct door-to-door, telephone or other cold-call marketing activities.

d. The PH-MCO must ensure that all outreach plans, procedures and materials are accurate and do not mislead, confuse or defraud either the Recipient or the Department. Refer to Exhibit X, HealthChoices MCO Guidelines for Advertising, Sponsorships, and Outreach.

3. PH-MCO Outreach Activities

The PH-MCO must comply with the following principles for all PH-MCO outreach activities:

a. Due to the Department's use of HealthChoices Enrollment Specialists, the PH-MCO is prohibited from engaging in any marketing activities associated with Enrollment into a PH-MCO in any HealthChoices Zone, with the exceptions listed in 3b through 3f below. The PH-MCO is prohibited from engaging in any marketing activities associated with Enrollment into their PH-MCO program.

The PH-MCO is also prohibited from subcontracting with an outside entity to engage in outreach activities associated with any form of Enrollment to eligible or potential Recipients. The PH-MCO must not engage in outreach activities associated with Enrollments, which include but are not limited to, the following locations and activities:

- County Assistance Offices (CAOs)
- Providers' offices
- Malls/Commercial or retail establishments
- Hospitals
- Check cashing establishments

- Door-to-door visitations
- Telemarketing
- Community Centers
- Churches
- Direct Mail

b. The PH-MCO, either individually or as a joint effort with other PH-MCOs in the HealthChoices Zone, may use but not be limited to commonly accepted media methods for the advertisement of quality initiatives, educational outreach, and health-related materials and activities.

The PH-MCO must not include, in administrative costs reported to the Department, the cost of advertisements in mass media, including but not limited to television, radio, billboards, the Internet and printed media for purposes other than noted above unless specific prior approval is provided by the Department.

Any advertising placed in mass media for any reason by the PH-MCO is subject to advance, written approval by the Department.

c. The PH-MCO may participate in or sponsor health fairs or community events. The Department reserves the right to set limits on contributions and/or payments made to non-profit groups in connection with health fairs or community events. Advance written approval is required for contributions and/or payments of $2,000.00 or more. The Department will consider such participation or sponsorship when a written request is submitted thirty (30) calendar days in advance of the event, thus allowing the Department reasonable time to review the request and provide timely advance written approval. All contributions/payments are subject to financial audit by the Department.

d. Items of little or no intrinsic value (i.e., trinkets with promotional PH-MCO logos) may be offered at health fairs or other approved community events. Such items must be made available to the general public, not to exceed $5.00 in retail value and must not be connected in any way to PH-

MCO Enrollment activity. All such items are subject to advance written approval by the Department.

e. The PH-MCO may offer Members health-related benefits in excess of those required by the Department, and is permitted to feature such expanded benefits in approved outreach materials. All such expanded benefits are subject to advance written approval by the Department and must meet the requirements of Section V.A.4. of this Agreement, Expanded Benefits.

f. The PH-MCO may offer Members consumer incentives only if they are directly related to improving health outcomes. The incentive cannot be used to influence a Member to receive any item or service from a particular Provider, practitioner or supplier. In addition, the incentive cannot exceed the total cost of the service being provided. The PH-MCO must receive advance written approval from the Department prior to offering a consumer incentive.

g. Unless approved by the Department, PH-MCOs are not permitted to directly provide products of value unless they are health related and are prescribed by a licensed Provider.

h. PH-MCOs may not offer Member coupons for products of value.

i. The PH-MCO must be responsible for bearing the cost of reprinting HealthChoices outreach materials, if a change involving content is made by the PH-MCO prior to the EAP's annual revision of materials. These changes include, but are not limited to, change in product names, logos, marks, insignias, program benefits and services made by the PH-MCO.

j. The Department reserves the right to review any and all outreach activities and advertising materials and procedures used by the PH-MCO for the HealthChoices Program. This includes all outreach activities, advertising materials, and corporate initiatives that are likely to reach Medical Assistance Recipients. In addition to any other sanctions, the Department may impose monetary or restricted Enrollment penalties should the PH-MCO be found to be using unapproved outreach materials or engaging in unapproved outreach practices. The Department reserves the right to suspend all outreach activities and the

completion of applications for new Members. Such suspensions may be imposed for a period of sixty (60) days from notification by the Department to the PH-MCO citing the violation.

k. The PH-MCO is prohibited from distributing, directly or through any agent or independent contractor, outreach materials that contain false or misleading information.

l. The PH-MCO must not, under any conditions use the Department's Client Information System (CIS) to identify and market to Recipients participating in the MA FFS Program or enrolled in another PH-MCO. The PH-MCO must not share or sell Recipient lists with other organizations for any purpose, with the limited permissible exception of sharing Member information with affiliated entities and/or subcontractors under Department-approved arrangements to fulfill the requirements of the applicable MCO agreement.

m. The PH-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with the guidelines outlined in Exhibit X of this Agreement, HealthChoices PH-MCO Guidelines for Advertising, Sponsorships, and Outreach.

4. Limited English Proficiency (LEP) Requirements

During the Enrollment Process, the PH-MCO and/or the Department's Enrollment Specialists must seek to identify Members who speak a language other than English as their first language.

The PH-MCO must provide, at no cost to Members, oral interpretation services in every language and sign language interpreter services to meet the needs of all Members, upon request by the Member.

The PH-MCO must make all vital documents disseminated to English speaking Members available in alternative languages, upon request of the member. Documents may be deemed vital if related to the access of LEP persons to programs and services.
The PH-MCO must include appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternate language. This information must also be posted on the PH-MCO's web site.

The PH-MCO must provide material to Members on how to access or receive interpreter and translation services for those individuals who are deaf or hard of hearing or who have LEP. This information must also be posted on the PH-MCO's web site.

5. Alternate Format Requirements

The PH-MCO must provide alternative methods of communication for Members who are visually or hearing impaired, including Braille, audio tapes, large print, compact disc (CD), DVD, computer diskette, and/or electronic communication. The PH-MCO must, upon request from the Member, make all written materials disseminated to Members accessible to visually impaired Members. The PH-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Members who are deaf or hearing impaired, upon request.

The PH-MCO must include appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternate format.

6. PH-MCO Enrollment Procedures

The PH-MCO must have in effect written administrative policies and procedures for newly enrolled Members. The PH-MCO must also provide written policies and procedures for coordinating Enrollment information with the Department's EAP contractor. The PH-MCO must receive advance written approval from the Department regarding these policies and procedures. The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department for operation in a HC Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

The PH-MCO must enroll any eligible Recipient who selects or is assigned to the PH-MCO in accordance with the Enrollment/Disenrollment dating rules that are determined and provided by the Department on the HealthChoices Intranet site and the Automatic Assignment Exhibit, regardless of the Recipient's race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, Grievance status, MA category status, health status,

pre-existing condition, physical or mental disability or anticipated need for health care.

7. Enrollment of Newborns

The PH-MCO must have written administrative policies and procedures to enroll and provide all Medically Necessary services to newborn infants of Members, effective from the time of birth, without delay, in accordance with Section V.F.12 of this Agreement, Services for New Members, and Exhibit BB of this Agreement, MCO Recipient Coverage Document. The PH-MCO must receive advance written approval from the Department regarding these policies and procedures.

It is the responsibility of the PH-MCO to notify the Department if there are errors or inconsistencies in the newborn's Medical Assistance or PH-MCO eligibility dates per the established procedures found on the HealthChoices Intranet.

For pregnant members, the PH-MCO must make every effort to identify what PCP/pediatrician the mother chooses to use for the newborn prior to the birth, so that this chosen Provider can be assigned to the newborn on the date of birth.

The PH-MCO is not responsible for the payment of newborn metabolic screenings.

8. Transitioning Members Between PH-MCOs

It may be necessary to transition a Member between PH-MCOs. Members with Special Needs should be assisted by the SNU(s) to facilitate a seamless transition. The PH-MCO must follow the Department's established procedures as outlined in Exhibit BB of this Agreement, MCO Recipient Coverage Document.

9. Change in Status

The PH-MCO 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 Section VIII.B.5 of this Agreement.

The PH-MCO 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. A detailed explanation of how the information was verified must also be included on the form.

10. Membership Files

a. Monthly File

The Department will provide an 834 Monthly Membership File for each MCO on the next to the last Saturday of each month. The file contains the MA Eligibility Period, PH-MCO coverage, BH-MCO coverage and other Recipient demographic information. It will contain only one record for each Managed Care Recipient (the most current) where the Member is both MA and Managed Care eligible at some point in the following month. The PH-MCO 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.

Recipients not included on this file with an indication of prospective coverage will not be the responsibility of the PH-MCO unless a subsequent 834 Daily Membership File indicates otherwise. Those with an indication of future month coverage will not be the responsibility of the PH-MCO if an 834 Daily Membership File received by the PH-MCO prior to the beginning of the future month indicates otherwise.

b. Daily File

The Department will provide to the PH-MCO an 834 Daily Membership File that contains record(s) for each Managed Care Recipient where data for that Recipient (contained in the 834 file layout) has changed that day. The file will contain add, termination and change records, but will contain only one type of managed care coverage—either PH or BH. The file contains demographic changes, eligibility changes, Enrollment changes, Members enrolled through the automatic assignment process, and TPL information. The PH-MCO must process and load this file in its entirety within 24 hours of receipt.

The PH-MCO must reconcile all components of this file against its internal membership information and notify the

Department within thirty (30) Business Days in order to resolve problems.

11. Enrollment and Disenrollment Updates

a. Weekly Enrollment/Alert Reconciliation File

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

b. Disenrollment Effective Dates

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

c. Discharge/Transition Planning

When any Member is disenrolled from the PH-MCO because of:

- Admission to or length of stay in a facility,
- A waiver program eligibility which makes the Member exempt from the HealthChoices Program, or
- A child's placement in substitute care outside the HealthChoices Zone covered by this Agreement,

the PH-MCO from which the Member disenrolled must remain responsible for participating in discharge/transition planning for up to six (6) months from the initial date of Disenrollment. The PH-MCO must remain the Recipient's PH-MCO upon discharge (upon returning to the HealthChoices Zone covered by this Agreement), unless the Recipient chooses a different PH-MCO or is determined to no longer be eligible for participation in HealthChoices, provided that the Recipient is discharged within six (6) months of the initial PH-MCO Disenrollment date.

If the Recipient chooses a different PH-MCO, the gaining PH-MCO must participate in the discharge/transition

planning upon notification that the Recipient has chosen their PH-MCO.

12. Services for New Members

The PH-MCO must make available the full scope of benefits to which a Member is entitled from the effective Enrollment date provided by the Department.

The PH-MCO must ensure that pertinent demographic information about the Recipient, i.e., Special Needs data collected through the EAP or directly indicated to the PH-MCO by the Recipient after Enrollment, will be used by the PH-MCO upon the new Member's effective Enrollment date in the PH-MCO. If a Special Need is indicated, the PH-MCO is required to place a Special Needs indicator on the Member's record and must outreach to that Member to identify their Special Need or circumstance. The PH-MCO must assure that the Member's needs are adequately addressed.

The PH-MCO must comply with access standards as required in Exhibit AAA(1), AAA(2), or AAA(3), as applicable, of this Agreement, Provider Network Composition/Service Access and follow the appointment standards described in Exhibit AAA(1), AAA(2), or AAA(3), as applicable, when an appointment is requested by a Member.

13. New Member Orientation

The PH-MCO must have written policies and procedures for new Members or a written orientation plan or program that includes:

- Orienting new Members to their benefits (e.g., prenatal care, dental care, and specialty care),
- Educational and preventative care programs that include an emphasis on health promotion, wellness and healthy lifestyles and practices,
- The proper use of the PH-MCO identification card and the Department's ACCESS Card,
- The role of the PCP,
- What to do in an emergency or urgent medical situation,

- How to utilize services in other circumstances,

- How to request information from the PH-MCO, and

- How to register a Complaint, file a Grievance or request a DPW Fair Hearing.

These policies and procedures must receive advance written approval by the Department.

The PH-MCO is prohibited from contacting a potential Member who is identified on the Daily Membership File with an automatic assignment indicator (either an "A" auto assigned or "M" Member assigned) until five (5) Business Days before the effective date of the Member's Enrollment unless it is the PH-MCO's responsibility under this Agreement.

14. PH-MCO Identification Cards

The PH-MCO must issue its own identification card to enrolled Members. The Department also issues an identification card, called an ACCESS Card, to each Recipient, which the Member is required to use when accessing services. Providers must use this card to access the Department's EVS and to verify the Member's eligibility. The ACCESS Card will allow the Provider the capacity to access the most current eligibility information without contacting the PH-MCO directly.

15. Member Handbook

The PH-MCO must provide a Member handbook, or other written materials, with information on Member rights and protections and how to access services, in the appropriate language or alternate format to Members within five (5) Business Days of a Member's effective date of Enrollment. The PH-MCO may provide the Member handbook in formats other than hard copy. If this option is exercised, the PH-MCO must inform Members what formats are available and how to access each format. The PH-MCO must maintain documentation verifying that the Member handbook is reviewed for accuracy at least once a year, and that all necessary modifications have been made. All Members must be notified on an annual basis of any changes made, and the formats and methods available to access the handbook. Upon request, the PH-MCO must provide a hard copy version of the Member handbook to the Member.

a. Member Handbook Requirements

The PH-MCO must ensure that the Member handbook is written at no higher than a sixth grade reading level and include, at a minimum, the information outlined in Exhibit DD of this Agreement, PH-MCO Member Handbook.

b. Department Approval

The PH-MCO must submit Member handbook language to the Department for advance written approval prior to distribution to Members. The PH-MCO must make modifications in the language contained in the Member handbook if ordered by the Department so as to comply with the requirements described in Section V.F.15.a., Member Handbook Requirements, above.

c. Languages Other than English

The PH-MCO must follow the Member access standards for Member handbooks outlined in Section V.F.4, Limited English Proficiency (LEP) Requirements, and V.F.5, Alternate Format Requirements, of this Agreement.

16. Provider Directories

Directories must be available for all types of Providers in the PH-MCO's Network, including, but not limited to: PCPs, hospitals, specialists, Providers of ancillary services, Nursing Facilities, etc.
The PH-MCO must utilize a web-based Provider directory. The PH-MCO must establish a process to ensure the accuracy of electronically posted content, including a method to monitor and update changes in Provider information. The PH-MCO must perform monthly reviews of the web-based Provider directory, subject to random monitoring by the Department to ensure complete and accurate entries.

The PH-MCO must provide the EAP contractor with an updated electronic version of their Provider directory at a minimum on a weekly basis. This will include information regarding terminations, additions, PCPs and specialists not accepting new assignments, and other information determined by the Department to be necessary. The PH-MCO 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 Providers in the PH-MCO's Network

- The location where the PCP will see Members, as well as whether the PCP has evening and/or weekend hours

- Wheel chair accessibility of Provider sites

- Language indicators including non-English language spoken by current Providers in the Member's service area.

A PH-MCO will not be certified as "ready" without the completion of the electronic Provider directory component as determined and provided by the Department on the HealthChoices Intranet site.

The PH-MCO must notify its Members annually of their right to request and obtain Provider directories. Upon request, the PH-MCO must provide its Members with directories for PCPs, dentists, specialists, hospitals, and Providers of ancillary services, which include, at a minimum, the information listed in Exhibit FF of this Agreement, PCP, Dentists, Specialists and Providers of Ancillary Services Directories. Upon request from the Member, the PH-MCO may print the most recent electronic version from their Provider file and mail it to the Member.

The PH-MCO must submit PCP, specialist, and Provider of ancillary services directories to the Department for advance written approval before distribution to its Members if there are significant format changes to the directory. The PH-MCO also must make modifications to its Provider directories if ordered by the Department.

17. Member Disenrollment

The PH-MCO may not request Disenrollment of a Member because of an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her Special Needs. The PH-MCO may not reassign or remove Members involuntarily from Network Providers who are willing and able to serve the Member.

G. Member Services

1. General

The PH-MCO's Member services functions must be operational at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday) and one (1) evening per week (5:00 p.m. to 8:00 p.m.) or one (1) weekend per month to address non-emergency problems encountered by Members. The PH-MCO must have arrangements to receive, identify, and resolve in a timely manner Emergency Member Issues on a twenty-four (24) hour, seven (7) day-a-week basis. The PH-MCO's Member services functions must include, but are not limited to, the following Member services standards:

- Explaining the operation of the PH-MCO and assisting Members in the selection of a PCP.

- Assisting Members with making appointments and obtaining services.

- Assisting with arranging transportation for Members through the MATP. See Section V.A.15. of this Agreement, Transportation and Exhibit L of this Agreement, Medical Assistance Transportation Program.

- Receiving, identifying and resolving Emergency Member Issues.

Under no circumstances will unlicensed Member services staff provide health-related advice to Members requesting clinical information. The PH-MCO must ensure that all such inquiries are addressed by clinical personnel acting within the scope of their licensure to practice a health-related profession.

2. PH-MCO Internal Member Dedicated Hotline

The PH-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated hotline to respond to Members' inquiries, issues and problems raised regarding services. The PH-MCO's internal Member hotline staff are required to ask the callers whether or not they are satisfied with the response given to their call. All calls must be documented and if the caller is not satisfied, the PH-MCO must ensure that the call is referred to the appropriate individual within the PH-MCO for follow-up and/or resolution. This referral must take place within forty-eight (48) hours of the call.

The PH-MCO must provide the Department with the capability to monitor the PH-MCO's Member services and internal Member dedicated hotline from each of the PH-MCO's offices. The Department will only monitor calls from HealthChoices Members or their representatives and will cease all monitoring activity as soon as it becomes apparent that the call is not related to a HealthChoices Member.

The PH-MCO is not permitted to utilize electronic call answering methods, as a substitute for staff persons, to perform this service. The PH-MCO must ensure that its dedicated hotline meets the following Member services performance standards:

- Provide for a dedicated phone line for its Members.

- Provide for necessary translation and interpreter assistance for Members who speak a language other than English.

- Be staffed by individuals trained in:
  - Cultural Competency;
  - addressing the needs of special populations;
  - the availability of and the functions of the SNU;
  - the services which the PH-MCO is required to make available to all Members; and
  - the availability of social services within the community.

- Be staffed with representatives familiar with accessing medical transportation.

- Be staffed with adequate service representatives to ensure an abandonment rate of less than or equal to five percent (5%) of the total calls.

- Be staffed with adequate service representatives to ensure that at least 85% of all calls are answered within thirty (30) seconds.

- Provide for TTY and/or Pennsylvania Telecommunication Relay Service availability for Members who are Deaf or hard of hearing.

3. Education and Outreach/Health Education Advisory Committee

The PH-MCO must develop and implement effective Member education and outreach programs that may include health education programs focusing on the leading causes of

hospitalization and emergency room use, and health initiatives that target Members with Special Needs, including but not limited to: HIV/AIDS, Mental Retardation/Developmental Disabilities, Dual Eligibility (Medicare/ Medicaid), etc.

The PH-MCO must establish and maintain a Health Education Advisory Committee that includes Recipients and Providers of the community to advise on the health education needs of HealthChoices Members. Representation on this Committee must include, but not be limited to, women, minorities, persons with Special Needs and at least one (1) person with expertise on the medical needs of children with Special Needs. Provider representation includes physical health, behavioral health, and dental health Providers. The PH-MCO must provide the Department annually with the membership (including designation) and meeting schedule of the Health Education Advisory Committee.

The PH-MCO must provide for and document coordination of health education materials, activities and programs with public health entities, particularly as they relate to public health priorities and population-based interventions that are relevant to the populations being served and that take into consideration the ability of these populations to understand and act upon health information. The PH-MCO must also work with the Department to ensure that its Health Education Advisory Committees are provided with an effective means to consult with each other and, when appropriate, coordinate efforts and resources for the benefit of the entire HealthChoices population in the HC Zone and/or populations with Special Needs.

The PH-MCO must provide the Department with a written description of all planned health education activities and targeted implementation dates on an annual basis.

4. Informational Materials

All information given to Members and potential Members must be easily understood and must comply with all requirements outlined in the RFP and Agreement and the provisions of Section 2136 of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2136. Vital informational material distributed to HealthChoices Members, including but not limited to Provider directories and Member handbooks, must be available in alternate languages, upon request of the member. However, large documents may not need to be translated in their entirety. Informational material distributed to HealthChoices Members, including but not limited to Provider

directories and Member handbooks, must be available, upon request, in Braille, large print, audio tape, Compact Disc (CD), DVD, and computer diskette and must be provided in the format requested by the person with a visual impairment. The information contained in the Provider directories may cover only those zip codes or other geographic locations that the person with a visual impairment requests. The PH-MCO must comply with Member Handbook requirements as outlined in Exhibit DD of the Agreement, PH-MCO Member Handbook, and with Provider Directories requirements as outlined in Exhibit FF of the Agreement, PCP, Dentists, Specialists and Providers of Ancillary Services Directories.

The PH-MCO must distribute member newsletters at least three times each year to each Member household. The PH-MCO may provide the member newsletters in formats other than hard copy. If this option is exercised, the PH-MCO must inform Members what formats are available and how to access the member newsletters in each format. The PH-MCO must include costs of common procedures in its member newsletter, and make the same information available on its web site. The intent of this requirement is that the PH-MCO provide general information regarding common procedure costs for the purpose of increasing member health literacy. This information may be general, aggregate procedure costs, and need not include or divulge PH-MCO-specific payment amounts. The PH-MCO must obtain advance written approval from the Department of all Member newsletters, and will be required to add information provided by the Department related to Departmental initiatives. The PH-MCO must post the Department-approved member newsletters in an easily accessible location on the PH-MCO's website. The PH-MCO must notify all Members of the availability and methods to access each member newsletter. Upon request, the PH-MCO must provide a hard copy version of the member newsletter(s) to the Member.

The PH-MCO must obtain advance written approval from the Department to use Member or HealthChoices Program related information on electronic web sites and bulletin boards which are accessible to the public or to the PH-MCO's Members.

H. Additional Addressee

The PH-MCO must have administrative mechanisms for sending copies of information, notices and other written materials to a designated third party upon the request and signed consent of the Member. The PH-MCO must develop plans to process such individual requests and for obtaining the

necessary releases signed by the Member to ensure that the Member's rights regarding confidentiality are maintained.

I. Member Complaint, Grievance and DPW Fair Hearing Process

1. Member Complaint, Grievance and DPW Fair Hearing Process

The PH-MCO must develop, implement, and maintain a Complaint and Grievance process that provides for settlement of Members' Complaints and Grievances and the processing of requests for DPW Fair Hearings as outlined in Exhibit GG of this Agreement, Complaint, Grievance, and DPW Fair Hearing Processes. The PH-MCO must use the templates provided by the Department in Exhibits GG(1) through GG(14) to inform Members regarding decisions and the process.

The PH-MCO must have written policies and procedures approved by the Department, for resolving Member Complaints and for processing Grievances and DPW Fair Hearing requests, that meet the requirements established by the Department and the provisions of 40 P.S. 991.2101 et seq. (known as Act 68), Pennsylvania Department of Health regulations (28 Pa. Code Chapter 9), Pennsylvania Insurance Department regulations (31 Pa. Code CHs. 154 and 301) and 42 CFR 431.200 et seq. of the Federal Regulations. The PH-MCO must also comply with 55 Pa. Code 275 et seq. regarding DPW Fair Hearing Requests and 42 CFR 438.406(b).

The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department for operation in a HealthChoices Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

The PH-MCO must require each of its subcontractors to comply with the Member Complaint, Grievance, and DPW Fair Hearing Process. This includes reporting requirements established by the PH-MCO, which have received advance written approval by the Department. The PH-MCO must provide to the Department for approval, its written procedures governing the resolution of Complaints and Grievances and the processing of DPW Fair Hearing requests. There must be no delegation of the Complaint,

Grievance and Fair Hearing process to a subcontractor without prior written approval of the Department.

The PH-MCO must abide by the final decision of the Departments of Health or Insurance (as applicable) when a Member has filed an external appeal of a second level Complaint decision.

When a Member files an external appeal of a second level Grievance decision, the PH-MCO must abide by the decision of the Department of Health's certified review entity (CRE), which was assigned to conduct the independent external review, unless appealed to the court of competent jurisdiction.

The PH-MCO must abide by the final decision of the Department of Public Welfare's Bureau of Hearings and Appeals for those cases when an Recipient has requested a DPW Fair Hearing, unless requesting reconsideration by the Secretary of the Department of Public Welfare. Only the Member may appeal to Commonwealth Court. The decisions of the Secretary and the Court are binding on the PH-MCO.

2. DPW Fair Hearing Process for Members

During all phases of the PH-MCO Grievance process, and in some instances involving Complaints, the Member has the right to request a Fair Hearing with the Department. The PH-MCO must comply with the DPW Fair Hearing Process requirements defined in Exhibit GG of this Agreement, Complaint, Grievance and DPW Fair Hearing Processes.

A request for a DPW Fair Hearing does not prevent a Member from also utilizing the PH-MCO's Complaint or Grievance process. If a member requests both an external appeal/review and a DPW Fair Hearing, and if the decisions rendered are in conflict with one another, the PH-MCO must abide by the decision most favorable to the member. In the event of a dispute or uncertainty regarding which decision is most favorable to the member, the PH-MCO will submit the matter to DPW's Grievance and Appeals Coordinator for review and resolution.

J. OMAP Hotlines

The PH-MCO agrees to cooperate with the functions of OMAP's Hotlines, which are intended to address clinically-related systems issues encountered by Recipients and their advocates or Providers.

K. Provider Dispute Resolution System

The PH-MCO must develop, implement, and maintain a Provider Dispute Resolution Process, which provides for informal resolution of Provider Disputes at the lowest level and a formal process for Provider Appeals. The resolution of all issues regarding the interpretation of Department-approved Provider PH-MCO contracts must be handled between the two (2) entities and shall not involve the Department; therefore, these are not within the scope of the Department's Bureau of Hearings and Appeals. Additionally, the Department's Bureau of Hearings and Appeals or its designee is not an appropriate forum for Provider Disputes/Appeals with the PH-MCO.

Prior to implementation, the PH-MCO must submit to the Department, their policies and procedures relating to the resolution of Provider Disputes/Provider Appeals for approval. Any changes made to the Provider Disputes/Provider Appeals policies and procedures must be submitted to the Department for approval prior to implementation of the changes.

The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department for operation in a HC Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

The PH-MCO's Provider Disputes/Provider Appeals policies and procedures must include at a minimum:

- Informal and formal processes for settlement of Provider Disputes;
- Acceptance and usage of the Department's definition/delineation of Provider Appeals and Provider Disputes;
- Timeframes for submission and resolution of Provider Disputes/Provider Appeals;
- Processes to ensure equitability for all Providers;
- Mechanisms and time-frames for reporting Provider Appeal decisions to PH-MCO administration, QM, Provider Relations and the Department; and

- Establishment of a PH-MCO Committee to process formal Provider Disputes/Provider Appeals which must include:

  – At least one-fourth (1/4th) of the membership of the Committee must be composed of Health Care Providers/peers;
  – Committee members who have the authority, training, and expertise to address and resolve Provider Dispute/Provider Appeal issues;
  – Access to data necessary to assist committee members in making decisions; and
  – Documentation of meetings and decisions of the Committee.

L. Certification of Authority and County Operational Authority

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

The PH-MCO must also maintain operating authority in each county covered by this HealthChoices Grant Agreement. The PH-MCO must provide to the Department a copy of the DOH correspondence granting operating authority in each county covered by this HealthChoices Grant Agreement upon request.

M. Executive Management

The PH-MCO must include in its Executive Management structure:

- A full-time Administrator with authority over the entire operation of the PH-MCO.

- A full-time HealthChoices Program Manager to oversee the operation of the Agreement, if different than the Administrator of the PH-MCO.

- A full-time Medical Director who is a current Pennsylvania-licensed physician. The Medical Director must be actively involved in all major clinical program components of the PH-MCO and directly participates in the oversight of the Special Needs Unit, QM Department and UM Department. The Medical Director and his/her staff/consultant physicians must devote sufficient time to the PH-MCO to ensure timely medical decisions, including after-hours consultation, as needed.

- A full-time Pharmacy Director who is a current Pennsylvania-licensed pharmacist. The Pharmacy Director oversees the Formulary and pharmacy utilization management and serves on the PH-MCO Pharmacy and Therapeutics Committee.

- A full-time Chief Financial Officer (CFO) to oversee the budget and accounting systems implemented by the PH-MCO. The CFO must ensure the timeliness and accuracy of all financial reports. The CFO shall devote sufficient time and resources to responsibilities under this Agreement.

- A full-time Information Systems (IS) Coordinator, who is responsible for the oversight of all information systems issues with the Department. The IS Coordinator must have a good working knowledge of the PH-MCO's entire program and operation, as well as the technical expertise to answer questions related to the operation of the information system.

- These full time positions must be solely dedicated to the PA Medicaid Managed Care Program.

N. Other Administrative Components

The PH-MCO must address each of the administrative functions listed below. For those positions not indicated as full time, the PH-MCO may combine or split the functions as long as the PH-MCO can demonstrate that the duties of these functions conform to the work statement described herein.

- A QM Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant with past experience or education in Quality Management systems. The Department may consider other advanced degrees relevant to Quality Management in lieu of professional licensure.

- A UM Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant with past experience or education in Utilization Management systems. The Department may consider other advanced degrees relevant to Utilization Management in lieu of professional licensure.

- A full-time SNU Coordinator who is a Pennsylvania-licensed or certified medical professional (or other health related license or certification), or has a bachelor’s degree in social work, teaching, or human services. In addition, the individual must have a minimum of three years past experience in dealing with special needs populations similar to those served by Medicaid. The SNU Coordinator must have access to and periodically consult with the PH-MCO’s Medical Director and must work in close collaboration with the SNU and SNU staff. The PH-MCO agrees to notify the Department within thirty (30) days of a

change in the SNU Coordinator. See also Section V.M of this Agreement, Executive Management.

- A full-time Government Liaison who serves as the Department's primary point of contact with the PH-MCO for the day-to-day management of contractual and operational issues. Since this position is a critical link in the day-to-day operations between the Department and the PH-MCO, the PH-MCO must have a designated back-up trained to be able to handle urgent or time-sensitive issues when the Government Liaison is not available.

- A Maternal Health/EPSDT Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant; or has a Master's degree in Health Services, Public Health, or Health Care Administration to coordinate maternity and prenatal care and EPSDT services.

- A Member Services Manager who oversees staff to coordinate communications with Members and act as Member advocates. There must be sufficient Member Services staff to enable Members to receive prompt resolution to their issues, problems or inquiries.

- A Provider Services Manager who oversees staff to coordinate communications between the PH-MCO and its Providers. There must be sufficient PH-MCO Provider Services, or equivalent department that addresses this function, staff to promptly resolve Provider Disputes, problems or inquiries.

- A Complaint, Grievance and DPW Fair Hearing Coordinator whose qualifications demonstrate the ability to assist Members throughout the Complaint, Grievance and DPW Fair Hearing processes.

- A Claims Administrator who oversees staff to ensure the timely and accurate processing of Claims, Encounter forms and other information necessary for meeting contract requirements and the efficient management of the PH-MCO.

- A Contract Compliance Officer who ensures that the PH-MCO is in compliance with all the requirements of the HealthChoices Agreement.

The PH-MCO must ensure that all staff has appropriate training, education, experience and orientation to fulfill the requirements of the position. The PH-MCO must submit job descriptions for each of the positions listed in Sections V.M, Executive Management, and V.N, Other Administrative Components, and update them if responsibilities for these positions change.

The PH-MCO's staffing should represent the racial, ethnic and cultural diversity of the Program and comply with all requirements of Exhibit D of this Agreement, Standard Contract Terms and Conditions for Services. Cultural Competency may be reflected by the PH-MCO's pursuit to:

- Identify and value differences;
- Acknowledge the interactive dynamics of cultural differences;
- Continually expand cultural knowledge and resources with regard to the populations served;
- Recruit racial and ethnic minority staff in proportion to the populations served;
- Collaborate with the community regarding service provisions and delivery; and
- Commit to cross-cultural training of staff and the development of policies to provide relevant, effective programs for the diversity of people served.

The PH-MCO must have in place sufficient administrative staff and organizational components to comply with the requirements of this Agreement. The PH-MCO must include in its organizational structure, the components outlined below. The functions must be staffed by qualified persons in numbers appropriate to the PH-MCO's size of Enrollment. The Department has the right to make the final determination regarding whether or not the PH-MCO is in compliance.

The PH-MCO may combine functions or split the responsibility for a function across multiple departments, unless otherwise indicated, as long as it can demonstrate that the duties of the function are being carried out. Similarly, the PH-MCO may contract with a third party to perform one (1) or more of these functions, subject to the subcontractor conditions described in Section XIII of this Agreement, Subcontractual Relationships. The PH-MCO is required to keep the Department informed at all times of the management individual(s) whose duties include each of the responsibilities outlined in this section.

O. Administration

The PH-MCO must comply with the program standards regarding PH-MCO Administration, which are set forth in this Agreement and in Exhibit D of this Agreement, Standard Grant Terms and Conditions for Services,

and in Exhibit E of this Agreement, DPW Addendum to Standard Contract Terms and Conditions.

The PH-MCO must have an administrative office within this HC Zone from which the HealthChoices Program is operated. However, exceptions to this requirement will be considered on an individual basis if the PH-MCO has administrative offices elsewhere in Pennsylvania and the PH-MCO is in compliance with all standards set forth by the Departments of Health and Insurance.

The PH-MCO must submit for review by the Department its organizational structure listing the function of each executive as well as administrative staff members. Staff positions outlined in this Agreement must be approved and maintained in accordance with the Department's requirements. The HealthChoices Program Manager must be accessible to the Department and may not be reassigned without advance notice to the Department.

1. Responsibility to Employ Recipients

The Contractor must provide a plan approved by the CAO Employment Unit Coordinator for the recruitment and hiring of Recipients as described in Exhibit E of this Agreement, Department of Public Welfare Addendum to Standard Contract Terms and Conditions.

2. Recipient Restriction Program

A Centralized Recipient Restriction (lock-in) Program is in place for the MA Fee-For-Service and the Managed Care delivery systems and is managed by the Department’s Bureau of Program Integrity (BPI).

The PH-MCO agrees to maintain a Recipient Restriction Program to interface with the Department’s Recipient Restriction Program, to provide for appropriate professional resources to manage the Program and to cooperate with the Department in all procedures necessary to restrict Members. The Department has the sole authority to restrict Recipients and has oversight responsibility of the PH-MCO’s Recipient Restriction Program. The PH-MCO is required to obtain approval from the Department prior to implementing a restriction, including approval of written policies and procedures and correspondence to Recipients. The PH-MCO’s process includes:

- Identifying Members who are overutilizing and/or misutilizing medical services.
- Evaluating the degree of abuse including review of pharmacy and medical claims history, diagnoses and other documentation, as applicable.
- Proposing whether the Member should be restricted to obtaining services from a single, designated Provider for a period of five years.
- Forwarding case information and supporting documentation to BPI at the address below, for review to determine appropriateness of restriction and to approve the action.
- Upon BPI approval, sending notification via certified mail to Member of proposed restriction, including reason for restriction, effective date and length of restriction, name of designated Provider(s) and option to change Provider, with a copy to BPI.
- Sending notification of Member's restriction to the designated Provider(s) and the County Assistance Office.
- Enforcing the restrictions through appropriate notifications and edits in the claims payment system.
- Preparing and presenting case at a DPW Fair Hearing to support restriction action.
- Monitoring subsequent utilization to ensure compliance.
- Changing the selected Provider per the Member's or Provider's request, within thirty (30) days from the date of the request, with prompt notification to BPI through the Intranet Provider change process.
- Continuing a Member restriction from the previous delivery system as a Member enrolls in the Managed Care Organization, with written notification to BPI.
- Reviewing the Member's services prior to the end of the five-year period of restriction to determine if the restriction should be removed or maintained, with notification of the results of the review to BPI, Member, Provider(s) and CAO.
- Performing necessary administrative activities to maintain accurate records.
- Educating Members and Providers to the restriction program, including explanations in handbooks and printed materials.

MA Recipients have the right to appeal a restriction by requesting a DPW Fair Hearing. Members may not file a Complaint or Grievance with the PH-MCO regarding the restriction action. A

request for a DPW Fair Hearing must be in writing, signed by the Member and sent to:

Department of Public Welfare
Office of Administration
Bureau of Program Integrity
Division of Program and Provider Compliance
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Phone number: (717) 772-4627

3. Contracts and Subcontracts

PH-MCO may, as provided below, rely on subcontractors to perform and/or arrange for the performance of services to be provided to Members on whose behalf the Department makes Capitation payments to PH-MCO. Notwithstanding its use of subcontractor(s), PH-MCO accepts and acknowledges its obligation and responsibility under this Agreement:

a. for the provision of and/or arrangement for the services to be provided under this Agreement;

b. for the evaluation of the prospective subcontractor's ability to perform the activities to be delegated;

c. for the payment of any and all claims payment liabilities owed to Providers for services rendered to Members under this Agreement, for which a subcontractor is the primary obligor provided that the Provider has exhausted its remedies against the subcontractor; provided further that such Provider would not be required to continue to pursue its remedies against the subcontractor in the event the subcontractor becomes Insolvent, in which case the Provider may seek payment of such claims from the PH-MCO. For the purposes of this section, the term "Insolvent" shall mean:

   i. The adjudication by a court of competent jurisdiction or administrative tribunal of a party as a bankrupt or otherwise approving a petition seeking reorganization, readjustment, arrangement, composition, or similar relief under the applicable bankruptcy laws or any other similar, applicable Federal or State law or statute; or

ii. The appointment by such a court or tribunal having competent jurisdiction of a receiver or receivers, or trustee, or liquidator or liquidators of a party or of all or any substantial part of its property upon the application of any creditor or other party entitled to so apply in any insolvency or bankruptcy proceeding or other creditor's suit; and

d. for the oversight and accountability for any functions and responsibilities delegated to any subcontractor.

The above notwithstanding, if the PH-MCO makes payments to a subcontractor over the course of a year that exceed one-half of the amount of the Department's payments to the PH-MCO, the PH-MCO is responsible for any obligation by the subcontractor to a Provider that is overdue by at least sixty (60) days.

PH-MCO shall indemnify and hold the Commonwealth of Pennsylvania, the Department and their officials, representatives and employees harmless from any and all liabilities, losses, settlements, claims, demands, and expenses of any kind (including but not limited to attorneys' fees) which are related to any and all Claims payment liabilities owed to Providers for services rendered to Members under this Agreement for which a subcontractor is the primary obligor, except to the extent that the PH-MCO and/or subcontractor has acted with respect to such Provider Claims in accordance with the terms of this Agreement.

The PH-MCO must make all Subcontracts available to the Department within five (5) days of a request by the Department. All Contracts and Subcontracts must be in writing and must include, at a minimum, the provisions contained in Exhibit II of this Agreement, Required Contract Terms for Administrative Subcontractors.

Subcontracts which must be submitted to the Department for advance written approval are:

Any Subcontract between the PH-MCO and any individual, firm, corporation or any other entity to perform part or all of the selected PH-MCO's responsibilities under this Agreement. This provision includes, but is not limited to, contracts for vision services, dental services, Claims processing, Member services, and pharmacy services. This provision does not include, for example, purchase orders.

4. Lobbying Disclosure

The PH-MCO is required to complete and return a “Lobbying Certification Form” and a “Disclosure of Lobbying Activities Form” found in Exhibit JJ of this Agreement, Lobbying Certification and Disclosure.

5. Records Retention

The PH-MCO will comply with the program standards regarding records retention, which are set forth in Exhibit D, Standard Grant Terms and Conditions for Services, of this Agreement, except that, for purposes of this Agreement, all records must be retained for a period of five (5) years beyond expiration or termination of the Agreement, unless otherwise authorized by the Department. Upon thirty (30) days notice from the Department, the PH-MCO must provide copies of all records to the Department at the PH-MCO's site, if requested. This thirty (30) days notice does not apply to records requested by the state or federal government for purposes of fiscal audits or Fraud and/or Abuse. The retention requirements in this section do not apply to DPW-generated Remittance Advices.

6. Fraud and Abuse

The PH-MCO must develop a written compliance plan that contains the following elements described in CMS publication “Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans” found at www.cms.hhs.gov/states/fraud:

- Written policies, procedures, and standards of conduct that articulate the PH-MCO’s commitment to comply with all Federal and State standards related to Medicaid MCOs.
- The designation of a compliance officer and a compliance committee that are accountable to PH-MCO senior management.
- Effective training and education for the compliance officer and MCO employees.
- Effective lines of communication between the compliance officer and MCO 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.

a. Fraud and Abuse Unit

The PH-MCO must establish 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 PH-MCO contracts. If the PH-MCO has multiple lines of business, the Fraud and Abuse Unit shall devote sufficient time and resources to Pennsylvania HealthChoices Program Fraud and Abuse activities. The Department has the right to make the final determination regarding whether or not the Contractor is in compliance with this requirement.

b. Written Policies

The PH-MCO must create and maintain written policies and procedures for the prevention, detection, investigation and reporting of suspected Fraud and Abuse, including written policies required under the Deficit Reduction Act. The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department for operation in a HC Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

c. Compliance with Agreement

The PH-MCO must, in order to remain in compliance with the Agreement, comply with its Fraud and Abuse policies and procedures.

d. Access to Provider Records

The PH-MCO's Fraud and Abuse policies and procedures must provide and certify that the PH-MCO's Fraud and Abuse unit has access to records of Network Providers.

e. Audit Protocol

The PH-MCO must inform all Network Providers of the Pennsylvania Medical Assistance Provider Self Audit

Protocol which allows Providers to voluntarily disclose overpayments or improper payments of MA funds.

The protocol is available on the Department's Web site at www.dpw.state.pa.us/ under "Fraud and Abuse."

f. Procedure for Identifying Fraud and Abuse

The policies and procedures 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 recipients 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.

g. Referral to the Department

The PH-MCO must establish a policy on referral of suspected Fraud and Abuse to the Department. A standardized referral process is outlined in Exhibit KK of this Agreement, Reporting Suspected Fraud and Abuse to the Department, to expedite information for appropriate disposition.

h. Education Plan

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

i. Referral to Senior Management

The PH-MCO must develop a certification process that demonstrates the policies and procedures were reviewed and approved by the PH-MCO's senior management.

j. Prior Department Approval

The Fraud and Abuse policies and procedures must be submitted to the Department for prior approval, and the Department may, upon review of these policies and procedures, require that specified changes be made within a designated time in order for the PH-MCO to remain in compliance with the terms of the Agreement. To the extent that changes to the Fraud and Abuse unit are made, or the policies or procedures are altered, updated policies and procedures must be submitted promptly to the Department. The Department may also require new or updated policies and procedures during the course of the Agreement period.

k. Duty to Cooperate with Oversight Agencies

The PH-MCO and its employees must cooperate fully with centralized oversight agencies responsible for Fraud and Abuse detection and prosecution activities. Such agencies include, but are not limited to, the Department's Bureau of Program Integrity, Governor's Office of the Budget, 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. In addition, such cooperation may include participating in periodic Fraud and Abuse training sessions, meetings, and joint reviews of subcontracted Providers or Members.

l. Hotline Information

The PH-MCO must ensure that the Department's toll-free MA Provider Compliance Hotline number and accompanying explanatory statement is distributed to its Members and Providers through its Member and Provider handbooks. Notwithstanding this requirement, the PH-MCO is not required to re-print handbooks for the sole purpose of revising them to include MA Provider Compliance Hotline information. The PH-MCO must, however, include such information in any new version of these documents to be distributed to Members and Providers.

m. Duty to Notify

i. Department's Responsibility

The Department will provide the PH-MCO with immediate notice via electronic transmission or access to Medicheck listings or upon request if a Provider with whom the PH-MCO has entered into an agreement is subsequently suspended or terminated from participation in the Medicaid or Medicare Programs. Upon notification from the Department that a Provider with whom the PH-MCO has entered into an agreement is suspended or terminated from participation in the Medicaid or Medicare Programs, the PH-MCO must immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

ii. PH-MCO's Responsibility

The PH-MCO may not knowingly have a Relationship with the following:

- An individual 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 in paragraph (a)(1).

"Relationship", for purposes of this section, is defined as follows:

- A director, officer, or partner of the PH-MCO.
- A person with beneficial ownership of five percent (5%) or more of the PH-MCO's equity.
- A person with an employment, consulting or other arrangement for the provision of items and services that are significant and material to the

PH-MCO's obligations under this Agreement with the Department.

The PH-MCO must immediately notify the Department, in writing, if a Provider or subcontractor with whom the PH-MCO has entered into an agreement is subsequently suspended, terminated or voluntarily withdraws from participation in the program as a result of suspected or confirmed Fraud or Abuse. The PH-MCO 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 PH-MCO must inform the Department, in writing, of the specific underlying conduct that lead to the suspension, termination, or voluntary withdrawal. Provider Agreements must carry notification of the prohibition and sanctions for submission of false Claims and statements. PH-MCOs who fail to report such information are subject to sanctions, penalties, or other actions. The Department's enforcement guidelines are outlined in Exhibit LL of this Agreement, Guidelines for Sanctions Regarding Fraud and Abuse.

The PH-MCO must also notify the Department if it recovers overpayments or improper payments related to Fraud, Abuse or waste of Medical Assistance funds from non-administrative overpayments or improper payments made to Network Providers, or otherwise takes an adverse action against a Provider, e.g. restricting the Members or services of a PCP.

n. Sanctions

The Department may impose sanctions, penalties, or take other actions if it determines that a PH-MCO, Network Provider, employee, or subcontractor has committed "Fraud" or "Abuse" as defined in this Agreement or has otherwise violated applicable law. Exhibit LL of this Agreement, Guidelines for Sanctions Regarding Fraud and Abuse, identifies the Fraud and Abuse issues that may result in sanctions, as well as the range of sanctions available to the Department.

o. Subcontracts

i. The PH-MCO will require that all Health Care Providers and all subcontractors take such actions as are necessary to permit the PH-MCO to comply with the Fraud and Abuse requirements listed in this Agreement.

ii. To the extent that the PH-MCO delegates oversight responsibilities to a third party (such as a Pharmacy Benefit Manager), the PH-MCO must require that such third party complies with sections 6a. – 6h. above, of this Agreement relating to Fraud and Abuse.

iii. Although all Health Care Providers with whom the PH-MCO subcontracts are enrolled in the MA program and subject to MA regulations, the PH-MCO agrees to require, via contract, that such Health Care Providers comply with MA regulations and any enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions, among others.

p. Fraud, Abuse and Prosecution Agencies

Disputes of any kind resulting from any action taken by the oversight agencies are directed to the responsible agency. Examples include: Department's Bureau of Program Integrity, the Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania Office of Inspector General, the CMS Office of Inspector General, and the United States Justice Department.

q. Overpayment Recovery

- The PH-MCO shall have the right to audit, review and investigate providers within its network. The PH-MCO shall have the right to recover any overpayments directly from its providers for audits, reviews or investigations conducted solely by the PH-MCO.

- The Department shall have the right to audit, review and investigate providers within the PH-MCO's network.

- The Department will develop a vetting process to coordinate audits, reviews or investigations of the PH-MCO's network providers to avoid duplication of effort.
- The Department will inform the PH-MCO of its findings related to the PH-MCOs network providers.

- Overpayment recoveries resulting from audits, reviews or investigations conducted solely by the Department will be recouped from the PH-MCO.
  - The PH-MCO shall recover any overpayments identified by the department from its provider after the PH-MCO receives the final results of the review from the department.
  - The PH-MCO shall remit the overpayment to the department no later than 180 calendar days after the PH-MCO receives the final result of the review from the department.

- The Department shall have the right to request the PH-MCO to withhold payment to a provider in its network as a result of the Department's audits, reviews or investigations of managed care claims.

- Joint reviews, audits or investigations between the PH-MCO and Department may be conducted. Any recoveries as a result of a joint audit, review or investigation shall be shared equally between the PH-MCO and Department.

7. Management Information Systems

The PH-MCO 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. See the information provided on the DPW Internet at the following link: http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/busandtechstandards/appii/index.htm.

a. The PH-MCO 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.

b. The PH-MCO 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 PH-MCO's membership files consistent with information provided by the Department. The PH-MCO 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 PH-MCO'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. The PH-MCO must also be able to cross-reference their internal Provider identification number to the correct PROMISe™ Provider ID and/or the Provider's NPI number in PROMISe™ for each location in which the provider renders services for the PH-MCO.

e. The PH-MCO's Claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements identified in this Agreement.

f. The PH-MCO's Authorization system must be linked with the Claims processing component.

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

h. The PH-MCO's credentialing system must have the capability to store and report on Provider specific data sufficient to meet the Provider credentialing requirements listed in Exhibit M(1), Quality Management and Utilization Management Program Requirements, of this Agreement.

i. The PH-MCO must have sufficient telecommunication capabilities, including electronic mail, to meet the requirements of this Agreement.

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

k. The PH-MCO's MIS must be bi-directionally linked to the other operational systems listed in this Agreement, 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.

l. The PH-MCO must comply with all applicable business and technical standards available on the DPW Internet site at the following link: http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/p_031942.pdf. This includes compliance with the standards for connectivity to the Commonwealth's network. The PH-MCO's MIS must be compatible with the Department's MIS. The PH-MCO must also comply with the Department's Se-Government Data Exchange Standards. In addition, the PH-MCO must comply with any changes made to the Commonwealth's Business and Technical Standards. Whenever possible, the Department will provide advance notice of at least sixty (60) days prior to the implementation of changes. For more complex changes, every effort will be made to provide additional notice.

m. The PH-MCO must be prepared to document its ability to expand Claims processing or MIS capacity should either or both be exceeded through the Enrollment of program Members.

n. The PH-MCO must designate appropriate staff to participate in DPW directed development and implementation activities.

o. Subcontractors must meet the same MIS requirements as the PH-MCO and the PH-MCO will be held responsible for MIS errors or noncompliance resulting from the action of a

subcontractor. The PH-MCO must provide its subcontractors with the appropriate files and information to meet this requirement (i.e. the daily eligibility file, provider files, etc.)

p. The PH-MCO's MIS shall be subject to review and approval during the Department's HealthChoices Readiness Review process as referenced in Section VI of this Agreement, Program Outcomes and Deliverables.

q. Prior to any major modifications to the PH-MCO's information system, including upgrades and/or new purchases, the PH-MCO must inform the Department in writing of the potential changes. A work plan detailing recovery effort and use of parallel system testing must be included.

r. The PH-MCO must be able to accept and generate HIPAA compliant transactions as requested by Providers or the Department.

s. The Department will make reference files (Drug, Procedure Code, Diagnosis Code) available to the PH-MCO on a routine basis that will allow it to effectively meet its obligation to provide services and record information consistent with requirements in this Agreement. If the PH-MCO chooses not to use these files, it is required to use comparable files to meet its obligation with this Agreement. Exhibit CC, Data Support for PH-MCOs, provides a listing of these files. Information about these files is available on the HealthChoices Intranet site.

t. The Department will make available provider informational files on a routine basis that will allow it to effectively meet its obligation consistent with requirements in this Agreement. These files include: List of Active and Closed Providers (PRV414 and PRV415) file; NPI Crosswalk (PRV430) file; and Managed Care Affiliations (PRV640Q) file. The Contractor must use these files to record and provide provider information, and to reconcile their provider file with the Department's provider file. The PRV414 and/or PRV415 file, in coordination with the PRV430 file, must be used monthly to reconcile the plan's provider file against the provider information listed in PROMIS*e*™ to include the following:

- Ensure all service locations are enrolled and active with Medical Assistance.
- Ensure provider license information is kept valid in PROMIS*e*™.
- Ensure the PT/Specialty is the same in PROMIS*e*™.
- Ensure the NPI is the same in PROMIS*e*™ for each service location.

Discrepancies must be addressed with the provider. The PRV640Q file must be used to reconcile what had been previously sent on the PRV640 files. Exhibit CC, Data Support for PH-MCOs, provides a listing of these files. Information about these files is available on the HealthChoices Intranet site.

u. The PH-MCO 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.

8. Department Access and Availability

The PH-MCO is responsible for providing Department staff with access to appropriate on-site private office space and equipment including, but not limited to, the following:

- Two (2) desks and two (2) chairs;
- Two (2) telephones, one (1) of which has speaker phone capabilities;
- One (1) personal computer and printer with on-line access to the PH-MCO's MIS;
- FAX machine; and
- Bookcase.

The PH-MCO must ensure Department access to administrative policies and procedures pertaining to operations under this Agreement, including, but not limited to;

- Personnel policies and procedures
- Procurement policies and procedures
- Public relations policies and procedures
- Operations policies and procedures

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

P. Special Needs Unit (SNU)

1. Establishment of Special Needs Unit

a. The PH-MCO must develop, train, and maintain a unit within its organizational structure to deal with issues relating to Members with Special Needs ("Special Needs Unit" [SNU]). The purpose of the SNU is to ensure that each Member with Special Needs receives access to PCPs, dentists, and specialists trained and skilled in the Special Needs of the Member; information about and access to a specialist, as appropriate; information about and access to all covered services appropriate to the Member's condition or circumstance, including Pharmacy, Durable Medical Equipment (DME); access to LEP and sign language interpreter services, LEP translation services and access to needed community services. The PH-MCO must show evidence they can execute agreements with individuals who have expertise in the treatment of Special Needs to provide consultation to the SNU staff, as needed.

b. The PH-MCO agrees to comply with the Department's requirements and determination of whether a Member shall be classified as having a Special Need, which determination must be based on criteria set forth in Exhibit NN of this Agreement, Special Needs Unit.

c. It is the responsibility of the SNU to arrange for and ensure coordination between the PH-MCO and other health, education, and human service systems for Members with Special Needs. See Exhibit OO of this Agreement, Coordination of Care Entities, for an example but not an all-inclusive list. The PH-MCO is responsible to coordinate the comprehensive in-plan package of services with entities providing Out-of-Plan Services.

d. The PH-MCO must assure that outpatient case management services for Members under age twenty-one (21) are not provided through any individual employed by the PH-MCO or through a subcontractor of the PH-MCO if the individual's responsibilities include outpatient utilization review or otherwise include reviews of requests for authorization of outpatient benefits. In addition, if the PH-MCO provides

Case Management Services to Members under the age of twenty-one (21) through the SNU, the PH-MCO must assure that the SNU assists individuals in gaining access to necessary medical, social, education, and other services in accordance with MA Bulletin #1239-94-01 Medical Assistance Case Management Services for Recipients Under the Age of 21.

e. The PH-MCO must comply with SNU reporting requirements as specified by the Department and described in Exhibit NN of this Agreement, Special Needs Unit.

2. Special Needs Coordinator

The PH-MCO must employ a full-time SNU Coordinator. Required qualifications for this position are set forth in Section V.N of this Agreement, Other Administrative Components.

3. Responsibilities of Special Needs Unit Staff

a. The PH-MCO agrees that the staff members which it employs within the SNU must assist Members in accessing services and benefits and act as liaisons with various government offices, Providers, public entities, and county entities which shall include, but shall not be limited to the list of Providers in Exhibit OO of this Agreement, Coordination of Care Entities.

b. The staff members of this unit must work in close collaboration with the Special Needs Section (SNS) operated by the Department and the EAP contractor's SN contact person.

c. The PH-MCO must demonstrate to the Department that its SNU staff is qualified to perform the functions outlined in Exhibit NN of this Agreement, Special Needs Unit.

Q. Assignment of PCPs

The PH-MCO must have written policies and procedures for Members and parents, guardians, or others acting in loco parentis for Members with Special Needs, who require assistance in the selection of a PCP. The PH-MCO must receive advance written approval by the Department regarding these policies and procedures. The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures

which have been prior approved by the Department for operation in a HC Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

The PH-MCO must ensure that the process includes, at a minimum, the following features:

- The PH-MCO must ensure that a Member's selection of a PCP through the EAP contractor is honored upon commencement of PH-MCO coverage. If the PH-MCO is not able to honor the selection, the PH-MCO is required to follow the guidelines described further under this provision.

- The PH-MCO is permitted to allow selection of a PCP group. Should the PH-MCO permit selection of a PCP group and the Member has selected a PCP group in the PH-MCO's Network through the Enrollment Specialist, the PH-MCO must ensure that upon commencement of the PH-MCO coverage, the Member's selection is honored. In addition, the PH-MCO is permitted to assign a PCP group to a Member if the Member has not selected a PCP or a PCP group at the time of Enrollment.

- If the Member has not selected a PCP through the Enrollment Specialist for reasons other than cause, the PH-MCO must make contact with the Member within seven (7) Business Days of his or her Enrollment and provide information on options for selecting a PCP, unless the PH-MCO has information that the Member should be immediately contacted due to a medical condition requiring immediate care. To the extent practical, the PH-MCO must offer freedom of choice to Members in making a PCP selection.

- If a Member does not select a PCP within fourteen (14) Business Days of Enrollment, the PH-MCO must make an automatic assignment. The PH-MCO must consider such factors (to the extent they are known), as current Provider relationships, need of children to be followed by a pediatrician, special medical needs, physical disabilities of the Member, language needs, area of residence and access to transportation. The PH-MCO must then notify the Member by telephone or in writing of his/her PCP's name, location and office telephone number. The PH-MCO must make every effort to determine PCP choice and confirm this with the Member prior to the commencement of the PH-MCO coverage in accordance with Section V.F of this Agreement, Member Enrollment and Disenrollment, so that new Members do not go without a PCP for a period of time after Enrollment begins.

- The PH-MCO must take into consideration, language and cultural compatibility between the Member and the PCP.

- If a Member requests a change in his or her PCP selection following the initial visit, the PH-MCO must promptly grant the request and process the change in a timely manner.

- The PH-MCO must have written policies and procedures for allowing Members to select or be assigned to a new PCP whenever requested by the Member, when a PCP is terminated from the PH-MCO's Network or when a PCP change is required as part of the resolution to a Grievance or Complaint proceeding. The policies and procedures must receive advance written approval by the Department.

- In cases where a PCP has been terminated for reasons other than cause, the PH-MCO must immediately inform Members assigned to that PCP in order to allow them to select another PCP prior to the PCP's termination effective date. In cases where a Recipient fails to select a new PCP, re-assignment must take place prior to the PCP's termination effective date.

- The PH-MCO must consider that a Member with Special Needs can request a specialist as a PCP. If the PH-MCO denies the request, that Denial is appealable.

- If a member with special health care needs (including but not limited to chronic illnesses or physical and developmental disabilities) who is 18 (eighteen) years of age or older uses a Pediatrician or Pediatric Specialist as a PCP, the PH-MCO must, upon request from a family member, assist with the transition to a PCP who provides services for adults.

Should the PH-MCO choose to implement a process for the assignment of a primary dentist, the PH-MCO must submit the process for advance written approval from the Department prior to its implementation.

R. Provider Services

The PH-MCO must operate Provider services functions at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday). Provider services functions include, but are not limited to, the following:

- Assisting Providers with questions concerning Member eligibility status.

- Assisting Providers with PH-MCO Prior Authorization and referral procedures.

- Assisting Providers with Claims payment procedures and handling Provider Disputes and issues.

- Facilitating transfer of Member medical records among medical Providers, as necessary.

- Providing to PCPs a monthly list of Members who are under their care, including identification of new and deleted Members. An explanation guide detailing use of the list must also be provided to PCPs.

- Developing a process to respond to Provider inquiries regarding current Enrollment.

- Coordinating the administration of Out-of-Plan Services.

1. Provider Manual

The PH-MCO must keep its Network Providers up-to-date with the latest policy and procedures changes as they affect the MA Program. The key to maintaining this level of communication is the publication of a Provider manual. Copies of the Provider manual must be distributed in a manner that makes them easily accessible to all participating Providers. The PH-MCO may specifically delegate this responsibility to large Providers in its Provider Agreement. The Provider manual must be updated annually. The Department may grant an exception to this annual requirement upon written request from the PH-MCO provided there are no major changes to the manual. For a complete description of the Provider manual contents and information requirements, refer to Exhibit PP of this Agreement, Provider Manuals.

2. Provider Education

The PH-MCO must demonstrate that its Provider Network is knowledgeable and experienced in treating Members with Special Needs. The PH-MCO must submit an annual Provider Education and Training plan to the Department that outlines its plans to educate and train Providers. This training plan can be done in conjunction with the SNU training requirements as outlined in

Exhibit NN to this Agreement, Special Needs Unit, and must also include Special Needs Recipients, advocates and family members in developing the design and implementation of the training plan.

The PH-MCO must submit in its annual plan the PH-MCO process for measuring training outcomes including the tracking of training schedules and Provider attendance.

At a minimum, the PH-MCO must conduct the Provider training for PCPs and dentists, as appropriate, and include the following areas:

a. EPSDT training for any Providers who serve Members under age twenty-one (21).

b. Identification and appropriate referral for mental health, drug and alcohol and substance abuse services.

c. Sensitivity training on diverse and Special Needs populations such as persons who are deaf or hard of hearing: how to obtain sign language interpreters and how to work effectively with sign language interpreters.

d. Cultural Competency, including: the right of Members with limited English proficiency to engage in effective communication in their language; how to obtain interpreters, and; how to work effectively with interpreters.

e. Treating Special Needs populations, including the right to treatment for individuals with disabilities.

f. Administrative processes that include, but are not limited to: coordination of benefits, Recipient Restriction Program, Encounter Data reporting and Dual Eligibles.

g. Issues identified by Provider relations or Provider hotline staff in response to calls or complaints by Providers.

h. Issues identified through the Quality Management process.

The PH-MCO may submit an alternate Provider training and education plan should the PH-MCO wish to combine its activities with other PH-MCOs operating in the HealthChoices Zone covered by this Agreement or wish to develop and implement new and innovative methods for Provider training and education. However, this alternative plan must have advance written approval by the Department. Should the Department approve an alternative plan,

the PH-MCO must have the ability to track and report on the components included in the PH-MCO's alternative Provider training and education plan.

3. Panel Listing Requirements

The PH-MCO is required to give its Network Providers panel listings of Members who receive EPSDT services. Panel listings should be provided electronically at the request of the Provider, in a format determined by the PH-MCO. Panel listings supplied to Providers must include, at least, the following data elements:

- Member identification (Last, First and Middle Name)
- Date of birth
- Age
- Telephone number
- Address
- Identification of new patients
- Date of last EPSDT Screen
- Screen Due or Overdue

S. Provider Network

The PH-MCO must establish and maintain adequate Provider Networks to serve all of the eligible HealthChoices populations in this HC Zone. Provider Networks must include, but not be limited to: hospitals, children's tertiary care hospitals, specialty clinics, trauma centers, facilities for high-risk deliveries and neonates, specialists, dentists, orthodontists, physicians, pharmacies, emergency transportation services, long-term care facilities, rehab facilities, home health agencies, certified hospice providers and DME suppliers in sufficient numbers to make available all services in a timely manner. Detailed requirements related to the composition of Provider Networks and members' access to services from the providers in those networks are located in Exhibit AAA(1), AAA(2), or AAA(3), Provider Network Composition/Service Access, as applicable.

If the PH-MCO's Provider Network is unable to provide necessary medical services covered under the Agreement, to a particular Member, the PH-MCO must adequately and timely cover these services out-of-network, for

the Member for as long as the PH-MCO is unable to provide them and must coordinate with the Out-of-Network Provider with respect to payment.

1. Provider Agreements

The PH-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Member access to all Medically Necessary services covered by the HealthChoices Program.

The requirements for these Provider Agreements are set forth in Exhibit CCC to this Agreement, PH-MCO Provider Agreements.

2. Cultural Competency

Both the PH-MCO and Providers must demonstrate Cultural Competency and must understand that racial, ethnic and cultural differences between Provider and Member cannot be permitted to present barriers to accessing and receiving quality health care; must demonstrate the willingness and ability to make the necessary distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the Member's racial, ethnic or cultural background and which may be equally or more effective and appropriate for the particular Member; and demonstrate consistency in providing quality care across a variety of races, ethnicities and cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, etc., may make one treatment method more palatable to a Member of a particular culture than to another of a differing culture.

3. Primary Care Practitioner (PCP) Responsibilities

The PH-MCO must have written policies and procedures for assuring that every Member is assigned to a PCP. The PCP must serve as the Member's initial and most important point of contact regarding health care needs. As such, PCP responsibilities include at a minimum:

a. Providing primary and preventive care and acting as the Member's advocate, providing, recommending and arranging for care.

b. Documenting all care rendered in a complete and accurate Encounter record that meets or exceeds the DPW data specifications.

c. Maintaining continuity of each Member's health care.

d. Communicating effectively with the Member by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with LEP when needed by the Member. Services must be free of charge to the Member.

e. Making referrals for specialty care and other Medically Necessary services, both in and out-of-plan.

f. Maintaining a current medical record for the Member, including documentation of all services provided to the Member by the PCP, as well as any specialty or referral services.

g. Arranging for Behavioral Health Services in accordance with Exhibit U of this Agreement, Behavioral Health Services.

The PH-MCO agrees to retain responsibility for monitoring PCP actions to ensure they comply with the provisions of this Agreement.

4. Specialists as PCPs

A Member may qualify to select a specialist to act as PCP if s/he has a disease or condition that is life threatening, degenerative, or disabling.

The PH-MCO must adopt and maintain procedures by which a Member with a life-threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation and, if the PH-MCO's established standards are met, be permitted to receive:

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

- The designation of a specialist to provide and coordinate the Member's primary and specialty care.

The referral to or designation of a specialist must be pursuant to a treatment plan approved by the PH-MCO, in consultation with the PCP, the Member and, as appropriate, the specialist. When possible, the specialist must be a Health Care Provider participating in the PH-MCO's Network. If the specialist is not a Network

Provider, the PH-MCO may require the specialist to meet the requirements of the PH-MCO's Network Providers, including the PH-MCO's credentialing criteria and QM/UM Program policies and procedures.

Information for Recipients must include a description of the procedures that a Member with a life-threatening, degenerative or disabling disease or condition shall follow and satisfy to be eligible for:

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

- The designation of a specialist to provide and coordinate the Member's primary and specialty care.

It is the responsibility of the PH-MCO to ensure adequate Network capacity of qualified specialists as PCPs. These physicians may be predetermined and listed in the directory but may also be determined on an as needed basis. All determinations must comply with specifications set out by Act 68 regulations. The PH-MCO must establish and maintain its own credentialing and recredentialing policies and procedures to ensure compliance with these specifications.

The PH-MCO must ensure that Providers credentialed as specialists and as PCPs agree to meet all of the PH-MCO's standards for credentialing PCPs and specialists, including compliance with record keeping standards, the Department's access and availability standards and other QM/UM Program standards. The specialist as a PCP must agree to provide or arrange for all primary care, consistent with PH-MCO preventive care guidelines, including routine preventive care, and to provide those specialty medical services consistent with the Member's "special need" in accordance with the PH-MCO's standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist as a PCP also must have admitting privileges at a hospital in the PH-MCO's Network.

5. Related Party Hospitals

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.

6. Mainstreaming

The PH-MCO must ensure that Network Providers do not intentionally segregate their Members in any way from other persons receiving services.

The PH-MCO must investigate Complaints and take affirmative action so that Members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, MA status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

- Denying or not providing a Member any MA covered service or availability of a facility within the PH-MCO's Network. The PH-MCO must have explicit policies to provide access to complex interventions such as cardiopulmonary resuscitations, intensive care, transplantation and rehabilitation when medically indicated and must educate its Providers on these policies. Health care and treatment necessary to preserve life must be provided to all persons who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

- Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members, public or private patients, in any manner related to the receipt of any MA covered service, except where Medically Necessary.

- The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, language, MA status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the participants to be served.

If the PH-MCO knowingly executes an agreement with a Provider with the intent of allowing or permitting the Provider to implement barriers to care (i.e. the terms of the Provider Agreement are more

restrictive than this Agreement), the PH-MCO shall be in breach of this Agreement.

7. Network Changes/Provider Terminations

a. Network Changes

i) Notification to the Department
Other than terminations outlined below in Section 7.b (Provider Terminations), the PH-MCO must review its network and notify the Department of any changes to its Provider Network (closed panels, relocations, death of a provider, etc.) through the quarterly additions/deletions provider network reporting.

ii) Procedures and Work Plans
The PH-MCO must have procedures to address changes in its Network that impact Member access to services, in accordance with the requirements of Exhibit AAA (1), AAA(2), or AAA(3), as applicable, Network Composition, of this Agreement. Failure of the PH-MCO to address changes in Network composition that negatively affect Member access to services may be grounds for termination of this Agreement.

iii) Timeframes for Notification to Members
The PH-MCO must update web-based Provider directories to reflect any changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

b. Provider Terminations
The PH-MCO must comply with the Department's requirements for provider terminations as outlined in Exhibit C, PH-MCO Requirements for Provider Terminations.

8. Other Provider Enrollment Standards

The PH-MCO will comply with the program standards regarding Provider enrollment that are set forth in this Agreement.

All Providers operating within the PH-MCO's Network who provide services to Recipients must be enrolled in the Commonwealth's MA Program and possess an active PROMISe™ Provider ID for each location in which they provide services for the PH-MCO. In addition, the PH-MCO must be able to store and utilize the

PROMISe™ Provider ID and NPI stored in PROMISe™ for each location.

The PH-MCO must enroll a sufficient number of Providers qualified to conduct the specialty evaluations necessary for investigating alleged physical and/or sexual abuse.

The Department encourages the use of Providers currently contracting with the County Children and Youth Agencies who have experience with the foster care population and who have been providing services to children and youth Recipients for many years.

9. Twenty-Four Hour Coverage

It is the responsibility of the PH-MCO to have coverage available directly or through its PCPs, who may have on-call arrangements with other qualified Providers, for urgent or emergency care on a twenty-four (24) hour, seven (7) day-a-week basis. The PH-MCO must not use answering services in lieu of the above PCP emergency coverage requirements without the knowledge of the Member. For Emergency or Urgent Medical Conditions, the PH-MCO must have written policies and procedures on how Members and Providers can make contact to receive instruction for treatment. If the PCP determines that emergency care is not required, 1) the PCP must see the Member in accordance with the time frame specified in Exhibit AAA(1), AAA(2), or AAA(3), as applicable, under Appointment Standards, or 2) the Member must be referred to an urgent care clinic which can see the Member in accordance with the time frame specified in Exhibit AAA(1), AAA(2), or AAA(3), as applicable, under Appointment Standards.

T. QM and UM Program Requirements

1. Overview

The PH-MCO must comply with the Department's Quality Management (QM) and Utilization Management (UM) Program standards and requirements described in Exhibit M(1) Quality Management and Utilization Management Program Requirements, Exhibit M(2) External Quality Review, and Exhibit M(4) Healthcare Effectiveness Data and Information Set (HEDIS). The Quality Management/Utilization Management Deliverables are available on the HealthChoices Intranet site. The Department retains the right of advance written approval and to review on an ongoing basis all aspects of the PH-MCO QM and UM programs, including

subsequent changes. The PH-MCO must comply with all QM and UM program reporting requirements and must submit data in formats to be determined by the Department.

The Department, in collaboration with the PH-MCO, retains the right to determine and prioritize QM and UM activities and initiatives based on areas of importance to the Department and CMS.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

The PH-MCO must submit HEDIS data to the Department by June 15th of the current year.as outlined in Exhibit M(4) Healthcare Effectiveness Data and Information Set (HEDIS). The previous calendar year is the standard measurement year for HEDIS data.

3. External Quality Review (EQR)

On at least an annual basis, the PH-MCO agrees to cooperate fully with any external evaluations and assessments of its performance authorized by the Department under this Agreement and conducted by the Department's contracted External Quality Review Organization (EQRO) or other designee. Independent assessments will include, but not be limited to, any independent evaluation required or allowed by federal or state statute or regulation. See Exhibit M(2) External Quality Review. The Department may use the term PA Performance Measures in place of External Quality Review performance measures throughout this Agreement.

4. Pay for Performance Programs

The Department conducts a Pay for Performance (P4P) Program that provides financial incentives for MCOs that meet quality goals. Information regarding Provider Pay for Performance Programs may be found in Exhibit B(3), HealthChoices Provider Pay for Performance Program.

5. QM/UM Program Reporting Requirements

The PH-MCO agrees to comply with all QM and UM program reporting requirements and time frames outlined in Exhibit M(1) Quality Management and Utilization Management Program Requirements and Quality Management/Utilization Management Deliverables, available on the HealthChoices Intranet. The Department will, on a periodic basis, review the required reports and make changes to the information/data and/or formats requested based on the changing needs of the HealthChoices Program. The PH-MCO must comply with all requested changes to

the report information and formats as deemed necessary by the Department. The Department will provide the PH-MCO with at least sixty (60) days notice of changes to the QM/UM reporting requirements. Information regarding QM and UM reporting requirements may be found on the HealthChoices Intranet at: http://dpwintra.dpw.state.pa.us/HealthChoices/custom/program/repreq/qmum/qmum.asp

6. Delegated Quality Management and Utilization Management Functions

Compensation and payments to individuals or entities that conduct Utilization Management activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

7. Consumer Involvement in the Quality Management and Utilization Management Programs

The PH-MCO agrees to participate and cooperate in the work and review of the Department's formal advisory body through participation in the Medical Assistance Advisory Committee (MAAC) and its subcommittees.

8. Confidentiality

The PH-MCO must have written policies and procedures for maintaining the confidentiality of data that addresses medical records, Member information and Provider information and is in compliance with the provisions set forth in Section 2131 of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2131; 55 Pa. Code 105; and 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information).

The PH-MCO must ensure that Provider offices/sites have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information to persons outside the PH-MCO.

Release of data by the PH-MCO to third parties requires the Department's advance written approval, except for releases for the purpose of individual care and coordination among Providers, releases authorized by the Member or those releases required by court order, subpoena or law.

9. Department Oversight

The PH-MCO and its subcontractor(s) agree to make available to the Department upon request, data, clinical and other records and reports for review of quality of care, access and utilization issues including but not limited to activities related to External Quality Review, HEDIS, Encounter Data validation, and other related activities.

The PH-MCO must submit a plan, in accordance with the time frames established by the Department, to resolve any performance or quality of care deficiencies identified through ongoing monitoring activities and any independent assessments or evaluations requested by the Department.

The PH-MCO must obtain advance written approval from the Department before releasing or sharing data, correspondence and/or improvements from the Department regarding the PH-MCO's internal QM and UM programs with any of the other HealthChoices PH-MCOs or any external entity.

The PH-MCO must obtain advance written approval from the Department before participating in or providing letters of support for QM or UM data studies and/or any data related external research projects related to HealthChoices with any entity.

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

1. Mergers and Acquisitions

The Department must be notified at least thirty (30) calendar days in advance of a merger or acquisition of the PH-MCO. The PH-MCO must be responsible for bearing the cost of reprinting HealthChoices outreach material, if a change involving content is made prior to the EAP's annual revision of materials.

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

The PH-MCO must submit mark, insignia, logo, and product name changes within thirty (30) calendar days of projected implementation for the Department's review. The PH-MCO must be responsible for bearing the cost of reprinting HealthChoices outreach materials, if a change is made prior to the EAP's annual revision of materials. These changes, made by the PH-MCO include, but are not limited to, change in mark, insignia, logo, and product name of the PH-MCO.

SECTION VI: PROGRAM OUTCOMES AND DELIVERABLES

The PH-MCO must obtain Department's prior written approval of all Deliverables prior to the operational date of the Initial Term and throughout the duration of the Agreement unless otherwise specified by the Department. Deliverables include, but are not limited to: operational policies and procedures, required materials, letters of agreement, Provider Agreements, Provider reimbursement methodology, coordination agreements, reports, tracking systems, required files, QM/UM documents, and referral systems.

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

The Department will conduct on-site Readiness Reviews, for implementation of a new procurement or reprocurement, to document the PH-MCO's compliance with this Agreement. Upon request by the Department, as part of the readiness review, the Contractor must provide detailed written descriptions of how the Contractor is complying with Agreement requirements and standards. The Department retains the right to continue development of readiness review elements, program standards and forms prior to scheduling the actual on-site readiness review visits.

SECTION VII: FINANCIAL REQUIREMENTS

A. Financial Standards

As proof of financial responsibility and adequate protection against insolvency in accordance with 42 CFR 438.116, the PH-MCO agrees to the requirements in Section VII.A.

1. Risk Protection Reinsurance for High Cost Cases

If this Agreement includes a High Cost Risk Pool, risk protection reinsurance is not required. Reinsurance is also not required if the PH-MCO has, at a minimum, a combined membership of 60,000 Members across all Pennsylvania lines of business.

a. If risk protection reinsurance is required, the reinsurance must cover, at a minimum, eighty (80) percent of Inpatient costs incurred by one (1) Member in one (1) year in excess of $200,000 except as provided at 1. b) below. The Department reserves the right to alter or waive the reinsurance requirement if the PH-MCO proposes an alternative risk protection arrangement that the Department determines is acceptable.

The PH-MCO may not change or discontinue the approved risk protection arrangement without advance written approval from the Department, which approval shall not be unreasonably withheld. Not less than forty-five (45) days before each risk protection arrangement expires, the PH-MCO must provide the Department with a detailed plan for risk protection after the current arrangement expires, including any planned changes. The PH-MCO must submit each risk protection arrangement to the Department for prior approval. If the risk protection arrangement is an annual agreement, each annual agreement must be submitted to the Department for prior approval.

b. The reinsurance threshold requirement shall be $100,000, if any of the following criteria is met:

i. The PH-MCO has been operational (providing medical benefits to any type of consumer) for less than three (3) years; or

ii. The PH-MCO's Statutory Accounting Principles (SAP) basis Equity is less than six (6.0) percent of revenue earned by the licensed HMO during the most recent four (4) quarters for which the due date has passed for submission of the unaudited reports filed by the PH-MCO with the Pennsylvania Insurance Department (PID); or

iii. The net income as reported to the Pennsylvania Insurance Department over the past three (3) years was less than zero.

c. The PH-MCO may not purchase required reinsurance risk protection from a Related Party or an Affiliate unless all of the following conditions are met:

- The Related Party or Affiliate is a reinsurance or insurance company in the business to provide such reinsurance risk protection;

- The PH-MCO's reinsurance risk protection annual premium is less than six (6.0) percent of the Related Party or Affiliate's total annual written reinsurance or insurance related premium; and

- The PH-MCO has received prior written approval from the Department to purchase the reinsurance risk protection from the Related Party or Affiliate.

2. Equity Requirements and Solvency Protection

The PH-MCO must meet the Equity and solvency protection requirements set forth below. The PH-MCO must comply with all financial requirements included in this Agreement, in addition to those of the Pennsylvania Insurance Department.

The PH-MCO must maintain SAP-basis Equity 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;

- 6.000% of revenue earned by the licensed HMO during the most recent four (4) calendar quarters; or

- 6.000% of revenue earned by the licensed HMO during the current quarter multiplied by three (3).

Revenue, for the purpose of the Equity 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 Pennsylvania Insurance Department report.

For the purpose of this requirement, Equity 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 Pennsylvania Insurance Department (PID). The Department will accept PID determinations of Equity amounts, and in the absence of such determination, will rely on required financial statements filed by the PH-MCO with PID to determine Equity amounts.

The PH-MCO must provide the Department with reports as specified in Section VIII.D of this Agreement, Financial Reports.

3. Risk Based Capital (RBC)

The RBC ratio is defined as:

- The Total Adjusted Capital figure in Column One from the page titled Five Year Historical Data in the Annual Statement for the most recent year filed most recently with the Pennsylvania Insurance Department, divided by the Authorized Control Level Risk-based Capital figure .

The PH-MCO must maintain a RBC ratio of 2.0.

4. Prior Approval of Payments to Affiliates

With the exception of payment of a Claim for a medical product or service that was provided to a Member, and that is paid in accordance with a written agreement with the Provider, the PH-MCO may not pay money or transfer any assets for any reason to an Affiliate without prior approval from the Department, if any of the following criteria apply:

a. The PH-MCO's RBC ratio was less than 2.0 as of December 31 of the most recent year for which the due date for filing the annual unaudited Pennsylvania Insurance Department financial report has passed;

b. The PH-MCO was not in compliance with the Agreement Equity and solvency protection requirement as of the last day of the most recent quarter for which the due date for filing Pennsylvania Insurance Department financial reports has passed;

c. After the proposed transaction took place, the PH-MCO would not be in compliance with the Agreement Equity and solvency protection requirement; or

d. Subsequent adjustments are made to the PH-MCO's financial statement as the result of an audit, or otherwise modified, such that after the transaction took place, a final determination is made that the PH-MCO was not in compliance with the contract Equity requirements. In this event, the Department may require repayment of amounts involved in the transaction.

The Department may elect to waive the requirements of this section.

5. Change in Independent Actuary or Independent Auditor

The PH-MCO must notify the Department 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.

6. Modified Current Ratio

The PH-MCO must maintain current assets, plus long-term investments that can be converted to cash within five (5) Business Days without incurring a penalty of more than twenty (20) percent, that equal or exceed current liabilities.

- If a penalty for conversion of long-term investments is applicable, only the value net of the penalty may be counted for the purpose of compliance with this requirement.

- The definitions of current assets and current liabilities are included in the Financial Reporting Requirements.

- Restricted assets may be included only with authorization from the Department.

- The following types of long-term investments may be counted, consistent with above requirements, so long as they are not issued by or include an interest in an Affiliate:

  – Certificates of Deposit
  – United States Treasury Notes and Bonds
  – United States Treasury Bills
  – Federal Farm Credit Funding Corporation Notes and Bonds
  – Federal Home Loan Bank Bonds
  – Federal National Mortgage Association Bonds
  – Government National Mortgage Association Bonds
  – Municipal Bonds
  – Corporate Bonds
  – Stocks
  – Mutual Funds

7. Limitation of Liability

In accordance with 42 CFR 438.106, the PH-MCO must assure that Members shall not be liable for the PH-MCO's debts if the PH-MCO becomes insolvent.

8. Sanctions

In addition to the Department's general sanction authority specified in Section VIII.I of this Agreement, Sanctions, if the PH-MCO fails to comply with the requirements of Section VII.A, the Department may take any or all of the following actions, in accordance with 42 CFR 438.700; 438.702; and 438.704:

- Discuss fiscal plans with the PH-MCO's management;
- Suspend payments or a portion of payments for Members enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for the imposition of the sanction no longer exists and is not likely to recur;
- Require the PH-MCO to submit and implement a corrective action plan;
- Suspend some or all Enrollment of Members into the PH-MCO, including auto-assignments, after the effective date of the sanction; and/or
- Terminate this Agreement upon forty-five (45) days written notice, in accordance with Section XI of this Agreement, Termination and Default.

In addition, the sanctions described above may be imposed when a PH-MCO acts or fails to act as follows:

- Fails substantially to arrange for Medically Necessary services that the PH-MCO is required to provide under law or under its Agreement with the State, to a Member covered under the Agreement.
- Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among Members on the basis of their health status or need for health care services.

- Misrepresents or falsifies information that it furnishes to CMS, the State, Members, potential Members, or Health Care Providers.

- Fails to comply with requirements for Physician Incentive Plans as set forth in 42 CFR 422.208 and 422.210.

- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

9. Medical Cost Accruals

As part of its accounting and budgeting function, the PH-MCO must establish and maintain an actuarially sound process for estimating and tracking Incurred But Not Reported (IBNR) amounts. The PH-MCO must reserve funds by major categories of service to cover IBNR amounts. As part of its reserving methodology, the PH-MCO must conduct annual reviews to assess its reserving methodology and make adjustments, as necessary.

10. DSH/GME Payment for Disproportionate Share Hospitals (DSH)/ Graduate Medical Education (GME)

The Department will make direct payments of DSH/GME to hospitals. DSH and GME amounts shall not be included in FFS cost equivalent projections or in Capitation payments paid by the Department to the PH-MCO.

11. Member Liability

The PH-MCO is prohibited from holding the Member liable for the following:

a. Debts of the PH-MCO in the event of the PH-MCO's insolvency.

b. Services provided to the Member in the event of the PH-MCO 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 PH-MCO failing to receive payment from the Department or the PH-MCO for such services.

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

B. Commonwealth Capitation Payments

1. Payments For In-Plan Services

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

a. Capitation Payments

i. The PH-MCO shall receive capitated payments for In-Plan Services as defined in Section VII.B.1 of this Agreement, Payments for In-Plan Services, and in Appendix 3b, Explanation of Capitation Payments.

ii. The Department will compute Capitation payments using per diem rates. The Department will make a monthly payment to the PH-MCO for each Recipient enrolled in the PH-MCO, for the first day in the month the Recipient is enrolled in the PH-MCO and for each subsequent day, through and including the last day of the month.

iii. The Department will not make a Capitation payment for a Recipient Month if the Department notifies the PH-MCO before the first of the month that the individual's MA eligibility or PH-MCO Enrollment ends prior to the first of the month.

iv. The Department will seek to make arrangements for payment by wire transfer or electronic funds transfer. If such arrangements are not in place, payment shall be made by U.S. Mail.

v. This paragraph v. will be applicable only upon notice to the PH-MCO by the Department, for months specified by the Department. By the fifteenth (15^{th}) of each month, the Department will make a Capitation

payment, referenced in Section VII.B.1.a, for each Member for all dates of Enrollment indicated on the Department's CIS through the last day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the PH-MCO.

vi. This paragraph vi. is applicable unless it is superseded by paragraph v. above. By the fifteenth (15^{th}) of each month, the Department will make a Capitation payment, referenced in Section VII.B.1.a, for each Member for all dates of Enrollment indicated on the Department's CIS prior to the first day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the PH-MCO.

Exception: Any Capitation payment that would otherwise be payable in the month of June will be payable by July 15 of the same year.

vi The Department will recover Capitation payments made for Members who were later determined to be ineligible for managed care for up to twelve (12) months after the service month for which payment was made. The Department will recover Capitation payments made for deceased Recipients for up to eighteen (18) months after the service month for which payment was made. See Exhibit BB of this Agreement, MCO Recipient Coverage Document.

2. Maternity Care Payment

For each live birth, the Department will make a one-time maternity care payment to the PH-MCO with whom the mother is enrolled on the date of birth; however, if the mother is admitted to a hospital and a change in the PH-MCO coverage occurs during the hospital admission, the PH-MCO responsible for the hospital stay shall receive the maternity care payment. In the event of multiple births (twins, etc.), the Department will make only one maternity care payment.

The PH-MCO must pay fees for delivery services at least equal to the Department's Medical Assistance fee schedule when the PH-MCO is the primary payer.

The PH-MCO must submit information on maternity events to PROMISe™ in accordance with Section VIII.B.6. of this Agreement.

The PH-MCO must follow and maintain written policies and procedures for receiving, processing, and reconciling maternity care payments.

3. Program Changes

Amendments, revisions, or additions to the Medicaid State Plan or to state or federal regulations, laws, guidelines, or policies shall, insofar as they affect the scope or nature of benefits available to eligible persons, amend the PH-MCO's obligations as specified herein, unless the Department notifies the PH-MCO otherwise. The Department will inform the PH-MCO of any changes, amendments, revisions, or additions to the Medicaid State Plan or changes in the Department's regulations, guidelines, or policies in a timely manner.

If the scope of consumers or services, inclusive of limitations on those services, that are the responsibility of the PH-MCO is changed, the Department will determine whether the change is sufficient that an actuarial analysis might conclude that a rate change is appropriate. If yes, the Department will 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 the Department will consider input from the PH-MCO, 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 consumers that are the responsibility of the PH-MCO is changed, upon request by the PH-MCO, 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 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.

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**,** unless modified to reflect changes to the scope of services or consumers in the manner described in the preceding paragraph.

C. Appeals Relating to Actuarially Sound Rates

By executing the Agreement, the PH-MCO has reviewed the rates set forth in Appendix 3f, Capitation Rates, and accepts the rates for the relevant Agreement period.

D. Claims Processing Standards, Monthly Report and Penalties

1. Timeliness Standards

The PH-MCO must adjudicate Provider Claims consistent with the requirements below. These requirements apply collectively to Claims processed by the PH-MCO and any subcontractor. Subcapitation payments are excluded from these requirements.

The adjudication timeliness standards follow for each of three (3) categories of Claims:

a. Claims received from a hospital for inpatient admissions ("Inpatient")

90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt.

100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt.

100.0% of all Claims must be adjudicated within ninety (90) days of receipt.

b. Drug Claims

90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt.

100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt.

100.0% of all Claims must be adjudicated within ninety (90) days of receipt.

c. All Claims other than inpatient and drug:

90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt.

100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt.

100.0% of all Claims must be adjudicated within ninety (90) days of receipt.

The adjudication timeliness standards do not apply to Claims submitted by Providers under investigation for Fraud or Abuse from the date of service to the date of adjudication of the Claims. Providers can be under investigation by a governmental agency or the PH-MCO; however, if under investigation by the PH-MCO, the Department must have immediate written notification of the investigation.

Every Claim entered into the PH-MCO's computer information system that is not a Rejected Claim must be adjudicated. The PH-MCO must maintain an electronic file of Rejected Claims, inclusive of a reason or reason code for rejection. A claim containing a Recipient who was not a MCO Member as of the date of service should be denied and the Provider notified.

The amount of time required to adjudicate a paid Claim is computed by comparing the date the Claim was received with the check date or the MCO bank notification date for electronic payment. The check date is the date printed on the check. The amount of time required to adjudicate a Denied Claim is computed by comparing the date the Claim was received with the date the denial notice was created or the transmission date of an electronic denial notice. Checks must be mailed not later than three (3) Business Days from the check date. Electronic payments must also occur within three (3) Business Days of the bank notification date.

The PH-MCO must record, on every Claim processed, the date the Claim was received. A date of receipt imbedded in a Claim reference number is acceptable for this purpose. This date must be carried on Claims records in the Claims processing computer system. Each hardcopy Claim received by the PH-MCO, or the electronic image thereof, must be date-stamped with the date of receipt no later than the first (1^{st}) Business Day after the date of receipt. The PH-MCO must add a date of receipt to each Claim received in the form of an electronic record or file within one (1) Business Day of receipt.

If responsibility to receive Claims is subcontracted, the date of initial receipt by the subcontractor determines the date of receipt applicable to these requirements.

2. Sanctions

The Department will utilize the monthly report that is due on the fifth (5^{th}) calendar day of the fifth (5^{th}) subsequent month after the Claim is received to determine Claims processing penalties. For example, the Department shall utilize the monthly report that is due January 5th, to determine Claims processing penalties for Claims received in the previous August. The Department shall utilize the monthly report that is due February 5th, to determine Claims processing penalties for Claims received in the previous September. The Department shall utilize the monthly report that is due March 5th, to determine Claims processing penalties for Claims received in the previous October, and so on.

All Claims received during the month, for which a penalty is being computed, that remain unadjudicated at the time the sanction is being determined, shall be considered a Clean Claim.

If a Commonwealth audit, or an audit required or paid for by the Commonwealth, determines Claims processing timeliness data that are different than data submitted by the PH-MCO, or if the PH-MCO has not submitted required Claims processing data, the Department will use the audit results to determine the penalty amount.

The penalties included in the charts below shall apply separately to:

a. Inpatient Claims.

b. Claims other than inpatient and drug.

The penalties provided by this Section apply to all Claims included in each of the two (2) Claim categories specified above, including Claims processed by any subcontractor.

The PH-MCO will be considered in compliance with the requirement for adjudication of 100.0% of all inpatient Claims if 99.5% of all inpatient Claims are adjudicated within ninety (90) days of receipt. The PH-MCO will be considered in compliance with the requirement of adjudication of 100.0% of all Claims other than inpatient and drug if 99.5% of all Claims other than inpatient and drug are adjudicated within ninety (90) days of receipt.

Penalties in the charts below shall be reduced by one-third if the PH-MCO has 25,000-50,000 Recipients. Penalties in the charts below shall be reduced by two-thirds if the PH-MCO has less than 25,000 Recipients.

Effective with the Claims processing report due on January 5, 2009 from the PH-MCO, the total penalty for the current month will increase to $10,000 if the following conditions exist:

- PH-MCO fails to comply with any adjudication timeliness requirement for Claims received in any seven (7) of the nine (9) previous months; and

- The sum of adjudication timeliness penalties for the current month is greater than zero (0) but less than $10,000.

CLAIMS ADJUDICATION MONTHLY PENALTY CHART

This chart is used to compute any applicable penalty for failure to adjudicate inpatient Claims timely. This chart is also used to compute any applicable penalty for failure to adjudicate Claims other than inpatient or drug.

Percentage of Clean Claims Adjudicated in 30 Days	Penalty
88.0 – 89.9	$1,000
80.0 – 87.9	$3,000
70.0 – 79.9	$5,000
60.0 – 69.9	$8,000
50.0 – 59.9	$10,000
Less than 50.0	$15,000
Percentage of Clean Claims Adjudicated in 45 Days	Penalty
98.0 – 99.5	$1,000
90.0 – 97.9	$3,000
80.0 – 89.9	$5,000
70.0 – 79.9	$8,000
60.0 – 69.9	$10,000
Less than 60.0	$15,000
Percentage of All Claims Adjudicated in 90 Days	Penalty
98.0 – 99.5	$1,000
90.0 – 97.9	$3,000
80.0 – 89.9	$5,000

70.0 – 79.9	$8,000
60.0 – 69.9	$10,000
Less than 60.0	$15,000

E. Other Financial Requirements

1. Physician Incentive Arrangements

a. PH-MCOs must comply with the Physician Incentive Plan Physician Incentive Plan requirements included under 42 CFR § 422.208 and 422.210, which apply to Medicaid managed care under 42 CFR 438.6(h).

b. MCOs are only permitted to operate Physician Incentive Plans if 1) no specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to a Member; and 2) the disclosure, computation of Substantial Financial Risk, Stop-Loss Protection, and Member survey requirements of this section are met.

c. MCOs must provide information specified in the regulations to the Department and CMS, upon request. In addition, MCOs must provide the information on their Physician Incentive Plans to any Recipient, upon request. MCOs that have Physician Incentive Plans placing a physician or physician group at Substantial Financial Risk for the cost of services the physician or physician group does not furnish must assure that the physician or physician group has adequate Stop-Loss Protection. MCOs that have Physician Incentive Plans placing a physician or physician group at Substantial Financial Risk for the cost of service the physician or physician group does not furnish must also conduct surveys of Members and disenrollees addressing their satisfaction with the quality of services and their degree of access to the services.

d. MCOs must provide the following disclosure information concerning its Physician Incentive Plans to the Department prior to approval of the contract:

- whether referral services are included in the Physician Incentive Plan,

- the type of incentive arrangement used, i.e. withhold bonus, capitation,

- a determination of the percent of payment under the contract that is based on the use of referral services to determine if Substantial Financial Risk exists,

- panel size, and if patients are pooled, pooling method used to determine if Substantial Financial Risk exists,

- assurance that the physician or physician group has adequate Stop-Loss Protection and the type of coverage, if this requirement applies.

Where Member/disenrollee survey requirements exist, MCOs must provide the survey results.

e. The PH-MCO must provide the disclosure information specified in 3.d. above to the Department annually, unless the Department has provided the PH-MCO with notice of suspension of this requirement.

f. These Physician Incentive Plan regulations apply to all MCOs and any of their subcontracting arrangements that utilize a Physician Incentive Plan in their payment arrangements with individual physicians or physician groups. Physician Incentive Plan regulations require that physicians and physician groups be protected from risk beyond the stop-loss threshold.

2. Retroactive Eligibility Period

The PH-MCO 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 PH-MCO.

3. In-Network Services

The PH-MCO must make timely payment for Medically Necessary, covered services rendered by Network Providers when:

a. Services were rendered to treat an Emergency Medical Condition;

b. Services were rendered under the terms of the PH-MCO’s agreement with the Provider;

c. Services were Prior Authorized; or

d. It is determined by the Department, after a hearing, that the services should have been authorized.

The PH-MCO is not financially liable for:

a. Services rendered to treat a non-emergency condition in a hospital emergency room (except to the extent required elsewhere by law), unless the services were Prior Authorized or otherwise conformed to the terms of the PH-MCO's agreement with the Provider; or

b. Prescriptions presented at Network Pharmacies that were written by non-participating/non-network prescribers unless:

- the non-participating/non-network provider arrangement was approved in advance by the PH-MCO and any prior authorization requirements (if applicable) were met;
- the non-participating/non-network prescriber is the member's Medicare provider; or
- the member is covered by a third party carrier and the prescriber is the member's third party provider.

4. Payments for Out-of-Network Providers

The PH-MCO must make timely payments to Out-of-Network Providers for Medically Necessary, covered services when:

a. Services were rendered to treat an Emergency Medical Condition;

b. Services were Prior Authorized;

c. It is determined by the Department, after a hearing, that the services should have been authorized; or

d. A child enrolled in the PH-MCO is placed in emergency substitute care and the county placement agency cannot identify the child nor verify MA coverage.

The PH-MCO is not financially liable for:

a. Services rendered to treat a non-emergency condition in a hospital emergency room (except to the extent required

elsewhere in law), unless the services were Prior Authorized; or

b. Prescriptions presented at Out-of-Network Pharmacies that were written by non-participating/non-network prescribers unless:

- the non-participating/non-network provider arrangements were approved in advance by the PH-MCO and any prior authorization requirements (if applicable) were met;
- the non-participating/non-network prescriber and the pharmacy are the member's Medicare providers; or
- the member is covered by a third party carrier and the non-participating/non-network prescriber and the pharmacy are the member's third party providers.

The PH-MCO must assume financial responsibility, in accordance with applicable law, for emergency services and urgently needed services as defined in 42 CFR Section 417.401 that are obtained by its Members from Providers and suppliers outside the PH-MCO's Provider Network even in the absence of the PH-MCO's prior approval.

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

The PH-MCO will negotiate and pay FQHCs and RHCs at rates no less than what the PH-MCO pays to other Providers who provide comparable services in the PH-MCO's Provider Network. Exception: Physician fees required by the Affordable Care Act are excluded for the purposes of this requirement. Incentive or bonus payments must not be considered as reimbursements when determining whether or not payment rates to FQHCs and RHCs are comparable to the fees paid to like providers.

The PH-MCO may require that an FQHC and RHC comply with case management procedures that apply to other entities that provide similar benefits or services.

Effective with dates of services beginning on or after January 1, 2016, the PH-MCO must pay all FQHCs and RHCs rates that are not less than the Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by the Department. The PH-MCO must also include in its Provider Network every FQHC and RHC located within this HealthChoices Zone that is willing to accept PPS rates as payment in full.

6. Liability During an Active Grievance or Appeal

The PH-MCO shall not be liable to pay Claims to Providers if the validity of the Claim is being challenged by the PH-MCO through a Grievance or appeal, unless the PH-MCO is obligated to pay the Claim or a portion of the Claim through a separate agreement with the Provider.

7. Financial Responsibility for Dual Eligibles

Dual Eligibles age 21 and older who the Department has confirmed are enrolled in Medicare Part D will no longer participate in HealthChoices. Members who are confirmed to be enrolled in Medicare Part D will be disenrolled from HealthChoices prospectively. The PH-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries up to the managed care plan Disenrollment date, in accordance with Section 4714 of the Balanced Budget Act of 1997. The PH-MCO will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions.

If no contracted PH-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the PH-MCO must pay deductibles and coinsurance up to the applicable MA fee schedule for the service.

For Medicare services that are not covered by either MA or the PH-MCO, the PH-MCO must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the PH-MCO do not exceed eighty percent (80%) of the Medicare-approved amount.

The PH-MCO, its subcontractors and Providers are prohibited from balance billing Members for Medicare deductibles or coinsurance. The PH-MCO must ensure that a Member who is eligible for both Medicaid and Medicare benefits has the right to access a Medicare product or service from the Medicare Provider of his/her choice. The PH-MCO is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the PH-MCO's Provider Network and whether or not the Medicare Provider has complied with the Prior Authorization requirements of the PH-MCO.

8. Confidentiality

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

9. Third Party Liability (TPL)

The PH-MCO must comply with the Third Party Liability (TPL) procedures defined by Section 1902(a)(25) of the Social Security Act, 42 U.S.C. 1396a(a)(25) and implemented by the Department. Under this Agreement, the Third Party Liability responsibilities of the Department will be allocated between the Department and the PH-MCO.

a. Cost Avoidance Activities

i. The PH-MCO will have primary responsibility for cost avoidance through the Coordination of Benefits (COB) relative to federal and private health insurance-type resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA) plans, and workers compensation. Except as provided in subparagraph ii, the PH-MCO must attempt to avoid initial payment of Claims, whenever possible, where federal or private health insurance-type resources are available. All funds that are cost avoided by the MCO must be reported to the Commonwealth via Encounter Data submissions. The number of claims cost avoided by the MCO's claims system should be reported in Financial Report #8A, "Claims Cost Avoided." 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. The PH-MCO shall not be held responsible for any TPL errors in the Department's Eligibility Verification System (EVS) or the Department's TPL file.

ii. The PH-MCO agrees to pay, and to require that its subcontractors pay, all Clean Claims for prenatal or preventive pediatric care (including EPSDT services to children), and services to children having medical coverage under a Title IV-D child support order to the extent the PH-MCO is notified by the Department of such support orders or to the extent the PH-MCO becomes aware of such orders, and then seek reimbursement from liable third parties. The PH-MCO recognizes that cost avoidance of these Claims is prohibited with the exception of hospital delivery Claims, which may be cost-avoided.

iii. The PH-MCO may not deny or delay approval of otherwise covered treatment or services based upon Third Party Liability considerations. The PH-MCO may neither unreasonably delay payment nor deny payment of Claims unless the probable existence of Third Party Liability 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.

ii. The Department's Division of TPL retains the sole and exclusive right to investigate, pursue, collect, and retain all Other Resources as defined in Section II of this Agreement, Definitions. The Department is assigned the Contractor’s subrogation rights to collect the “Other Resources” covered by this provision. Any correspondence or Inquiry forwarded to the PH-MCO (by an attorney, provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-

related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the Recipient and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The PH-MCO may neither unreasonably delay payment nor deny payment of Claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by the Commonwealth under the scope of these "Other Resources" shall be retained by the Commonwealth.

With respect to any third party payment received by the PH-MCO from a provider, the PH-MCO shall return all casualty funds to the Department. PH-MCOs shall not instruct providers to send funds directly to the Department. These third party payments shall not be held by the MCO for more than 30 days. If the casualty funds received by the Department must be returned to the PH_MCO for any reason, for example, an out-dated check or the amount of the check does not match supporting documentation, the PH-MCO shall have 90 days to return all casualty funds to the Department using the established format.

iii. The PH-MCO is responsible for pursuing, collecting, and retaining recoveries of (1) a claim involving Workers' Compensation or (2) where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The PH-MCO is encouraged to 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.

iv. Due to potential time constraints involving cases subject to litigation and due to the large dollar value of many claims which are potentially recoverable by the Department's Division of TPL, the Department must ensure that it identifies these cases and establishes its claim before a settlement has been negotiated. Should the Department fail to identify and establish a claim prior to settlement due to the PH-MCO's untimely submission of notice of legal involvement

where the PH-MCO has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the PH-MCO. The Department's actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by the Department.

v. The PH-MCO has the sole and exclusive responsibility and right to pursue, collect and retain all health-related insurance resources for a period of nine (9) months from the date of service or six (6) months after the date of payment, whichever is later. The PH-MCO must indicate their intent to recover on health-related insurance by providing to the Department an electronic file of those cases that will be pursued. The cases must be identified and a file provided to the Department by the PH-MCO within the window of opportunity afforded by the nine (9) months from the date of service or six (6) months after the date of payment unless otherwise granted by the Department. The Department's Division of TPL may pursue, collect and retain recoveries of all health-related insurance cases which are outstanding, that is, not identified by the PH-MCO for recovery, after the later of nine (9) months from the date of service or six (6) months after the date of payment. Notification of intent to pursue, collect and retain health-related insurance is the sole responsibility of the PH-MCO, and cases not identified for recovery will become the sole and exclusive right of the Department to pursue, collect and retain. In such cases where the PH-MCO has identified the cases to be pursued, the PH-MCO shall retain the exclusive responsibility for the cases for a period not to exceed eighteen (18) months. The calculation of the eighteen (18) month period shall commence with receipt of the file from the PH-MCO identifying the cases to be pursued. Any case not completed within the eighteen (18) month period will become the sole and exclusive right of the Department to pursue, collect and retain. The PH-MCO is responsible to notify the Department through the prescribed electronic file process of all outcomes for those cases identified for pursuit. Cases included in Encounter files that were suspended will not be able to be included in the flagging process since the

Claims cannot be adjusted in the Department's automated processing system.

vi. Should the Department lose recovery rights to any Claim due to late or untimely filing of a Claim with the liable third party, and the untimeliness in billing that specific Claim is directly related to untimely submission of Encounter Data or additional records under special request, or inappropriate denial of Claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable Claim shall be assessed against the PH-MCO.

vii. Encounter Data that is not submitted to the Department in accordance with the data requirements and/or time frames identified in this Agreement can possibly result in a loss of revenue to the Department. Strict compliance with these requirements and time frames shall therefore be enforced by the Department and could result in the assessment of sanctions against the PH-MCO.

viii. As part of its authority under paragraph v. above, the PH-MCO is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources where the liable party has improperly denied payment based upon either lack of a Medically Necessary determination or lack of coverage. The PH-MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases which are susceptible to collection through either legal action or traditional subrogation and collection procedures.

10. Health Insurance Premium Payment (HIPP) Program

The HIPP Program pays for employment-related health insurance for Recipients when it is determined to be cost effective. The cost effectiveness determination involves the review of group health insurance benefits offered by employers to their employees to determine if the anticipated expenditures in MA payments are likely to be greater than the cost of paying the premiums under a group plan for those services.

The Department does not purchase Medigap policies for Recipients.

11. Requests for Additional Data

The PH-MCO must provide, at the Department's request, such information not included in the Encounter Data submissions that may be necessary for the administration of TPL activity. The PH-MCO must use its best efforts to provide this information within fifteen (15) calendar days of the Department's request. There are certain urgent requests involving cases for minors that require information within forty-eight (48) hours. Such information may include, but is not limited to, individual medical records for the express purpose of determining TPL for the services rendered. Confidentiality of the information must be maintained as required by federal and state regulations.

12. Accessibility to TPL Data

The Department will provide the PH-MCO with access to data maintained on the TPL file.

13. Third Party Resource Identification

Third Party Resources identified by the PH-MCO or its subcontractors, which do not appear on the Department's TPL database, must be supplied to the Department's TPL Division by the PH-MCO. 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 PH-MCO. A web-based referral is only to be submitted in the following instances: to correct or negate an already end-dated resource or to negate a resource for which the begin date is over 5 years from the Department's processing date. For web-based referrals, the PH-MCO must use an exact replica of the TPL resource referral form supplied by the Department. For electronic submissions, the PH-MCO must follow the required report format, data elements, and tape specifications supplied by the Department.

The Department will contact the PH-MCO when the validity of a resource is in question. The PH-MCO shall verify inconclusive resource information within two (2) business days of notification by the Department that the resource information is in dispute.

The PH-MCO must use the Department's verification systems (i.e. POSNet and EVS) to assure detailed information is provided for insurance carriers when a resource is received that does not have a unique carrier code.

14. Estate Recovery

Section 1412 of the Public Welfare Code, 62 P.S. 1412, requires the Department to recover MA costs paid on behalf of certain deceased individuals. Individuals age fifty-five (55) and older who were receiving MA benefits for any of the following services are affected:

a. Public or private Nursing Facility services;

b. Residential care at home or in a community setting; or

c. Any hospital care and prescription drug services provided while receiving Nursing Facility services or residential care at home or in a community setting.

The applicable MA costs are recovered from the assets of the individual's probate estate. The Department's Division of TPL is solely responsible for administering the Estate Recovery Program.

15. Audits

The PH-MCO is responsible to comply with audit requirements as specified in Exhibit WW of this Agreement, HealthChoices Audit Clause.

16. Restitution

The PH-MCO 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 PH-MCO under this Agreement whether such overpayment is discovered by the PH-MCO, the Department, or other third party.

SECTION VIII: REPORTING REQUIREMENTS

A. General

The PH-MCO must comply with state and federal reporting requirements that are set forth in this section and throughout this Agreement.

The PH-MCO must certify all data to the extent required in 42 CFR 438.604 submitted to the Department, whether in written or electronic form. Such certification must be submitted concurrently with the certified data and must be based on the knowledge, information and belief of the Chief Executive Officer (CEO), Chief Financial Officer (CFO) or an individual who has delegated authority to sign for, and who reports directly to the CEO or CFO according to 42 CFR Part 438.604.

The PH-MCO agrees to provide the certification via hard copy or electronic format, on the form provided by the Department.

B. Systems Reporting

The PH-MCO must submit electronic files and data as specified by the Department. To the extent possible, the Department will provide reasonable advance notice of such reports.

Exhibit CC, Data Support for PH-MCOs, provides a listing of these and other reports provided to and by the MCOs. Information on the submission of the Department's data files is available on the HealthChoices Intranet site.

1. Encounter Data Reporting

The PH-MCO 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. A service rendered under this Agreement is considered an Encounter regardless of whether or not it has an associated Claim. The PH-MCO shall only submit Encounter Data for Members enrolled in their MCO on date of service and not submit any duplicate records.

The PH-MCO must maintain appropriate systems and mechanisms to obtain all necessary data from its Health Care Providers to ensure its ability to comply with the Encounter Data reporting requirements. The failure of a Health Care Provider or Subcontractor to provide the PH-MCO with necessary Encounter Data shall not excuse the PH-MCO's noncompliance with this requirement.

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

a. Data Format

The PH-MCO 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
- 837I - Inpatient
- 837I – Outpatient
- 837I – LTC
- 837I – Outpatient Drug
- 837 Dental
- NCPDP batch files

b. Timing of Data Submittal

i. Provider Claims

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

It is acceptable for the PH-MCO 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 PH-MCO by the end of the month following the month of adjudication.

ii. 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 PH-MCO 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 due to Department edits are returned to the PH-MCO and must be corrected. Denied

Encounter records must be resubmitted as a "new" Encounter record if appropriate and 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 PH-MCO's noncompliance with this requirement.

iii. Encounter File Specifications

The PH-MCO must adhere to the file size and format specifications provided by the Department. PH-MCOs must also adhere to the Encounter file submission schedule provided by the Department.

iv. 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 PROMIS*e*™ ICN associated with each processed Encounter Data record returned on the files.

c. Data Completeness

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

i. Demonstrates that all Claims and Encounters submitted to the PH-MCO 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;

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

iii. Demonstrates the PH-MCO 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 PH-MCO must submit an annual Data Completeness Plan for review and approval. This Data Completeness Plan must include the three elements listed above.

d. Financial Penalties

The PH-MCO must provide complete, accurate, and timely Encounter Data to the Department. In addition, the PH-MCO must maintain complete medical service history data.

The Department may request the PH-MCO to submit a Corrective Action Plan when areas of noncompliance are identified.

Assessment of financial penalties is based on the identification of penalty occurrences. Encounter Data Penalty occurrences/assessments of financial penalties are outlined in Exhibit XX of this Agreement, Encounter Data Submission Requirements and Penalty Applications.

e. Data Validation

The PH-MCO agrees to assist the Department in its validation of Encounter Data by making available medical records and Claims data as requested. The validation may be completed by Department staff and/or independent, external review organizations.

In addition, the PH-MCO will validate files sent to them when requested.

f. Secondary Release of Encounter Data

All Encounter Data recorded to document services rendered to Recipients under this Agreement are the property of the Department. Access to this data is provided to the PH-MCO and its agents for the sole purpose of operating the HealthChoices Program under this Agreement. The PH-MCO and its agents are prohibited from releasing any data resulting from this Agreement to any third party without the

advance written approval of the Department. This prohibition does not apply to internal quality improvement or Disease Management activities undertaken by the PH-MCO or its agents in the routine operation of a managed care plan.

g. Drug Rebate Supplemental File

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

2. Third Party Liability Reporting

Third Party Resources identified by the PH-MCO or its subcontractors, which do not appear on the Department's TPL database, must be supplied to the Department's Division of TPL within two weeks of its receipt by the PH-MCO. The Department will contact the PH-MCO when the validity of a resource is in question. The PH-MCO shall verify inconclusive resource information within two (2) business days of notification by the Department that the resource information is in dispute. The method of reporting shall be by electronic submission via a batch file or by hardcopy document, whichever is deemed most convenient and efficient by the PH-MCO for its individual use. For electronic submissions, the PH-MCO must follow the required report format, data elements, and tape specifications supplied by the Department. For hardcopy submissions, the PH-MCO must use an exact replica of the TPL resource referral form supplied by the Department. Submissions lacking information key to the TPL database update process will be considered incomplete and will be returned to the PH-MCO for correction and subsequent resubmission.

3. PCP Assignment for Members

The PH-MCO must provide a file through the Department to the Department's Provider Reimbursement and Operations Management Information System electronic (PROMIS*e*™) of PCP assignments for all its Members.

The PH-MCO must provide this file at least weekly or more frequently if requested by the Department. The PH-MCO must ensure that the PCP assignment information is consistent with all requirements specified by the Department by utilizing the response report provided by the Department. The PH-MCO must use this report to reconcile and correct any errors. Information on the PCP file submission is available on the HealthChoices Intranet.

4. Provider Network

The PH-MCO must provide a file through the Department, to the Department's PROMISe™ contractor, of its entire Provider Network, including the network of its subcontractors.

The PH-MCO must provide this file monthly. The PH-MCO must ensure the information is consistent with all requirements specified by the Department by utilizing the response report provided by the Department. The PH-MCO must use this report to reconcile and correct any errors. Information on the Provider Network file submission is available on the HealthChoices Intranet.

5. Alerts

The PH-MCO must report to the Department on a Weekly Enrollment/Alert file: pregnancy, death, newborn and return mail alerts.

The PH-MCO must provide this file weekly. The PH-MCO must ensure the information is consistent with all requirements specified by the Department. Information on the submission of alerts on the Weekly Enrollment/Alert File is on the HealthChoices Intranet.

6. Maternity Care

The PH-MCO must submit a maternity care claim through the Department to the Department's PROMISe™ contractor.

The PH-MCO must use either an 837P transaction or the Internet to submit information on maternity events and ensure the information is consistent with all requirements specified by the Department. Information on the submission of maternity care claims are on the HealthChoices Intranet.

C. Operations Reporting

The PH-MCO is required to submit such reports as specified by the Department to enable the Department to monitor the PH-MCO's internal operations and service delivery. These reports include, but are not limited to, the following:

1. Federal Waiver Reporting Requirements

As a condition of approval of the Waiver for the operation of HealthChoices in Pennsylvania, the Centers for Medicare and Medicaid Services (CMS) has imposed specific reporting requirements related to the AIDS Home and Community Based Waiver. In the event that CMS requests this information, the PH-MCO must provide the information necessary to meet these reporting requirements. To the extent possible, the Department will provide reasonable advance notice of such reports.

2. Fraud and Abuse

The PH-MCO must submit to the Department quarterly statistical reports which relate to its Fraud and Abuse detection and sanctioning activities regarding Providers. The quarterly report must include information for all situations where a Provider action caused an overpayment to occur. The quarterly report must identify cases under review (including approximate dollar amounts), Providers terminated due to Medicare/Medicaid preclusion, and overpayments recovered.

Detailed information regarding Operational Reports may be found at:
https://www.dpwds.state.pa.us/docushare/dsweb/View/Collection-29547

D. Financial Reports

The PH-MCO agrees to submit such reports as specified by the Department to assist the Department in assessing the PH-MCO's financial viability and to ensure compliance with this Agreement.

The Department will distribute financial reporting requirements to the PH-MCO. The PH-MCO must furnish all financial reports timely and accurately, with content in the format prescribed by the Department. This includes, but is not limited to, the HealthChoices financial reporting requirements issued by the Department.

E. Equity

Not later than May 25, August 25, and November 25 of each agreement year, the PH-MCO must provide the Department with:

- A copy of quarterly reports filed with PID, for the quarter ending the last day of the second (2^{nd}) previous month.

- A statement that its Equity is in compliance with the Equity requirements or is not in compliance with the Equity requirements.

- If Equity is not in compliance with the Equity requirements, the PH-MCO must supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve fiscal health.

Not later than March 10 of each agreement year, the PH-MCO must provide the Department with:

- A copy of unaudited annual reports filed with PID.

- A statement that its Equity is in compliance with the Equity requirements or is not in compliance with the Equity requirements.

- If Equity is not in compliance with the Equity requirements, the PH-MCO must supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve fiscal health.

F. Claims Processing Reports

The PH-MCO must provide the Department with monthly Claims processing reports with content and in a format specified by DPW. The reports are due on the fifth (5^{th}) calendar day of the second (2^{nd}) subsequent month. Claims returned by a web-based clearinghouse (example- WebMD Envoy) are not considered as claims received and would be excluded from claims reports.

Failure to submit a Claims processing report timely that is accurate and fully compliant with the reporting requirements shall result in the following penalties: $200 per day for the first ten (10) calendar days from the date that the report is due and $1,000 per day for each calendar day thereafter.

G. Presentation of Findings

The PH-MCO must obtain advance written approval from the Department before publishing or making formal public presentations of statistical or analytical material based on its HealthChoices membership.

H. Sanctions

1. The Department may impose sanctions for noncompliance with the requirements under this Agreement and failure to meet applicable requirements in Sections 1932, 1903(m), and 1905(t) of the Social Security Act and in accordance with Sections 42 CFR 438.700; 438.702; and 438.704 in addition to any penalties described in

Exhibit D of this Agreement, Standard Grant Terms and Conditions for Services, and in Exhibit E of this Agreement, DPW Addendum to Standard Contract Terms and Conditions. The sanctions which can be imposed shall depend on the nature and severity of the breach, which the Department, in its reasonable discretion, will determine as follows:

a. Imposing civil monetary penalties of a minimum of $1,000.00 per day for noncompliance;

b. Requiring the submission of a corrective action plan;

c. Limiting Enrollment of new Recipients;

d. Suspension of payments;

e. Temporary management subject to applicable federal or state law; and/or

f. Termination of the Agreement: The Department has the authority to terminate a PH-MCO Agreement and enroll that entity's Members in another PH-MCO or provide their Members' Medical Assistance benefits through other options included in the State plan.

2. Where this Agreement provides for a specific sanction for a defined infraction, the Department may, at its discretion, apply the specific sanction provided for the noncompliance or apply any of the general sanctions set forth in Section VIII.H of this Agreement, Sanctions. Specific sanctions contained in this Agreement include the following:

a. Claims Processing: Sanctions related to Claims processing are provided in Section VII D.2 of this Agreement, Sanctions.

b. Report or File, exclusive of Audit Reports: If the PH-MCO fails to provide any report or file that is specified by this Agreement by the applicable due date, or if the PH-MCO provides any report or file specified by this Agreement that does not meet established criteria, a subsequent payment to the PH-MCO may be reduced by the Department. The reduction shall equal the number of days that elapse between the due date and the day that the Department receives a report or file that meets established criteria, multiplied by the average Per-Member-Per-Month Capitation rate that applies to the first (1st) month of the Agreement

year. If the PH-MCO provides a report or file on or before the due date, and if the Department notifies the PH-MCO after the fifteenth (15th) calendar day after the due date that the report or file does not meet established criteria, no reduction in payment shall apply to the sixteenth (16th) day after the due date through the date that the Department notifies the PH-MCO.

c. Encounter Data Reporting: The penalties related to the submission of Encounter Data are set forth in Section VIII.B of this Agreement, Systems Reports, and Exhibit XX of this Agreement, Encounter Data Submission Requirements and Penalty Applications.

d. Marketing: The sanctions for engaging in unapproved marketing practices are described in Section V.F.3 of this Agreement, PH-MCO Outreach Activities.

e. Access Standard: The sanction for noncompliance with the access standard is set forth in Exhibit AAA(1), AAA(2), or AAA(3) of this Agreement, as applicable, Provider Network Composition/Service Access, Part 4, Compliance with Access Standards.

f. Subcontractor Prior Approval: The PH-MCO's failure to obtain advance written approval of a Subcontract will result in the application a penalty of one (1) month's Capitation rate for a categorically needy adult female TANF consumer for each day that the subcontractor was in effect without the Department's approval.

I. Non-Duplication of Financial Penalties

If the Department assesses a financial penalty pursuant to one (1) of the provisions of Section VIII.H of this Agreement, Sanctions, it will not impose a financial sanction pursuant to Section VIII.H with respect to the same infraction.

SECTION IX: REPRESENTATIONS AND WARRANTIES OF THE PH-MCO

A. Accuracy of Proposal

The PH-MCO acknowledges and warrants that the representations made to the Department in the Proposal are true and correct. The PH-MCO further acknowledges and warrants that all of the information submitted to

the Department in or with the Proposal is accurate and complete in all material respects. The PH-MCO agrees that such representations must be continuing ones, and that it is the PH-MCO'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 PH-MCO's submission of the Proposal, which affects the truth, accuracy, or completeness of such representations.

B. Disclosure of Interests

The PH-MCO 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 PH-MCO. The PH-MCO must inform the Department, in writing, of any change in or addition to the ownership or control of the PH-MCO. Such disclosure must be made within thirty (30) days of any change or addition. The PH-MCO acknowledges and agrees that any failure to comply with this provision in any material respect, or making of any misrepresentation which would cause the PH-MCO's application to be precluded from participation in the MA Program, shall entitle the Department to recover all payments made to the PH-MCO subsequent to the date of the misrepresentation.

C. Disclosure of Change in Circumstances

The PH-MCO agrees to report to the Department, as well as the Departments of Health and Insurance, within ten (10) Business Days of the PH-MCO's notice of same, any change in circumstances that may have a material adverse effect upon financial or operational conditions of the PH-MCO or PH-MCO'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 PH-MCO, PH-MCO'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 PH-MCO's Equity who has been debarred from participating in 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 PH-MCO, PH-MCO'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 PH-MCO, PH-MCO's parent(s), or any Affiliate or Related Party of either, which would have a material impact upon the PH-MCO's financial condition or ability to perform under this Agreement.

D. PH-MCO's Disadvantaged Business Commitment

PH-MCO's Disadvantaged Business commitment, as set forth in PH-MCO's Proposal, is hereby incorporated as a contractual obligation during the term of this Agreement. The PH-MCO must make every reasonable effort to utilize Disadvantaged Business services. The PH-MCO must submit quarterly reports to the Department outlining Disadvantaged Business utilization.

All Agreements containing Disadvantaged Business participation must also include a provision requiring the PH-MCO to meet and maintain those commitments made to Disadvantaged Businesses at the time of submittal or Agreement negotiation, unless a change in the commitment is approved by the Department upon recommendation by the Department of General Services, Bureau of Minority and Women Business Opportunities (BMWBO). All Agreements containing Disadvantaged Business participation must include a provision requiring Disadvantaged Business subcontractors and Disadvantaged Businesses in a joint venture to incur at least fifty percent (50%) of the cost of the Subcontract or Disadvantaged Business portion of the joint venture, not including materials.

Commitments to Disadvantaged Business firms made at the time of bidding must be maintained throughout the term of the Agreement. The PH-MCO must submit any proposed change to BMWBO which will recommend a course of action to the Department.

If an Agreement is assigned to another PH-MCO, the new PH-MCO must maintain the Disadvantaged Business participation of the original Agreement.

Questions regarding this Program can be directed to:

Department of General Services
Bureau of Minority and Women Business Opportunities
Room 611, North Office Building
Harrisburg, PA 17125
Phone: (717) 787-6708
Fax: (717) 772-0021

Email: **gs-bmwbo@state.pa.us**

SECTION X: DURATION OF AGREEMENT AND RENEWAL

The terms of this Agreement are described in Appendix 8, Duration of Agreement and Renewal.

SECTION XI: TERMINATION AND DEFAULT

A. Termination by the Department

In conjunction with termination provisions in Section 18 of Exhibit D, Standard Grant Terms and Conditions for Services, this Agreement may be terminated by the Department upon the occurrence of any of the following events and upon compliance with the notice provisions set forth below:

1. Termination for Convenience Upon Notice

Under Section 18.a of Exhibit D, Standard Grant Terms and Conditions for Services, the Department may terminate this Agreement at any time for convenience upon giving one hundred twenty (120) days advance written notice to the PH-MCO. The effective date of the termination shall be the last day of the month in which the one hundred twentieth (120^{th}) day falls. The requirement of one hundred twenty days advance notice does not apply if this is replaced by another agreement to operate a HealthChoices Program in the same zone.

2. Termination for Cause

Under Section 18.c of Exhibit D, Standard Grant Terms and Conditions for Services, the Department may terminate this Agreement for cause upon forty-five (45) days written notice, which notice shall set forth the grounds for termination and, with the exception of termination under Section XI.A.2.b below, shall provide the PH-MCO with forty-five (45) days in which to implement corrective action and cure the deficiency. If corrective action is not implemented to the satisfaction of the Department within the forty-five (45) day cure period, the termination shall be effective at the expiration of the forty-five (45) day cure period. In addition to the provisions of Section 18.c of Exhibit D, Standard Grant Terms and Conditions for Services, "cause" shall mean the following for the purposes of termination under this Agreement:

a. The PH-MCO defaults in the performance of any material duties or obligations hereunder or is in material breach of any provision of this Agreement; or

b. The PH-MCO commits an act of theft or Fraud against the Department, any state agency, or the Federal Government; or

c. An adverse material change in circumstances as described in Section IX.C of this Agreement, Disclosure of Change in Circumstances.

3. Termination Due to Unavailability of Funds/Approvals

In addition to Section 18.b of Exhibit D, Standard Grant Terms and Conditions for Services, the Department may terminate this Agreement immediately upon the occurrence of any of the following events:

a. Notification by the United States Department of Health and Human Services of the withdrawal of Federal Financial Participation (FFP) in all or part of the cost hereof for covered services/contracts; or

b. Notification that there shall be an unavailability of funds available for the HealthChoices Program; or

c. Notification that the federal approvals necessary to operate the HealthChoices Program shall not be retained; or

d. Notification by the Pennsylvania Insurance Department or Health Department that the authority under which the PH-MCO operates is subject to suspension or revocation proceedings or sanctions, has been suspended, limited, or curtailed to any extent, or has been revoked, or has expired and shall not be renewed.

B. Termination by the PH-MCO

The PH-MCO may terminate this Agreement at any time upon giving one hundred twenty (120) days advance written notice to the Department. The effective date of the termination shall be the last day of the month in which the one hundred twentieth (120^{th}) day falls.

C. Responsibilities of the PH-MCO Upon Termination

1. Continuing Obligations

Termination or expiration of this Agreement shall not discharge the PH-MCO of obligations with respect to services or items furnished prior to termination, including retention of records and verification of overpayments or underpayments. Termination or expiration shall not discharge the Department's payment obligations to the PH-MCO or the PH-MCO's payment obligations to its subcontractors and Providers.

Upon any termination or expiration of this Agreement, in accordance with the provisions in this section, the PH-MCO must:

a. Provide the Department with all information deemed necessary by the Department within thirty (30) days of the request;

b. Be financially responsible for MA Claims with dates of service through the day of termination, except as provided in c. below, including those submitted within established time limits after the day of termination;

c. Be financially responsible for hospitalized patients through the date of discharge or thirty-one (31) days after termination or expiration of this Agreement, whichever is earlier;

d. Be financially responsible for services rendered through 11:59 p.m. on the day of termination, except as provided in c. above or f. below, for which payment is denied by the PH-MCO and subsequently approved upon appeal by the Provider;

e. Be financially responsible for Recipient appeals of adverse decisions rendered by the PH-MCO concerning treatment of services requested prior to termination that would have been provided but for the denial prior to termination, which are subsequently overturned at a DPW Fair Hearing or Grievance proceeding; and

f. Arrange for the orderly transfer of patient care and patient records to those Providers who will be assuming care for the Member.

2. Notice to Members

In the event that this Agreement is terminated pursuant to Sections XI.A or XI.B above, or expires without a new Agreement in place, the PH-MCO must notify all Members of such termination or such expiration at least forty-five (45) days in advance of the effective date of termination, if practical. Notice must be made available in an accessible format for individuals with visual impairments and in the relevant language for Members with limited English proficiency. The PH-MCO must be responsible for coordinating the continuation of care prior to termination for Members who are undergoing treatment for an acute condition.

3. Submission of Invoices

Upon termination, the PH-MCO must submit to the Department all outstanding invoices for allowable services rendered prior to the date of termination in the form stipulated by the Department. Such invoices must be submitted promptly but in no event later than forty-five (45) days from the effective date of termination. Invoices submitted later than forty-five (45) days from the effective date of termination shall not be payable. This does not apply to submissions and payments in Appendices 3a – 3g.

4. Failure to Perform

If the Department terminates a contract due to failure to perform, the Department may add that PH-MCO's responsibility to the responsibilities of one (1) or more different PH-MCOs who are also operating within the context of the HealthChoices Program in this HC Zone, subject to consent by the PH-MCO which would gain that responsibility. The Department will develop a transition plan should it choose to terminate or not extend a contract with one (1) or more PH-MCOs operating the HealthChoices Program in this HC Zone.

During the final quarter of this Agreement, the PH-MCO must work cooperatively with, and supply program information to, any subsequent PH-MCOs. Both the program information and the working relationship among the PH-MCOs will be defined by the Department.

5. Termination Requirements

In addition to the termination requirements specified in this section, the PH-MCO must also provide the Department with substantially all outstanding Encounter Data. If either the Department or the Contractor provides written notice of termination, ten percent (10%) of one (1) month's Capitation due to the Contractor will be

withheld. Once the Department determines that the Contractor has substantially complied with the termination requirements in this section, the withheld portion of the Capitation will be paid to the Contractor. The Department will not unreasonably delay or deny a determination that the Contractor substantially complied with the termination requirements. The Department will share with the Contractor a determination on substantial compliance with the termination requirements by the first (1st) day of the fifth (5th) month after the contract ends. If the Department determines that the Contractor has not substantially complied, the Department will share a subsequent determination by the first (1st) day of each subsequent month. If the Department determines that the Contractor has substantially complied with termination requirements, it will promptly pay the money that was withheld.

D. Transition at Expiration and/or Termination of Agreement

If no new Agreement is in place, a transition period shall begin prior to the last day the PH-MCO awarded this Agreement is responsible for operating under this Agreement. During the transition period, the PH-MCO must work cooperatively with any subsequent PH-MCO and the Department. Both the program information and the working relationship between the two (2) PH-MCOs shall be defined by the Department. The Department will consult with the PH-MCO regarding such information and relationship. The length of the transition period shall be no less than three (3) months and no more than six (6) months in duration.

The costs relating to the transfer of materials and responsibilities must be paid by the PH-MCO as a normal part of doing business with the Department.

The PH-MCO must be responsible for the provision of necessary information to the new PH-MCO and/or the Department during the transition period to ensure a smooth transition of responsibility. The Department will define the information required during this period and time frames for submission, and may solicit input from the PH-MCOs involved.

SECTION XII: RECORDS

A. Financial Records Retention

1. The PH-MCO must maintain and must cause its subcontractors to maintain all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity pursuant to this Agreement in accordance with the standards and procedures specified in Section V.O.5 of this Agreement, Records Retention.

2. The PH-MCO agrees to submit to the Department or to the Secretary of Health and Human Services or their designees, within thirty-five (35) days of a request, information related to the PH-MCO's business transactions which are related to the provision of services for the HealthChoices Program pursuant to this Agreement which shall include full and complete information regarding:

   a. The PH-MCO's ownership of any subcontractor with whom the PH-MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and

   b. Any significant business transactions between the PH-MCO and any wholly-owned supplier or between the PH-MCO and any subcontractor during the five (5) year period ending on the date of the request.

3. The PH-MCO agrees to include the requirements set forth in Section XIII in this Agreement, Subcontractual Relationships, in all contracts it enters with subcontractors under the HealthChoices Program, and to ensure that all persons and/or entities with whom it so contracts agree to comply with said provisions.

B. Operational Data Reports

The PH-MCO must maintain and must cause its subcontractors to maintain all source records for data reports in accordance with the procedures specified in Section V.O.5 of this Agreement, Records Retention.

C. Medical Records Retention

The PH-MCO must maintain and must cause its subcontractors to maintain all medical records in accordance with the procedures outlined in Section V.O.5 of this Agreement, Records Retention.

The PH-MCO must provide Recipients' medical records, subject to this Agreement, to the Department or its contractor(s) within twenty (20) Business Days of the Department's request. Copies of such records must be mailed to the Department if requested.

D. Review of Records

1. The PH-MCO must make all records relating to the HealthChoices Program, including but not limited to the records referenced in this

Section, available for audit, review, or evaluation by the Department, or federal agencies. Such records shall be made available on site at the PH-MCO's chosen location, subject to the Department's approval, during normal business hours or through the mail. The Department will, to the extent required by law, maintain as confidential any confidential information provided by the PH-MCO.

2. In the event that the Department or federal agencies request access to records, subject to this Agreement, after the expiration or termination of this Agreement or at such time that the records no longer are required by the terms of this Agreement to be maintained at the PH-MCO's location, but in any case, before the expiration of the period for which the PH-MCO is required to retain such records, the PH-MCO, at its own expense, must send copies of the requested records to the requesting entity within thirty (30) days of such request.

SECTION XIII: SUBCONTRACTUAL RELATIONSHIPS

A. Compliance with Program Standards

As part of its Contracting or Subcontracting, with the exception of Provider Agreements which are outlined in Section V.S.1 of this Agreement, Provider Agreements, the PH-MCO agrees that it must comply with the procedures set forth in Section V.O.3 of this Agreement, Contracts and Subcontracts and in Exhibit II, Required Contract Terms for Administrative Subcontractors.

The written information that must be provided to the Department prior to the awarding of any contract or Subcontract must provide disclosure of ownership interests of five percent (5%) or more in any entity or subcontractor.

All contracts and Subcontracts must be in writing and must contain all items set forth in this Agreement.

The PH-MCO must require its subcontractors to provide written notification of a denial, partial approval, reduction, or termination of service or coverage, or a change in the level of care, according to the standards outlined in Exhibit M(1) of this Agreement, Quality Management and Utilization Management Program Requirements and using the denial notice templates provided in Exhibits N(1) – N(7) and Exhibits BBB(3) – (5), Standard and Pharmacy Denial Notices. In addition, all contracts or Subcontracts that cover the provision of medical services to the PH-MCO’s Members must include the following provisions:

1. A requirement for cooperation with the submission of all Encounter Data for all services provided within the time frames required in Section VIII of this Agreement, Reporting Requirements, no matter whether reimbursement for these services is made by the PH-MCO either directly or indirectly through capitation.

2. Language which ensures compliance with all applicable federal and state laws.

3. Language which prohibits gag clauses which would limit the subcontractor from disclosure of Medically Necessary or appropriate health care information or alternative therapies to Members, other Health Care Providers, or to the Department.

4. A requirement that ensures that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Recipients.

5. The definition of Medically Necessary as outlined in Section II of this Agreement, Definitions.

6. The PH-MCO must ensure, if applicable, that its Subcontracts adhere to the standards for Network composition and adequacy.

7. Should the PH-MCO use a subcontracted utilization review entity, the PH-MCO must ensure that its subcontractors process each request for benefits in accordance with Section V.B.1 of this Agreement, General Prior Authorization Requirements.

8. Should the PH-MCO subcontract with an entity to provide any information systems services, the Subcontract must include provisions for a transition plan in the event that the PH-MCO terminates the Subcontract or enters into a Subcontract with a different entity. This transition plan must include information on how the data shall be converted and made available to the new subcontractor. The data must include all historical Claims and service data.

The PH-MCO must make all necessary revisions to its Subcontracts to be in compliance with the requirements set forth in Section XIII.A of this Agreement, Compliance with Program Standards. Revisions may be completed as contracts and Subcontracts become due for renewal provided that all contracts and Subcontracts are amended within one (1) year of execution of this Agreement with the exception of the Encounter Data requirements, which must be amended immediately, if necessary, to

ensure that all subcontractors are submitting Encounter Data to the PH-MCO within the time frames specified in Section VIII.B of this Agreement, Systems Reports.

B. Consistency with Policy Statements

The PH-MCO agrees that its agreements with all subcontractors must be consistent, as may be applicable, with Department of Health regulations governing HMO Contracting with Integrated Delivery Systems at 28 Pa. Code §§ 9.721 – 9.725 and Pennsylvania Insurance Department regulations at 31 Pa. Code §§ 301.301 – 301.314.

SECTION XIV: CONFIDENTIALITY

A. The PH-MCO must comply with all applicable federal and state laws regarding the confidentiality of medical records. The PH-MCO must also cause each of its subcontractors to comply with all applicable federal and state laws regarding the confidentiality of medical records. The PH-MCO must comply with the Management Information System and System Performance Review (SPR) Standards, available on the HealthChoices Intranet, regarding maintaining confidentiality of data. The federal and state laws with regard to confidentiality of medical records 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 (Standards for Privacy of Individually Identifiable Health Information); and the 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; 55 Pa. Code 105.1 et seq.; and 42 CFR 431 et seq.

B. The PH-MCO must be liable for any state or federal fines, financial penalties, or damages levied upon the Department for a breach of confidentiality due to the negligent or intentional conduct of the PH-MCO in relation to the PH-MCO's systems, staff, or other area of responsibility.

C. The PH-MCO agrees to 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 can be used by the PH-MCO for any purpose after the expiration or termination of this Agreement. The PH-MCO also agrees to transfer all such information to a subsequent PH-MCO at the direction of the Department.

D. The PH-MCO considers its financial reports and information, marketing plans, Provider rates, trade secrets, information or materials relating to the PH-MCO’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 PH-MCO’s

competitive position to be confidential information. 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 HealthChoices Program. The Department will notify the PH-MCO when it determines that disclosure of information is necessary for the administration of the HC Program. The PH-MCO will be given the opportunity to respond to such a determination prior to the disclosure of the information.

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

SECTION XV: INDEMNIFICATION AND INSURANCE

A. Indemnification

1. In addition to Section 14 of Exhibit D, Standard Grant Terms and Conditions for Services, the PH-MCO must indemnify and hold the Department and the Commonwealth of Pennsylvania, their respective employees, agents, and representatives free and harmless against any and all liabilities, losses, settlements, Claims, demands, and expenses of any kind (including, but not limited to, attorneys' fees) which may result or arise out of any dispute of any kind by and between the PH-MCO and its subcontractors with Members, agents, clients, or any defamation, malpractice, Fraud, negligence, or intentional misconduct caused or alleged to have been caused by the PH-MCO or its agents, subcontractors, employees, or representatives in the performance or omission of any act or responsibility assumed by the PH-MCO pursuant to this Agreement.

2. In addition to Section 14 of Exhibit D, Standard Grant Terms and Conditions for Services, the PH-MCO must indemnify and hold harmless the Department and the Commonwealth of Pennsylvania from any audit disallowance imposed by the federal government resulting from the PH-MCO's failure to follow state or federal rules, regulations, or procedures unless prior authorization was given by the Department. The Department shall provide timely notice of any disallowance to the PH-MCO and allow the PH-MCO an opportunity to participate in the disallowance appeal process and any subsequent judicial review to the extent permitted by law. Any payment required under this provision shall be due from the PH-MCO upon notice from the Department. The indemnification provision hereunder shall not extend to disallowances which result from a determination by the federal government that the terms of this Agreement are not in accordance with federal law. The

obligations under this paragraph shall survive any termination or cancellation of this Agreement.

B. Insurance

The PH-MCO must maintain for itself, each of its employees, agents, and representatives, general liability and all other types of insurance in such amounts as reasonably required by the Department and all applicable laws. In addition, the PH-MCO must require that each of the Health Care Providers with which the PH-MCO contracts maintains professional malpractice and all other types of insurance in such amounts as required by all applicable laws. The PH-MCO must provide to the Department, upon the Department's request, certificates evidencing such insurance coverage.

SECTION XVI: DISPUTES

A. In the event that a dispute arises between the parties relating to any matter regarding this Agreement, the PH-MCO must send written notice of an initial level dispute to the Contracting Officer for this Agreement, who will make a determination in writing of his/her interpretation and will send the same to the PH-MCO within thirty (30) days of the PH-MCO's written request for same. That interpretation shall be final, conclusive, and binding on the PH-MCO, and unreviewable in all respects unless the PH-MCO within twenty (20) days of its receipt of said interpretation, delivers a written appeal to the Secretary of Public Welfare. Unless the PH-MCO consents to extend the time for disposition by the Secretary, the decision of the Secretary shall be released within thirty (30) days of the PH-MCO's written appeal and shall be final, conclusive, and binding, and the PH-MCO must thereafter with good faith and diligence, render such performance in compliance with the Secretary's determination; subject to the provisions of Section XVIII.B below. Notice of initial level dispute must be sent to:

Department of Public Welfare
Office of Medical Assistance Programs
Director, Bureau of Managed Care Operations
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

B. Any appealable action regarding this Agreement must be filed by the PH-MCO in the Department’s Bureau of Hearings and Appeals in accordance with 67 Pa.C.S. Sections 101 – 106 and the standing practice order and regulations issued pursuant thereto.

SECTION XVII: FORCE MAJEURE

In the event of a major disaster or epidemic as declared by the Governor of the Commonwealth of Pennsylvania or terrorist activities, an act of any military or civil authority, or outage of communications, power, or other utility, the PH-MCO must cause its employees and all Providers to render all services provided for in the RFP and herein as is practical within the limits of facilities and available staff for Providers and the PH-MCO. The PH-MCO, however, shall not be liable nor deemed to be in default for any Provider's failure to provide services or for any delay in the provision of services when such a failure or delay is the direct or proximate result of the depletion of staff or facilities by the major disaster or epidemic, or terrorist activities, act of any military or civil authority, or outage of communications, power, or other utility; provided, however, in the event that the provision of services is substantially interrupted, the Department will have the right to terminate this Agreement upon ten (10) days written notice to the PH-MCO.

SECTION XVIII: GENERAL

A. Suspension From Other Programs

In the event that the PH-MCO learns that a Health Care Provider with whom the PH-MCO contracts is suspended or terminated from participation in the MA Program of this or another state or from the Medicare Program or other government funded program, the PH-MCO must promptly notify the Department, in writing, of such suspension or termination.

No payment shall be made to any Health Care Provider for any services rendered by a Health Care Provider during the period the PH-MCO knew, or should have known, such Provider was suspended or terminated from the Medical Assistance Program of this or another state, or the Medicare Program or other government funded program.

B. Rights of the Department and the PH-MCO

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 Section XVI of this Agreement, Disputes, the rights and remedies of the PH-MCO provided herein shall not be exclusive and are in addition to any rights and remedies provided by law.

C. 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.

D. 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.

E. Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania.

F. 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., DHL, 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
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
Beech Drive
DGS Annex Complex
Harrisburg, Pennsylvania 17110

With a Copy to:

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

To the PH-MCO – See Appendix 4 of this Agreement, PH-MCO Information, for name and address.

G. 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.

H. Headings

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

I. Assignment

Neither this Agreement nor any of the parties' rights hereunder shall be assignable by either party hereto without the advance written approval of the other party hereto, which approval shall not be unreasonably withheld. If circumstances allow, at least thirty (30) days notice with adequate detail will be given for the request of approval.

J. 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.

K. News Releases

News releases pertaining to the HealthChoices Program may not be made without advance written approval by the Department, and then only in conjunction with the Issuing Office.

L. Entire Agreement Modification

This Agreement and applicable final schedule of base Capitation and Maternity Care Rates constitute the entire understanding of the parties hereto and supersedes any and all written or oral agreements, representations, or understandings. No modifications, discharges, amendments, or alterations shall be effective unless evidenced by an instrument in writing signed by both parties. Furthermore, neither this Agreement nor any modifications, discharges, amendments or alterations thereof shall be considered executed by or binding upon the Department or the Commonwealth of Pennsylvania unless and until signed by a duly authorized officer of the Department or Commonwealth of Pennsylvania.

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.

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, unless the Department informs the PH-MCO that risk adjustment does not apply.

The Department will risk adjust the Recipient Groups for Newly Eligible (Medicaid expansion) Recipient Groups beginning with the January 2016 program month.

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 or combinations thereof.

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 and Community Based Care Management

If this Agreement provides for Provider Pay-for-Performance and Community Based Care Management payments per Exhibit B (3), the Department will provide the PH-MCO with a per-member-per-month (PMPM) amount(s), as identified in Appendix 3f, Capitation Rates. The Department will pay any PMPM amount(s) that pertain to either of these programs to the PH-MCO for each Member enrolled in the PH-MCO, 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 Capitation Payment Rate equals the Risk Adjusted Rate of $97.10.

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. Maternity Care Payment

If there are Health Insurance Providers Fee (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.

G. 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 3d

Risk Corridor

This Appendix establishes a risk corridor arrangement (Arrangement) between the Department and the PH-MCO. The Arrangement applies collectively to all HealthChoices Agreements between the PH-MCO and the Department in all HealthChoices zones.

This Arrangement applies to the HealthChoices program calendar years 2015 and 2016 only (Arrangement Years). Each year will be a separate Arrangement.

I. Covered Members

This Arrangement applies collectively to all members covered by the PH-MCO's HealthChoices Agreements for which the Department has made or will make a capitation payment under one of the Newly Eligible rating groups, as identified in Appendices 3f, for the applicable Arrangement Year.

II. Covered Costs

Covered Costs include the net cost to the PH-MCO of all medical products and services paid by the PH-MCO for Covered Members. This includes capitation payments made by the PH-MCO for medical products and services.

In addition, costs incurred for quality improvement initiatives will be included as Covered Costs per this Arrangement. These initiatives must receive approval from the Department and will be limited to costs incurred within each initiative's approved budget. The Department will use the CMS criteria that are used for the purpose of the ACA Medical Loss Ratio requirement to determine allowable quality improvement expenses. The Department will cap allowable quality improvement expenses at two percent (2.0%) of Net Revenue for all zones aggregated as defined below.

Non-medical products and services, including administrative services and the cost of taxes, are not covered by this Arrangement with the exception of approved quality improvement initiatives.

III. Net Revenue

Net Revenue is defined as the total payments paid or payable by the Department to the PH-MCO for the HealthChoices Agreements in all zones, per the Department's records, to the PH-MCO for Covered Members for the applicable Arrangement Year. This amount will be reduced by any portion of this revenue provided by the Department attributable to the Gross Receipts Tax. This amount will be further reduced by revenue paid or payable by the Department for the Health Insurance Provider's Fee (HIPF).

Net Revenue does not include a previous or potential Risk Corridor payment or revenue reduction. Net Revenue includes the net impact of Home Nursing Risk Sharing on Covered Members. For the 2016 Arrangement Year, Net Revenue is inclusive of High Cost Risk Pool impact and risk adjustment of rates for Covered Members. Net Revenue includes pro rata MCO P4P, calculated using member months.

IV. Payment by the PH-MCO to the Department

For each Arrangement Year, if 85.00 percent (85.00%) of the Net Revenue paid or payable by the Department per this Agreement specific to the Arrangement Year is greater than the Covered Costs, the PH-MCO will pay the Department 80.00 percent (80.00%) of the difference.

V. Payment by the Department to the PH-MCO

The Department will pay the PH-MCO an amount equal to 80.00 percent (80.00%) of the amount by which the Covered Costs specific to this Arrangement Year exceed 93.00 percent (93.00%) of the Net Revenue paid or payable by the Department specific to this Arrangement Year.

VI. Settlement

A. Interim Settlement

The Department will complete an interim settlement for each Arrangement Year.

The Department will determine the Net Revenue as defined in Section III above.

The PH-MCO will provide the Department with an interim report on Covered Costs for the Covered Members for the Arrangement Year. This report will be due July 31 of the first year after the Arrangement Year. The Department will provide a format for this report which will include the following for both the individual zone and all zones aggregated:

1. A lag report that provides information on medical claims payments by program month and payment month. The payment months will extend at least through the third month after the end of the Arrangement Year.
2. Incurred But Not Reported (IBNR) amounts by major claims type and for all claims.
3. Claims settlement amounts paid that are not included in the lag report
4. Capitation payments to providers
5. Costs incurred for quality improvement initiatives approved by the Department limited to costs incurred within each initiative's budget but not to exceed two percent (2%) of Net Revenue.
6. Any other costs that meet criteria for Covered Costs
7. Attestation by an independent CPA
8. Certification of the IBNR by an actuary.

The PH-MCO will provide supporting information upon request by the Department. The Department may choose to review or audit the information or to prepare a replacement report. The Department will make the final decisions about Covered Costs included in the settlement.

The Department will calculate and determine the Net Revenue figure.

The Department will use the criteria included in this Appendix to determine the interim settlement amount and will allocate it across the HealthChoices Agreements with this PH-MCO using a method determined by the Department and shared with the PH-MCO.

B. Final Settlement

The Department will complete a final settlement for each Arrangement Year.

The Department will determine the Net Revenue as defined in Section III above.

The PH-MCO will provide the Department with a final report on Covered Costs for the Covered Members for the Arrangement Year. This report will be due September 15 of the second year after the Arrangement Year. The Department will provide a format for this report which will include the following for both the individual zone and all zones aggregated:

1. A lag report that provides information on medical claims payments by program month and payment month. The payment months will extend at least through the eighteenth month after the end of the Arrangement Year.
2. Claims settlement amounts paid that are not included in the lag report
3. Capitation payments to providers
4. Costs incurred for quality improvement initiatives approved by the Department limited to costs incurred within each initiative's budget but not to exceed two percent (2%) of Net Revenue.
5. Any other costs that meet criteria for Covered Costs
6. Attestation by an independent CPA

The Covered Costs included in the final report will not include IBNR.

The final settlement amount will be net of any interim settlement amount for the same Arrangement Year.

The PH-MCO will provide supporting information upon request by the Department.

The Department may choose to review or audit the information or to prepare a replacement report. The Department will make the final decisions about Covered Costs included in the settlement.

The Department will calculate and determine the Net Revenue figure.

The Department will use the criteria included in this Appendix to determine the final settlement amount and will allocate it across the HealthChoices Agreements with this PH-MCO using a method determined by the Department and shared with the PH-MCO.

VII. Gross Receipts Tax

If either the PH-MCO or the Department has an obligation under this Arrangement, the total due to the Department or the PH-MCO per Sections IV, V and VI above will be multiplied by 1.0627 to account for the legitimate and marginal administrative cost of the

Gross Receipts Tax (GRT). The result will be the final amount owed to the PH-MCO or to the Department for each applicable Arrangement Year per this Appendix.

If the GRT is reduced or ended or if the PH-MCO has an additional obligation under the GRT due to PURTA, the obligation for GRT will be appropriately adjusted or eliminated.

If the Commonwealth replaces GRT with another tax on PH-MCO revenue, the Department will adjust the calculation above to reflect the effect on the tax obligation of revenue provided or adjusted per this Appendix.

VIII. Payments

The Department will provide the PH-MCO with written notification and corresponding documentation prior to initiating a payment or payment reduction. The PH-MCO will be afforded the opportunity to review the documentation and provide comment to the Department within 30 days from the date of the written notification.

The total payment due to/from the Department/PH-MCO will be allocated by zone.

The PH-MCO must submit payment to the Department within fifteen calendar days of the date of notification of the PH-MCO's obligation to the Department, as identified above. Alternatively, the Department may choose to recover any obligation due from the PH-MCO by offsetting a subsequent monthly capitation payment.

If the Department has an obligation to the PH-MCO, it will initiate payment within fifteen calendar days after final determination.

HC Agreements
CY2015 Amendment with
HealthChoices Expansion
Updated May 7, 2015

APPENDIX 3k

HIGH COST RISK POOL

Overview

The Department will establish, administer, and distribute funds from a quarterly High Cost Risk Pool (HCRP). This Appendix 3k is effective January 1, 2015 and supersedes any previous version to define the HCRP for the January-March 2015 quarter and each subsequent quarter.

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

PH-MCO Inclusion/exclusion

The HCRP Threshold is $80,000.

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

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

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

The Department will deem this criterion to have been met if it was met by the PH-MCO or by a PH-MCO that operated in the same HealthChoices zone ("Previous PH-MCO") if one of the following criteria is met:

- The current PH-MCO purchased the assets or liabilities of the Previous PH-MCO; or

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

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

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

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

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

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

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

Newly Eligibles

The Newly Eligible rating groups will be included in High Cost Risk Pools effective with the April-June 2016 quarter. The cost of Newly Eligible members will not be included in High Cost Risk Pool calculations prior to the calculations for the April-June 2016 risk pools.

For those quarters in which Newly Eligible rating groups are not included in the quarterly HCRP, the PH-MCO has no obligation for HCRPAA for these Members and has no opportunity to include the cost of these Members in a calculation of a distribution of a HCRP.

DPW Calculation of Quarterly Funds in the Risk Pool

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

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

Beginning in the quarter the Newly Eligible Members are eligible for inclusion in the HCRP, the PH-MCO's HCRPAA obligation be defined as above plus the HCRPAAs for Newly Eligible Members multiplied by the applicable member months.

Covered Services

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

- For Members under the age of 21, no product or service that is a Covered Service under the Home Nursing Risk Sharing Arrangement is a Covered Service for the HCRP.

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

Defined Twelve Month Period

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

Example: The Defined Twelve Month Period for the January-March 2015 HCRP is January-December 2014.

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

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

The discharge date on an inpatient claim determines eligibility for inclusion in a Defined Twelve Month Period.

File Submission

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

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

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

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

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

Inpatient Hospital Repricing

The Department will reprice each acute inpatient hospital claim to the amount the Department would have paid for the admission.

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

Quarterly Distributions

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

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

Gross Receipts Tax and High Cost Risk Pool

The Department will multiply the PH-MCO's positive or negative result by 1.0627 to account for the legitimate and marginal administrative cost of the Gross Receipts Tax (GRT). The result will be the final amount paid to or collected from the PH-MCO per this Appendix.

If the Department has notified the PH-MCO that the GRT is reduced or ended or if the PH-MCO has an additional obligation under the GRT due to PURTA , the obligation for GRT will be appropriately adjusted or eliminated.

If the Commonwealth replaces GRT with another tax on MCO revenue, the Department will adjust the calculation above to reflect the effect on the tax obligation of revenue provided or adjusted per this Appendix.

Subsequent Adjustments

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

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

Early Payment of a PH-MCO's HCRPAA Obligation

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

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

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

APPENDIX 14

APR/DRG ADJUSTMENT
INPATIENT ACUTE CARE SERVICES

I. DEFINITIONS

For the purposes of this Appendix 14, the term hospital means either of the following:

A. An acute care hospital, including critical access hospital, that receives APR/DRG payments from the Department under the MA Fee for Service Program;
B. An out of State acute care hospital that provides inpatient acute care services to a PH-MCO's members.

II. FUNDING BY THE DEPARTMENT TO THE PH-MCO

The rates in Appendix 3f include an APR Adjustment component. The APR Adjustment component, net of GRT, is specified in the charts below. The APR Adjustment component is subject to the same risk adjustment as contained in Appendix 3f.

January 1, 2015 through May 31, 2015	Southeast Philadelphia County	Southeast 4 Surrounding Counties
TANF-HB-MAGI < 2 Months	$609.01	$777.78
TANF-HB-MAGI 2-11.999 Months	$41.44	$31.00
TANF-HB-MAGI Ages 1-20	$7.82	$6.54
TANF-HB-MAGI Ages 21+	$15.81	$20.89
SSI-HH-Other Disabled	$72.35	$68.22
Breast and Cervical Cancer	$101.13	$101.13
"Newly Eligible" Women Ages 19 and 20	$29.56	$29.56
"Newly Eligible" Women Ages 21 to 34	$49.14	$49.14
"Newly Eligible" Women Ages 35 to 44	$76.78	$76.78
"Newly Eligible" Women Ages 45 to 54	$101.52	$101.52
"Newly Eligible" Women Ages 55 to 64	$142.49	$142.49
"Newly Eligible" Men Ages 19 and 20	$31.35	$31.35
"Newly Eligible" Men Ages 21 to 34	$50.28	$50.28
"Newly Eligible" Men Ages 35 to 44	$78.67	$78.67
"Newly Eligible" Men Ages 45 to 54	$115.52	$115.52
"Newly Eligible" Men Ages 55 to 64	$166.51	$166.51

June 1, 2015 through August 31, 2015	Southeast Philadelphia County	Southeast 4 Surrounding Counties
TANF-HB-MAGI < 2 Months	$609.01	$777.78
TANF-HB-MAGI 2-11.999 Months	$41.44	$31.00
TANF-HB-MAGI Ages 1-20	$7.82	$6.54
TANF-HB-MAGI Ages 21+	$15.81	$20.89
SSI-HH-Other Disabled	$72.35	$68.22
Breast and Cervical Cancer	$101.13	$101.13
"Newly Eligible" Women Ages 19 and 20	$29.56	$29.56
"Newly Eligible" Women Ages 21 to 34	$30.70	$30.70
"Newly Eligible" Women Ages 35 to 44	$50.36	$50.36
"Newly Eligible" Women Ages 45 to 54	$76.51	$76.51
"Newly Eligible" Women Ages 55 to 64	$106.72	$106.72
"Newly Eligible" Men Ages 19 and 20	$31.35	$31.35
"Newly Eligible" Men Ages 21 to 34	$38.62	$38.62
"Newly Eligible" Men Ages 35 to 44	$54.43	$54.43
"Newly Eligible" Men Ages 45 to 54	$84.45	$84.45
"Newly Eligible" Men Ages 55 to 64	$102.45	$102.45

September 1, 2015 through December 31, 2015	Southeast Philadelphia County	Southeast 4 Surrounding Counties
TANF-HB-MAGI < 2 Months	$609.01	$777.78
TANF-HB-MAGI 2-11.999 Months	$41.44	$31.00
TANF-HB-MAGI Ages 1-20	$7.82	$6.54
TANF-HB-MAGI Ages 21+	$15.81	$20.89
SSI-HH-Other Disabled	$72.35	$68.22
Breast and Cervical Cancer	$101.13	$101.13
"Newly Eligible" Women Ages 19 and 20	$29.56	$29.56
"Newly Eligible" Women Ages 21 to 34	$30.87	$30.87
"Newly Eligible" Women Ages 35 to 44	$51.72	$51.72
"Newly Eligible" Women Ages 45 to 54	$76.04	$76.04
"Newly Eligible" Women Ages 55 to 64	$105.75	$105.75
"Newly Eligible" Men Ages 19 and 20	$31.35	$31.35
"Newly Eligible" Men Ages 21 to 34	$35.59	$35.59
"Newly Eligible" Men Ages 35 to 44	$50.28	$50.28
"Newly Eligible" Men Ages 45 to 54	$80.05	$80.05
"Newly Eligible" Men Ages 55 to 64	$92.84	$92.84

III. INCREASED PAYMENTS BY THE PH-MCO TO HOSPITALS

A. The PH-MCO must use the funds received from the APR Adjustment component to increase the payments made by the PH-MCO to hospitals for inpatient acute care services.

B. The PH-MCO must provide documentation to the Department in a form designated by the Department that all funds received from the APR Adjustment component are used in accordance with this Appendix.

IV. CLAIMS PROCESSING REQUIREMENTS

A. An APR Adjustment payment to a hospital by a PH-MCO is deemed payment of a clean Claim received from a hospital for an inpatient admission and is subject to Section VII.D. of this HealthChoices Physical Health Agreement.

B. Unless contract terms between the MCO and hospital specify otherwise, the amount of time required to adjudicate this Claim is computed by comparing the date the APR Adjustment payment was received by the PH-MCO from the Department with the date the payment is transmitted to the hospital.

EXHIBIT A
Managed Care Regulatory Compliance Guidelines

The following apply to all managed care organizations under contract with the Office of Medical Assistance Programs:

- All federal and state laws, including but not limited to 55 Pa.Code Chapters 1101-1249

- Non-compensable or non-covered services (managed care organizations may provide additional services beyond MA Fee for Service (FFS), but must cover, at a minimum, those services on the fee schedule in the same amount, duration and scope as the Fee for Service Program.)
- Scope of Benefits based on Recipient's eligibility (as determined by the County Assistance Office)
- Staff/Provider Licensing/Scope of Practice Requirements
- Frequency of service
- Program standards/quality of care standards
- Provider participation (enrolled as an MA Participating Provider)
- Utilization review
- Administrative sanctions
- Definitions

Specific Federal Regulatory Cites for Managed Care Agreements:

Citation	Requirement
1903(m)(4)(B)	The PH-MCO will make reports of any transactions between the PH-MCO and parties in interest that are provided to the State or other agencies available to PH-MCO enrollees upon reasonable request.
42 CFR 438.6(f)(2)(ii)	The PH-MCO will report all identified provider-preventable conditions in a form or frequency, which may be specified by the State.
ARRA 5006(a) State Medicaid Director Letter SMD #10-001 01/22/2010	The PH-MCO is prohibited from imposing enrollment fees, premiums, or similar charges on Indians served by an Indian health care provider; Indian Health Service (HIS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services (CHS).
ARRA 5006(d) SMD 10-001	The PH-MCO must permit any Indian who is enrolled in a non-Indian MCO and eligible to receive services from a participating I/T/U provider to choose to receive covered services from that I/T/U provider.
ARRA 5006(d) SMD 10-001	The PH-MCO must demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services

Citation	Requirement
	available under the Agreement for Indian enrollees who are eligible to receive services from such providers.
ARRA 5006(d) SMD 10-001	The PH-MCO must pay I/T/U providers, whether participating in the network or not, for covered managed care services provided to Indian enrollees who are eligible to receive services from the I/T/U either at a negotiated rate between the PH-MCO and the I/T/U provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the provider were not an I/T/U provider.
42 CFR 438 - 42 CFR 434.6(a)(12)(i)-42 CFR 447	The PH-MCO is prohibited from making payment to a provider for provider-preventable conditions that meet the following criteria: (i) Is identified in the State Plan (ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by the evidence-based guidelines (iii) Has a negative consequence for the beneficiary (iv) Is auditable (v) Includes, at a minimum, wrong surgical or other invasive procedures performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
42 CFR 438.6(f)(2)(ii) 42 CFR 434.6(a)(12)(ii)	The PH-MCO must require all providers to report provider-preventable conditions associated with claims for payments or enrollee treatments for which payment would otherwise be made.
1916(a)(2)(D) 1916(b)(2)(D)	Any cost sharing imposed by the PH-MCO

Citation	Requirement
42 CFR 438.108 42 CFR 447.50-60 State Medicaid Director Letter SMDL #06-015 6/16/2006	on enrollees is in accordance with Medicaid fee for service requirements at 42 CFR 447.50 through 42 CFR 447.60
1903(i) final sentence 1903(i)(2)(A)	The PH-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2),[203]
1903(i) final sentence 1903(i)(2)(B)	The PH-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
1903(i) final sentence 1903(i)(2)(C)	The PH-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend payments.
1903(i) final sentence 1903(i)(16)	The PH-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including

Citation	Requirement
	items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.
1903(i) final sentence 1903(i)(17)	The PH-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.
1903(i) final sentence 1903(i)(18)	The PH-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by any agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act.
1903(t) 42 CFR 495.332 (d)(2) 42 CFR 438.6(c)(5)(iii) 42 CFR 495.332 (d)(2) 42 CFR 438.6(c)(5)(iii) 42 CFR 495.304 42 CFR 495.310(c) 42 CFR 447.253(e) 42 CFR 495.370(a) SMD# 09-006, Attachment A 1903(t)(6)(A)(ii)	If the PH-MCO is required by the State to disburse electronic health records (EHR) incentive payments to eligible professionals, the agreement establishes a methodology for verifying that this process does not result in payments that exceed 105 percent of the capitation rate, in accordance with 42 CFR 438.6(c)(5)(iii).
1903(t)(6)(A)(ii) 495.310(k) 495.332(c)(9)	If the PH-MCO is required by the State to disburse EHR incentive payments to eligible professionals, the agreement includes a description of the process and methodology for ensuring and verifying that incentive payments are paid directly to the eligible professional (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.
1124(a)(2)(A) 1903(m)(2)(A)(viii)	The PH-MCO must disclose the following

Citation	Requirement
42 CFR 455.100-103 42 CFR 455.104(b)	information to the state for any person or corporation with ownership or control interest in the PH-MCO: • Name and address (the address for corporate entities must include as applicable primary business address, every business locatin, and P.O. Box address.) • Date of birth and Social Security Number (in the case of an individual) • Other tax identification number (in the case of a corporation) • Whether the person (individual or corporation) with an ownership or control interest in the PH-MCO or a PH-MCO subcontractor is related to another person with ownership or control interest in the PH-MCO as a spouse, parent, child, or sibling. • The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest. • The name, address, date of birth and Social Security Number of any managing employee of the PH-MCO.

The following, which may appear in any of the above sections or Medical Assistance Bulletins, will not apply to managed care organizations:

- Maximum frequency of service limits (managed care organizations may provide more than the maximum).
- Maximum service reimbursement rates.
- Payment methodology.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1101, General Provisions, with the following exceptions:	
1101.21 Definition of “Prior Authorization”	Definitions

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1101.21 Definition of "Shared Health Facility", (iv) and (v)	(iv) At least one practitioner receives payment on a fee for service basis. (v) A provider receiving more than $30,000 in payment from the MA Program during the 12-month period prior to the date of the initial or renewal application of the shared health facility for registration in the MA Program.
1101.21 Definition of "Medically Necessary"	A service, item, procedure or level of care that is: (i) Compensable under the MA Program. (ii) Necessary to the proper treatment or management of an illness, injury or disability. (iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.
1101.31(b) (13) "…Dental Services as specified in Chapter 1149 (relating to Dentists' Services)."	Benefits, Scope for categorically needy
1101.31(f) Note: The managed care organizations are not required to impose limits that apply in the Fee-for-Service delivery system, although they are permitted to do so. The managed care organizations may not impose limits that are more restrictive than the limits established in the Fee-for-Service system. If the managed care organizations impose limits, their exception process cannot be more restrictive than the process established in §1101.31(f).	Benefits, Exceptions (for limits specified in subsections (b) and (e) - FFS Program Exception Process
1101.32(a) (1) "…Medically needy children referred from EPSDT are not eligible for pharmaceuticals, medical supplies, equipment or prostheses and orthoses." 1101.32(a)(2)	Coverage Variations, Expanded coverage EPSDT Coverage Variations, Expanded Coverage School Medical Program for Medically Needy school children
1101.33(a) "…If the applicant is determined to be eligible, the Department issues Medical Services Eligibility (MSE) cards that are effective from the first of the month through the last day of the month..."	Recipient Eligibility, Verification of Eligibility (issuance of card)
1101.33(b)	Recipient Eligibility, Services restricted to a single provider
1101.51(a)	Responsibilities, Ongoing responsibilities of providers, Recipient freedom of choice of providers
1101.61	Fees and Payments, Reimbursement policies.
1101.62	Maximum fees
1101.63(b)(1) through (10)	Payment in full, Copayments for MA services
1101.63(c)	Payment in full, MA deductible
1101.64(b) "…Payment will be made in accordance with established MA rates and fees."	Third-party medical resources, Persons covered by Medicare and MA
1101.65	Method of payment
1101.67	Prior Authorization (including timeframes for notice)
1101.68	Invoicing for services
1101.69	Overpayment – underpayment (related to providers)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1101.69(a)	Establishment of a uniform period for the recoupment of overpayments from providers (COBRA)
1101.72	Invoice adjustment
1101.83	Restitution and repayment (related to providers for payments that should not have been made)
Managed care organizations are not required to adhere to the provisions of 55 Pa.Code Chapter 1102, Shared Health Facilities. Managed care organizations are responsible for establishing their own provider networks.	
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1121, Pharmaceutical Services, with the following exceptions:	
1121.2	Definitions of AWP, Compounded Prescription, Pricing Service, Federal Upper Limit, CMS Multi-source Drug, State MAC, and Usual and Customary Charge
1121.52(a)(6)	Payment conditions for various services (indication for "brand medically necessary")
1121.52(b)	Payment conditions for various services (prenatal vitamins)
1121.53(a)	Limitations on payment (not exceeding UCC to general public)
1121.53(b)(1)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(b)(2)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(c)	Limitations on payment (34 day supply or 100 units, total authorization not exceeding 6 months' or five refill supply)
1121.53(f)	Limitations on payment (Payment to pharmacy for prescriptions dispensed to a recipient in either a skilled nursing facility, an intermediate care facility or an intermediate care facility for the mentally retarded and specific scripts not included in the limitation)
1121.54(1) and (2)	Noncompensable services and items. (Methadone and drugs prescribed for treatment of pulmonary tuberculosis)
1121.54(5) "or whose use is not approved by the FDA"	Noncompensable services and items. (Drugs and devises not approved by the FDA or whose use is not approved by the FDA)
1121.54(7) "Legend and"	Noncompensable services and items. (Legend and nonlegend soaps, cleaning agents, etc.)
1121.54(10)	Noncompensable services and items. ("Drugs prescribed in conjunction with sex reassignment procedures or other noncompensable procedures.")
1121.54(17)	Noncompensable services and items. ("Legend and nonlegend pharmaceutical products distributed by a company that has not entered into a National rebate agreement with the Federal government..."
1121.55	Method of payment. (relating to the Department's payment to pharmacies)
1121.56	Drug cost determination.
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1123, Medical Supplies, with the following exceptions:	
1123.1 "and the MA Program fee schedule"	Policy. (Payment for medical supplies is subject to this chapter, Chapter 1101 (relating to general provisions) and the limitations established in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule.
1123.13(a) and (b).	Inpatient services.
1123.22(1).	Scope of benefits for the medically needy. ("Medical supplies which have been prescribed through the School Medical Program...")
1123.22(2) "who are enrolled in EPSDT, or which have been prior authorized by the Department as specified in 1123.56 (a) (2) (relating to vision aids)"	Scope of benefits for the medically needy. ("Eyeglasses which have been prescribed as treatment for individuals under 21 years of age who are enrolled in EPSDT...")
1123.51 "and the MA Program fee schedule"	Payment for Medical Supplies. General payment policy.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1123.53	Hemophilia products.
1123.54 “in accordance with the limitations described in this section and the maximum fees listed in Chapter 1150 (relating to Medical Assistance program payment policies) and the Medical Assistance Program fee schedule”	Orthopedic shoes, molded shoes and shoe inserts (Relating to payment when prescribed for eligible persons to approved MA providers)
1123.54(1) through (5).	Orthopedic shoes, molded shoes and shoe inserts (Relating to prior approval, conditions for payment, payment for modifications necessary for the application of a brace or splint, payment for repairs w/o a prescription or prior authorization, and payment for orthopedic shoes only if the recipient is 20 years of age or younger.”
1123.55(a) “The prescription shall contain the cardiopulmonary diagnosis”	Oxygen and related equipment. (Relating to payment conditions)
1123.55(b) and (c).	Oxygen and related equipment. (Relating to prior authorization and prescription inclusion requirements)
1123.55(d) “and recertification shall be kept by the provider”	Oxygen and related equipment. (“A physician shall recertify orders for oxygen at least every 6 months and recertification shall be kept by the provider.”)
1123.56(a)(1) through (3)	Vision aids. (“Payment for eyeglasses is made only if the recipient is 20 years of age or younger and the eyeglasses have been one of the following...”)
1123.56(b)(1) through(3)	Vision aids. (“Payment for low vision aids is made only if the recipient is categorically needy or if the recipient is medically needy and the low vision aid has been one of the following...”)
1123.56(c)	Vision aids. (“Payment for eye prostheses will be made only if the recipient is categorically needy.”)
1123.57(a) and (b)	Hearing aids. (Relating to payment for hearing aids only if recipient is 20 years of age or younger and have been prescribed through the EPSDT program, and for repairs to hearing aids owned by the recipient when the invoice is accompanied by an itemized statement.)
1123.58(1) and (2)	Prostheses and orthoses.
1123.60(a) through (i)	Limitations on payments.
1123.61 (1) through (8) and (10)	Noncompensable services and items. (Relating to when payment will not be made. (9) is not excluded, as it relates to items prescribed or ordered by a practitioner who has been barred or suspended during an administrative action from participation in the MA Program.)
1123.62	Method of payment.
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-86-02, Durable Medical Equipment Warranties.	
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 05-87-02, Coverage of Motorized Wheelchairs, with the following exceptions: **- requiring Prior Authorization at the State level.** **- Page 2, number 7.**	
Managed care organizations are to adhere to the provisions of Medical Assistance Bulletin 1123-91-01, EPSDT – OBRA ’89 with the following exceptions: **- Page 3 – Vision Services – the “age of 21” and the MA fee schedule do not apply.** **- Page 3 – Dental Services – the “age of 21” and the MA fee schedule do not apply.** **- Page 3 – Hearing Services – the “age of 21” and the MA fee schedule do not apply.** **- Page 3 – “and use of existing Medical Assistance Program Fee Schedule”**	
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-85-02, Policy Clarification for Services Provided to Hospitalized Recipients Under the DRG Payment System.	
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1126, Ambulatory Surgical Center and Hospital Short Procedure Unit Services, with the following exceptions:	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1126.51(f) through (h) and (k) through (m)	Payment for Same Day Surgical Services. General payment policy. ((f-h)Relating to submission of invoices to the Department, consideration if ASC or SPU has fee schedule based on patient's ability to pay that the Department will consider it as the usual and customary charge, and the Department's payment being the lesser of the facility's charge to general public to be the most frequent charge to the self-paying public for the same service.) and (k-m relating to payment when patient in conjunction with same day service are transferred to a hospital due to complications and when patients due to complications must be transferred to inpatient hospital care)
1126.52(a) and (b)	Payment criteria. (Relating to the Department's maximum reimbursement and developed fees.)
1126.53(b)	Limitations on covered procedures. (Relating to limits for appropriate same day surgical procedures for same day surgery but are not yet included in the established list of covered ASC/SPU services.)
1126.54(a)(7)	Procedures and medical care performed in connection with sex reassignment.
1126.54(a)(11) through (13) and (b)	Noncompensable services and items. ("...The Department does not pay ASCs and SPUs for services directly or indirectly related to, or in conjunction with...diagnostic tests and procedures that can be performed in a clinic or practitioner's office and diagnostic tests and procedures not related to the diagnosis"; "Services and items for which full payment equal to or in excess of the MA fee is available through Medicare or other financial resources or other health insurance programs"; "Services and items not ordinarily provided to the general public"; and "...if the admission to the ASC or SPU is not certified under the Department's utilization review process applicable to the type of provider furnishing the service".)
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1127, Birth Center Services, with the following exceptions:	
1127.51(d)	Payment for Birth Center Services. General payment policy. ("Claims shall be submitted to the Department under the provider handbook.")
1127.52(a) through (c)	Payment criteria. (Relating to the Department's establishment of maximum reimbursement fees and payment methodology)
1127.52(d) "The birth center visit fee shall be the amount equal to that of the midwives' or physicians' visit fee under the MA Program fee schedule."	Payment criteria. (Relating to termination of birth center services during prenatal care)
1127.52(e) "The amount of the payment is 50% of the third trimester rate of payment."	Payment criteria (to payment if complications develop during labor and patient is transferred to a hospital)
1127.53(c)	Limitations on payment.
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1128, Renal Dialysis Facilities, with the following exceptions:	
1128.51(a) "and the MA Program fee schedule"	Payment for Renal Dialysis Services. General payment policy.
1128.51(b)	General payment policy. ("A fee determined by the Department is paid for support services provided to an eligible recipient during the course of a dialysis procedure."
1128.51(c) "and for billings"	General payment policy. ("The dialysis facility is considered the provider regardless of whether the facility is operated directly by the enrolled provider or through contract between the provider and other organizations or individuals. The enrolled provider is responsible for the delivery of the service and for billings.")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1128.51(d) “up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee”	General payment policy. (“The Department will pay for the unsatisfied portion of the Medicare deductible and remaining 20% coinsurance up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee.”)
1128.51(f) through (i), (k) and (l)	General payment policy. (Relating to what is included in the fee paid to the facility, procedures fees are applicable to, Department's consideration of provider's usual and customary charge if facility has a fee schedule based on patient's ability to pay, and the Department's payment for dialysis services shall be considered payment in full.)
1128.51(m) “Payment shall be made in accordance with §1128.52 (relating to payment criteria).”	General payment policy. (“If a dialysis facility voluntarily terminates the provider agreement, payment is made for services provided prior to the effective date of the termination of the provider agreement. Payment shall be made in accordance with §1128.52 (relating to payment criteria).”)
1128.51(n)	General payment policy. (Relating to payment to out-of-State dialysis facility.)
1128.52	Payment criteria.
1128.53(a) through (e)	Limitations on payment.
1128.53(f) “Payment for backup visits to the facility is limited to no more than 15 in one calendar year”	Limitations on payment.
1128.53(g)	Limitations on payment. (Relating to payment for nonexpendable equipment or installation of equipment necessary for home dialysis)
1128.54(1)	Noncompensable services and items. (“The Department does not pay dialysis facilities for: (1) Services that do not conform to this chapter.”)
1128.54(4) through (7)	Noncompensable services and items. (Relating to Diagnostic or therapeutic procedures solely for experimental, research or educational purposes; procedures not listed in the MA Program fee schedule; services that are not medically necessary; and services provided to recipients who are hospital inpatients.)
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1129, Rural Health Clinic Services, with the following exceptions:	
1129.51(b) and (c)	Payment for Rural Health Clinic Services. General payment policy. (Relating to payment for rural health clinic services made on the basis of an all-inclusive visit fee established by the Medicare carrier. When the cost for a service provided by the clinic is included in the established visit fee, the practitioner rendering the service shall not bill the MA Program for it separately; and adjustment to the all-inclusive visit fee when Medicare determines the difference between the total payment due and the total payment made. The Department will make a lump sum payment for the amount due.)
1129.52	Payment policy for provider rural health clinics.
1129.53	Payment policy for independent rural health clinics.
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1130, Hospice Services, with the following exceptions:	
1130.22(4) “…Department’s…specified in Appendix A.” ***Note: The provider must have a Certification of Terminal Illness form containing the information found in Appendix A. The provider is not required to use the Department’s Certification of Terminal Illness form.***	Duration of coverage. Certification form. (Relating to certification of terminal illness carried out using the Department’s certification of terminal illness form.)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1130.41(a) "…specified in Appendix B." ***NOTE: The provider must have an Election statement containing the information found in Appendix B. The provider is not required to use the Department's Election statement.***	Election of hospice care. Election statement. (Relating to filing of the Election statement by the recipient or recipient's representative.)
1130.41(c) "specified in Appendix C." ***Note: The provider must have a Change of Hospice statement containing the information found in Appendix C. The provider is not required to use the Department's Change of Hospice statement.***	Election of hospice care. Change of designated hospice. (Relating to the ability to the ability to change hospices once in each certification period.)
1130.42(a) "specified in Appendix D." ***Note: The provider must have a Revocation statement containing the information found in Appendix D. The provider is not required to use the Department's Revocation statement.***	Revocation of hospice care. Right to revoke. (Relating to the ability of the recipient or recipient's representative to revoke the election of hospice care at any time utilizing the revocation statement.)
1130.63(b)	Limitations on coverage. (Relating to Respite care not exceeding a total of 5 days in a 60 day certification period.)
1130.63(c) "…but it is not reimbursable."	Limitations on coverage. (Relating to Bereavement counseling being a required hospice service but it is not reimbursable.)
1130.63(d) "…participating in the MA Program."	Limitations on coverage. (Relating to general inpatient care being provided in a general hospital, skilled nursing facility or a freestanding hospice participating in the MA Program.)
1130.63(e)	Limitations on coverage. (Relating to intermediate care facilities may only provide respite services to the hospice. Eligible MA recipients residing in an intermediate care facility may elect to receive care from a participating hospice.)
1130.71(c) through (h)	Payment for Hospice Care. General payment policy. (Relating to days not covered by valid certification, limitations on inpatient respite care to 5 days in a 60 day certification period; payment limitation for general inpatient care, if lesser care was provided; no MA payments will be made directly to nursing facility for services provided to a recipient under the care of a hospice; ambulance transportation inclusion in daily rates; and the Department's reduction in payment for hospice care by the amount of income available from the recipient towards the hospice care rate established by the Department.)
1130.72.	Payment for physicians' services. (Relating to the services performed by hospice physicians that are included in the level of care rates paid for a day of hospice care."
1130.73.	Additional payment for nursing facility residents. (Relating to additional payments made to a hospice for hospice care furnished to an MA recipient who is a resident of a skilled or intermediate care facility – taking into account the cost of room and board and how room and board rates will be calculated.)
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1140, Healthy Beginnings Plus Program, with the following exceptions:	
1140.52(2) "…billed to the Department…"	Payment for HBP Services. Payment Conditions.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1140.53	Limitations on Payment. (Relating to payment for the trimester component including all prenatal visits during the trimester; qualified providers may bill for either high risk maternity care package OR the basic maternity care package for each trimester; and the fee for the applicable trimester maternity care package includes payment to the practitioner performing the delivery and postpartum care.)
1140.54(1)	Noncompensable services and items.
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1141, Physicians' Services, with the following exceptions:	
1141.53(a) through (c)	Payment conditions for outpatient services. (Relating to payment made in an approved SPU only if the service could not appropriately and safely be performed in the physician's office, clinic or ER of a hospital; prior authorization requirements for specialists' examinations and consultations; and services provided to recipients in skilled and intermediate care facilities by the physician administrator or medical director.)
1141.53(f) and (g)	Payment conditions for outpatient services. (Relating to all covered outpatient physicians' services billed to the Department shall be performed by such physician personally or by a registered nurse, physician's assistant, or a midwife under the physician's direct supervision; and payment by the Department of a $10 per month fee to physicians who are approved by the Department to participate in the restricted recipient program.)
1141.54(a)(1) through (3)	Payment conditions for inpatient services. (Relating to when a physician is eligible to bill the Department for services provided to a hospitalized recipient.)
1141.54(f)	Payment conditions for inpatient services. (Relating to inpatient physicians' services billed to the Department shall be performed by the physician, an RN, PA or midwife under the physician's direct supervision.)
1141.55(b)(1) "MA 31"; "in accordance with all instructions in the Provider Handbook"; and "See Appendix A for a facsimile of the Consent Form and the Provider Handbook for detailed instructions on its completion." ***NOTE: A consent form is required and must contain all the information found in Appendix A.***	Payment conditions for sterilizations. (Relating to consent requirements and use of the MA31 Consent Form.)
1141.55(c) "MA 31" 1141.55(c)(2) "in accordance with instructions in the Provider Handbook" 1141.55(c)(3) "in accordance with instructions in the Provider Handbook"	Payment conditions for sterilizations. ("A Consent Form, MA 31, is considered to be completed correctly only if all of the following requirements are met:") Payment conditions for sterilizations. ("The person obtaining informed consent has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given." Payment conditions for sterilizations. ("Any other witness or interpreter has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given.")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.56(a)(3) "See the Provider Handbook for a facsimile of the Patient Acknowledgement Form for Hysterectomy, MA 30, and for instructions on its completion."	Payment conditions for hysterectomies. (Relating to Patient Acknowledgement Form for Hysterectomy MA 30)
1141.57(a)(2) "and the incident was reported to a law enforcement agency or to a public health service within 72 hours of its occurrence in the case of rape and within 72 hours of the time the physician notified the patient that she was pregnant in the case of incest. A law enforcement agency means an agency or part of an agency that is responsible for the enforcement of the criminal laws, such as a local police department or sheriff's office. A public health service means an agency of the Federal, State, or local government or a facility certified by the Federal government as a Rural Health Clinic that provides health or medical services except for those agencies whose principal function is the performance of abortions."	Payment conditions for necessary abortions (Where the recipient was the victim of rape or incest)
1141.57(a)(2)(i) "with the Medical Services Invoice along with documentation signed by an official of the law enforcement agency or public health service to which the rape or incest was reported. The documentation shall include the following": 1141.57(a)(2)(i)(A) and (B)	Payment conditions for necessary abortions (Payment will be made only if a licensed physician submits a signed ''Physician Certification for an Abortion'' form, as set forth in Appendix B,) (A) All of the information specified in subparagraph (ii). (B) A statement that the report was signed by the person making the report.
1141.57(a)(2)(ii)(A) through (D)	Payment conditions for necessary abortions (report of rape or incest)
1141.57(c)	Abortions after the first 12 weeks
1141.59(1) through (5)	Payment for Physician Services, Noncompensable services, Procedures not listed in the Medical Assistance program fee schedule. Medical services or surgical procedures performed on an inpatient basis that could have been performed in the physician's office, the clinic, the emergency room, or a short procedure unit without endangering the life or health of the patient, Medical or surgical procedures designated in the Medical Assistance program fee schedule as outpatient procedures, Dental rehabilitation and restorative services, Diagnostic tests, for which a patient was admitted, that may be performed on an outpatient basis; tests not related to the diagnosis and treatment of the illness for which the patient was admitted; tests for which there is no medical justification.
1141.59(7) and (8)	Payment for Physician Services, Noncompensable services, Hysterectomy performed solely for the purpose of rendering an individual incapable of reproducing, Acupuncture, medically unnecessary surgery, insertion of penile prosthesis, gastroplasty for morbid obesity, gastric stapling or ileo-jejunal shunt—except when all other types of treatment of morbid obesity have failed—
1141.59(10) and (11)	Services to inpatients who no longer require acute inpatient care and surgical procedures and medical care provided in connection with sex reassignment.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.59 (14) through (16)	Diagnostic pathological examinations of body fluids or tissues, Services and procedures related to the delivery within the antepartum period and postpartum period, Medical services or surgical procedures performed in a short procedure unit that could have been appropriately and safely performed in the physician's office, the clinic, or the emergency room without endangering the life or health of the patient.
1141.60	Payment for medications dispensed or ordered in the course of an office visit.
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1142, Midwives' Services, with the following exceptions:	
1142.51 "and the MA payment fee schedule"	General payment policy for Midwife services
1142.52(2) "billed to the Department"	General payment policy for Midwife services
1142.55(1) through (4)	Noncompensable Midwife services. Procedures not listed in the fee schedule in the MA Program fee schedule, More than 12 midwife visits per recipient per 365 days. Services and procedures furnished by the midwife for which payment is made to an enrolled physician, rural health clinic, hospital or independent medical clinic. Services and procedures for which payment is available through other public agencies or private insurance plans as described in § 1101.64 (relating to third party medical resources (TPR)).
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1143, Podiatrists' Services, with the following exceptions:	
1143.2 Definition of "Medically-necessary"	A term used to describe those medical conditions for which treatment is necessary, as determined by the Department, and which are compensable under the MA Program.
1143.2 Definition of "Non-emergency medical services."	A compensable podiatrists' service provided for conditions not requiring immediate medical intervention in order to sustain the life of the person or to prevent damage to health.
1143.51 "and the MA Program fee schedule" and "as specified in §1101.62(relating to maximum fees)."	General Payment Policy
1143.53	Payment conditions for outpatient services.
1143.54	Payment conditions for inpatient hospital services.
1143.55(1),(2) and (4)	Payment conditions for diagnostic X-ray services performed in the podiatrist's office.
1143.56	Payment conditions for orthopedic shoes, molded shoes and shoe inserts (enrolled medical suppliers). Refers to 1123.54
1143.57	Limitations on payment for podiatrist visits and x-rays.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1143.58(a)(1) through (12)	Noncompensable services and items for podiatry services. (1) Services and items not listed in the MA Program fee schedule. (2) Fabricating or dispensing orthopedic shoes, shoe inserts and other supportive devices for the feet. (3) Casting for shoe inserts. (4) Medical services or surgical procedures performed on an inpatient basis that could have been performed in the podiatrist's office, the emergency room, or a short procedure unit without endangering the life or health of the patient. (5) Medical or surgical procedures designated in the fee schedule in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule as outpatient procedures. (6) Medical services or surgical procedures performed on an inpatient basis if the Department denies payment to the hospital for the days during which the podiatrist's care is rendered. (7) Services rendered in the emergency room of a hospital if the recipient is admitted to the hospital as an inpatient on the same day or the service is a nonemergency medical service. (8) Treatment of flat foot. (9) Treatment of subluxations of the foot. (10) Routine foot care, including the cutting or removal of corns, callouses, the trimming of nails and other routine hygienic care. (11) Physical therapy. (12) Diagnostic or therapeutic procedures for experimental, research or educational purposes.
1143.58(a)(13) "as specified in § 1101.62 (relating to maximum fees)"	Compensable podiatrist services if full payment is available from another agency, insurance or health program.
1143.58(b)	Noncompensable services and items. Payment is not made for sneakers, sandals etc, even if prescribed by a podiatrist.
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1144, Certified Registered Nurse Practitioner Services, with the following exceptions:	
1144.42(b) "to the Department"	Ongoing responsibilities of providers
1144.52(1)	Payment conditions for CRNP services. CRNP employee
1144.52(2) "billed to the Department"	Payment conditions for CRNP services. CRNP employee
1144.52(3)	Payment conditions for CRNP services. CRNP employee
1144.53(1), (2), and (4)	Noncompensable services. Procedures not listed in the MA Program fee schedule. Services and procedures furnished by the CRNP for which payment is made to an enrolled medical service provider or practitioner. The same service and procedure furnished to the same recipient by a CRNP and physician.
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1145, Chiropractor's Services, with the following exceptions:	
1145.11	Types of services covered. Evaluation by means of examination. Treatment by means of manual manipulation of the spine.
1145.12	Services are covered when rendered in the chiropractors' office, the home of the patient or in a skilled nursing or intermediate care facility.
1145.13	Chiropractors' services are not covered when rendered in a location in a hospital.
1145.14	Payment will not be made for treatment other than manipulation of the spine, physical therapy, traction, physical examinations, and consultations.
1145.51 "and the MA Program fee schedule" and "Chiropractors' services shall be billed in the name of the chiropractor providing the services."	Payment policy for chiropractor services.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1145.54	Noncompensable services. Payment will not be made to a chiropractor for 1) Orthotics, 2) Prosthetics, 3) Medical supplies, 4) X-rays, 5) Services not included in Chapter 1150
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1147, Optometrists' Services, with the following exceptions:	
1147.2 Delete the following portion included in the definition of eyeglasses: "untinted."	Definitions - *Eyeglasses*—A pair of untinted prescription lenses and a frame.
1147.12 "Outpatient optometric services are compensable when provided in the optometrist's office, the office of another optometrist during the other optometrist's temporary absence from practice, a hospital, a nursing home or in the patient's home when the patient is physically incapable of coming to the optometrist's office." "and the MA Program Fee Schedule"	Outpatient services
1147.13 "and the MA Program Fee Schedule"	Inpatient services
1147.14(1)	Non-covered services: Orthoptic training.
1147.21 "They are not eligible for eyeglasses unless they are 20 years of age or younger and the eyeglasses have been: " 1147.21(1) through (3)	Scope of benefits for the categorically needy: eyeglasses. Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program.
1147.22 "They are not eligible for eyeglasses, low vision aids or prostheses unless they are 20 years of age or younger and the eyeglasses, low vision aids or prostheses have been:" 1147.22 (1) through (3)	Scope of benefits for the medically needy: eyeglasses. Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program.
1147.23 "only" and "They are not eligible for eyeglasses, low vision aids or eye prostheses. However, State Blind Pension recipients are eligible for eye prostheses if they are also categorically needy."	Scope of benefits for State Blind pension recipients.
1147.51 "and §§ 1147.53 and 1147.54 (relating to limitations on payment; and noncompensable services and items)" and "and the MA Program fee schedule" and "Optometric services shall be billed in the name of the optometrist providing the service."	General payment policy for optometric services
1147.53	Limitations on payments for optometric services
1147.54	Noncompensable optometric services and items
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1149, Dentists' Services, with the following exceptions:	
1149.1 "and the MA Program Fee Schedule"	Dental services general policy
1149.43(6)	Radiographs are requested by the Department for prior authorization purposes

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1149.43(9) through (11)	Pathology reports are required for surgical excision services. Pre-operative X-rays are required for surgical services. Postoperative X-rays are required for endodontic procedures.
1149.51 "and the MA Program Fee Schedule" and “The following payment policies are applicable for dental services:”	General payment policy for dental services
1149.51(1) and (2)	General payment policy for dental services
1149.52	Payment conditions for various dental services
1149.54 "and the MA Program Fee Schedule" 1149.54 (1) through (7) 1149.54(10)	Payment policies for orthodontic services
1149.55(1) 1149.55(5) through (8)	Payment conditions for orthodontic services
1149.56	Payment limitations for orthodontic services
1149.57	Noncompensable dental services and items
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1150, MA Program Payment Policies, with the following exceptions:	
1150.2 Definitions of PSR and Second Opinion program	Definitions
1150.51(a) "Payment will be made to providers. Payment may be made to practitioners' professional corporations or partnerships if the professional corporation or partnership is composed of like practitioners. Payment will be made directly to practitioners if they are members of professional corporations or partnerships composed of unlike practitioners. Practitioners who render services at eligible provider hospitals, either through direct employment or through contract, may direct that payment be made to the eligible provider hospital." **and** "Payment will not be made for services that are not medically necessary." 1150.51(b) 1150.51(c) “facilities and practitioners rendering services which require a PSR or second opinion, or both” and “funeral directors” 1150.51(d) “which is contained in the Provider’s Handbook” and the following” 1150.51(d)(1) “all-inclusive” 1150.51(d) (2) through (8) 1150.51(e) through (h)	General MA Program Payment policies
1150.52	Payment for Anesthesia services
1150.54	Payment for Surgical Services

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1150.55	Payment for Obstetrical Services
1150.56	Payment for Medical Services
1150.56a	Payment Policy for Consultations
1150.57	Payment for Diagnostic Services and Radiation Therapy
1150.58	Prior authorization for services in the MA Program Fee Schedule
1150.59	PSR Program
1150.60	Second Opinion Program
1150.61	Guidelines for Fee Schedule changes
1150.62	Payment levels and notice of rate setting changes
1150.63 1150.63(a) Delete the word “Department” 1150.63(b) Delete the word “Department”. Also delete in second sentence “the practitioner may either …by mail.” 1150.63(c) Delete the first two sentences: The CAO shall …consultants. The office of MA…decision.” 1150.63(d)Delete the word “Department”	Waiver of General Payment Policies. The plan must adhere to the following section, except:
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1151, Inpatient Psychiatric Services, with the following exceptions:	
1151.34	Inpatient Psychiatric Services, Provider Participation, Changes of ownership or control
1151.41(b)	Payment for inpatient psychiatric services, Readmission within 24 hours after discharge
1151.41(c) (1) and (2)	Payment for Inpatient Psychiatric Services, Admitted and discharged the same calendar day
1151.41(d), (i) and (j)	Payment for Preadmission diagnostics, transfer to another facility due to strike, payment for studies related to the patient’s condition not preprinted regimen.
1151.42 (a), (c) and (d)	Payment methods and rates
1151.43(a) and (b)	Limitations on payments
1151.45(2) and (3)	Nonallowable costs, costs related to a noncompensable item, costs related to preadmission diagnostics
1151.46	Payment rate calculations for FY 1993-94 and 1994 - 95
1151.48(a)(2)through (6), (9) through (16) and (18) through (20)	Noncompensable services and items, experimental procedures and services, inpatient treatment for diagnostic testing that could be done as outpatient, inpatient care if payment is available from another source, services not normally provided to the public, methadone maintenance, days of inpatient care that the patient was absent due to training, meetings or conferences, unnecessary inpatient care, and days of care that are not certified or failure to apply for a court-ordered commitment.
1151.52	Payment for capital costs not included in the base year
1151.53	Billing requirements for inpatient psychiatric services
1151.54	Disproportionate share payments
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1153, Outpatient Psychiatric Services, with the following exceptions:	
1153.1 “and the MA Program fee schedule”	Outpatient psychiatric services, general policy
1153.2 Psychiatric outpatient clinic services -- "listed in the MA Program Fee Schedule"	Definitions

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1153.2 Psychiatric partial hospitalization -- "listed in the MA Program Fee Schedule" and "and a maximum of six hours in a 24 hour period"	Definitions
1153.11 "as specified in the MA Program Fee Schedule"	Types of Outpatient Psychiatric Services
1153.12 "specified in the MA Program Fee Schedule"	Coverage of outpatient Psychiatric services
1153.14(2), (3), (9) and(13)	Noncovered services: cancelled appointments, covered services not rendered, Psychiatric outpatient clinic services and psychiatric partial hospitalization provided on the same day to the same patient, and Services not specifically included in the MA Program Fee Schedule
1153.21 "in the MA Program Fee Schedule"	Scope of benefits for the categorically needy
1153.22 "in the MA Program Fee Schedule"	Scope of benefits for the medically needy
1153.23 "in the MA Program Fee Schedule"	Scope of benefits for State Blind Pension recipients
1153.51 "and the MA Program Fee Schedule"	Payment for Outpatient Psychiatric clinic and partial hospitalization
1153.52(a)(2) "Separate billings for these additional services are not compensable."	Additional interviews with other staff may be included as part of the examination but shall be included in the psychiatric evaluation fee.
1153.52(d) "listed in the MA Program Fee Schedule"	Psychiatric clinic services provided in the home.
1153.53	Limitations on payments
1153.53a	Request for waiver of hourly limits
1153.54	Noncompensable services and items

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 1157-95-01</u> Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children Under 21 Years of Age with the following exceptions: ▪ Page 2, A. 2. c. ▪ Page 3, A. 4. ▪ Page 3, Section B. ▪ Page 3, C. "To receive MA reimbursement," ▪ Page 3, D. 1. ▪ Page 3, D. 2. "Payment will be made only for services prior approved by OMAP." ▪ Pages 5-7 Sections A and B. ▪ Attachment 2, 3.e.; 4.b.; and 4.e. ▪ Attachment 5 ▪ Attachment 6 ▪ Attachment 7 ▪ Attachment 8 ▪ Attachment 9 ▪ Attachment 11	
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1163, Inpatient Hospital Services, Subchapter A, Acute Care General Hospitals Under the Prospective Payment System, with the following exceptions:	
1163.32	Hospital Units excluded from the DRG prospective payment system
1163.41	General participation requirements for general hospitals and out of state hospitals for Commonwealth recipients
1163.51 (a) through (s)	General payment policy for hospital services
1163.52 through 1163.59	Prospective payment methodology, assignment of DRG, prospective capital reimbursement system, payments for direct medical education, outliers, payment policy for readmissions and transfers, and noncompensable services and items and outlier days.
1163.60(b)(1) “in accordance with the instructions in the Provider Handbook”.	Informed consent for voluntary sterilization
1163.60(c)(2) “in accordance with the instructions in the Provider Handbook”.	The person obtaining informed consent signs and dates the form on same day informed consent was obtained.
1163.60(c)(3) “in accordance with the instructions in the Provider Handbook”.	Another witness or interpreter must sign the consent form.
1163.62 (a) (2) through 1163.65	Payment conditions for abortions if the recipient was a victim of rape or incest, billing, cost reports and payment for out of state services.
1163.67	Disproportionate share payments

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1163.70 through 1163.71	Changes of ownership or control and scope of utilization review process
1163.72 (a), (c) through (g)	General utilization review, admissions, day and cost outliers.
1163.73 through 1163.75 (6) and (8) through (12)	Hospital utilization review plan, requirements for hospital utilization review committees, and responsibilities for hospital utilization review committees.
1163.76 through 1163.77	Written plan of care within 2 days of admission and Admission review requirements within 24 hours of admission
1163.78a and 1163.78b	Review requirements for day outliers and cost outliers
1163.92 (a) through (f)	Administrative sanctions
1163.122	Determination of DRG relative values
1163.126	Computation of hospital specific computation rates
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1163, Inpatient Hospital Services, Subchapter B, Hospitals and Hospital Units Under Cost Reimbursement Principles, with the following exceptions:	
1163.402 Definition of "certified day"	Definitions
1163.451 (a) through (g), (i), (k) through (o)	General payment policy
1163.452	Payment methods and rates
1163.453 (a) and (c)	Allowable and nonallowable costs, allowable costs for inpatient services, payment not higher than hospital's customary charge
1163.453 (d) (2) through (9)	Costs not allowable under the MA Program
1163.453 (e) and (f)	Allowable costs
1163.454	Limitations on payment
1163.455 (a)(1) through (5) and (7) through (16)	Noncompensable inpatient services
1163.455 (b) and (c)	Noncompensable inpatient services
1163.457	Payment policies relating to out of state hospitals
1163.458	Payment policies relating to same calendar day admissions and discharges
1163.459	Disproportionate share payments
1163.481(b) and (c)	Utilization review sanctions
1163.511	Change of ownership or control

Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 1165-93-07 Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age with the following exceptions:

- Page 1 - Beginning with the second sentence "The procedures described in this Bulletin apply to every child." up to "A separate bulletin will describe the procedures necessary to seek reimbursement for other mental health services not on the Medical Assistance Fee Schedule."
- Page 2, Section A.4.
- Pages 3 - 4, Sections C through E
- Attachment 6
- Attachment 7
- Attachment 8
- Attachment 9

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 1165-95-01</u> Update JCAHO-Accredited RTF Services with the following exceptions: ▪ Page 2 - The two paragraphs following item c. "If a child is admitted . . . alternative to RTF." ▪ Page 2 - The third complete paragraph, "All admissions are subject," through the end of 3. ▪ Page 3, number 4.	
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions:	
1221.43 through 1221.45	Participation requirements for hospital clinics and emergency rooms for higher reimbursement rate, additional participation requirements for independent clinics, and additional participation requirements for medical school clinics.
1221.51 and 1221.52	General payment policy for clinic and emergency room services and payment conditions for various services.
1221.55 (b) (1). NOTE: A consent form is required and must contain all of the information found in Appendix A to 55 PA Code Chapter 1141	Voluntary informed consent for sterilizations
1221.57(a) (2) and 1221.57(c). NOTE: PH-MCO must comply with MA Bulletin 99-95-09	Payment conditions for necessary abortions for victims of rape or incest
1221.58 and 1221.59	Limitations on payments and noncompensable services and items
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletins related to 55 PA Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions: ▪ 11-95-04 ▪ 11-95-10 ▪ 11-95-12	
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1223, Outpatient Drug and Alcohol Clinic Services, with the following exceptions:	
1223.1 “and the MA fee schedule”	Payment for specific medically necessary outpatient drug and alcohol clinic services rendered to eligible recipients by drug/alcohol outpatient clinics.
1223.11 “as specified in the fee schedule in the Medical Assistance program fee schedule”	Medical Assistance Program coverage for outpatient drug/alcohol clinics is limited to professional medical and psychiatric services.
1223.12 "specified in the Medical Assistance program fee schedule"; "and the Medical Assistance program fee schedule"; and "fee for service"	Outpatient drug and alcohol clinic services
1223.14 (3) and (4)	Noncovered services: Cancelled appointments and Covered services that have not been rendered.
1223.14(6) “and the Medical Assistance program fee schedule”	Noncovered services: Vocational rehabilitation; day care; drug/alcohol or mental health partial hospitalization; reentry programs, occupational or recreational therapy; Driving While Intoxicated (DWI) or Driving Under the Influence Programs or Schools; referral, information or education services; experimental services; training; administration; follow-up or aftercare; program evaluation; case management; central intake or records; shelter services; research; drop-in, hot-line or social services; inpatient nonhospital or occupational program services, or any other service or program not specifically identified as a covered service in Chapter 1150.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1223.14 (8) and (9)	Drug/alcohol outpatient clinic services provided to residents of treatment institutions. outpatient clinic services provided to residents of inpatient nonhospital and shelter facilities. outpatient clinic services provided to patients receiving psychiatric partial hospitalization services or drug/alcohol partial hospitalization services
1223.14(14)	Methadone maintenance clinic services provided before the date of the physician's comprehensive medical examination, diagnosis and treatment plan.
1223.21 "in the MA Program fee schedule"	Scope of services for the categorically needy
1223.22 "in the MA Program fee schedule"	Scope of services for the medically needy
1223.23 "in the MA Program fee schedule"	Scope of services for State Blind Pension recipients
1223.51 "and the Medical Assistance program fee schedule"	General payment policy for outpatient drug/alcohol clinic services
1223.52(a)(2) and (a)(3) "Separate billings for these interviews are not compensable."	Additional interviews with other staff
1223.52(a)(5) "listed in the Medical Assistance Program Fee Schedule"	Diagnostic psychological services
1223.52(c) "Separate billings for these interviews are not compensable."	Interviews or consultations with family members alone, without the presence of the family member with a drug/alcohol abuse or dependence problem, are considered to be part of the family psychotherapy fee.
1223.53	Limitations on Payment for outpatient drug and alcohol clinic services
1223.54(2) "and the Medical Assistance program fee schedule"	Items and services not listed as compensable in Chapter 1150
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1225, Family Planning Clinic Services, with the following exceptions:	
1225.1 "and the MA Program fee schedule"	General provisions
1225.51"and the MA Program fee schedule"	General payment policy
1225.54(2)	Noncompensable family planning services
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1229, Health Maintenance Organizations Services, with the following exceptions:	
NONE	
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1230, Portable X-Ray Services, with the following exceptions:	
1230.1 "and the MA Program fee schedule"	General provisions
1230.51 "and the MA fee schedule"	General payment policy for portable x-ray services
1230.52(b) "and the MA Program fee schedule"	Payment for transporting portable X-ray equipment from the provider's office to the place of service
1230.53 (a) through (c)	Portable x-ray services, provider maximum payment, payment for transportation of portable x-ray equipment and electrocardiogram services
1230.54 (1)	Noncompensable services, procedures not listed in the MA Program fee schedule
Managed care organizations are to adhere to the requirements of Medical Assistance Bulletin 99-94-08 (relating to 55 Pa. Code Chapter 1239, Medical Case Management), Medical Assistance Case Management Services for Recipients Under the Age of 21, with the following exceptions: ▪ Discussion ▪ Page 2, paragraph 3 "The OMAP reserves the right to limit the number of recipients in a case manager's caseload." ▪ Page 3, Payment for case management services covered by this bulletin, 1 through 3 and 4 c through f	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1241, Early and Periodic Screening, Diagnosis and Treatment Program, with the following exceptions:	
1241.2 Definition of "Administrative contractors"	Definitions
1241.42(1) "or to the CAO for supportive help in locating an appropriate provider"	If not licensed or equipped to render the necessary treatment or further diagnosis, the screening provider shall refer the individual to an appropriate enrolled practitioner or facility.
1241.51	Payment to the provider
1241.53	Limitations on payments
1241.54 (a) (1) through (5)	Noncompensable services and items
1241.54 (b) (1) through (5)	Noncompensable services and items
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1243, Outpatient Laboratory Services, with the following exceptions:	
1243.51 "and the MA Program fee schedule"	General payment policy for outpatient laboratory services
1243.52(b) "billed to the Department"	Laboratory services billed to the Department will be based on the written request of the practitioner
1243.53 (a)	The fees listed in the MA Program fee schedule are the maximum allowed
1243.54 (1) and (2)	Noncompensable services
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1245, Ambulance Transportation, with the following exceptions:	
1245.1 "and the MA Program fee schedule"	General provisions for payment of ambulance transportation to eligible beneficiaries
1245.21 "and the MA Program fee schedule"	Scope of services for the categorically needy
1245.22 "and the MA Program fee schedule"	Scope of services for the medically needy
1245.23 "and the MA Program fee schedule"	Scope of services for State Blind Pension recipients
1245.51 (b)	Ambulance services which obtain Voluntary Ambulance Service Certification (VASC) from the Department of Health will be reimbursed at a higher rate than non-VASC certified services
1245.52(1)	Payment conditions for ambulance transportation, medically necessary
1245.52(3) through (5)	Transportation to the nearest appropriate medical facility and medical services/supplies invoice.
1245.53	Limitations on payment for ambulance service when more than one patient is transported. Payment is made for transportation of the patient whose destination is the greatest distance. No additional payment is allowed for the additional person.
1245.54(1) through (7)	Noncompensable services and items relating to ambulance transportation.
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1249, Home Health Agency Services, with the following exceptions:	
1249.51 "and the MA Program fee schedule"	General payment policy for Home Health Services
1249.55(b)	Payment conditions for medical supplies. Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care services. Payment for these supplies is included in the comprehensive fee.
1249.57	Payment conditions for maternal/child services
1249.58	Payment conditions for travel costs
1249.59	Limitations on payments for home health agency services

EXHIBIT Z
AUTOMATIC ASSIGNMENT

With the expansion of HealthChoices in 2015 to include the population covered by the *Healthy Pennsylvania* Private Coverage Organizations (PCOs), there will be a specific process for the initial auto-assignment of those consumers to HealthChoices physical health-managed care organizations (PH-MCOs). The PCO beneficiary population will be afforded a PH-MCO selection period. Following the consumer selection period, the remaining PCO beneficiary population that has not proactively selected a PH-MCO will be auto assigned based upon the following elements:

1. If the HealthChoices Zone in which the PCO beneficiary resides contains a related party "sister" PH-MCO to the assigned PCO, the PCO beneficiary will be auto-assigned to the related party "sister" PH-MCO.

2. If the PCO beneficiary had previously been a member of a HealthChoices PH-MCO within the past six months, the PCO beneficiary will be reinstated back to that PH-MCO if it operates in the Zone in which the PCO beneficiary resides.

PCO beneficiaries that had not previously been members of HealthChoices PH-MCOs will be auto-assigned in the following manner:

1. If the PCO beneficiary is in a case with a member of HealthChoices PH-MCOs, the PCO beneficiary will be auto-assigned to the other case member's HealthChoices PH-MCO.

2. If there is no other member in the PCO beneficiary's case, then the PCO beneficiary will be auto assigned in the standard processes.

Following the conclusion of the transition of the *Healthy Pennsylvania* PCO beneficiary population to HealthChoices, the following standard auto-assignment processes will be applied to all Consumers.

Any Consumer who does not select a PH-MCO and is mandated into the HealthChoices Program will be subject to the auto-assignment process as described below. The auto-assignment process does not negate the Consumer's option to change his/her PH-MCO. An eligible Consumer who has not made a PH-MCO selection and who has a case record that also includes another active member in the case with an active PH-MCO record will be assigned to that same PH-MCO. These Consumers will not count toward the percentages designated for auto-assignment. Consumers in a family unit will be assigned together to a PH-MCO. All remaining eligible Consumers, who have not voluntarily selected a PH-MCO, will be considered in the pool of Consumers who will be equally auto-assigned to PH-MCOs. The formula will direct a straight equitable distribution of the auto-assignment pool in all HealthChoices Zones monthly based on the number of PH-MCOs in the Zone. For example, if there are five PH-MCOs in the Zone, each PH-MCO would receive 20%.

EXHIBIT Z
AUTOMATIC ASSIGNMENT

A. **Consumer Re-Assignment Following Resumption of Eligibility:** Consumers who lose eligibility and regain it within six (6) months will automatically be re-enrolled in their previously selected PH-MCO, as long as the Consumer's eligibility status or geographical residence is still valid for participation in that same PH-MCO.

   If the Consumer loses eligibility and regains it after six (6) months, s/he may be enrolled in the same PH-MCO as the payment name, the case payment name or any other Member in the case that has an active PH-MCO record. If there is no active PH-MCO record in the case, s/he will automatically become enrolled in a PH-MCO through the automatic assignment process.

   Prior to the future begin date for the auto-assigned PH-MCO, the Consumer may select a different PH-MCO and override the auto-assigned PH-MCO by contacting the EAP Contractor. When the Consumer contacts the EAP Contractor to make this change, it will be the EAP Contractor's responsibility to enroll the Consumer in the PH-MCO of his/her choice. The EAP Contractor will process the enrollment into the new PH-MCO through the weekly enrollment process.

B. **Continuing Enrollment When Moving Between Zones:** Eligible Consumers who move from one HealthChoices Zone to another will remain in the PH-MCO in which they were enrolled prior to their move, if the PH-MCO is also operational in the Zone to which they move.

The Department reserves the right to reassess the distribution process and to modify it in accordance with sound programmatic management principles. The Department shall institute such modifications at any time following appropriate notification to the PH-MCOs via executive correspondence.