Copy-ID:		GRANT Number:	SAP 4000014647

PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

GRANT AGREEMENT AMENDMENT #9

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. 2000 Market Street, Suite 850 Philadelphia, PA 19103 nlhardy@Aetna.com TELEPHONE NUMBER: 215-282-3503

FEDERAL I.D. NUMBER: [redacted]

HEALTHCHOICES SOUTHEAST PHYSICAL HEALTH AGREEMENT
No. 4000014647 Amendment # 9

THIS Amendment to Grant Agreement No. 4000014647 (the "Amendment") is made this 12 day of July 2016 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").

WITNESSETH:

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, 2016, Appendix 3a ACA Health Insurance Providers Fee (dated September 5, 2014) is replaced with the attached Appendix 3a, ACA Health Insurance Providers Fee (dated March 22, 2016).
b. Effective January 1, 2016, Appendix 3b Explanation of Capitation Payments (dated April 6, 2015) is replaced with the attached Appendix 3b Explanation of Capitation Rates (dated April 11, 2016).
c. Effective January 1, 2016, Appendix 3c Home Nursing Risk Sharing Arrangement (dated December 12, 2014) is replaced with the attached Appendix 3c Home Nursing Risk Sharing Arrangement (dated February 23, 2016).
d. Effective January 1, 2016, Appendix 3d Risk Corridor (dated April 12, 2015) is replaced with the attached Appendix 3d Risk Corridor (dated November 8, 2015).

e. For services provided on or after January 1, 2016, Appendix 3f Capitation Rates (Prepared on March 30, 2015) is replaced with the attached Exhibit 3f Capitation Rates (Prepared on March 23, 2016).
f. Effective January 1, 2016, Appendix 3g Overview of Methodologies for Rate Setting and Determination of Risk Sharing Withhold Amounts (dated August 18, 2014) is replaced with the attached Appendix 3g Overview of Methodologies for Rate Setting and Determination of Risk Sharing Withhold Amounts (dated November 8, 2015).
g. Effective December 31, 2015 Appendix 3i Five Percent Capitation Withhold (dated September 1, 2014) has been removed.
h. Effective January 1, 2016, Appendix 3k High Cost Risk Pool (dated May 7, 2015) is replaced with the attached Appendix 3k High Cost Risk Pool (dated April 5, 2016).
i. Effective January 1, 2016, Appendix 3m Gross Receipts Tax (dated August 18, 2014) is replaced with the attached Appendix 3m (dated July 17, 2015).
j. Effective January 1, 2016, Appendix 3m-1 MCO Assessment (dated March 26, 2016) is added as a new appendix.
k. Effective January 1, 2016, Appendix 5 Specialty Drug Risk Sharing and Quality Risk Pools (dated March 26, 2016) is added as a new appendix.
l. Effective January 1, 2016, Appendix 14 APR/DRG Adjustment Inpatient Acute Care Services (dated March 17, 2015) is replaced with the attached Appendix 14 APR/DRG Adjustment Inpatient Acute Care Services (dated March 26, 2016).
m. Effective January 1, 2016, Appendix 16 Enhanced Access Payments Specialty Physician Services State Related Academic Medical Center (dated March 30, 2016) is added as a new appendix.
n. Effective January 1, 2016, Appendix 16a Enhanced Access Payments Specialty Physician Services (dated March 30, 2016) is added as a new appendix.
o. Effective January 1, 2016, the following exhibits are replaced: Exhibit A, Exhibit B(1), Exhibit B(2), Exhibit B(3), Exhibit C, Exhibit C(4), Exhibit E, Exhibit E(1), Exhibit H, Exhibit M(1), Exhibit N(1), Exhibit N(2), Exhibit N(3), Exhibit N(4), Exhibit N(5), Exhibit N(6), Exhibit Q, Exhibit X, Exhibit Z, Exhibit BB, Exhibit CC, Exhibit DD, Exhibit GG, Exhibit GG(1), Exhibit GG(2a), Exhibit GG(2b), Exhibit GG(3a), Exhibit GG(3b), Exhibit GG(4), Exhibit GG(5), Exhibit GG(6a), Exhibit GG(6b), Exhibit GG(7), Exhibit GG(8), Exhibit GG(9), Exhibit GG(10), Exhibit GG(11), Exhibit GG(12), Exhibit GG(13), Exhibit NN, Exhibit PP, Exhibit XX, Exhibit AAA(1), Exhibit BBB, and Exhibit CCC.
p. Effective January 1, 2016, the following exhibits are added: Exhibit V and Exhibit GG(14b).
q. Effective January 1, 2016, Exhibit GG(14) has been replaced with Exhibit GG(14a).
r. Effective December 31, 2015, the following exhibits have been removed: Exhibit B(1)(a), Exhibit B(3)(a), Exhibit B(3)(b), Exhibit AA, Exhibit BBB(1), Exhibit BBB(2) and Exhibit BBB(6).

2. The attached Appendix 3a, Appendix 3b, Appendix 3c, Appendix 3d, Appendix 3f, Appendix 3g, Appendix 3k, Appendix 3m, Appendix 3m-1, Appendix 5, Appendix 14, Appendix 16, Appendix 16a, Exhibit A, Exhibit B(1), Exhibit B(2), Exhibit B(3), Exhibit C, Exhibit C(4), Exhibit E, Exhibit E(1), Exhibit H, Exhibit M(1), Exhibit N(1), Exhibit N(2), Exhibit N(3), Exhibit N(4), Exhibit N(5), Exhibit N(6), Exhibit Q, Exhibit V, Exhibit X, Exhibit Z, Exhibit BB, Exhibit CC, Exhibit DD, Exhibit GG, Exhibit GG(1), Exhibit GG(2a), Exhibit GG(2b), Exhibit GG(3a), Exhibit GG(3b), Exhibit GG(4), Exhibit GG(5), Exhibit GG(6a), Exhibit GG(6b), Exhibit GG(7), Exhibit GG(8), Exhibit GG(9), Exhibit GG(10), Exhibit GG(11), Exhibit GG(12), Exhibit GG(13), Exhibit GG(14a), Exhibit GG(14b), Exhibit NN, Exhibit PP, Exhibit XX, Exhibit AAA(1), Exhibit BBB, and Exhibit CCC are incorporated and made part of this Grant Agreement.

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

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

GRANTEE

SIGNATURE
Elaine R. Cofrancesco, VP & Treasurer

SIGNATURE
Michael M. Sinisgalli, Assistant Treasurer

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

Program Deputy Secretary

SIGNATURE

Secretary

SIGNATURE

MAY 3 1 2016

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 07/12/2016

Approved as to Legality and Form:

OFFICE OF LEGAL COUNSEL
DEPARTMENT OF PUBLIC WELFARE
6/15/16

DEPUTY ATTORNEY GENERAL
OFFICE OF ATTORNEY GENERAL
(when required)
6/30/16

DEPUTY GENERAL COUNSEL
OFFICE OF GENERAL COUNSEL
(when required)
6/20/16

HEALTHCHOICES PHYSICAL HEALTH AGREEMENT

BETWEEN

COMMONWEALTH OF PENNSYLVANIA

AND

AETNA BETTER HEALTH, INC.

HEALTHCHOICES AGREEMENT

Table of Contents

SECTION I: INCORPORATION OF DOCUMENTS 10

A. Operative Documents 10
B. Operational Updates and Department Communications 11
1. Managed Care Operations Memos (MC OPS Memos) 11
2. HealthChoices Intranet 11
3. DHS Web Site 11

SECTION II: DEFINITIONS 11

AGREEMENT and RFP ACRONYMS 34

SECTION III: RELATIONSHIP OF PARTIES 38

A. Basic Relationship 38
B. Nature of Contract 38
C. Chronic Care Initiative 39

SECTION IV: APPLICABLE LAWS AND REGULATIONS 39

A. Certification and Licensing 39
B. Specific to MA Program 39
C. General Laws and Regulations 39
D. Limitation on the Department's Obligations 41
E. Health Care Legislation 41
F. Health Information Technology and the American Recovery and Reinvestment Act of 2009 (ARRA) 41

SECTION V: PROGRAM REQUIREMENTS 42

A. In-Plan Services 42
1. Amount, Duration and Scope 42
2. In-Home and Community Services 43
3. Program Exceptions 44
4. Expanded Benefits 44
5. Referrals 45
6. Self Referral/Direct Access 45
7. Behavioral Health Services 46
8. Pharmacy Services 46
9. EPSDT Services 47
10. Emergency Services 47

11. Post-Stabilization Services 48
12. Examinations to Determine Abuse or Neglect 49
13. Hospice Services 50
14. Organ Transplants 50
15. Transportation 51
16. Waiver Services/State Plan Amendments 51
17. Nursing Facility Services 52
18. Benefit Limits and Benefit Limit Exceptions (BLEs) 53
B. Prior Authorization of Services 54
1. General Prior Authorization Requirements 54
2. Time Frames for Notice of Prior Authorization Decisions 56
3. Prior Authorization of Outpatient Drug Services 58
C. Continuity of Care 58
D. Coordination of Care 58
1. Coordination of Care/Letters of Agreement 60
2. PH-MCO and BH-MCO Coordination 61
3. Disability Advocacy Program 61
E. PH-MCO Responsibility for Reportable Conditions 62
F. Member Enrollment and Disenrollment 62
1. General 62
2. PH-MCO Outreach Materials 62
3. PH-MCO Outreach Activities 63
4. Limited English Proficiency (LEP) Requirements 66
5. Alternate Format Requirements 67
6. PH-MCO Enrollment Procedures 67
7. Enrollment of Newborns 68
8. Transitioning Members Between PH-MCOs 68
9. Change in Status 69
10. Membership Files 69
11. Enrollment and Disenrollment Updates 70
12. Services for New Members 71
13. New Member Orientation 71
14. PH-MCO Identification Cards 72
15. Member Handbook 73
16. Provider Directories 73
17. Member Disenrollment 75
G. Member Services 75
1. General 75
2. PH-MCO Internal Member Dedicated Hotline 76
3. Education and Outreach/Health Education Advisory Committee 77
4. Informational Materials 78
H. Additional Addressee 79
I. Member Complaint, Grievance and DHS Fair Hearing Process 79
1. Member Complaint, Grievance and DHS Fair Hearing Process 79
2. DHS Fair Hearing Process for Members 80
J. OMAP Hotlines 81

K. Provider Dispute Resolution System 81
L. Certification of Authority and County Operational Authority 82
M. Executive Management 82
N. Other Administrative Components 83
O. Administration 86
1. Responsibility to Employ Recipients 86
2. Recipient Restriction Program 87
3. Contracts and Subcontracts 88
4. Lobbying Disclosure 90
5. Records Retention 90
6. Fraud and Abuse 90
7. Management Information Systems 98
8. Department Access and Availability 102
P. Special Needs Unit (SNU) 102
1. Establishment of Special Needs Unit 102
2. Special Needs Coordinator 103
3. Responsibilities of Special Needs Unit Staff 104
Q. Assignment of PCPs 104
R. Provider Services 106
1. Provider Manual 107
2. Provider Education 107
3. Panel Listing Requirements 108
S. Provider Network 109
1. Provider Agreements 109
2. Cultural Competency 110
3. Primary Care Practitioner (PCP) Responsibilities 110
4. Specialists as PCPs 111
5. Related Party Hospitals 112
6. Mainstreaming 112
7. Network Changes/Provider Terminations 113
8. Other Provider Enrollment Standards 114
9. Twenty-Four Hour Coverage 115
T. QM and UM Program Requirements 115
1. Overview 115
2. Healthcare Effectiveness Data and Information Set (HEDIS) 115
3. External Quality Review (EQR) 116
4. Pay for Performance Programs 116
5. QM/UM Program Reporting Requirements 116
6. Delegated Quality Management and Utilization Management Functions 116
7. Consumer Involvement in the Quality Management and Utilization Management Programs 117
8. Confidentiality 117
9. Department Oversight 117
U. Mergers, Acquisitions, Mark, Insignia, Logo and Product Name 118
1. Mergers and Acquisitions 118

2. Mark, Insignia, Logo, and Product Name Changes 118

SECTION VI: PROGRAM OUTCOMES AND DELIVERABLES 119

SECTION VII: FINANCIAL REQUIREMENTS 119

A. Financial Standards 119
1. Risk Protection Reinsurance for High Cost Cases 119
2. Equity Requirements and Solvency Protection 121
3. Risk Based Capital (RBC) 122
4. Prior Approval of Payments to Affiliates 122
5. Change in Independent Actuary or Independent Auditor 123
6. Modified Current Ratio 123
7. Limitation of Liability 124
8. Sanctions 124
9. Medical Cost Accruals 125
10. DSH/GME Payment for Disproportionate Share Hospitals (DSH)/ Graduate Medical Education (GME) 125
11. Member Liability 125
B. Commonwealth Capitation Payments 126
1. Payments for In-Plan Services 126
2. Maternity Care Payment 127
3. Program Changes 128
C. Appeals Relating to Actuarially Sound Rates 129
D. Claims Processing Standards, Monthly Report and Penalties 129
1. Timeliness Standards 129
2. Sanctions 131
E. Other Financial Requirements 133
1. Physician Incentive Arrangements 133
2. Retroactive Eligibility Period 134
3. In-Network Services 134
4. Payments for Out-of-Network Providers 135
5. Payments to FQHCs and Rural Health Centers (RHCs) 136
6. Payment to the PH-MCO when the Agreement is Ended 136
7. Liability During an Active Grievance or Appeal 137
8. Financial Responsibility for Dual Eligibles 137
9. Telephonic Psychiatric Consultation Team Services 138
10. Confidentiality 138
11. Third Party Liability (TPL) 138
12. Health Insurance Premium Payment (HIPP) Program 143
13. Requests for Additional Data 143
14. Accessibility to TPL Data 143
15. Third Party Resource Identification 143
16. Estate Recovery 144
17. Audits 144
18. Restitution 144

SECTION VIII: REPORTING REQUIREMENTS 145

A. General 145
B. Systems Reporting 145
1. Encounter Data Reporting 145
2. Third Party Liability Reporting 149
3. PCP Assignment for Members 150
4. Provider Network 150
5. Alerts 150
6. Maternity Care 150
C. Operations Reporting 151
1. Federal Waiver Reporting Requirements 151
2. Fraud and Abuse 151
D. Financial Reports 151
E. Equity 152
F. Claims Processing Reports 152
G. Presentation of Findings 153
H. Sanctions 153
I. Non-Duplication of Financial Penalties 155

SECTION IX: REPRESENTATIONS AND WARRANTIES OF THE PH-MCO 155

A. Accuracy of Proposal 155
B. Disclosure of Interests 155
C. Disclosure of Change in Circumstances 155
D. PH-MCO's Disadvantaged Business Commitment 156

SECTION X: DURATION OF AGREEMENT AND RENEWAL 157

SECTION XI: TERMINATION AND DEFAULT 157

A. Termination by the Department 157
1. Termination for Convenience Upon Notice 157
2. Termination for Cause 158
3. Termination Due to Unavailability of Funds/Approvals 158
B. Termination by the PH-MCO 159
C. Responsibilities of the PH-MCO Upon Termination 159
1. Continuing Obligations 159
2. Notice to Members 160
3. Submission of Invoices 160
4. Failure to Perform 160
5. Termination Requirements 161
D. Transition at Expiration and/or Termination of Agreement 161

SECTION XII: RECORDS 162

A. Financial Records Retention 162
B. Operational Data Reports 162

C. Medical Records Retention 163
D. Review of Records 163

SECTION XIII: SUBCONTRACTUAL RELATIONSHIPS 163

A. Compliance with Program Standards 163
B. Consistency with Policy Statements 165

SECTION XIV: CONFIDENTIALITY 165

SECTION XV: INDEMNIFICATION AND INSURANCE 166

A. Indemnification 166
B. Insurance 167

SECTION XVI: DISPUTES 167

SECTION XVII: FORCE MAJEURE 168

SECTION XVIII: GENERAL 168

A. Suspension From Other Programs 169
B. Rights of the Department and the PH-MCO 169
C. Waiver 169
D. Invalid Provisions 169
E. Governing Law 169
F. Notice 169
G. Counterparts 170
H. Headings 170
I. Assignment 171
J. No Third Party Beneficiaries 171
K. News Releases 171
L. Entire Agreement Modification 171

APPENDICES

1----------HealthChoices RFP
2----------Proposal
3a----------ACA Health Insurance Providers Fee
3b----------Explanation of Capitation Payments
3c----------Home Nursing Risk Sharing Arrangement (if applicable)
3d----------Risk Corridor
3e----------Family Planning (if applicable)
3f----------Capitation Rates
3g----------Overview of Methodologies for Rate Setting and Determination of Risk Sharing Withhold Amounts
3h----------Reserved
3i----------Reserved
3j----------Reserved
3k----------High Cost Risk Pool (if applicable)
3m----------Gross Receipts Tax
3m-1 ----------MCO Assessment
4----------PH-MCO Information
5----------Specialty Drug Risk Sharing and Quality Risk Pools
6----------Reserved
7----------Reserved
8----------Duration of Agreement and Renewal
9----------Reserved
10----------Reserved
11----------Reserved
12----------Reserved
13----------Reserved
14----------APR/DRG Adjustment Inpatient Acute Care Services
16----------Enhanced Access Payments Specialty Physician Services State Related Academic Medical Center (SE Zone only)
16a----------Enhanced Access Payments Specialty Physician Services (SE Zone only)

AGREEMENT EXHIBITS

A ----------Managed Care Regulatory Compliance Guidelines
B(1)----------MCO Pay for Performance Program
B(2)----------PH-MCO and BH-MCO Integrated Care Plan (ICP) Program - Pay for Performance Program
B(2)a----------Reserved
B(3)----------Provider Pay for Performance Program and Community Based Care Management Program
B(3)(a)--------Reserved
B(3)(b)--------Reserved
C ----------PH-MCO Requirements for Provider Terminations
C(1) ----------Provider Termination Template

C(2)----------Hospital/Specialty Unit Within a Facility or Hospital Termination Template
C(3)----------Provider Termination Template for Specialists and FQHC Providers Who Are Not PCPs
C(4)----------Continuity of Care Denial Notice
D ----------Standard Grant Terms and Conditions for Services
E ----------DHS Addendum to Standard Contract Terms and Conditions
E(1)----------Other Federal Requirements
F ----------Family Planning Services Procedures
G ----------Reserved
H ----------Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program
I ----------Reserved
J----------EPSDT Guidelines
K ----------Emergency Services
L----------Medical Assistance Transportation Program
M----------Reserved
M(1) ----------Quality Management and Utilization Management Program Requirements
M(2) ----------External Quality Review
M(3) ----------Reserved
M(4) ----------Healthcare Effectiveness Data and Information Set (HEDIS)
N ----------Notice of Denial
N(1) ----------Standard Denial Notice—Complete Denial
N(2) ----------Standard Denial Notice—Partial Approval of Requested Service/Item
N(3) ----------Standard Denial Notice—Approval of Different Service/Item
N(4) ----------Standard Benefit Limit Exception (BLE) Denial Notice – Complete Denial
N(5) ----------Standard Benefit Limit Exception (BLE) Denial Notice – Partial Approval of Requested Service/Item
N(6) ----------Standard Benefit Limit Exception (BLE) Denial Notice – Approval of Different Service/Item
N(7) ----------Request for Additional Information Letter
O ----------Description of Facilities and Related Services
P ----------Out-of-Plan Services
Q ----------Sample Model Agreement
R ----------Coordination with BH-MCOs
S ----------Written Coordination Agreements Between PH-MCO and Service Providers
T.----------Reserved
U ----------Behavioral Health Services
V----------Telephonic Psychiatric Consultation Team Services
W ----------Reserved
X ----------HealthChoices PH-MCO Guidelines for Advertising, Sponsorships, and Outreach
Y ----------Reserved
Z ----------Auto-Assignment
Z(1)----------Reserved
Z(2)----------Reserved

Z(3)----------Reserved
Z(4)----------Reserved
Z(5)----------Reserved
AA ----------Reserved
BB ----------PH-MCO Recipient Coverage Document
CC ----------Data Support for PH-MCOs
DD ----------PH-MCO Member Handbook
EE ----------Reserved
FF----------PCP, Dentists, Specialists, and Providers of Ancillary Services Directories
GG----------Complaint, Grievance, and DHS Fair Hearing Processes
GG(1) ---------Notice for Failure of PH-MCO to Meet Complaint or Grievance Time Frames
GG(2a) -------1st Level Complaint Acknowledgment Letter
GG(2b) -------Failure to Provide Service(s)/Item(s) in a Timely Manner Acknowledgment Letter
GG(3a) -------1st Level Complaint Decision Notice
GG(3b) -------1st Level Grievance Decision Notice
GG(4) ---------2nd Level Complaint Acknowledgment Letter
GG(5) ---------2nd Level Complaint Decision Notice
GG(6a) -------Expedited Complaint Decision Notice
GG(6b) -------Notice of Failure to Receive Provider Certification for an Expedited Complaint or Grievance
GG(7) ---------1st Level Grievance Acknowledgment Letter
GG(8) ---------2nd Level Grievance Acknowledgment Letter
GG(9) ---------2nd Level Grievance Decision Notice
GG(10) -------Expedited Grievance Decision Notice
GG(11) -------Notice for Payment Denial Because the Service(s)/Item(s) Was Provided Without Authorization by a Provider Not Enrolled in the Pennsylvania Medical Assistance Program
GG(12) -------Notice for Payment Denial Because the Service(s)/Item(s) Was Not a Covered Benefit for the Member
GG(13) -------Notice for Denial of Payment After a Service(s) Has Been Delivered Because the Emergency Room Service(s) Was Not Medically Necessary
GG(14a)------In-Person (First/Second Level) (Complaint/Grievance) Review Template
GG(14b) -----(First/Second Level)(Complaint/Grievance) Review Template
HH ----------Reserved
II----------Required Contract Terms for Administrative Subcontractors
JJ ----------Lobbying Certification and Disclosure
KK ----------Reporting Suspected Fraud and Abuse to the Department
LL ----------Guidelines for Sanctions Regarding Fraud and Abuse
MM ----------Reserved
NN ----------Special Needs Unit
OO----------Coordination of Care Entities
PP ----------Provider Manuals
QQ----------Reserved
RR ----------Reserved

SS ----------Reserved
TT----------Reserved
UU----------Reserved
VV ----------Reserved
WW----------HealthChoices Audit Clause
XX ----------Encounter Data Submission Requirements and Penalty Applications
YY ----------Reserved
ZZ----------Reserved
AAA(1)--------Provider Network/Services Access (Lehigh-Capital, Southwest, and Southeast Zones) (if applicable)
AAA(2)-------- Provider Network/Service Access (New West Zone) (if applicable)
AAA(3)---------Provider Network/Service Access (New East Zone) (if applicable)
BBB----------Outpatient Drug Services
BBB(1)--------Reserved
BBB(2)--------Reserved
BBB(3)--------Pharmacy Denial Notice Complete Denial
BBB(4)--------Pharmacy Denial Notice Partial Approval
BBB(5)--------Pharmacy Denial Notice Different Approval
BBB(6)--------Reserved
CCC----------Physical Health MCO Provider Agreements

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 https://dpwintra.dpw.state.pa.us/healthchoices/ . To access the HealthChoices Intranet, the MCO must have established connectivity with DHS.

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 and system notices.

PH-MCOs must routinely check the HealthChoices Intranet for information on MMIS requirements. All systems information for conducting business with DHS is located on this site.

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. DHS Web Site

MA Bulletins, RFPs, Program information and other Department communications are available on the DHS Web site at http://www.dhs.pa.gov/.

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.

Covered Outpatient Drug — In accordance with 42 U.S.C.A. 1396r-8(k)(2) and 55 Pa. Code Chapter 1121, the term means a brand name drug, a generic drug, or an over-the-counter (OTC) drug which:

1. Is approved by the Federal Food and Drug Administration.
2. Is distributed by a manufacturer that entered into a Federal Drug Rebate Program agreement with the Centers for Medicare and Medicaid Services (CMS).
3. May be dispensed only upon prescription in the MA Program.
4. Has been prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice.
5. Is dispensed or administered in an outpatient setting.

The term includes biological products and insulin.

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 DHS/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 PROMIS*e*™ contractor.

Day — Indicates a calendar day unless specifically denoted otherwise. See Business Day.

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 Human Services (DHS) 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.

DHS Fair Hearing — A hearing conducted by the Department of Human Services, 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.

Expansion Counties — The Expansion Counties are all other counties not specified in the definition of a Heritage County.

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 — A Department-approved list of outpatient drugs determined by the PH-MCO's Pharmacy and Therapeutics (P&T) Committee to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, and cost for the PH-MCO members.

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 DHS 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-Acquired Condition (HCAC) — A condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of Health and Human Services under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis(DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

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.

Heritage Counties — The Heritage Counties are the following counties: Adams, Allegheny, Armstrong, Beaver, Berks, Bucks, Butler, Chester, Cumberland, Dauphin, Delaware, Fayette, Greene, Indiana, Lancaster, Lawrence, Lebanon, Lehigh, Montgomery, Northampton, Perry, Philadelphia, Washington, Westmoreland, and York.

Holdback — A PH-MCO capitation payment reduction taken by the Department that is subsequently paid to the PH-MCO as provided by the agreement.

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.

Indian — An individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f), 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal

Organization, or Urban Indian Organization – I/T/U) or through referral under Contract Health Services (CHS).

Indian Health Care Provider — A health care program, including CHS, operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Information Resource Management (IRM) — A program planned, developed, implemented and managed by DHS's Bureau of Information Systems, the purpose of which is to ensure the coordinated, effective and efficient employment of information resources in support of DHS 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/intellectual-developmental disability 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, Intellectual/Developmental Disability, 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 Human Services.

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 DHS/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 PROMISe™ 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 DHS Fair Hearing is pending, a request to refill that prescription, made after the Grievance or DHS 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 Provider-Preventable Condition (OPPC)— A condition occurring in any health care setting that meets the following criteria:

- Is identified in the State plan,
- 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 evidence-based guidelines,
- Has a negative consequence for the beneficiary,
- Is auditable, and
- Includes, at a minimum, the following:
  - Wrong surgical or other invasive procedure performed on a patient,
  - Surgical or other invasive procedure performed on the wrong body part, and
  - Surgical or other invasive procedure performed on the wrong patient.

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 Drug List — A list of Department-approved outpatient drugs designated as preferred products because they were determined to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness and cost for the PH-MCO members by the PH-MCO's Pharmacy and Therapeutics (P&T) Committee.

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, determined to be Medically Necessary, 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-Preventable Condition (PPC) — A condition that meets the definition of a health care-acquired condition (HCAC) or other provider-preventable condition (PPC) as defined in 42 CFR 447.26(b).

Provider Reimbursement (and) Operations Management Information System electronic (PROMISe™) — A claims processing and management system implemented by the Department of Human Services 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 Group — The Recipient Group is the group to which a specific MA recipient is assigned for payment. The Recipient Groups to which a MA recipient can be assigned are found on Appendix 3f.

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 Human Services 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 DHS 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 type of Prior Authorization requirement, sometimes referred to as a fail first requirement, intended as a cost savings that begins drug therapy with the most cost-effective drug therapy, and progresses to other more costly therapies determined to be medically necessary.

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.
CHS — Contract Health 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.
DHS — Department of Human Services.
DME — Durable Medical Equipment.
DOH — Department of Health (of the Commonwealth of Pennsylvania).
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.
HCAC — Health Care-Acquired Condition.
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.
IHS — Indian Health Service.
IRM — Information Resource Management
I/T/U — Indian Tribe, Tribal Organization, or Urban Indian Organization.
JCAHO — Joint Commission for the Accreditation of Healthcare Organizations.
LIFE — Living Independence for the Elderly.
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.
OPPC — Other Provider-Preventable Condition.
ORC — Other Related Conditions.
OTC — Over-the-Counter.
P&T — Pharmacy & Therapeutics.
PARP — Prior Authorization Review Panel.
PBM — Pharmacy Benefit Manager.
PCP — Primary Care Practitioner.
PDA — Pennsylvania Department of Aging.
PDL — Preferred Drug List.
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.
PPC — Provider Preventable Condition.
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 DHS 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 Human Services 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. Additionally, the PH-MCO must comply with Exhibit E, DHS Addendum to Standard Contract Terms and Conditions of this Agreement and Exhibit E(1) Other Federal Requirements of this Agreement.

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 outpatient drug services standards and requirements described in:

- Exhibit BBB Outpatient Drug Services
- 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

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 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.

b. Healthy Beginnings Plus (HBP) Program

The PH-MCO must provide services that meet or exceed HBP standards in effect as defined in current or future MA Bulletins that govern the HBP Program. The PH-MCO must also continue the coordinated prenatal activities of the HBP Program by utilizing enrolled HBP Providers or developing comparable resources. Such comparable programs will be subject to review and approval by the Department. 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.

Since the HBP program focuses on community based services provided by licensed and non-licensed providers who see recipients face-to-face in outpatient provider offices or community settings, the PH-MCO’s prenatal program

must have the majority of its pregnant Members seen face-to-face in the community setting. Majority is defined as greater than fifty percent (50%) of unique pregnant women that have an initial care management assessment as reported in Section II of the Operations 15 dashboard report. This will be accomplished by contractual relationships within the PH-MCO's Provider Network, MCO employees, or delegated vendor relationship.

The HBP Program also requires that high risk pregnant women should be adequately referred and treated for substance use disorder (SUD). The PH-MCO will contract with high volume obstetrical hospitals and health systems that perform more than 900 Medicaid deliveries to establish highly coordinated health homes for pregnant women with SUD. These health homes will be focused on identifying, initiating treatment, and referring pregnant women for comprehensive drug and alcohol counseling services. If the PH-MCO is unsuccessful in contracting with any of the high volume obstetrical hospitals or health systems, it must document its efforts to negotiate with the provider for review by the Department.

c. 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, 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.

2. Time Frames for Notice of Prior Authorization 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 of Outpatient Drug Services

See Exhibit BBB for additional requirements specific to Prior Authorization of Outpatient Drug Services.

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. See Exhibit BBB for additional requirements specific to Outpatient Drug Services.

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.

The PH-MCO must 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 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 DHS 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 DHS Fair Hearing Process

1. Member Complaint, Grievance and DHS 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 DHS Fair Hearings as outlined in Exhibit GG of this Agreement, Complaint, Grievance, and DHS 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 DHS 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 DHS 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 DHS 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 DHS 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 Human Services's Bureau of Hearings and Appeals for those cases when an Recipient has requested a DHS Fair Hearing, unless requesting reconsideration by the Secretary of the Department of Human Services. Only the Member may appeal to Commonwealth Court. The decisions of the Secretary and the Court are binding on the PH-MCO.

2. DHS 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 DHS Fair Hearing Process requirements defined in Exhibit GG of this Agreement, Complaint, Grievance and DHS Fair Hearing Processes.

A request for a DHS 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 DHS 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 DHS'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 outpatient drug 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 DHS Fair Hearing Coordinator whose qualifications demonstrate the ability to assist Members throughout the Complaint, Grievance and DHS 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, DHS 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 Human Services 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 DHS 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 DHS Fair Hearing. Members may not file a Complaint or Grievance with the PH-MCO regarding the restriction action. A request for a DHS Fair Hearing must be in writing, signed by the Member and sent to:

Department of Human Services
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 DHS-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 https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf :

- 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.dhs.pa.gov/ 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 DHS Internet at the following link: http://www.dhs.pa.gov/provider/busandtechstandards/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, Prior 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. The PH-MCOs must ensure that each provider service location is enrolled and active with Medical Assistance. In addition, the PH-MCOs must maintain all service locations in their own system. The PH-MCOs must ensure that each provider's license information is kept valid in PROMISe™, and must outreach to their providers to stress the importance of maintaining up to date information in PROMISe™. Additionally, the PH-MCOs must ensure that providers enrolled in their plan with a specific provider type/specialty have the same provider type/specialty in PROMISe™ for each service location.

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 Prior 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 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, rate setting 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 DHS Internet site at the following link: http://www.dhs.pa.gov/provider/busandtechstandards/index.htm. 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 DHS 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 at least sixty (60) days prior

to the change. 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 required in the ASC X12 Implementation Guides, 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 the PH-MCO 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 PROMISe™ to include the following:

- Ensure all service locations as defined by MA enrollment rules, are enrolled and active with Medical Assistance.
- Ensure participating provider license information is kept valid in PROMISe™.
- Ensure the PT/Specialty is the same in PROMISe™.

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 DHS 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. This requirement is effective as indicated by the Bureau of Data and Claims Management. 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: https://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.

Exceptions:

a) Any Capitation payment that would otherwise be payable in the month of May for the Heritage Counties will be payable by July 22.

b) Capitation for the June program month will be payable by July 8 of the same year.

c) An exception does not apply if the Department has notified the PH-MCO that v above will apply.

vii. 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 (1st) 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 (5th) calendar day of the fifth (5th) 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)

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. Payment to the PH-MCO when the Agreement is Ended

The Department's obligation to make payments under this HealthChoices Agreement survives the expiration or termination of the Agreement.

The PH-MCO's obligation to make payment under this HealthChoices Agreement survives the expiration or termination of this Agreement.

7. 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.

8. 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.

9. Telephonic Psychiatric Consultation Team Services

The Telephonic Psychiatric Consultation Team Services capitation rate components are specified in Appendix 3f. The PH-MCO will provide documentation on the expenditure of the funds.

10. 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.

11. 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 outdated 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.

12. 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.

13. 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.

14. Accessibility to TPL Data

The Department will provide the PH-MCO with access to data maintained on the TPL file.

15. 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.

16. Estate Recovery

Section 1412 of the Human Services 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.

17. Audits

The PH-MCO is responsible to comply with audit requirements as specified in Exhibit WW of this Agreement, HealthChoices Audit Clause.

18. 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 DHS 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 ASC X12 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 PROMISe™ 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 complete, accurate, and timely monthly file containing supplemental data for the purpose of drug rebate dispute resolution. The file must be submitted by the 15th day of the month following the month in which the drug transaction was processed in PROMISe™ as specified on the HealthChoices Intranet site.

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 (PROMISe™) 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 DHS. 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, DHS 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 (120th) 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 DHS 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 (1^{st}) day of the fifth (5^{th}) 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 (1^{st}) 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) – BBB(5). 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. To facilitate the efficient administration of the Medical Assistance Program and to enhance the treatment of Members who need behavioral health or their services that are not the responsibility of the PH-MCO, the PH-MCO may receive all information relating to the health status of its Members, including treatment information, by the exchange of data and such other mechanisms as the Department approves, 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 Human Services. 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 Human Services
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 Human Services
Director, Bureau of Managed Care Operations
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

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

Department of Human Services
Director, Bureau of Managed Care Operations
Commonwealth Tower, 6th Floor
303 Walnut Street
Harrisburg, Pennsylvania 17101

With a Copy to:

Department of Human Services
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 3a

ACA Health Insurance Providers Fee

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

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

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

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

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

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

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

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

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

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

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

B. The Department will:

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

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

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

      Single-person covered entity or controlled group HIPF% =

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX 3b

EXPLANATION OF CAPITATION PAYMENTS

I. Base Capitation Rates

The final schedule of Base Capitation Rates and Maternity Care Rates 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 Recipient Groups included in this Agreement using an actuarially sound method to adjust Base Capitation Rates to reflect differences in health status and demographics of the Members enrolled in each PH-MCO's program.

The 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 in accordance with a periodicity schedule determined by the Department.

C. Risk Adjusted Rate

The Risk Adjusted Rate is the portion of the Base Capitation Rate that is subject to risk adjustment multiplied by the applicable RAR MCO Plan Factor issued by the Department.

The Adjusted Base Capitation Rate is the lowest Base Capitation Rate Net of HIPF Withhold for this Recipient Group, Zone and Rate Region for the applicable program month that is included in a HealthChoices Agreement with any MCO.

This is calculated as follows.

	Adjusted Base Capitation Rate
MINUS	Home Nursing Risk Sharing Withhold
MINUS	High Cost Risk Pool Allocation Amount
MINUS	Specialty Drug Risk Sharing Premium
MINUS	Hepatitis C Quality Risk Pool Premium
MINUS	$14.53 (July-December 2016 program months only; zero for other program months)
EQUALS	Portion of Base Capitation Rate Subject to Risk Adjustment
MULTIPLIED BY	RAR MCO Plan Factor
EQUALS	Risk Adjusted Rate.

This paragraph provides for an exception to all of the above. For the Breast and Cervical Cancer Rating Group, the Risk Adjusted Rate will be the Base Capitation Rate net of HIPF Withhold.

D. Quality Incentives

Appendix 3f specifies per-member-per-month (PMPM) amounts for Provider Pay for Performance and Community Based Care Management. The Department will pay these amounts to the PH-MCO, in accordance with

Exhibit B(3). These amounts are not subject to risk adjustment and will be paid separately from other capitation.

E. Capitation Payment Rate

The Capitation Payment Rate is equal to the Risk Adjusted Rate plus the amounts included in the Base Capitation Rate net of HIPF Withhold that are not subject to risk adjustment.

If the Base Capitation Rate Net of HIPF Withhold for this Recipient Group, Zone and Rate Region for the applicable program month that is included in Appendix 3f of this HealthChoices Agreement is higher than the lowest Base Capitation Rate Net of HIPF Withhold for this Recipient Group, Zone and Rate Region for the applicable program month that is included in Appendix 3f of a HealthChoices Agreement with another MCO, the difference is referred to as Amount A.

If the MCO Assessment portion of the Capitation rate has been adjusted per Section H. of this Appendix, the amount of the adjustment inclusive of the two multipliers specified in Section H. is referred to as Amount B. Amount B could potentially be positive or negative.

This is calculated as follows.

	Risk Adjusted Rate
PLUS	Amount A
PLUS	Home Nursing Risk Sharing Withhold
PLUS	High Cost Risk Pool Allocation Amount
PLUS	Specialty Drug Risk Sharing Premium
PLUS	Hepatitis C Quality Risk Pool Premium
PLUS	$14.53 (July-December 2016 program months only; zero for other program months)
PLUS	Amount B
EQUALS	Capitation Payment Rate.

In accordance with Section VII.B.a.ii, the Department will make capitation payments at per diem equivalents of the Capitation Payment Rates that are calculated and issued by the Department.

This paragraph provides for an exception to all of the above. For the Breast and Cervical Cancer Rating Group, the Capitation Payment Rate will be the Base Capitation Rate net of HIPF Withhold.

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. Newly Eligible

For purposes of this Agreement, Newly Eligible is defined as a Member who has a category of assistance/program status code combination of MG91 or MG92 and Members age 19 and 20 who have a category of assistance/program status code combination of MG90.

H. MCO Assessment

The MCO Assessment portion of capitation rates is not subject to risk adjustment.

The monthly Base Capitation Rates in Appendix 3f include an MCO Assessment fee amount of $13.48. If the Secretary of Human Services issues a different MCO Assessment fee amount in accordance with 62 P.S. § 803-I, the Department will pay monthly Capitation Payment Rates after an adjustment that reflects the difference between $13.48 and the revised amount after this difference has been multiplied by 1.0142 and multiplied again by 1.0627. This is applicable only to program months affected by the revised MCO Assessment fee amount.

If the Department has notified the PH-MCO that the GRT is reduced or ended, then the above calculation will be appropriately adjusted or eliminated to accurately reflect the PH-MCO's obligation for the GRT.

Illustrative example: The rates in Appendix 3f include an MCO Assessment fee amount of $13.48. The rates further include a multiplier of 1.0142 that is applied to this figure. The product is further multiplied by 1.0627 (for GRT) to yield an amount of $14.53 applicable to the MCO Assessment that is included in each rate in Appendix 3f. In this Illustrative example the Department issues a new MCO Assessment fee amount of $13.98 effective October 2016. $13.98 minus $13.48 equals $0.50 multiplied by 1.0142 multiplied by 1.0627 equals $0.54. The Capitation Payment Rate determined per this Appendix will be increased by $0.54 for the October 2016 program month and beyond.

I. Telephonic Psychiatric Consultation amounts

The Telephonic Psychiatric Consultation PMPMs specified in Appendix 3f are part of the Base Capitation Rate and will be risk adjusted.

APPENDIX 3c

HOME NURSING RISK SHARING ARRANGEMENT

This Agreement establishes a risk sharing arrangement (Arrangement) between the Department and the PH-MCO for certain HealthChoices Members who incur significant costs for home nursing services.

This Appendix 3c supersedes any previous version to define the Arrangement for the Arrangement Year beginning January 1, 2016 and subsequent Arrangement Years.

I. Arrangement Years

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

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

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

II. Covered Services and Members

A. This Arrangement covers services provided by a Licensed Practical Nurse, Registered Nurse, Home Health Aide, or Personal Care Provider in a home, home-like, or school based setting paid by the PH-MCO for a HealthChoices Member enrolled with the PH-MCO with a date of service during the Arrangement Year (Covered Services). This Arrangement only covers Members under age twenty-one (21), who do not reside in any of the following types of facility:

- State Intermediate Care Centers for Intellectual Disabilities
- Intermediate Care Facility for the Intellectually Disabled
- South Mountain Restoration Center
- County Nursing Facility
- General Nursing Facility
- Hospice
- Intermediate Care Facility for Persons with Other Related Conditions

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

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

D. Covered Services for a Member enrolled in HealthChoices under the Breast and Cervical Cancer Program are not eligible for reimbursement under this Arrangement.

III. Risk Sharing

In each Arrangement Year that is equivalent to a calendar year, the PH-MCO is responsible for the first $3,000 (Threshold Amount) in paid amounts of Covered Services provided to each Member as identified in Section II above. The Department will reimburse the PH-MCO 85.0 percent (85.0%) of Covered Services (net of third party liability/other insurance) submitted by the PH-MCO that are greater than $3,000.

If the Arrangement Year begins after January 31, the Department will provide the PH-MCO with a Threshold Amount that will apply in lieu of $3,000. The Department will provide documentation that its actuarial consultant has determined that the Threshold Amount is actuarially appropriate for the terms of the Home Nursing Risk Sharing Agreement inclusive of the applicable Withhold Amounts.

IV. Home Nursing Risk Sharing Withhold Amounts

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

B. The Department will determine the Home Nursing Risk Sharing Withhold Amount obligation by multiplying the Home Nursing Risk Sharing Premiums by the total PH-MCO's Member Months for the applicable Arrangement Year.

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

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

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

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

V. Claims Notification

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

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

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

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

E. The submission schedule includes quarterly submissions which are optional, those which are required, and instances where there should be no submission. For an optional submission, if the PH-MCO elects to submit a file, it will notify the Department by the due date of the submission.

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

VI. Payment to the PH-MCO

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

VII. Gross Receipts Tax

If the Department has an obligation due to the PH-MCO, as determined by Section IV.B above, the amount due will be multiplied by 1.0627 to account for the legitimate and marginal administrative cost of the Gross Receipts Tax (GRT).

If the PH-MCO has an obligation due to the Department, as determined by Section IV.B above, the final amount due will be multiplied by 1.0627 to recover the legitimate and marginal administrative cost of the GRT that was included in the capitation payment. The Department will complete this adjustment only when completing the final settlement for each applicable Arrangement Year.

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 or assessment on PH-MCO revenue or

if a new tax or assessment is implemented in addition to the GRT, then the Department will adjust the calculation above to reflect the effect on the tax or assessment obligation on revenue provided or adjusted per this Appendix.

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 and/or MCO Assessment. 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 or supplements GRT with another tax or assessment 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.

Aetna Better Health, Inc. Capitation Rates - Effective January 1, 2016 - June 30, 2016

SOUTHEAST ZONE		Capitation Payment Rate Calculation						Applicable Withhold Amounts						
Rate Region 1 - Philadelphia and Delaware counties	**Maternity Care Payment with HIPF Allowance**	**Base Capitation Rate with HIPF Allowance**	**HIPF Withhold**	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**Home Nursing Risk Sharing Withhold**	**High Cost Risk Pool Allocation Amount**	**Specialty Drug Risk Sharing Premium**	**Hepatitis C Quality Risk Pool**	**Provider Pay for Performance**	**Community Based Care Management**	**Telephonic Psychiatric Consultation**
TANF-MAGI < 2 Months		$5,216.01	$0.00	$5,216.01	TBD	TBD	TBD	$4.80	$10.65	N/A	N/A	$1.00	$0.55	$0.09
TANF-MAGI 2-11.999 Months		$500.90	$0.00	$500.90	TBD	TBD	TBD	$4.80	$10.65	N/A	N/A	$1.00	$0.55	$0.09
TANF-MAGI Ages 1-20		$185.51	$0.00	$185.51	TBD	TBD	TBD	$4.80	$10.65	$0.14	$0.02	$1.00	$0.55	$0.09
TANF-MAGI Ages 21+		$381.36	$0.00	$381.36	TBD	TBD	TBD	N/A	$10.65	$10.23	$1.28	$1.00	$0.55	$0.09
SSI-HH-Other Disabled		$1,399.05	$0.00	$1,399.05	TBD	TBD	TBD	$62.69	$102.15	$41.77	$4.84	$1.00	$0.55	$0.09
Breast and Cervical Cancer		$2,777.35	$0.00	$2,777.35	$2,777.35	$2,777.35	TBD	N/A	$102.15	N/A	N/A	$1.00	$0.55	$0.09
Newly Eligible Women Ages 19 and 20		$381.82	$0.00	$381.82	TBD	TBD	TBD	$13.32	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Women Ages 21 to 34		$433.67	$0.00	$433.67	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Women Ages 35 to 44		$644.40	$0.00	$644.40	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Women Ages 45 to 54		$918.37	$0.00	$918.37	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Women Ages 55 to 64		$1,074.56	$0.00	$1,074.56	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 19 and 20		$285.03	$0.00	$285.03	TBD	TBD	TBD	$13.32	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 21 to 34		$383.30	$0.00	$383.30	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 35 to 44		$612.79	$0.00	$612.79	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 45 to 54		$896.09	$0.00	$896.09	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 55 to 64		$1,154.86	$0.00	$1,154.86	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Maternity Care	$11,530.07		$0.00	$11,530.07										
Rate Region 2 - Bucks, Chester, and Montgomery counties	**Maternity Care Payment with HIPF Allowance**	**Base Capitation Rate with HIPF Allowance**	**HIPF Withhold**	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**Home Nursing Risk Sharing Withhold**	**High Cost Risk Pool Allocation Amount**	**Specialty Drug Risk Sharing Premium**	**Hepatitis C Quality Risk Pool**	**Provider Pay for Performance**	**Community Based Care Management**	**Telephonic Psychiatric Consultation**
TANF-MAGI < 2 Months		$3,893.46	$0.00	$3,893.46	TBD	TBD	TBD	$4.80	$10.65	N/A	N/A	$1.00	$0.55	$0.09
TANF-MAGI 2-11.999 Months		$331.14	$0.00	$331.14	TBD	TBD	TBD	$4.80	$10.65	N/A	N/A	$1.00	$0.55	$0.09
TANF-MAGI Ages 1-20		$171.73	$0.00	$171.73	TBD	TBD	TBD	$4.80	$10.65	$0.14	$0.02	$1.00	$0.55	$0.09
TANF-MAGI Ages 21+		$381.10	$0.00	$381.10	TBD	TBD	TBD	N/A	$10.65	$10.23	$1.28	$1.00	$0.55	$0.09
SSI-HH-Other Disabled		$1,084.75	$0.00	$1,084.75	TBD	TBD	TBD	$62.69	$102.15	$41.77	$4.84	$1.00	$0.55	$0.09
Breast and Cervical Cancer		$2,777.35	$0.00	$2,777.35	$2,777.35	$2,777.35	TBD	N/A	$102.15	N/A	N/A	$1.00	$0.55	$0.09
Newly Eligible Women Ages 19 and 20		$381.82	$0.00	$381.82	TBD	TBD	TBD	$13.32	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Women Ages 21 to 34		$433.67	$0.00	$433.67	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Women Ages 35 to 44		$644.40	$0.00	$644.40	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Women Ages 45 to 54		$918.37	$0.00	$918.37	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Women Ages 55 to 64		$1,074.56	$0.00	$1,074.56	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 19 and 20		$285.03	$0.00	$285.03	TBD	TBD	TBD	$13.32	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 21 to 34		$383.30	$0.00	$383.30	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 35 to 44		$612.79	$0.00	$612.79	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 45 to 54		$896.09	$0.00	$896.09	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Newly Eligible Men Ages 55 to 64		$1,154.86	$0.00	$1,154.86	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.55	N/A
Maternity Care	$9,461.53		$0.00	$9,461.53										

TBD - To Be Determined

The Department's obligation is determined by the amounts included in the column titled "Base Capitation Rate / Maternity Care Payment". The capitation amounts will be converted to per diems as provided by the Agreement. The Department's potential obligation to pay some portion or all of the HIPF Withhold is defined in Appendix 3a. The 2016 rates include no HIPF Withhold.

These rates were developed using Rate Setting Methodology #2 - Use of Managed Care Data. An overview of this methodology is found in Appendix 3g of the HealthChoices Agreement.

These base rates have been developed taking into account an additional administrative expense related to the 5.90% Gross Receipts Tax rate.

The amounts shown in the Applicable Withhold Amounts columns are not to be withheld from the capitation rate. The Home Nursing Risk Sharing Withhold amounts are used to determine the MCO's Home Nursing Risk Sharing Withhold Amount obligation as per Appendix 3c of the HealthChoices Agreement. The High Cost Risk Pool Allocation Amounts are used to determine the MCO's HCRPAA obligation as per Appendix 3k of the HealthChoices Agreement. The Newly Eligible rating groups are in the High Cost Risk Pool effective April 1, 2016. More information about the Specialty Drug Risk Sharing Premiums and Hepatitis C Quality Risk Pool is in Appendix 5.

DHS will pay the Provider Pay for Performance amount for each MCO member month as provided by Exhibit B (3) of the HealthChoices Agreement.

DHS will pay the Community Based Care Management amount for each MCO member month as provided by Exhibit B (3) of the HealthChoices Agreement.

The capitation rates will be reduced by an amount not to exceed the APR Adjustment component specified in Appendix 14, if the Department determines such reduction is necessary to prevent expenditure of revenue that is not available from the Quality Care Assessment.

Further information about Telephonic Psychiatric Consultation Team Services amounts is provided in Exhibit V.

Aetna Better Health, Inc. Capitation Rates - Effective July 1, 2016 - December 31, 2016

SOUTHEAST ZONE		Capitation Payment Rate Calculation						Applicable Withhold Amounts						
Rate Region 1 - Philadelphia and Delaware counties	**Maternity Care Payment with HIPF Allowance**	**Base Capitation Rate with HIPF Allowance**	**HIPF Withhold**	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**Home Nursing Risk Sharing Withhold**	**High Cost Risk Pool Allocation Amount**	**Specialty Drug Risk Sharing Premium**	**Hepatitis C Quality Risk Pool**	**Provider Pay for Performance**	**Community Based Care Management**	**Telephonic Psychiatric Consultation**
TANF-MAGI < 2 Months		$5,243.54	$0.00	$5,243.54	TBD	TBD	TBD	$4.80	$10.65	N/A	N/A	$1.00	$0.65	$0.09
TANF-MAGI 2-11.999 Months		$516.68	$0.00	$516.68	TBD	TBD	TBD	$4.80	$10.65	N/A	N/A	$1.00	$0.65	$0.09
TANF-MAGI Ages 1-20		$200.50	$0.00	$200.50	TBD	TBD	TBD	$4.80	$10.65	$0.14	$0.02	$1.00	$0.65	$0.09
TANF-MAGI Ages 21+		$396.85	$0.00	$396.85	TBD	TBD	TBD	N/A	$10.65	$10.23	$1.28	$1.00	$0.65	$0.09
SSI-HH-Other Disabled		$1,417.07	$0.00	$1,417.07	TBD	TBD	TBD	$62.69	$102.15	$41.77	$4.84	$1.00	$0.65	$0.09
Breast and Cervical Cancer		$2,798.81	$0.00	$2,798.81	$2,798.81	$2,798.81	TBD	N/A	$102.15	N/A	N/A	$1.00	$0.65	$0.09
Newly Eligible Women Ages 19 and 20		$397.30	$0.00	$397.30	TBD	TBD	TBD	$13.32	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Women Ages 21 to 34		$449.28	$0.00	$449.28	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Women Ages 35 to 44		$660.53	$0.00	$660.53	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Women Ages 45 to 54		$935.20	$0.00	$935.20	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Women Ages 55 to 64		$1,091.77	$0.00	$1,091.77	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 19 and 20		$300.27	$0.00	$300.27	TBD	TBD	TBD	$13.32	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 21 to 34		$398.79	$0.00	$398.79	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 35 to 44		$628.85	$0.00	$628.85	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 45 to 54		$912.85	$0.00	$912.85	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 55 to 64		$1,172.27	$0.00	$1,172.27	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Maternity Care	$11,558.83		$0.00	$11,558.83										
Rate Region 2 - Bucks, Chester, and Montgomery counties	**Maternity Care Payment with HIPF Allowance**	**Base Capitation Rate with HIPF Allowance**	**HIPF Withhold**	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**Home Nursing Risk Sharing Withhold**	**High Cost Risk Pool Allocation Amount**	**Specialty Drug Risk Sharing Premium**	**Hepatitis C Quality Risk Pool**	**Provider Pay for Performance**	**Community Based Care Management**	**Telephonic Psychiatric Consultation**
TANF-MAGI < 2 Months		$3,917.70	$0.00	$3,917.70	TBD	TBD	TBD	$4.80	$10.65	N/A	N/A	$1.00	$0.65	$0.09
TANF-MAGI 2-11.999 Months		$346.50	$0.00	$346.50	TBD	TBD	TBD	$4.80	$10.65	N/A	N/A	$1.00	$0.65	$0.09
TANF-MAGI Ages 1-20		$186.68	$0.00	$186.68	TBD	TBD	TBD	$4.80	$10.65	$0.14	$0.02	$1.00	$0.65	$0.09
TANF-MAGI Ages 21+		$396.58	$0.00	$396.58	TBD	TBD	TBD	N/A	$10.65	$10.23	$1.28	$1.00	$0.65	$0.09
SSI-HH-Other Disabled		$1,101.99	$0.00	$1,101.99	TBD	TBD	TBD	$62.69	$102.15	$41.77	$4.84	$1.00	$0.65	$0.09
Breast and Cervical Cancer		$2,798.81	$0.00	$2,798.81	$2,798.81	$2,798.81	TBD	N/A	$102.15	N/A	N/A	$1.00	$0.65	$0.09
Newly Eligible Women Ages 19 and 20		$397.30	$0.00	$397.30	TBD	TBD	TBD	$13.32	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Women Ages 21 to 34		$449.28	$0.00	$449.28	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Women Ages 35 to 44		$660.53	$0.00	$660.53	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Women Ages 45 to 54		$935.20	$0.00	$935.20	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Women Ages 55 to 64		$1,091.77	$0.00	$1,091.77	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 19 and 20		$300.27	$0.00	$300.27	TBD	TBD	TBD	$13.32	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 21 to 34		$398.79	$0.00	$398.79	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 35 to 44		$628.85	$0.00	$628.85	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 45 to 54		$912.85	$0.00	$912.85	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Newly Eligible Men Ages 55 to 64		$1,172.27	$0.00	$1,172.27	TBD	TBD	TBD	N/A	$19.63	$14.82	$1.85	$1.00	$0.65	N/A
Maternity Care	$9,485.14		$0.00	$9,485.14										

TBD - To Be Determined

The Department's obligation is determined by the amounts included in the column titled "Base Capitation Rate / Maternity Care Payment". The capitation amounts will be converted to per diems as provided by the Agreement. The Department's potential obligation to pay some portion or all of the HIPF Withhold is defined in Appendix 3a. The 2016 rates include no HIPF Withhold.

These rates were developed using Rate Setting Methodology #2 - Use of Managed Care Data. An overview of this methodology is found in Appendix 3g of the HealthChoices Agreement.

These base rates have been developed taking into account an additional administrative expense related to the 5.90% Gross Receipts Tax rate.

These base rates include an amount for the MCO Assessment. Additional information is provided in Appendix 3b and Appendix 3m-1 of the HealthChoices Agreement.

The amounts shown in the Applicable Withhold Amounts columns are not to be withheld from the capitation rate. The Home Nursing Risk Sharing Withhold amounts are used to determine the MCO's Home Nursing Risk Sharing Withhold Amount obligation as per Appendix 3c of the HealthChoices Agreement. The High Cost Risk Pool Allocation Amounts are used to determine the MCO's HCRPAA obligation as per Appendix 3k of the HealthChoices Agreement. More information about the Specialty Drug Risk Sharing Premiums and Hepatitis C Quality Risk Pool is in Appendix 5.

DHS will pay the Provider Pay for Performance amount for each MCO member month as provided by Exhibit B (3) of the HealthChoices Agreement.

DHS will pay the Community Based Care Management amount for each MCO member month as provided by Exhibit B (3) of the HealthChoices Agreement.

The capitation rates will be reduced by an amount not to exceed the APR Adjustment component specified in Appendix 14, if the Department determines such reduction is necessary to prevent expenditure of revenue that is not available from the Quality Care Assessment.

Further information about Telephonic Psychiatric Consultation Team Services amounts is provided in Exhibit V.

HC Agreements
CY2016 Amendments
Updated November 8, 2015

APPENDIX 3g

OVERVIEW OF METHODOLOGIES FOR RATE SETTING AND DETERMINATION OF RISK SHARING WITHHOLD AMOUNTS

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

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

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

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

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

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

Include the Effect of Program/Policy Changes — The Commonwealth occasionally changes the services or populations covered under the HealthChoices program (e.g., expands dental care, restricts enrollment). These changes are included in the

capitation rates by either increasing or decreasing the FFS data by a certain percentage amount.

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

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

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

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

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

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

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

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

Include the Effect of Program/Policy Changes — The Commonwealth occasionally changes the services or populations covered under the HealthChoices program (e.g., expands dental care, restricts enrollment). Any new program/policy changes that were not already reflected in the managed care data are included in the capitation rates by either increasing or decreasing the managed care data by a certain percentage amount.

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

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

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

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

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

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

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

additional administration/profit amount is added to arrive at the final capitation rates under Track 1.

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

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

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

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

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

IV. Additional Information on Rate Development

The reimbursement provided under this contract is intended for Medically Necessary services covered under the Commonwealth's State Plan. The MCO has the option to utilize this reimbursement to provide alternatives to the Medically Necessary services covered under the State Plan in order to meet the needs of the individual enrollee in the most efficient manner. However, since the capitation rates cannot

include these cost-effective, alternative services, an adjustment may be required in the rate development process to incorporate only the cost of state plan services which would have been provided in the absence of alternative services.

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

V. Methodology to Determine Risk Sharing Withhold Amounts

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

VI. Information Sharing with MCOs

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

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

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

- Information on, and the value of, program-wide adjustments.

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

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

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

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

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

- The lower end, "midpoint," and upper end of the range of actuarially sound rates determined by the Commonwealth's actuaries for each rating group.

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

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

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

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

The amount that is withheld from the capitation rates to fund the High Cost Risk Pool (HCRP) is based on an analysis of data (FFS or managed care) from the population and services covered, as well as the design of the HCRP (e.g., threshold levels). This data is considered the primary source of information for developing the withhold amounts. Since any one (1) year may reflect unusual occurrences, when available,

multiple years of information are reviewed and combined together. Because the data is generally historical in nature and the withholds are applicable to the future capitation rates, the data must be trended and adjusted as necessary to coincide with the time period in which the rates will be paid. These trends are estimates of the future costs of services provided. Given the programs' narrow specificity of risk and high per recipient cost, total risk pool costs may fluctuate substantially from year to year.

HC Agreements
CY2016 Amendment
Updated April 5, 2016

APPENDIX 3k

HIGH COST RISK POOL

Overview

The Department will establish, administer, and distribute funds from three quarterly High Cost Risk Pools (HCRP). This Appendix 3k is effective January 1, 2016 and supersedes any previous version to define the HCRP for the January-March 2016 quarter and each subsequent quarter.

Each quarterly risk pool will be funded through High Cost Risk Pool Allocation Amounts (HCRPAA). The Department will utilize encounter data or files submitted by the PH-MCO 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 discharge, the Department will sum the amount spent by each PH-MCO in excess of the HCRP Threshold on each Member in each of three Medicaid Eligible Groups, defined below, 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.

Medicaid Eligible Group (MEG)

The Department will administer one risk pool per quarter per HealthChoices zone for each of the three defined MEGs:

- TANF – which is inclusive of Members with TANF and MAGI Medical Assistance (MA) eligibility with the exclusion of MAGI program status codes 90, 91 and 92,
- SSI/HH – which is inclusive of Members with SSI, Healthy Horizons, Breast and Cervical Cancer, Other Disabled MA eligibility and Member aged 21 or older having MAGI MA eligibility under program status code 90.
- Newly Eligible - which is inclusive of Members having eligibility under MAGI MA eligibility with the program status codes 91 and 92 and Members age 19 or 20 with program status code 90.

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 three HCRPs specific to each HealthChoices zone for each calendar quarter, even if HealthChoices agreements begin or end during the quarter.

Newly Eligibles

This section pertains only to Members for which the Department has made or will make capitation payments for this HealthChoices Agreement under one of the Newly Eligible rating groups, as identified in Appendix 3f.

These Members will initially be included in the HCRP beginning with the April to June 2016 quarter.
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.

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.
- Covered Services do not include any drug listed by the Department for the purposes of the Specialty Drug Risk Sharing, unless the date of service is not included within the Defined Twelve Month Period, as identified in Appendix 5.

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 2016 HCRP is January-December 2015.

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.

Data Source

The Department will use PROMISe-approved encounter data, unless the Department notifies the PH-MCO that it will use different data. The Department will provide the run dates for extraction of encounter data to the PH-MCO.

Upon notification by the Department, the PH-MCO will submit files in a format determined by the Department for the administration of the risk pools in lieu of encounter data.

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.

Covered Service cost for the Defined Twelve Month Period will be included in total for each Member exceeding the threshold in only one MEG's risk pool. This will be determined by the Member's category of aid/program status on the last day of the given Twelve Month period.

Inpatient Hospital Repricing

The Department will reprice each acute inpatient hospital claim to the amount the Department would have paid for the discharge except where necessary data is unavailable.

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

Quarterly Distributions

The Department will utilize PROMISe-approved encounter data to administer the steps outlined in this Appendix and to determine the adjusted amount each PH-MCO paid in excess of the HCRP Threshold for each Member for medical 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 or assessment on PH-MCO revenue or if a new tax or assessment is implemented in addition to the GRT, then the Department will adjust the calculation above to reflect the effect on the tax obligation of revenue provided or adjusted per this Appendix.

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 3m

GROSS RECEIPTS TAX

This appendix provides for certain responsibilities of the PH-MCO and the Department related to the Commonwealth's Gross Receipts Tax (GRT).

1. The PH-MCO will provide the Department with a copy of each GRT filing with the Department of Revenue, not later than three work days after submission to the Department of Revenue. This requirement applies to amended or corrected submissions, as well as original submissions.

2. If the PH-MCO is operating a HealthChoices program per this Agreement with the Department on March 1, 2016, or on March 1 of any subsequent year, and if the GRT has not been terminated before that date, the Department will complete a payment to the PH-MCO on or before that date. The amount of the payment will be determined by the formula below:

	Capitation paid by DPW for the December program month of the previous year
Multiplied by	5.9%
Multiplied by	9
Equals	Subtotal Figure.
	Sum of maternity care payments paid in the previous calendar year
Multiplied by	5.9%
Multiplied by	83%
Plus	Subtotal Figure
Equals	Amount of Payment Due by March 1 of That Year.

The payment will not be made to a PH-MCO that has not signed a HealthChoices Agreement for this HealthChoices zone that continues after June of the same year, except that the Department may elect to waive this provision.

If the Department has notified the PH-MCO of the termination of the GRT, the Department will proportionately reduce the payment provided by this Section 2.

3. If the Department completes the payment provided by Section 2 above, the Department will reduce the capitation payment for each program month from March through November of that year by one-ninth of the Amount of Payment Due by March 1 of That Year.

4. If the Department has not recovered the Payment Due by March 1 of That Year, by December 24 of the same year, as intended in Section 3 above, the PH-MCO will pay the amount not recovered to the Department by December 31 of the same year.

5. If either the Department or the PH-MCO notifies the other party that it is terminating this Agreement, the PH-MCO will pay to the Department the amount not yet recovered, as provided by Section 2 above, within fifteen calendar days of the date of notification.

6. If the Department makes an MCO Pay For Performance payment, as provided by Exhibit B(1) of this Agreement or a prior Agreement effective July 1, 2009 or a subsequent date, no additional payment specific to MCO Pay For Performance is due per this Appendix 3m. Exceptions:

    a. The Department will make a payment as needed to accommodate the difference between a GRT obligation by the PH-MCO at a tax rate higher than 5.9%, if any, and the tax rate that is inherent in the agreement revenue amounts on which the MCO Pay For Payment amount is calculated.
    b. If the PH-MCO's GRT obligation on an MCO Pay For Performance payment is at a tax rate of 5.9%, and if the tax rate that is inherent in the agreement revenue amounts on which the MCO Pay For Payment amount is calculated exceeds 5.9%, the amount of Department's MCO Pay For Performance obligation will be reduced by the difference.

APPENDIX 3m-1

MCO Assessment

The PH-MCO will provide MCO Assessment reports and make payments as directed by the Department in accordance with Act 92 of 2015 (62 P.S. § 801-I, et. seq).

The Department will make an Annual MCO Assessment Payment to the PH-MCO no later than May 15 each year. The Department will not make the payment if the PH-MCO has no obligation to make an MCO Assessment payment on its HealthChoices membership for the April – June calendar quarter of the same year. The Department will calculate the payment amount as follows:

	The MCO Assessment fee amount per person provided by statute or as adjusted by the Secretary in accordance with 62 P.S. § 803-I, if applicable, as of February of the same year
MULTIPLIED BY	The number of Heritage County Members enrolled in the PH-MCO on any one or more days in February of the current year per the Department's records in March
MULTIPLIED BY	Three
EQUALS	Product A
	The MCO Assessment fee amount per person provided by statute or as adjusted by the Secretary in accordance with 62 P.S. § 803-I, if applicable, as of February of the same year
MULTIPLIED BY	The number of Expansion County Members enrolled in the PH-MCO on any one or more days in February of the current year per the Department's records in March
MULTIPLIED BY	Two
EQUALS	Product B
	Product A
PLUS	Product B
EQUALS	The Department's Annual MCO Assessment Payment obligation amount to the PH-MCO

The Department will reduce payment(s) made to the PH-MCO in July of the same year by the amount of the Department's payment obligation amount to the PH-MCO per this Appendix for this year.

Heritage Counties are: Adams, Allegheny, Armstrong, Beaver, Berks, Bucks, Butler, Chester, Cumberland, Dauphin, Delaware, Fayette, Greene, Indiana, Lancaster,

Lawrence, Lebanon, Lehigh, Montgomery, Northampton, Perry, Philadelphia, Washington, Westmoreland, and York

Expansion Counties are all counties that are not a Heritage County.

APPENDIX 5

SPECIALTY DRUG RISK SHARING AND QUALITY RISK POOLS

This Appendix establishes a risk sharing arrangement between the Department and the PH-MCO for certain high cost drugs that are prescribed for Members with Hepatitis C or cystic fibrosis. This Appendix also establishes a quality risk pool arrangement between the Department and the PH-MCO for certain Hepatitis C drugs that is intended to incent positive outcomes.

The risk sharing arrangement is effective January 1, 2016. The risk sharing arrangement does not cover any costs incurred prior to January 1, 2016. The quality risk pool arrangement is also effective January 1, 2016, but some expenses incurred prior to this date can be counted as provided below.

Specialty drug risk sharing arrangement

Covered Drugs and Associated Re-Price Amounts

The Department will determine a list of covered drugs specific to Hepatitis C or cystic fibrosis. The Department will make decisions about updating the list as the marketplace changes. These decisions will take into account the purposes of the risk sharing arrangement and the continued appropriateness of the premiums if changes are made.

The Department will provide the PH-MCO with a price list for covered drugs that will be used for the purpose of administration of the specialty drug risk sharing arrangement. The price list will be based on current information available related to potential discount and rebate levels associated with the Hepatitis C and cystic fibrosis drugs contained within the list of covered drugs. The price list will provide separate amounts for 340b and non-340b drug pricing. A net cost based on an established unit criteria (scripts or possibly a smaller unit level) will be provided for this list of drugs. These net costs will be utilized in the re-pricing component of the risk sharing arrangement. The Department will review and update the price list as appropriate on a quarterly basis or more frequently.

Risk sharing

The Department will reimburse the PH-MCO eighty percent (80%) of the re-priced cost of the covered drugs. There is no deductible.

The Department will re-price covered drugs per the price list that it has provided to the PH-MCO that covers the date of service. The Department will use the 340b covered entity Medicaid exclusion list located on the HRSA web site to determine which price list to use.

The Department might require the PH-MCO to submit files to support the administration of the risk sharing.

There will be quarterly settlements. Each settlement will include covered drugs paid by the PH-MCO for dates of service beginning with the risk sharing start date and limited to not more than 15 months prior to the end of the settlement quarter. Each settlement will exclude any claim that was included in a prior quarter's settlement. The risk sharing premiums for the MCO for this quarter will be charged as part of the financial settlement. The Department will provide the PH-MCO with the settlement amount and documentation not later than the last work day of the fourth month after the risk sharing quarter.

Risk sharing premiums

Specialty drug risk sharing premiums are specified in Appendix 3f.

Premiums will be charged as part of settlements. They will not be withheld from capitation payments.

Quality risk pools (Hepatitis C)

The Department will administer two semi-annual quality risk pools in each zone. The quality risk pools will be specific to Hepatitis C and will be funded by the quality risk pool premiums specified in Appendix 3f. There will be separate risk pools for the traditional HealthChoices population and Medicaid expansion members.

The Department will use the covered drug lists that are specified for the purposes of the risk sharing arrangement for the purposes of the quality risk pool arrangement, along with the price lists specified by the Department.

The PH-MCO will notify the Department of SVR-12s it has obtained that document undetectable Hepatitis C RNA twelve weeks following completion of therapy.

The Department will allocate each SVR-12 to one risk pool. The quarterly risk pool will be determined by the last date of service for a covered drug. The Department will not utilize an SVR-12 if it utilized an SVR-12 for the same Member that is dated less than 24 months prior, or if the MCO has not followed procedures specified by the Department.

The Department will determine credits to proportionally allocate each risk pool. Credits are earned as follows:

- If one PH-MCO has provided notice of the SVR-12 and has paid for all covered drugs for the Member, the PH-MCO receives one credit.
- If more than one PH-MCO has covered the responsibilities of notice of the SVR-12 and payment for covered drugs, the credit will be allocated as follows:
    - 20% of one credit for notification of the SVR-12; and
    - 80% of one SVR-12 credit to an MCO who incurred all of the Hepatitis C costs for the Member.
    - If more than one MCO reported Hepatitis C drug costs for the Member, the 80% credit for drug costs will be allocated to each MCO on the basis of the repriced covered Hepatitis C drug costs borne by each MCO for this Member with dates of

service prior to the SVR-12 date. Claims with dates of service more than 24 months prior to the SVR-12 date are excluded.

- Example:
  - MCO A submitted the SVR-12.
  - MCO A paid 50% of the drugs after repricing.
  - MCO B paid 50% of the drugs after repricing.
  - Result: MCO A gets 60% credit for this SVR-12. MCO B gets 40% of the credit for this SVR-12.

- Example of risk pool distribution: Of the 100 credits included in this risk pool, MCO A has 36 (taking into account partial credits as covered above). Their slice of the risk pool is 36%.

The quality risk pool premiums for the PH-MCO for this semi-annual period will be charged as part of the financial settlement. They will not be withheld from capitation payments. This subtraction takes place after risk pool percentages have been determined.

The Department will notify the PH-MCO of risk pool settlements by the last work day of the seventh month after the end of the semi-annual period. The financial settlement will follow.

If a PH-MCO provides the Department with untimely notice of an SVR-12, OMAP will allow inclusion in the next following semi-annual risk pool if notification is provided timely for this purpose.

A PH-MCO may only provide notice of an SVR-12 if it paid for a covered drug or if the Member is enrolled in the PH-MCO at the time it provides notice of the SVR-12.

The Department will count as drugs paid by the PH-MCO any covered drugs that the PH-MCO paid under this HealthChoices Agreement or a different HealthChoices Agreement with the Department.

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously had an Agreement with the Department to operate a HealthChoices program (“Previous PH-MCO”); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will include claims paid by the Previous PH-MCO.

Gross Receipts Tax

If the Department has an obligation due to the PH-MCO per this Appendix, the amount due will be multiplied by 1.0627 to account for the legitimate and marginal administrative cost of the Gross Receipts Tax (GRT).

If the PH-MCO has an obligation due to the Department per this Appendix, the amount due will be multiplied by 1.0627 to recover the legitimate and marginal administrative cost of the GRT that was included in the capitation payment.

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 or assessment on PH-MCO revenue or if a new tax or assessment is implemented in addition to the GRT, then the Department will adjust the calculation above to reflect the effect on the tax or assessment obligation on revenue provided or adjusted per this Appendix.

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 or other assessment on PH-MCO revenue, is specified in the chart below. The APR Adjustment component is subject to the same risk adjustment as the rates included in Appendix 3f.

January 1, 2016 through December 31, 2016	Rate Region 1: Philadelphia and Delaware Counties	Rate Region 2: Bucks, Chester and Montgomery Counties
TANF-MAGI < 2 Months	$1,252.82	$949.06
TANF-MAGI 2-11.999 Months	$73.90	$32.69
TANF-MAGI Ages 1-20	$12.85	$7.98
TANF-MAGI Ages 21+	$27.34	$27.71
SSI-HH-Other Disabled	$128.97	$81.87
Breast and Cervical Cancer	$168.95	$168.95
Newly Eligible Women Ages 19 and 20	$21.67	$21.67
Newly Eligible Women Ages 21 to 34	$28.44	$28.44
Newly Eligible Women Ages 35 to 44	$51.94	$51.94
Newly Eligible Women Ages 45 to 54	$79.80	$79.80
Newly Eligible Women Ages 55 to 64	$108.12	$108.12
Newly Eligible Men Ages 19 and 20	$18.42	$18.42
Newly Eligible Men Ages 21 to 34	$34.79	$34.79
Newly Eligible Men Ages 35 to 44	$57.95	$57.95
Newly Eligible Men Ages 45 to 54	$80.46	$80.46
Newly Eligible Men Ages 55 to 64	$103.20	$103.20

A. If the PH-MCO is operating a HealthChoices program per this Agreement with the Department on May 1 of the current year, and if the hospital assessment has

not been terminated before that date, the Department will complete a payment to the PH-MCO on or before May 15. The amount of the payment will be calculated as follows:

Step #1. The Department will determine the number of Recipient Months, for each Recipient Group and Rate Region combination, for which it paid a capitation payment to the PH-MCO for the February program month. The result will be referred to as Schedule A.

Step #2. The Department will multiply each APR Adjustment component above by the appropriate RAR MCO Plan Factor that the Department has promulgated to the PH-MCO for the February program month. The result will be referred to as Schedule B. If no RAR MCO Plan Factor is applicable, the APR Adjustment component above will be used to populate Schedule B.

Step #3. The Department will multiply each amount in Schedule A by the corresponding amount in Schedule B and sum the results. This sum will be referred to as Amount C.

Step #4. The Department will multiply Amount C by two (2).

B. If the Department completes the payment provided by II.A. above, the Department will reduce a payment made in July of the same year by the amount of the payment.

C. If either the Department or the PH-MCO notifies the other party that it is terminating this Agreement, the PH-MCO will pay to the Department the amount not yet recovered, as provided by II.B. above, within fifteen calendar days of the date of notification.

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.

C. The PH-MCO must make timely payment of all funds received for the APR Adjustment component to the satisfaction of the Department.

APPENDIX 16

ENHANCED ACCESS PAYMENTS
SPECIALTY PHYSICIAN SERVICES
STATE RELATED ACADEMIC MEDICAL CENTER

This appendix is effective for program months beginning on and after April 1, 2016.

I. DEFINITIONS

For the purposes of this Appendix 16, the term physician practice plan means:

A physician practice plan affiliated with a state-related academic medical center.

II. FUNDING BY THE DEPARTMENT TO THE PH-MCO

The rates in Appendix 3f include an Access to Care Adjustment component. The Access to Care Adjustment component, net of GRT, is specified in the chart below. The Access to Care Adjustment component is subject to the same risk adjustment as the rates included in Appendix 3f.

January 1, 2016 through December 31, 2016	Rate Region 1: Philadelphia and Delaware Counties	Rate Region 2: Bucks, Chester and Montgomery Counties
TANF-MAGI < 2 Months	$21.46	$14.66
TANF-MAGI 2-11.999 Months	$3.16	$3.09
TANF-MAGI Ages 1-20	$0.71	$0.82
TANF-MAGI Ages 21+	$1.50	$1.53
SSI-HH-Other Disabled	$2.66	$2.01
Breast and Cervical Cancer	$5.44	$5.44
Newly Eligible Women Ages 19 and 20	$1.06	$1.06
Newly Eligible Women Ages 21 to 34	$1.57	$1.57
Newly Eligible Women Ages 35 to 44	$1.81	$1.81
Newly Eligible Women Ages 45 to 54	$2.33	$2.33
Newly Eligible Women Ages 55 to 64	$2.66	$2.66
Newly Eligible Men Ages 19 and 20	$0.43	$0.43
Newly Eligible Men Ages 21 to 34	$0.80	$0.80
Newly Eligible Men Ages 35 to 44	$1.50	$1.50
Newly Eligible Men Ages 45 to 54	$2.20	$2.20
Newly Eligible Men Ages 55 to 64	$2.78	$2.78

III. INCREASED PAYMENTS BY THE PH-MCO TO PHYSICIAN PRACTICE PLANS AFFILIATED WITH STATE-RELATED ACADEMIC MEDICAL CENTERS

A. The PH-MCO must use the funds received from the Access to Care Adjustment component to increase the payments made by the PH-MCO to physician practice plans associated with a state-related academic medical center to ensure access to specialty physician services for enrollees in the HealthChoices Program.

B. The PH-MCO must provide documentation to the Department in a form designated by the Department that all funds received from the Access to Care Adjustment component are used in accordance with this Appendix.

C. The PH-MCO must make timely payment of all funds received for the Access to Care Adjustment component to the satisfaction of the Department.

APPENDIX 16A

ENHANCED ACCESS PAYMENTS
SPECIALTY PHYSICIAN SERVICES

This appendix is effective for program months beginning on and after April 1, 2016.

I. DEFINITIONS

For the purposes of this Appendix 16A, the term physician practice plan means:

A physician practice plan affiliated with a medical school that is located in Philadelphia and has been accredited by the Liaison Committee on Medical Education.

II. FUNDING BY THE DEPARTMENT TO THE PH-MCO

The rates in Appendix 3f include an Access to Care Adjustment II component. The Access to Care Adjustment II component, net of GRT, is specified in the chart below. The Access to Care Adjustment II component is subject to the same risk adjustment as the rates included in Appendix 3f.

January 1, 2016 through December 31, 2016	Rate Region 1: Philadelphia and Delaware Counties	Rate Region 2: Bucks, Chester and Montgomery Counties
TANF-MAGI < 2 Months	$55.23	$37.73
TANF-MAGI 2-11.999 Months	$8.14	$7.95
TANF-MAGI Ages 1-20	$1.83	$2.11
TANF-MAGI Ages 21+	$3.85	$3.93
SSI-HH-Other Disabled	$6.86	$5.16
Breast and Cervical Cancer	$14.00	$14.00
Newly Eligible Women Ages 19 and 20	$2.73	$2.73
Newly Eligible Women Ages 21 to 34	$4.05	$4.05
Newly Eligible Women Ages 35 to 44	$4.65	$4.65
Newly Eligible Women Ages 45 to 54	$6.00	$6.00
Newly Eligible Women Ages 55 to 64	$6.86	$6.86
Newly Eligible Men Ages 19 and 20	$1.11	$1.11
Newly Eligible Men Ages 21 to 34	$2.07	$2.07
Newly Eligible Men Ages 35 to 44	$3.86	$3.86
Newly Eligible Men Ages 45 to 54	$5.65	$5.65
Newly Eligible Men Ages 55 to 64	$7.15	$7.15

III. INCREASED PAYMENTS BY THE PH-MCO TO PHYSICIAN PRACTICE PLANS

A. The PH-MCO must use the funds received from the Access to Care Adjustment II component to increase the payments made by the PH-MCO to physician practice plans affiliated with a medical school that is located in Philadelphia and has been accredited by the Liaison Committee on Medical Education to ensure access to specialty physician services for enrollees in the HealthChoices Program.

B. The PH-MCO must provide documentation to the Department in a form designated by the Department that all funds received from the Access to Care Adjustment II component are used in accordance with this Appendix.

C. The PH-MCO must make timely payment of all funds received for the Access to Care Adjustment II component to the satisfaction of the Department.

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

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
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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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."	Coverage Variations, Expanded coverage EPSDT
1101.32(a)(2)	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)
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")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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)
1121.55	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.
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...")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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:	
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.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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.")
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.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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.)
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.)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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.
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.)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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.")
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)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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.
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:	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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.
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.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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.
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.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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
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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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
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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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
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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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

Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 1157-95-01 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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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
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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 1165-93-07</u> 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	
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	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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.
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	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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	
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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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 B (1)
HEALTHCHOICES MCO PAY FOR PERFORMANCE PROGRAM

This Exhibit B (1) defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® 2016, as defined below.

This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2016. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2016, the Department has no payment obligation under this Exhibit.

This Exhibit supplements but does not supplant Exhibits that provide for Pay for Performance (P4P) and incorporate different dates in Section B. below.

A. Quality Performance Measures

The Department selected eight (8) HEDIS® 2016 and one (1) 2016 Pennsylvania Performance Measure (PAPM) as quality indicators (representing CY 2015 data) for the MCO P4P program. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices Program as well as the potential to improve health care for a broad base of the HealthChoices population. The nine (9) quality indicators are:

HEDIS®

1. Adolescent Well-Care Visits
2. Annual Dental Visit (Ages 2 – 20 years)
3. Comprehensive Diabetes Care: HbA1c Poor Control
4. Controlling High Blood Pressure
5. Frequency of Ongoing Prenatal Care: ≥81 Percent of Expected Number of Prenatal Care Visits
6. Prenatal Care in the First Trimester
7. Postpartum Care
8. Well-Child Visits in the First 15 Months of Life, 6 or more

PAPM

1. Reducing Potentially Preventable Readmissions

The MCO P4P Program measures Benchmark Performance and Improvement Performance. The PAPM measure, Reducing Potentially Preventable Readmissions, will be eligible for the Improvement Performance component. In addition, the Department has set a performance goal for Reducing Potentially Preventable Readmissions. While this is not a national benchmark, the measure value will be calculated the same as HEDIS measures in the benchmark performance, Section A.1, below.

1. **Benchmark Performance***:* The Department will award a Benchmark Performance payout amount for each measure in Section A that will range from 0% up to and including 125% of the measure's value, defined as two-thirds of the PH-MCO's Maximum Program Payout amount (equivalent to 1.0% of the sum of the amounts

defined in Section B. below) divided by ten (10) (Nine (9) quality indicators with Annual Dental Visit counted twice). The Department will make Benchmark Performance payouts for performance relative to the HEDIS® 2016 (CY 2015) benchmarks, for all measures excluding Reducing Potentially Preventable Readmissions. A goal of 8.50 percent (8.50%) has been set for this measure (see Section A.1.c.). If the PH-MCO's HEDIS 2016 (CY 2015) performance rate is below the 50th Percentile Benchmark, the Department will implement a -25% off-set. The Department will distribute the payouts according to the following criteria:

a. All HEDIS® Measures

- HEDIS® 2016 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
- HEDIS® 2016 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
- HEDIS® 2016 rate at or above the 50th percentile and below the 75th percentile benchmark: 25 percent of the measure value.
- HEDIS® 2016 rate below the 50th percentile benchmark: -25 percent offset

b. Annual Dental Visit Performance Only

- The Benchmark Performance measure value applicable to Annual Dental Visit Performance is equal to fifty (50) percent of the sum of double the Benchmark Performance measure value (as identified in Section A.1) and double the Improvement Performance measure value (identified in Section A.2).
- The -25% off-set will be applied to double the Benchmark Performance measure value (as identified in Section A.1).

c. Reducing Potentially Preventable Readmissions

- Performance goal at or below 8.5 percent (8.50%): 100 percent of the measure value.
- Performance goal above 8.5 percent (8.50%): No payout.

2. **Improvement Performance***:* The Department will award an Improvement Performance payout amount for each measure in Section A that will range from 0% up to and including 100% of the measure's value, defined as one-third of the PH-MCO's Maximum Program Payout amount (equivalent to 0.5% of the sum of the amounts defined in Section B. below) divided by ten (10) (Nine (9) unique quality indicators with Annual Dental Visit counted twice).

   The improvement performance payout scales will be applied contingent on benchmark percentile performance for each HEDIS 2016 measure (see Section A.2.a and A.2.b).

   - If improvement is achieved and the benchmark performance for that measure is less than the 75th percentile, Scale 1 will be applied.

- If improvement is achieved and the benchmark performance equal to or greater than the 75th percentile (see Section A.2.b), Scale 2 will be applied.
- Scale 2 applies to improvement performance for the PAPM, Reducing Potentially Preventable Readmission measure, and is not contingent on meeting the 8.50 percent (8.50%) goal.

a. Scale 1:

- The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® 2015 (CY 2014) to HEDIS® 2016 (CY 2015).

  - ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
  - ≥ 4 and < 5 Percentage Point Improvement: 80 percent the measure value.
  - ≥ 3 and < 4 Percentage Point Improvement: 60 percent the measure value.
  - ≥ 2 and < 3 Percentage Point Improvement: 40 percent the measure value.
  - ≥ 1 and < 2 Percentage Point Improvement: 20 percent the measure value.
  - < 1 Percentage Point Improvement: No payout.

b. Scale 2:

- The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® 2015 (CY 2014) to HEDIS® 2016 (CY 2015) and PAPM 2015 (CY 2014) to PAPM 2016 (CY 2015).

  - ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
  - ≥ 4 and < 5 Percentage Point Improvement: 100 percent the measure value.
  - ≥ 3 and < 4 Percentage Point Improvement: 100 percent the measure value.
  - ≥ 2 and < 3 Percentage Point Improvement: 85 percent the measure value.
  - ≥ 1 and < 2 Percentage Point Improvement: 75 percent the measure value.
  - ≥ 0.5 and < 1 Percentage Point Improvement: 50 percent the measure value.
  - < 0.5 Percentage Point Improvement: No payout.

c. Annual Dental Visit Performance Only

- The Improvement Performance measure value available for Annual Dental Visit Performance is equal to fifty percent of the sum of double the Benchmark Performance measure value (as identified in Section A.1) and double the Improvement Performance measure value (identified in Section A.2).

3. **Limitation on Payout Amounts**: The total awarded payout amount to a PH-MCO, which includes Benchmark Performance (A.1) and Improvement Performance (A.2), cannot exceed the Maximum Program Payout amount, as identified in Section B below.

B. Payment for MCO Pay for Performance

The Department will inform the PH-MCO of the Maximum Program Payout amount by November 30, 2016. For the purposes of Section B of this Exhibit B (1), the term Agreement refers to this Agreement and also any other Agreement between the PH-MCO or a predecessor PH-MCO and the Department to operate a HealthChoices program in this zone for a similar population with one or more program months between July 2015 and June 2016. If there is more than one Agreement between the PH-MCO or a predecessor PH-MCO and the Department to operate a HealthChoices program in this zone for a similar population with one or more program months between July 2015 and June 2016, the Department will make a payment only per the terms of the more recent Agreement.

The Maximum Program Payout amount will be equivalent to one and one-half (1.5) percent of the sum of the amounts defined below:

1. *Capitation Revenue*. For the purpose of this Exhibit, Capitation Revenue is defined as all Capitation revenues paid or payable by the Department to the PH-MCO in accordance with this Agreement, inclusive of Appendix 3b and Appendix 3f, for the program period July 2015 through June 2016.

2. *Maternity Care Revenue.* For the purpose of this Exhibit, Maternity Care Revenue is defined as all Maternity Care payments, paid or payable by the Department to the PH-MCO in accordance with this Agreement, for the program period July 2015 through June 2016.

3. *Home Nursing Risk Sharing Revenue*. For the purpose of this Exhibit, Home Nursing Risk Sharing Revenue is defined as the follows:

   The Department's gross Home Nursing Risk Sharing obligation for the program period January 2015 through December 2015, before the PH-MCO's Home Nursing Risk Sharing Withhold Amount obligation for the same period is taken into account. This includes only Home Nursing Risk Sharing submissions from the PH-MCO that have been processed by the Department as of October 31, 2016.

MINUS The PH-MCO's Home Nursing Risk Sharing Withhold Amount obligation for the program period January 2015 through December 2015, regardless of whether this obligation has been satisfied to date.

EQUALS Home Nursing Risk Sharing Revenue, for the purpose of this Exhibit B (1). This amount may be a positive or negative number.

4. *High Cost Risk Pool Revenue.* For the purpose of this Exhibit, High Cost Risk Pool Revenue is defined as the sum of the following:

   a. The revenue paid or payable by the Department to the PH-MCO in accordance with this Agreement inclusive of Appendix 3k, for the High Cost Risk Pool for the quarter of July-September 2015; or, if applicable, the amount of a reduction applied to a future payment if the Department determined the amount payable from the High Cost Risk Pool was less than the Withhold Amounts applicable to the same quarter for the PH-MCO. If the latter applies, the High Cost Risk Pool Revenue amount for this quarter, for the purpose of this Exhibit, is a negative number.

   PLUS

   b. The revenue paid or payable by the Department to the PH-MCO in accordance with this Agreement inclusive of Appendix 3k, for the High Cost Risk Pool for the quarter of October-December 2015; or, if applicable, the amount of a reduction applied to a future payment if the Department determined the amount payable from the High Cost Risk Pool was less than the Withhold Amounts applicable to the same quarter for the PH-MCO. If the latter applies, the High Cost Risk Pool Revenue amount for this quarter, for the purpose of this Exhibit, is a negative number.

   PLUS

   c. The revenue paid or payable by the Department to the PH-MCO in accordance with this Agreement inclusive of Appendix 3k, for the High Cost Risk Pool for the quarter of January-March 2016; or, if applicable, the amount of a reduction applied to a future payment if the Department determined the amount payable from the High Cost Risk Pool was less than the Withhold Amounts applicable to the same quarter for the PH-MCO. If the latter applies, the High Cost Risk Pool Revenue amount for this quarter, for the purpose of this Exhibit, is a negative number.

   PLUS

   d. The revenue paid or payable by the Department to the PH-MCO in accordance with this Agreement inclusive of Appendix 3k, for the High Cost Risk Pool for the quarter of April-June 2016; or, if applicable, the amount of a reduction applied to a future payment if the Department determined the amount payable from the High Cost Risk Pool was less than the Withhold Amounts applicable to the same quarter for the PH-MCO. If the latter applies, the High Cost Risk Pool Revenue amount for this quarter, for the purpose of this Exhibit, is a negative number. If

this payment is not determined by October 15, 2015, then the Department will use the best estimate in place of the actual payment/reduction.

The Department will make a payment, as provided by this Exhibit B (1), only to the extent that adequate funds are included for the purpose of Exhibit B (1) payments to all PH-MCOs in the Commonwealth enacted budget for fiscal year 2017-18 within the capitation appropriation. If the Department has an obligation to the PH-MCO, the Department will issue the payment by August 31, 2017.

Exhibit B (2)

PH-MCO and BH-MCO Integrated Care Plan (ICP) Program
Pay for Performance Program

This Exhibit B (2) defines a potential payment obligation by the Department to the PH-MCOs for Quality Performance Measures achieved per HEDIS 2017 and select Pennsylvania Performance Measures (PAPMs), as defined below.

This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2016. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2016, the Department has no payment obligation under this Exhibit.

The Department will provide financial incentives to the PH-MCOs and the Behavioral Health Managed Care Organizations (BH-MCOs) for the Integrated Care Plan (ICP) Program. The Department will provide a funding pool from which dollars will be paid to the PH-MCO based on shared PH/BH-MCO performance measures outlined in this Exhibit. The Department expects this ICP Program to improve the quality of health care and reduce Medical Assistance (MA) expenditures through enhanced coordination of care between the PH-MCOs, BH-MCOs and providers.

In order to be eligible for payments under the ICP, the PH-MCO must submit Operations Report 17 for Calendar Year (CY) 2016 following the time frames outlined within the Report Description and that contains the following specific data requirements for individuals with serious persistent mental illness (SPMI).

1. **Member stratification**- Initial baseline stratification shall be conducted on all members in the targeted SPMI population at the start of the program on January 1, 2016. New members shall have an initial stratification level established within sixty (60) days of the date of enrollment and identification that a member has SPMI. The PH-MCO will report on the member ID, initial stratification level, and six (6) month re-stratification level. Members will be stratified as follows:

    a. Four (4) = high PH/high BH needs
    b. Three (3) = high PH/low BH needs
    c. Two (2) = low PH/high BH needs
    d. One (1) = low PH/low BH needs

2. **Integrated Care Plan/Member Profile**- At least **500 members** must receive an ICP that has been used in care management activity by both the PH and BH MCO. For purposes of this requirement, the Department considers an ICP or member profile, to be the collection, integration and documentation of key

physical and behavioral health information that is easily accessible in a timely manner to persons with designated access.

3. **Hospitalization Notification and Coordination-** Each PH-MCO and BH-MCO will jointly share responsibility for notification of a hospital admission and will coordinate discharge and follow-up. This includes but is not limited to, sharing discharge instructions, medications, and recommended follow-up appointments to respective PH-MCO, BH-MCO as appropriate per HIPAA and regulatory standards. Notification to the partner MCO of hospital admissions shall occur within one (1) business day of when the responsible MCO partner learns of the admission (e.g., if the PH-MCO knows of an admission, it will notify the BH-MCO within one (1) business day and vice versa). Each PH-MCO will attest on the Operations 17 report that 90% of the admission notifications occurred within one (1) business day of the PH-MCO learning of the admission. The PH-MCO must maintain documentation to support the attestation of 90% admissions notifications.

The Operations Report 17 will be audited to verify the accuracy of the stratification, integrated care plan and hospital notification information.

Performance Measures

The performance measures for the 2016 ICP Program include the following:

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment *
    a. Initiation rate*
    b. Engagement rate*

2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia *

3. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI)**

4. Emergency Department Utilization for Individuals with Serious Persistent Mental Illness (SPMI)**

5. Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI)**

NCQA HEDIS measure* * Pennsylvania Performance measure defined by EQRO*

Payment for MCO Performance

Ten million dollars ($10M) will be allocated for the ICP Program in CY 2016 for the PH-MCO. The funding will be allocated to each PH-MCO according to its overall percent of HealthChoices member months for CY 2016.

Each of the measures defined below will be weighted equally and receive 20% of the allocated funding. Each component of the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment will receive 10% of the allocated funding. Payments will be based on incremental improvement calculated from the base clinical care measurement year of 2015 (HEDIS/PAPM 2016) to the initial intervention year of 2016 (HEDIS/PAPM 2017).

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - **20%***
    a. Initiation rate-10%
    b. Engagement rate- 10%

2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia-**20%** *

3. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI)-**20**%**

4. Emergency Department Utilization for Individuals with Serious Persistent Mental Illness (SPMI)- **20**%**

5. Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI)-**20**%**

NCQA HEDIS measure* * Pennsylvania Performance measure defined by EQRO*

The incremental payments will be based on the following scale for measures 1, 2 and 3.

Incremental Improvement	**% Payout**
≥ 3 Percentage Point Improvement	100.0%
≥ 2 and < 3 Percentage Point Improvement	85.0%
≥ 1 and < 2 Percentage Point Improvement	75.0%
0.5 - < 1 Percentage Point Improvement	50.0%

For measures 4 and 5, 100% payout will be made if there is a reduction of ≤3.0 events per 1000 member months and a 75% payout if there is a reduction in ≤2.0 events per 1000 member months.

The Department will make a payment, as provided by this Exhibit B (2), only to the extent that adequate funds are included for the purpose of Exhibit B (2) payments to all PH-MCOs and BH-MCOs in the Commonwealth enacted budget for fiscal year 2017-18 within the capitation appropriation. If the Department has an obligation to the PH-MCO and BH-MCO the Department will issue the payment by August 31, 2018.

Exhibit B (3)
Provider Pay for Performance Program and Community Based Care Management Program

The Provider Pay-for-Performance (P4P) program described in this Exhibit B(3) is for services rendered by providers during a Calendar Year (CY) and defined in the PH-MCO specific Quality Performance Program approved by the Department for Section I below. The Community Based Care Management (CBCM) Program requirements described in this Exhibit B(3) is for care rendered during a CY and defined in the PH-MCO specific CBCM Program approved by the Department for Section II below.

I. Provider P4P Program Requirements

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

Quality Performance Program (QPP):

A. The PH-MCO is required to develop a QPP using the following **mandatory eight (8)** HEDIS Quality Measures (per HEDIS® 2016 Technical Specifications, Vol. 2) and one (1) **electronic quality measure**:
   1. Adolescent Well-Care Visit
   2. Annual Dental Visit (Age 2 – 20 Years)
      a. Part of the incentive for the Annual Dental Visit measure must include payments to dental providers.
   3. Controlling High Blood Pressure
   4. Comprehensive Diabetes Care: HbA1c Poorly Controlled (>9%)
   5. Frequency of Ongoing Prenatal Care: ≥81 Percent of the Expected Number of Prenatal Care Visits
   6. Prenatal Care in the First Trimester
   7. Postpartum Care
   8. Well-Child Visits in the First 15 Months of Life, 6 or more
   9. Payment for electronic submission of any mandatory measure, optional measure, the Obstetrical Needs Assessment Form (ONAF), or any Clinical Quality Measure (CQM) approved by the current CMS meaningful use electronic health record program rules. Information on these CQMs may be found at the following link:

http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

B. The PH-MCO has the option of including any or all of the following **optional three (3)** HEDIS Quality Measures and **one (1)** Pennsylvania Performance Measure (PA PM):
   1. Breast Cancer Screening (Ages 50 – 74)
   2. Cervical Cancer Screening (Ages 21 – 64)
   3. Emergency Room (ER) Utilization
   4. Readmissions

C. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its QPP. PH-MCO must complete and submit proposals using template B (3)(b), the QPP Submission Template. Proposals are due no later than December 1, 2015 and must be submitted to the appropriate folder on DocuShare. The QPP proposal must include:

1. A detailed description of the program, including the mandatory HEDIS Quality Measures, electronic quality measures and any optional HEDIS/PA PM Quality Measures;
2. Targeted providers for each measure;
3. Proposed payout amount and payout schedule to provider(s) for each specific measure;
4. Description of the specific requirements the provider(s) must complete to receive the incentive;
5. How Provider(s) success or compliance will be measured;
6. Brief description of the roll-out strategy to notify and educate providers about the Provider P4P program;
7. How the PH-MCO will evaluate the effectiveness of its Provider P4P program;
8. PH-MCO single point of contact name, email and phone number responsible for submission of template B (3)(a), Provider P4P Submission Change form; and
9. Attestation from the Medical Director.

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

E. The PH-MCO must annually evaluate the effectiveness of its approved QPP. The results of this analysis must be submitted to the Department no later than August 31st of the subsequent calendar year to the appropriate folder on DocuShare. The analysis must include, at a minimum, the following:

1. A description of the provider education done on the Provider P4P program and any modifications that may have been made over the year where improvements were identified and put into place;
2. A separate list of the top 25 providers for each zone in which the PH-MCO operates with the highest dollar payout for each incentive offered;
3. A brief explanation of the effectiveness of the electronic quality measure submission to include but not be limited to:
   a. What were the measures;

b. Who were the providers;
c. Amount of payouts;
d. Accomplishments;
e. Opportunities for Improvement;

4. Identify next steps and potential revisions for the next CY Provider P4P program.

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

II. Community Based Care Management (CBCM) Program Requirements

A. CBCM activities and funding must primarily be focused on reducing preventable admissions, readmissions, non-emergent visits to the emergency department (ED), enhancing behavioral and physical health coordination of services, target providers/organizations that serve a large volume of complex MA recipients including high risk pregnant women and increasing access to pediatric dental preventive and restorative services. **Funding used for approved CBCM services only, as defined in the approval letter from the Department.**

B. A member of the CBCM team must spend the majority of time in face-to face-encounters with members either in the community setting, provider outpatient setting, hospital, or ED. They can be embedded in one outpatient service site, float between multiple outpatient sites, provide transition of care services from the hospital or ED setting, and provide home based care coordination.

C. CBCM activity can involve care coordination by licensed and non-licensed team members as defined by the latest version of the Operations 15 report. Examples of licensed providers include but are not limited to: physicians, dentists, dental hygienists, public health dental hygienists, physician's assistants, Certified Registered Nurse Practitioners (CRNPs), nurse midwives, RNs, LPNs, MSWs, dieticians, psychologists, and pharmacists. Examples of non-licensed team members include but are not limited to: medical assistants/technicians, community health workers, doulas, paramedics/EMTs, faith-based ministries, and peer specialists. This list of examples is not fully inclusive. These team members' activities need to be accounted for on the Operations 15 report.

D. Members of the CBCM team can be employed by the PH-MCO, employed by a provider organization, or hired by a third party through a contract with the PH-MCO. The PH-MCO will be responsible for reporting the targeted

providers/organizations, targeted recipients, and define the financial spending for each arrangement (see more details below). Because of limited funding, the PH-MCO should target providers/organizations that serve a large volume of complex MA recipients including high risk pregnant women. Preference should be given to large health systems, FQHCs and high volume dental providers. Preference should be given to programs that focus on co-location of care management services for consumers with persistent serious mental illness (PSMI) and substance use disorder (SUD).

E. Payment arrangements can include but not be limited to: practice PMPM payments for care management services, payment for direct or contractual employment costs for FTEs, payment of care management CPT codes including transition of care codes, payment for special needs transportation to access MA services, and payment of pharmacy medication management codes.

F. When selecting providers/organizations to fund CBCM, the PH-MCO must require that the provider/organizations make use of electronic medical records with the intent of achieving Meaningful Use under the CMS specifications for Medicare or Medicaid. Providers/organizations that receive direct or indirect funding must be willing to participate in best practice collaborative learning sessions.

G. If the PH-MCO does business in multiple HealthChoices zones, CBCM Program funds can be allocated across any zone in which they are licensed.

H. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its CBCM Program. The CBCM Program may include multiple programs for use of the CBCM funds. If multiple programs are identified, each one must follow the requirements below. Proposals are due no later than December 1, 2015 and must be submitted to the appropriate folder in Docushare using template B(3)(c), CBCM Proposal template. Each CBCM proposal must include:

   1. An initial CBCM program description that lists targeted providers/organizations, an initial six (6) and twelve (12) month budget, and an operations timeline that outlines the startup of the program from January 1, 2016 through December 31, 2016.
   2. The targeted providers/organizations, larger volume health systems, FQHC's, or co-location of services being involved with CBCM. The PH-

MCO will be responsible for reporting the targeted providers/organizations, targeted recipients, and define the financial spending for each arrangement.

3. The number of FTE's involved with or employed as a CBCM worker whether the FTE is full or part-time, licensed or unlicensed, contracted or part of the PH-MCO staff.
4. An outline of interventions that the CBCM worker will be performing for each of the targeted providers.
5. Outline payment mechanisms and time frames to providers for CBCM.
6. Program Budget, which should include the payment terms.

I. Should the PH-MCO need to request a change to a currently approved CBCM program and/or replace a CBCM program with another program, please submit your proposal changes on template B(3)(d), CBCM Proposal Change Form, that is available on Docushare.

III. Payments to the PH-MCO

A. The Department will make payments for Provider P4P and CBCM based on a per member per month (PMPM) rate, noted in Appendix 3f. This payment is separate from the monthly capitation process, as identified in Appendix 3b, and will be made via Gross Adjustment.

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

C. If the Commonwealth replaces GRT with another tax on PH-MCO revenue or if a new tax is implemented in addition to the GRT, then the Department will adjust the percentage in contained III.B, above, to accurately reflect the effect of the tax obligation on revenue provided.

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

E. Provider Pay-for-Performance

1. The Department will process a quarterly Provider P4P payment in the second subsequent month following the quarter end.
2. Payments made to the PH-MCO under the Provider P4P program are intended to fund all mandatory measures first prior to funding optional measures.
3. If the PH-MCO has unspent Provider P4P funds after all final disbursements have been made for the approved QPP above, upon advanced written notice to the PH-MCO, the Department may reduce a future Provider P4P payment by the unspent amount.
4. If at any time the Department determines Provider P4P funds were not disbursed in accordance with the approved QPP above, upon advanced written notice to the PH-MCO, the Department may elect to reduce a future Provider P4P payment by the amount identified.

F. Community Based Care Management

1. The Department will process a monthly payment for CBCM in the month subsequent to the month in which capitation was paid.
2. If the PH-MCO has unspent CBCM funds, determined as of March 31 of the subsequent calendar year, the PH-MCO will return the unspent funds to the Department upon request. Alternatively, the Department may choose to reduce a future CBCM payment in the amount of unspent funds.
3. If the PH-MCO does business in multiple HealthChoices zones, CBCM funds can be allocated across any and/or all of the zones, in which the PH-MCO operates.
4. Payments for the CBCM program cannot exceed more than 110.0 percent (110.0%) of the approved budget, as identified in Section II.H.7 above, without prior approval by the Department.

IV. Payments to Providers

A. Provider Pay-for-Performance

1. All Provider P4P funds received from the Department for this HealthChoices Agreement should be paid to network providers in accordance with the approved QPP above.
2. The PH-MCO is required to develop and maintain a separate accounting process of the receipts and disbursements of Provider P4P funds. The PH-MCO must be able to separately identify and track each payment to a provider on a per-claim basis for each specific mandatory and optional HEDIS Quality Measure identified in the QPP.

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

B. Community Based Care Management

1. The PH-MCO should make payment to providers within the approved time period in the approved CBCM program, as identified in Section II.H.7 above.

V. Reporting

A. Provider Pay-for-Performance

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

B. Community Based Care Management

1. All PH-MCO must submit an analysis of their Enhanced Medical Home/Case Management in addition to submitting a sub-analysis of the Community Based Case Management program. These analysis must be submitted as part of Operations Report #15 to the Department on the scheduled reporting due date(s).
2. An analysis of CBCM services should be a subset of the Enhanced Medical Home Program which details each provider involved as well as the Community Based Care Management interventions utilized during member interactions that impacted or reduced preventable readmissions or non-emergent visits to the ED, or enhanced coordination of BH/PH services. For dental related services, MCO will report the impact of CBCM activity to increase the CMS 416 rate of preventive dental services as well as the HEDIS pediatric dental rate.

3. The PH-MCO will report on the clinical and financial outcomes of the program. The analysis should be a subset of the Operations 15 report and must describe the program's return on investment (ROI).
4. Beginning with July 31 of the current calendar year, the PH-MCO must submit the first of three financial reports with payment activity for all approved CBCM programs for the current CBCM program year. A second report will be due 30 days after the end of the calendar year, and will be cumulative in nature. The last report will be due to the Department no later than March 31, and will contain all payments made for the approved CBCM program for the previous calendar year. In future years, the Department may choose to make the first two reports part of Operations Report #15.

VI. Clinical Review

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

EXHIBIT C

PH-MCO REQUIREMENTS FOR PROVIDER TERMINATIONS

The PH-MCO must comply with the requirements outlined in this Exhibit when they experience a termination with a provider. The requirements have been delineated to identify the requirements for terminations that are initiated by the PH-MCO and terminations that are initiated by the provider. Also provided in this Exhibit are the requirements for submission of workplans and supporting documentation that is to be submitted to the Department for hospital terminations, terminations of a specialty unit within a facility and terminations with large provider groups, which would negatively impact the ability of members to access services.

1. Termination by the PH-MCO

A. Notification to Department

The PH-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes a hospital, specialty unit within a facility, and/or a large provider group) sixty (60) days prior to the effective date of the termination.

The PH-MCO must submit a Provider termination work plan and supporting documentation within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates to this information. The requirements for the workplan and supporting documentation are found in this Exhibit, under 3. Workplans and Supporting Documentation.

B. Continuity of Care

The PH-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 Pa. Code § 9.684.

Unless the Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), the PH-MCO must allow a Member to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Member is notified by the PH-MCO of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater. A Member is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve (12) months the Member was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been Prior Authorized**.** Any adult member with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the provider, unless the

appointment is for a well adult check-up. Any child (under age 21) with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing course of treatment from the provider. Per Department of Health regulation Title 28, §9.684(d), the transitional period may be extended by the PH-MCO if the extension is determined to be clinically appropriate. The PH-MCO shall consult with the Member and the health care provider in making the determination. The PH-MCO must also allow a Member who is pregnant to continue to receive care from the Provider that is being terminated through the completion of the Member's postpartum care.

The PH-MCO must review each request to continue an ongoing course of treatment and notify the Member of the decision as expeditiously as the Member's health condition requires, but no later than 2 business days. If the PH-MCO determines what the Member is requesting is not an ongoing course of treatment, the PH-MCO must issue the Member a denial notice using the template notice titled C(4) Continuity of Care Denial Notice found on the HealthChoices and ACCESS Plus Intranet site.

The PH-MCO must also inform the Provider that to be eligible for payment for services provided to a Member after the Provider is terminated from the Network, the Provider must agree to meet the same terms and conditions as participating Providers.

C. Notification to Members

If the Provider that is being terminated from the Network is a PCP, the PH-MCO, using the template notice titled C(1) Provider Termination Template For PCPs found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members who receive primary care services from the Provider thirty (30) days prior to the effective date of the Provider's termination. Members who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Member is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is not a PCP or a hospital, the PH-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members who have received services from the Provider during the previous twelve (12) months, as identified through referral and claims data; all Members who are scheduled to receive services from the Provider; and all Members who have a pending or approved prior authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination. Members who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Member is

notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is a hospital (including a specialty unit within a facility or hospital), the PH-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members assigned to a PCP with admitting privileges at the hospital, all Members assigned to a PCP that is owned by the hospital, and all Members who have utilized the hospital's services within the past twelve (12) months thirty (30) days prior to the effective date of the hospital's termination. The MCO must utilize claims data to identify these Members.

If the PH-MCO is terminating a specialty unit within a facility or hospital**,** the Department may require the PH-MCO to provide thirty (30) day advance written notice to a specific Member population or to all of its Members, based on the impact of the termination.

The Department, at its sole discretion, may allow exceptions to the thirty (30) day advance written notice depending upon verified status of contract negotiations between the PH-MCO and Provider.

The Department, in coordination with DOH, may require the PH-MCO to include additional information in the notice of a termination to Members.

The thirty (30) day advance written notice requirement does not apply to terminations by the PH-MCO for cause in accordance with 40 P.S. Section 991.2117(b). The PH-MCO must notify Members within five (5) Business Days using the template notice titled C(1) Provider Termination Template For PCPs, found on the HealthChoices and ACCESS Plus Intranet site.

The PH-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

2. Termination by the Provider

A. Notification to Department

If the PH-MCO is informed by a Provider that the Provider intends to no longer participate in the PH-MCO's Network, the PH-MCO must notify the Department in writing sixty (60) days prior to the date the Provider will no longer participate in the PH-MCO's Network. If the PH-MCO receives less than sixty (60) days notice that a Provider will no longer participate in the PH-MCO's Network, the PH-MCO must notify the Department by the next Business Day after receiving notice from the Provider.

The PH-MCO must submit a Provider termination work plan within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly status updates to the workplan. The requirements for the workplan are found in this Exhibit, under 3. Workplans and Supporting Documentation.

The PH-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 Pa. Code § 9.684.

B. Notification to Members

If the Provider that is terminating its participation in the Network is a PCP, the PH-MCO, using the template notice titled C(1) Provider Termination Template For PCPs, found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members who receive primary care services from the Provider.

If the Provider that is terminating its participation in the Network is not a PCP or a hospital, the PH-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members, who have received services from the Provider during the previous twelve (12) months; all Members who were scheduled to receive services from the terminating Provider; and all Members who have a pending or approved Prior Authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination. The PH-MCO must use referral and claims data to identify these Members.

If the Provider that is terminating its participation in the Network is a hospital or specialty unit within a facility, the PH-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination, found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members assigned to a PCP with admitting privileges at the hospital, all Members assigned to a PCP that is owned by the hospital, and all members who have utilized the terminating hospital's services within the past twelve (12) months thirty (30) days prior to the effective date of the Hospital's termination. The MCO must use referral and claims data to identify these Members.

If the Provider that is terminating its participation in the Network is a specialty unit within a facility or hospital**,** the Department may require the PH-MCO to provide thirty (30) days advance written notice to a specific Member population or to <u>all</u> of its Members ,based on the impact of the termination.

The Department, in coordination with DOH, may require additional information be included in the notice of a termination to Members.

The PH-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

3. Workplans and Supporting Documentation

A. Workplan Submission

The PH-MCO must submit a Provider termination work plan within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates to the workplan. The workplan must provide detailed information on the tasks that will take place to ensure the termination is tracked from the time it is first identified until the termination effective date. The workplan should be organized by Task, Responsible Person(s), Target Dates, Completed Date and Status. The workplan should define the steps within each of the Tasks. The Tasks may include, but not be limited to:

- Commonwealth Notifications (DHS and DOH)
- Provider Impact and Analysis
- Provider Notification of the Termination
- Member Impact and Analysis
- Member Notification of the Termination
- Member Transition
- Member Continuity of Care
- Systems Changes
- Provider Directory Updates for Enrollment Contractor (include date when all updates will appear on Provider files sent to enrollment broker)
- PH-MCO Online Directory Updates
- Member Service and Provider Service Script Updates
- Submission of Required Documents to the Department (member notices and scripts for prior approval)
- Submission of Final Member Notices to the Department (also include date that DOH received the final notices)
- Communication with the Public Related to the Termination
- Termination Retraction Plan, if necessary

B. Supporting Documentation

The Department is also requesting the PH-MCO submit the following supporting documentation, in addition to the workplan, within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates as appropriate. The Department is not prescribing the format for the supporting documentation. However, it is required to be submitted through electronic means, if possible.

1) Background Information

a) Submit a summary of issues/reasons for termination.
b) Submit information on negotiations or outreach that has occurred between the PH-MCO and the Provider including dates, parties present and outcomes.

2) Member Access to Provider Services

a) Submit information that identifies Providers remaining in the Network by Provider type and location that would be available within the appropriate travel times for those members once the termination is effective. Provide the travel times for the remaining providers based upon the travel standards outlined in Exhibit AAA of the contract. For PCPs also list current panel sizes and the number of additional members that are able to be assigned to those PCPs.
b) Submit geographic access reports and maps documenting that all Members currently accessing terminating providers can access services being provided by the terminating Provider from remaining Network Providers who are accepting new Members. This documentation must be broken out by Provider type.
c) Submit a comprehensive list of all Providers, broken out by Provider type, who are affected by the termination and that also Indicates the current number of members either assigned (for PCPs) or utilizing these providers.
d) Submit information that includes the admitting privileges at other hospitals or facilities for each affected Provider and whether each affected Provider can serve the PH-MCO's Members at another hospital or facility.
e) Submit a copy of the final provider notices to the Department.

3) Member Identification and Notification Process

a) Submit information that identifies the total number of Members affected by the termination, i.e., assigned to an owned/affiliated PCP or utilizing the hospital or owned/affiliated provider within the twelve (12) months preceding the termination date, broken down by Provider.
b) Submit information on the number of members with prior authorizations in place that will extend beyond the provider termination date.
c) Submit draft and final Member notices, utilizing the templates included as C(1) – C(4), Provider and Hospital Termination Templates and Continuity of Care Denial Notice, found on the HealthChoices and ACCESS Plus Intranet site, as appropriate, for Department review and prior approval.

4) Member Services

a) Submit for Department prior approval, the call center script to be used for the termination.

b) Identify the plan for handling increased call volume in the call center while maintaining call center standards.
c) Submit to the Department a call center report for the reporting of summary call center statistics, if requested as part of the termination. This call center report should include, at a minimum, the following elements:

- Total Number of Inbound Member Services Calls (broken out by PCP, Specialist, and Hospital)
- Termination Call Reasons (broken out by Inquiries, PCP Change, Opt Out/Plan Change)

5) Affected Members in Care Management

a) Submit the total number of members in Care Management affected by the termination with sub-breakdowns by members who are pregnant (broken out by total number of pregnant members in care management, those who will deliver before the termination and those members whose due date is past the termination); members with HIV/AIDS; Children in Substitute Care; and members identified as high risk.
b) Submit the criteria to the Department that the PH-MCO will utilize for continuity of care for members affected by the termination.
c) Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform members in care management about the termination.

6) Enrollment Services

a) Submit final, approved member notices to the Department, the member notices should be on PH-MCO letterhead.

7) News Releases

Any news releases related to the termination must be submitted to the Department for prior approval.

8) Website Update

Indicate when the PH-MCO's web-based Provider directories will be updated, and what if any additional information will be posted to the PH-MCO website.

EXHIBIT C(4)

CONTINUITY OF CARE DENIAL NOTICE

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed your request for continuation of **[*identify SPECIFIC service/item*]** care provided by **[*Provider's name*]** who will no longer be serving **[PH-MCO Name]** members beginning **[Effective *date*]**. After PH-MCO review, your request for continuity of care is:

Denied because**: *[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [Effective *date*].

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

2) File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

3) Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
Office of Medical Assistance Programs
HealthChoices Program/Complaint, Grievance and Fair Hearing
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written

letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

4) Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: Terminating Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

DEPARTMENT OF HUMAN SERVICES ADDENDUM TO
STANDARD CONTRACT TERMS AND CONDITIONS

A. APPLICABILITY

This Addendum is intended to supplement the Standard Terms and Conditions. To the extent any of the terms contained herein conflict with terms contained in the Standard Contract Terms and Conditions, the terms in the Standard Contract Terms and Conditions shall take precedence. Further, it is recognized that certain terms contained herein may not be applicable to all the services which may be provided through Department contracts.

B. CONFIDENTIALITY

The parties shall not use or disclose any information about a recipient of the services to be provided under this contract for any purpose not connected with the parties' contract responsibilities except with written consent of such recipient, recipient's attorney, or recipient's parent or legal guardian.

C. INFORMATION

During the period of this contract, all information obtained by the Contractor through work on the project will be made available to the Department immediately upon demand. If requested, the Contractor shall deliver to the Department background material prepared or obtained by the Contractor incident to the performance of this agreement. Background material is defined as original work, papers, notes and drafts prepared by the Contractor to support the data and conclusions in final reports, and includes completed questionnaires, materials in electronic data processing form, computer programs, other printed materials, pamphlets, maps, drawings and all data directly related to the services being rendered.

D. CERTIFICATION AND LICENSING

Contractor agrees to obtain all licenses, certifications and permits from Federal, State and Local authorities permitting it to carry on its activities under this contract.

E. PROGRAM SERVICES

Definitions of service, eligibility of recipients of service and other limitations in this contract are subject to modification by amendments to Federal, State and Local laws, regulations and program requirements without further notice to the Contractor hereunder.

F. CHILD PROTECTIVE SERVICE LAWS

In the event that the contract calls for services to minors, the contractor shall comply with the provisions of the Child Protective Services Law (Act of November 26, 1975, P.L. 438, No. 124; 23 P.S. SS 6301-6384, as amended by Act of July 1, 1985, P.L. 124, No. 33) and all regulations promulgated thereunder (55Pa. Code, chapter 3490).

G. PRO-CHILDREN ACT OF 1994

The Contractor agrees to comply with the requirements of the Pro-Children Act of 1994; Public Law 103-277, Part C-Environment Tobacco Smoke (also known as the Pro-Children Act of 1994) requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health care services, day care and education to children under the age of 18, if the services are funded by Federal programs whether directly or through State and Local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.

H. MEDICARE/MEDICAID REIMBURSEMENT

1. To the extent that services are furnished by contractors, subcontractors, or organizations related to the contractor/subcontractor and such services may in whole or in part be claimed by the

Commonwealth for Medicare/Medicaid reimbursements, contractor/subcontractor agrees to comply with 42 C.F.R.,Part 420, including:

a. Preservation of books, documents and records until the expiration of four (4) years after the services are furnished under the contract.

b. Full and free access to (i) the Commonwealth, (ii) the U.S. Comptroller General, (iii) the U.S. Department of Health and Human Services, and their authorized representatives.

2. Your signature on the proposal certifies under penalty of law that you have not been suspended/ terminated from the Medicare/Medicaid Program and will notify the contracting DHS Facility or DHS Program Office immediately should a suspension/termination occur during the contract period.

I. TRAVEL AND PER DIEM EXPENSES

Contractor shall not be allowed or paid travel or per diem expenses except as provided for in Contractor's Budget and included in the contract amount. Any reimbursement to the Contractor for travel, lodging or meals under this contract shall be at or below state rates as provided in Management Directive 230.10, Commonwealth Travel Policy, as may be amended, unless the Contractor has higher rates which have been established by its offices/officials, and published prior to entering into this contract. Higher rates must be supported by a copy of the minutes or other official documents, and submitted to the Department. Documentation in support of travel and per diem expenses will be the same as required of state employees.

J. INSURANCE

1. The contractor shall accept full responsibility for the payment of premiums for Workers' Compensation, Unemployment Compensation, Social Security, and all income tax deductions required by law for its employees who are performing services under this contract. As required by law, an independent contractor is responsible for Malpractice Insurance for health care personnel. Contractor shall provide insurance Policy Number and Provider'' Name, or a copy of the policy with all renewals for the entire contract period.

2. The contractor shall, at its expense, procure and maintain during the term of the contract, the following types of insurance, issued by companies acceptable to the Department and authorized to conduct such business under the laws of the Commonwealth of Pennsylvania:

   a. Worker's Compensation Insurance for all of the Contractor's employees and those of any subcontractor, engaged in work at the site of the project as required by law.

   b. Public liability and property damage insurance to protect the Commonwealth, the Contractor, and any and all subcontractors from claim for damages for personal injury (including bodily injury), sickness or disease, accidental death and damage to property, including loss of use resulting from any property damage, which may arise from the activities performed under this contract or the failure to perform under this contract whether such performance or nonperformance be by the contractor, by any subcontractor, or by anyone directly or indirectly employed by either. The limits of such insurance shall be in an amount not less than $500,000 each person and $2,000,000 each occurrence, personal injury and property damage combined. Such policies shall be occurrence rather than claims-made policies and shall name the Commonwealth of Pennsylvania as an additional insured. The insurance shall not contain any endorsements or any other form designated to limit or restrict any action by the Commonwealth, as an additional insured, against the insurance coverage in regard to work performed for the Commonwealth.

Prior to commencement of the work under the contract and during the term of the contract, the Contractor shall provide the Department with current certificates of insurance. These certificates shall contain a provision that the coverages afforded under the policies will not be cancelled or changed until at least thirty (30) days' written notice has been given to the Department.

K. PROPERTY AND SUPPLIES

1. Contractor agrees to obtain all supplies and equipment for use in the performance of this contract at the lowest practicable cost and to purchase by means of competitive bidding whenever required by law.

2. Title to all property furnished in-kind by the Department shall remain with the Department.

3. Contractor has title to all personal property acquired by the contractor, including purchase by lease/purchase agreement, for which the contractor is to be reimbursed under this contract. Upon cancellation or termination of this contract, disposition of such purchased personal property which has a remaining useful life shall be made in accordance with the following provisions.

    a. The contractor and the Department may agree to transfer any item of such purchased property to another contractor designated by the Department. Cost of transportation shall be born by the contractor receiving the property and will be reimbursed by the Department. Title to all transferred property shall vest in the designated contractor. The Department will reimburse the Contractor for its share, if any, of the value of the remaining life of the property in the same manner as provided under subclause b of this paragraph.

    b. If the contractor wishes to retain any items of such purchased property, depreciation tables shall be used to ascertain the value of the remaining useful life of the property. The contractor shall reimburse the Department in the amount determined from the tables.

    c. When authorized by the Department in writing, the contractor may sell the property and reimburse the Department for its share. The Department reserves the right to fix the minimum sale price it will accept.

4. All property furnished by the Department or personal property acquired by the contractor, including purchase by lease-purchase contract, for which the contractor is to be reimbursed under this contract shall be deemed "Department Property" for the purposes of subsection 5, 6 and 7 of this section.

5. Contractor shall maintain and administer in accordance with sound business practice a program for the maintenance, repair, protection, preservation and insurance of Department Property so as to assure its full availability and usefulness.

6. Department property shall, unless otherwise approved in writing by the Department, be used only for the performance of this contract.

7. In the event that the contractor is indemnified, reimbursed or otherwise compensated for any loss, destruction or damage to Department Property, it shall use the proceeds to replace, repair or renovate the property involved, or shall credit such proceeds against the cost of the work covered by the contract, or shall reimburse the Department, at the Department's direction.

L. DISASTERS

If, during the terms of this contract, the Commonwealth's premises are so damaged by flood, fire or other Acts of God as to render them unfit for use; then the Agency shall be under no liability or obligation to the contractor hereunder during the period of time there is no need for the services provided by the contractor except to render compensation which the contractor was entitled to under this agreement prior to such damage.

M. SUSPENSION OR DEBARMENT

In the event of suspension or debarment, 4 Pa Code Chapter 60.1 through 60.7, as it may be amended, shall apply.

N. COVENANT AGAINST CONTINGENT FEES

The contractor warrants that no person or selling agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee (excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business). For breach or violation of this warranty, the Department shall have the right to annul this contract without liability or, in its discretion, to deduct from

the consideration otherwise due under the contract, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

O. CONTRACTOR'S CONFLICT OF INTEREST

The contractor hereby assures that it presently has not interest and will not acquired any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The contractor further assures that in the performance of this contract, it will not knowingly employ any person having such interest. Contractor hereby certifies that no member of the Board of the contractor or any of its officers or directors has such an adverse interest.

P. INTEREST OF THE COMMONWEALTH AND OTHERS

No officer, member or employee of the Commonwealth and no member of its General Assembly, who exercises any functions or responsibilities under this contract, shall participate in any decision relating to this contract which affects his personal interest or the interest of any corporation, partnership or association in which he is, directly or indirectly, interested; nor shall any such officer, member or employee of the Commonwealth or member of its General Assembly have interest, direct or indirect, in this contract or the proceeds thereof.

Q. CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS

(Applicable to contracts $25,000 or more)

1. The contractor, within 10 days of receiving the notice to proceed, must contact the Department of Public Welfare's Contractor Partnership Program (CPP) to present, for review and approval, the contractor's plan for recruiting and hiring recipients currently receiving cash assistance. If the contract was not procured via Request for Proposal (RFP); such plan must be submitted on Form PA-778. The plan must identify a specified number (not percentage) of hires to be made under this contract. If no employment opportunities arise as a result of this contract, the contractor must identify other employment opportunities available within the organization that are not a result of this contract. The entire completed plan (Form PA-778) must be submitted to the Bureau of Employment and Training Programs (BETP)**:** Attention CPP Division. (Note: Do not keep the pink copy of Form PA-778). The approved plan will become a part of the contract.

2. The contractor's CPP approved recruiting and hiring plan shall be maintained throughout the term of the contract and through any renewal or extension of the contract. Any proposed change must be submitted to the CPP Division which will make a recommendation to the Contracting Officer regarding course of action. If a contract is assigned to another contractor, the new contractor must maintain the CPP recruiting and hiring plan of the original contract.

3. The contractor, within 10 days of receiving the notice to proceed, must register in the Commonwealth Workforce Development System (CWDS). In order to register the selected contractor must provide business, location and contact details by creating an Employer Business Folder for review and approval, within CWDS at HTTPS://WWW.CWDS.State.PA.US . Upon CPP review and approval of Form PA-778 and the Employer Business Folder in CWDS, the Contractor will receive written notice (via the pink Contractor's copy of Form PA-778) that the plan has been approved.

4. Hiring under the approved plan will be monitored and verified by Quarterly Employment Reports (Form PA-1540); submitted by the contractor to the Central Office of Employment and Training – CPP Division. A copy of the submitted Form PA-1540 must also be submitted (by the contractor) to the DHS Contract Monitor (i.e. Contract Officer). The reports must be submitted on the DHS Form PA-1540. The form may not be revised, altered, or re-created.

5. If the contractor is non-compliant, CPP Division will contact the Contract Monitor to request corrective action. The Department may cancel this contract upon thirty (30) days written notice in the event of the contractor's failure to implement or abide by the approved plan.

R. TUBERCULOSIS CONTROL

As recommended by the Centers for Disease Control and the Occupational Safety and Health Administration, effective August 9, 1996, in all State Mental Health and Mental Retardation Facilities, all

full-time and part-time employees (temporary and permanent), including contract service providers, having direct patient contact or providing service in patient care areas, are to be tested serially with PPD by Mantoux skin tests. PPD testing will be provided free of charge from the state MH/MR facility. If the contract service provider has written proof of a PPD by Mantoux method within the last six months, the MH/MR facility will accept this documentation in lieu of administration of a repeat test. In addition, documented results of a PPD by Mantoux method will be accepted by the MH/MR facility. In the event that a contractor is unwilling to submit to the test due to previous positive reading, allergy to PPD material or refusal, the risk assessment questionnaire must be completed. If a contractor refuses to be tested in accordance with this new policy, the facility will not be able to contract with this provider and will need to procure the services from another source.

S. ACT 13 APPLICATION TO CONTRACTOR

Contractor shall be required to submit with their bid information obtained within the preceding one-year period for any personnel who will have or may have direct contact with residents from the facility or unsupervised access to their personal living quarters in accordance with the following:

1. Pursuant to 18 Pa.C.S. Ch. 91(relating to criminal history record information) a report of criminal history information from the Pennsylvania State Police or a statement from the State Police that their central repository contains no such information relating to that person. The criminal history record information shall be limited to that which is disseminated pursuant to 18 Pa.C.S. 9121(b)(2) (relating to general regulations).

2. Where the applicant is not, and for the two years immediately preceding the date of application has not been a resident of this Commonwealth, the Department shall require the applicant to submit with the application a report of Federal criminal history record information pursuant to the Federal Bureau of Investigation's under Department of State, Justice, and Commerce, the Judiciary, and Related Agencies Appropriation Act, 1973 (Public Law 92-544, 86 Stat. 1109). For the purpose of this paragraph, the applicant shall submit a full set of fingerprints to the State Police, which shall forward them to the Federal Bureau of Investigation for a national criminal history check. The information obtained from the criminal record check shall be used by the Department to determine the applicant's eligibility. The Department shall insure confidentially of the information.

3. The Pennsylvania State Police may charge the applicant a fee of not more than $10 to conduct the criminal record check required under subsection 1. The State Police may charge a fee of not more than the established charge by the Federal Bureau of Investigation for the criminal history record check required under subsection 2.

The Contractor shall apply for clearance using the State Police Background Check (SP4164) at their own expense. The forms are available from any State Police Substation. When the State Police Criminal History Background Report is received, it must be forwarded to the Department. State Police Criminal History Background Reports not received within sixty (60) days may result in cancellation of the contract.

T. LOBBYING CERTIFICATION AND DISCLOUSRE

(applicable to contracts $100,000 or more)

Commonwealth agencies will not contract with outside firms or individuals to perform lobbying services, regardless of the source of funds. With respect to an award of a federal contract, grant, or cooperative agreement exceeding $100,000 or an award of a federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000 all recipients must certify that they will not use federal funds for lobbying and must disclose the use of non-federal funds for lobbying by filing required documentation. The contractor will be required to complete and return a "Lobbying Certification Form" and a "Disclosure of Lobbying Activities form" with their signed contract, which forms will be made attachments to the contract.

U. AUDIT CLAUSE

(applicable to contracts $100,000 or more)

This contract is subject to audit in accordance with the Audit Clause attached hereto and incorporated herein.

EXHIBIT E(1)

OTHER FEDERAL REQUIREMENTS

1. The contract shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contract involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

2. Contracts, subcontracts, and subgrants of amounts in excess of $100,000 shall contain a provision, which requires compliance with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 1178, and Environmental Protection Agency regulations (40 CFR part 15).

3. Contracts shall recognize mandatory standards and policies relating to energy efficiency, which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).

4. All contracts shall be in compliance with Equal Employment Opportunity (EEO) provisions.

5. All contracts in excess of $2,000 shall be in compliance with the Copeland Anti-Kickback Act and the Davis-Bacon Act.

6. All contracts in excess of $2,000 for construction and $2,500 employing mechanics or laborers, shall abide by and be in compliance with the Contract Work Hours and Safety Standards.

7. The PH-MCO must be in compliance with the Byrd Anti-Lobbying Amendment.

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 pursuant to Section 1903(m)(4)(A) of the Act available to PH-MCO enrollees upon reasonable request.

Citation	Requirement
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 (IHS); 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 and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services.
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 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 Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either at a rate negotiated 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.

Citation	Requirement
42 CFR 438.6(f)(2)(i) 42 CFR 434.6(a)(12)(i) 42 CFR 447.26(b)	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 procedure 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) 42 CFR 438.108 42 CFR 447.50-57 State Medicaid Director Letter SMDL #06-015 6/16/2006	Any cost sharing imposed by the PH-MCO on enrollees is in accordance with Medicaid fee for service requirements at 42 CFR 447.50 through 42 CFR 447.57
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).

Citation	Requirement
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 under the plan during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of Section 1862(o) of the Act and this subparagraph unless the State determines in accordance with such regulations that there is good cause not to suspend payments.
1903(i) final sentence 1903(i)(16)	The PH-MCO shall not make payment 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 shall not make payment with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

Citation	Requirement
1903(i) final sentence 1903(i)(18)	The PH-MCO shall not make payment with respect to any amount expended for home health care services provided by any agency or organization, unless the agency or organization 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 payment, 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 between the PH-MCO and the State 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.

Citation	Requirement
1124(a)(2)(A) 1903(m)(2)(A)(viii) 1903(t)(6)(A)(ii) 42 CFR 455.100-103 42 CFR 455.104(b)	In accordance with Section 1903(t)(6)(A)(ii) of the Act and the regulations implementing such section, the PH-MCO must disclose the following 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 location, 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.

EXHIBIT H

PRIOR AUTHORIZATION GUIDELINES FOR PARTICIPATING MANAGED CARE ORGANIZATIONS IN THE HEALTHCHOICES PROGRAM

A. GENERAL REQUIREMENT

The HealthChoices Physical Health Managed Care Organizations (PH-MCOs) must submit to the Department all written policies and procedures for the Prior Authorization of services. The PH-MCO may require Prior Authorization for any services that require Prior Authorization in the Medical Assistance Fee-for-Service (FFS) Program. The PH-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for determining if the service is Medically Necessary. The PH-MCO must receive advance written approval from the Department to require the Prior Authorization of any services not currently required to be Prior Authorized under the FFS Program. For each service to be Prior Authorized, the PH-MCO must submit for the Department's review and approval the written policies and procedures in accordance with the guidelines described below. The policies and procedures must:

- Be submitted in writing, for all new and revised criteria, prior to implementation;
- Be approved by the Department in writing prior to implementation;
- Adhere to specifications of the HealthChoices RFP, HealthChoices Agreement, federal regulations, and applicable policy in Medical Assistance General Regulations, Chapter 1101 and DHS regulations;
- Ensure that physical health care is Medically Necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- Adhere to the applicable requirements of Centers for Medicare and Medicaid Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- Include an expedited review process to address those situations when an item or service must be provided on an urgent basis.

Future changes in state and federal law, state and federal regulations, and court cases may require re-evaluation of any previously approved Prior Authorization proposal. Any deviation from the policies and procedures approved by the Department, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure of the PH-MCO to comply may result in sanctions and/or penalties by the Department.

The Department defines prior authorization as:
a determination made by a 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.

The DHS Prior Authorization Review Panel has the sole responsibility to review and approve all prior authorization proposals from the PH-MCOs.

B. GUIDELINES FOR REVIEW

1. Basic Requirements:

   a. The PH-MCO must identify individual service(s), medical item(s), and/or therapeutic categories of drugs to be Prior Authorized.

   b. If the Prior Authorization is limited to specific populations, the PH-MCO must identify all populations who will be affected by the proposal for Prior Authorization.

2. Medically Necessary Requirements:

   a. The PH-MCO must describe the process to validate medical necessity for:

      - covered care and services;
      - procedures and level of care;
      - medical or therapeutic items.

   b. The PH-MCO must identify the source of the criteria used to review the request for Prior Authorization of services. The criteria must be consistent with the HealthChoices contract definition for a service or benefit that is Medically Necessary. All criteria must be submitted to the Department for evaluation and approval under URCAP prior to implementation.

   c. For PH-MCOs, if the criteria being used are:

      - Purchased and licensed, the PH-MCO must identify the vendor;
      - Developed/recommended/endorsed by a national or state health care provider association or society, the PH-MCO must identify the association or society;
      - Based on national best practice guidelines, the PH-MCO must identify the source of those guidelines;
      - Based on the medical training, qualifications, and experience of the PH-MCO's Medical Director or other qualified and trained practitioners, the PH-

MCO must identify the individuals who will determine if the service or benefit is Medically Necessary.

d. PH-MCO guidelines to determine medical necessity of all drugs that require prior authorization must be posted for public view on the PH-MCO's website. This includes, but is not limited to, guidelines to determine medical necessity of both specific drugs and entire classes of drugs that require prior authorization for health and safety reasons, non-formulary designations, appropriate utilization, quantity limits, or mandatory generic substitution. The guidelines must specify all of the conditions that the PH-MCO reviewers will consider when determining medical necessity including requirements for step therapy.

e. The PH-MCO must identify the qualification of staff that will determine if the service is Medically Necessary. Health Care Providers, qualified and trained in accordance with the CMS Guidelines, the RFP, the HealthChoices Agreement, and applicable legal settlements must make the determination of Medically Necessary services.

   For children under the age of twenty-one (21), requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Member's condition or disease determines:

   - That the prescriber did not make a good faith effort to submit a complete request, or

   - That the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

3. Administrative Requirements

   a. The PH-MCO's written policies and procedures must identify the time frames for review and decisions and the PH-MCO must demonstrate that the time frames are consistent with the following required maximum time frames:

      - Immediate: Inpatient Place of Service Review for emergency and urgent admissions.

      - 24 hours: All drugs; and items or services which must be provided on an urgent basis.

      - 48 hours: (following receipt of required documentation): Home Health Services.

      - 21 days: All other services.

b. The PH-MCO's written policies and procedures must demonstrate how the PH-MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

c. The PH-MCO's written policies and procedures must explain how Prior Authorization data will be incorporated into the PH-MCO's overall Quality Management plan.

4. Notification, Grievance, and DHS Fair Hearing Requirements

The PH-MCO must demonstrate how written policies and procedures for requests for Prior Authorization comply and are integrated with the Member and Provider notification requirements and Member Grievance and DHS Fair Hearing requirements of the RFP and Agreement.

5. Requirements for Care Management/Care Coordination of Non Prior Authorized Service(s)/Items(s)

For purposes of tracking care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the PH-MCO may choose to establish a process or protocol requiring notification prior to service delivery. This process must not involve any approvals/denials or delays in receiving the service. The PH-MCO must notify Providers of this notification requirement. This process may not be administratively cumbersome to Providers and Members. These situations need not comply with the other Prior Authorization requirements contained in this Exhibit.

EXHIBIT M(1)

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS

The Department will monitor the Quality Management (QM) and Utilization Management (UM) programs of all PH-MCOs and retains the right of advance written approval of all QM and UM activities. The PH-MCO's QM and UM programs must be designed to assure and improve the accessibility, availability, and quality of care being provided to its members. The PH-MCO's QM and UM programs must, at a minimum:

A. Contain a written program description, work plan, evaluation and policies/procedures that meet requirements outlined in the agreement;

B. Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the PH-MCO in collaboration with the Department;

C. Be based on statistically valid clinical and financial analysis of Encounter Data, Member demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and other data that allows for the identification of prevalent medical conditions, barriers to care and racial/ethnic disparities to be targeted for quality improvement and disease management initiatives;

D. Allow for the continuous evaluation of its activities and adjustments to the program based on these evaluations;

E. Demonstrate sustained improvement for clinical performance over time; and

F. Allow for the timely, complete, and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including HEDIS and CAHPS as outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).

G. Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the PH-MCO or the Department that:

1) Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;

2) Allow for submission of improvement plans, as determined by and within time frames established by the Department. Failure by the PH-MCO to comply with the requirements and improvement actions requested by the Department may result in the application of penalties and/or sanctions as outlined in Section VIII.H, Sanctions, of the Agreement.

H. Obtain accreditation by a nationally recognized organization, such as National Committee of Quality Assurance (NCQA).

Standard I: The scope of the QM and UM programs must be comprehensive in nature; allow for improvement and be consistent with the Department's goals related to access, availability and quality of care. At a minimum, the PH-MCO's QM and UM programs, must:

A. Adhere to current Medicaid CMS guidelines.

B. Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and techniques of peer review.

C. Ensure that that all QM and UM activities and initiatives undertaken by the PH-MCO are–based upon clinical and financial analysis of Encounter Data, Member demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and/or other identified areas.

D. Contain policies and procedures which provide for the ongoing review of the entire scope of care provided by the PH-MCO assuring that all demographic groups, races, ethnicities, care settings and types of services are addressed.

E. Contain a written program description that addresses all standards, requirements and objectives established by the Department and that describes the goals, objectives, and structure of the PH-MCO's QM and UM programs. The written program description must, at a minimum:

1) Include standards and mechanisms for ensuring the accessibility of primary care services, specialty care services, urgent care services, and Member services in accordance with timeframes outlined in Exhibit AAA(1), Provider Network Composition/Service Access of the Agreement.

2) Include mechanisms for planned assessment and analysis of the quality of care provided and the utilization of services against formalized standards, including but not limited to:

a) Primary, secondary, and tertiary care;
b) Preventive care and wellness programs;
c) Acute and/or chronic conditions;
d) Dental care
e) Care coordination; and
f) Continuity of care.

3) Allow for the timely, accurate, complete collection and clinical and financial analysis of Encounter Data and other data including, but not limited to, HEDIS, CAHPS, and Pennsylvania Performance Measures.

4) Allow for systematic analysis and re-measurement of barriers to care, the quality of care provided to Members, and utilization of services over time.

F. Provide a comprehensive written evaluation, completed on at least an annual basis, that details all QM and UM program activities including, but not limited to:

a) Studies and activities undertaken; including the rationale, methodology and results
b) Subsequent improvement actions; and
c) Aggregate clinical and financial analysis of Encounter, HEDIS, CAHPS, Pennsylvania Performance Measures, and other data on the quality of care rendered to Members and utilization of services.

G. Include a work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, including, but not limited to:

1) Data collection and analysis;
2) Evaluation and reporting of findings;
3) Implementation of improvement actions where applicable; and
4) Individual accountability for each activity.

H. Provide for aggregate and individual analysis and feedback of Provider performance and PH-MCO performance in improving access to care, the quality of care provided to Members and utilization of services.

I. Include mechanisms and processes which ensure related and relevant operational components, activities, and initiatives from the QM and UM programs are integrated into activities and initiatives undertaken by other departments within the PH-MCO including, but not limited to, the following:

1) Special Needs;
2) Provider Relations;
3) Member Services; and
4) Management Information Systems

J. Include procedures for informing both physician and non-physician Providers about the written QM and UM programs, and for securing cooperation with the QM and UM programs in all physician and non-physician Provider agreements.

K. Include procedures for feedback and interpretation of findings from analysis of quality and utilization data to Providers, health professionals, PH-MCO staff, and MA Consumers/family members.

L. Include mechanisms and processes which allow for the development and implementation of PH-MCO wide and Provider specific improvement actions in response to identified barriers to care, quality of care concerns, and over-utilization, under-utilization and/or mis-utilization of services.

Standard II: The organizational structures of the PH-MCO must ensure that:

A. The Governing Body:

1) Has formally designated an accountable entity or entities, within the PH-MCO to provide oversight of QM and UM program activities or has formally decided to provide such oversight as a committee, e.g. Quality Management Committee.

2) Regularly receives written reports on the QM and UM program activities that describe actions taken, progress in meeting objectives and improvements made. The governing body formally reviews, on at least an annual basis, a written evaluation of the QM and UM program activities that includes studies undertaken, results of studies, and subsequent improvement actions taken. The written evaluation must include aggregate clinical and financial analysis of quality and utilization data, including HEDIS, CAHPS, and Pennsylvania Performance Measures.

3) Documents actions taken by the governing body in response to findings from QM and UM program activities.

B. The Quality Management Committee (QMC):

1) Must contain policies and procedures which describe the role, structure and function of the QMC that:

a) Demonstrate that the QMC has oversight responsibility and input, including review and approval, on all QM and UM program activities;

b) Ensure membership on the QMC and active participation by individuals representative of the composition of the PH-MCO's Providers; and

c) Provide for documentation of the QMC's activities, findings, recommendations, and actions.

2) Meets at least monthly, and otherwise as needed.

C. The Senior Medical Director must be directly accountable to and act as liaison to the Chief Medical Officer for DHS.

D. The Medical Director:

1) Serves as liaison and is accountable to the governing body and Quality Management Committee for all QM and UM activities and initiatives;

2) Is available to the PH-MCO's medical staff for consultation on referrals, denials, Complaints and problems;

3) Is directly involved in the PH-MCO's recruiting and credentialing activities;

4) Is familiar with local standards of medical practice and nationally accepted standards of practice;

5) Has knowledge of due process procedures for resolving issues between participating Providers and the PH-MCO administration, including those related to medical decision making and utilization review;

6) Is available to review, advise and take action on questionable hospital admissions, Medically Necessary days and all other medical care and medical cost issues;

7) Is directly involved in the PH-MCO's process for prior authorizing or denying services and is available to interact with Providers on denied authorizations;

8) Has knowledge of current peer review standards and techniques;

9) Has knowledge of risk management standards;

10) Is directly accountable for all Quality Management and Utilization Management activities and

11) Oversees and is accountable for:

a) Referrals to the Department and appropriate agencies for cases involving quality of care that have adverse effects or outcomes; and

b) The processes for potential Fraud and Abuse investigation, review, sanctioning and referral to the appropriate oversight agencies.

E. The PH-MCO must have sufficient material resources, and staff with the appropriate education, experience and training, to effectively implement the written QM and UM programs and related activities.

Standard III: The QM and UM programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services provided to Members through quality of care

studies and related activities with a focus on identifying and pursuing opportunities for continuous and sustained improvement.

A. The QM and UM programs must include professionally developed practice guidelines/standards of care that are:

1) Written in measurable and accepted professional formats,
2) Based on scientific evidence; and
3) Applicable to Providers for the delivery of certain types or aspects of health care.

B. The QM and UM programs must include clinical/quality Indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.

C. Practice guidelines and clinical indicators must address the full range of health care needs of the populations served by the PH-MCO. The clinical areas addressed must include, but are not limited to:

1) Adult preventive care;
2) Pediatric and adolescent preventive care with a focus on EPSDT services;
3) Obstetrical care including a requirement that Members be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;
4) Selected diagnoses and procedures relevant to the enrolled population;
5) Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the PH-MCO's membership; and
6) Preventive dental care.

D. The QM and UM programs must provide practice guidelines, clinical indicators and medical record keeping standards to all Providers and appropriate subcontractors. This information must also be provided to Members upon request.

E. The PH-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, and Providers of ancillary services not less than every two years (i.e. medical record audits). These methodologies must, at a minimum:

1) Demonstrate the degree to which PCPs, specialists, and dental Providers are complying with clinical and preventive care guidelines adopted by the plan;

2) Allow for the tracking and trending of individual and PH-MCO wide Provider performance over time;

3) Include active mechanisms and processes that allow for the identification, investigation and resolution of quality of care concerns, including events such as Health Care-Associated Infections and medical errors; and

4) Include mechanisms for detecting instances of over-utilization, under-utilization, and mis-utilization;

F. The QM and UM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:

1) Processes that allow for the identification, investigation and resolution of quality of care concerns including Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care patterns;

2) Processes for tracking and trending problematic patterns of care;

3) Use of progressive sanctions as indicated;

4) Person(s) or body responsible for making the final determinations regarding quality problems; and

5) Types of actions to be taken, such as:

a) Education;
b) Follow-up monitoring and re-evaluation;
c) Changes in processes, structures, forms;
d) Informal counseling;
e) Procedures for terminating the affiliation with the physician or other health professional or Provider;
f) Assessment of the effectiveness of the actions taken; and
g) Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care).

G. The QM and UM programs must include methodologies that allow for the identification, verification, and timely resolution of inpatient and outpatient quality of care concerns, Member quality of care complaints, over-utilization, under-utilization, and/or mis-utilization, access/availability issues, and quality of care referrals from other sources;

H. The QM and UM programs must contain procedures for Member satisfaction surveys that are conducted on at least an annual basis including the collection of annual Member satisfaction data through application of the CAHPS instrument as

outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).

I. The QM and UM programs must contain procedures for Provider satisfaction surveys to be conducted on at least an annual basis. Surveys are to include PCPs, and specialists, dental Providers, hospitals, and Providers of ancillary services.

J. Each PH-MCO will be required to comply with requirements for Performance Improvement Projects (PIPs) as outlined in Exhibit M(2) External Quality Review.

Standard IV: The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to Members through utilization review activities with a focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization.

A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web-based electronic formats) profiles comparing the average medical care utilization rates of the Members of each PCP to the average utilization rates of all PH-MCO Members. The PH-MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to:

1) Utilization information on Member Encounters with PCPs;
2) Specialty Claims;
3) Prescriptions;
4) Inpatient stays;
5) Emergency room use;
6) Clinical indicators for preventive care services (i.e., mammograms, immunizations, pap smear, etc.); and
7) Clinical indicators for EPSDT requirements.

B. The PH-MCO must have mechanisms and processes for profiling physicians using risk adjusted diagnostic data for profiles.

C. The QM and UM programs must implement statistically valid methodologies for analysis and follow-up of semi-annual practitioner utilization profiles for patterns and instances of over-utilization, under-utilization, and mis-utilization across the continuum of care, as well as, trending of Provider utilization patterns over time. Follow up includes but is not limited to Provider education, Provider improvement plans, and Provider sanctions as necessary.

D. The QM and UM programs must at least annually, provide for verification of Encounter reporting rates and accuracy and completeness of Encounter information submitted by PCPs.

Standard V: The PH-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for Members identified. Case/Disease and health management programs must:

A. Include mechanisms and processes that ensure the active collaboration and coordination of care and services for identified members.

B. Include mechanisms and processes that allow for the identification of conditions to be targeted for case/disease and health management programs and that allow for the assessment and evaluation of the effectiveness of these programs in improving outcomes for and meeting the needs of individuals with targeted conditions.

C. Include care guidelines and/or protocols for appropriate and effective management of individuals with specified conditions. These guidelines must be written in measurable and accepted professional formats and be based on scientific evidence.

D. Include performance indicators that allow for the objective measurement and analysis of individual and PH-MCO wide performance in order to demonstrate progress made in improving access and quality of care.

E. Include mechanisms and processes that lead to healthy lifestyles such as weight loss program memberships, gym memberships and asthma camps.

F. The PH-MCO agrees to comply with Department requirements and procedures related to the Enhanced Medical Home (EMH) model. EMH model is a system of care that provides access to a primary care provider, as well as targeted care management support for members at high risk of using acute medical services. There are four Pillars of the EMH model with which the PH-MCO would be expected to participate:
   - Embedded care managers in high volume practices (HVPs)
   - Working with HVP(s) to achieve NCQA Medical Home recognition
   - Transition of Care (TOC) nurses to work with high volume health systems
   - Participation with regional learning network collaboratives

Standard VI: The QM and UM programs must have mechanisms to ensure that Members receive seamless, continuous, and appropriate care throughout the continuum of care, by means of coordination of care, benefits, and quality improvement activities between:

A. PCPs and specialty care practitioners and other Providers**;**

B. Other HealthChoices PH-MCOs;

D. The PH-MCO and HealthChoices BH-MCOs;

E. The PH-MCOs and the Department's Fee For Service Program; and

F. The PH-MCO and other third party insurers

Standard VII: The PH-MCO must demonstrate that it retains accountability for all QM and UM program functions, including those that are delegated to other entities. The PH-MCO must:

A. Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the PH-MCO.

B. Have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. Document evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

D. Make available to the Department, and its authorized representatives, any and all records, documents, and data detailing its oversight of delegated QM and UM program functions.

E. Must ensure that delegated entities make available to the Department, and its authorized representatives, any and all records, documents and data detailing the delegated QM and UM program functions undertaken by the entity of behalf of the PH-MCO.

F. 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

Standard VIII: The QM/UM program must have standards for credentialing/ recredentialing Providers to determine whether physicians and other Health Care Providers, who are licensed by the Commonwealth and are under contract to the PH-MCO, are qualified to perform their services.

A. The PH-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types. Recredentialing activities must be conducted by the PH-MCO at least every three (3) years. Criteria must include, but not be limited to, the following:

1) Appropriate license or certification as required by Pennsylvania state law;

2) Verification that Providers have not been suspended, terminated or entered into a settlement for voluntary withdrawal from the Medicaid or Medicare Programs;

3) Verification that Providers and/or subcontractors have a current Provider Agreement and an active PROMISe™ Provider ID issued by the Department;

4) Evidence of malpractice/liability insurance;

5) A valid Drug Enforcement Agency (DEA) certification;

6) Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach;

7) Consideration of quality issues such as Member Complaint and/or Member satisfaction information, sentinel events and quality of care concerns.

B. For purposes of credentialing and recredentialing, the PH-MCO must perform a check on all PCPs and other physicians by contacting the National Practitioner Data Bank (NPDB). If the PH-MCO does not meet the statutory requirements for accessing the NPDB, then the PH-MCO must obtain information from the Federation of State Medical Boards

C. Appropriate PCP qualifications:

1) Seventy-five to 100% of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics;

2) No more than 25% of the Network consists of PCPs without appropriate residencies but who have, within the past seven years, five years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described; and

3) No more than 10% of the Network consists of PCPs who were previously trained as specialist physicians and changed their areas of practice to primary care, and who have completed Department-approved primary care retraining programs.

4) A PCP must have the ability to perform or directly supervise the ambulatory primary care services of Members;

5) Membership of the medical staff with admitting privileges of at least one general hospital or an acceptable arrangement with a PCP with admitting privileges;

6) Demonstrate evidence of continuing professional medical education;

7) Attend at least one PH-MCO sponsored Provider education training session as outlined in Section V.R.2, Provider Education, of the Agreement.

D. Assurance that any CRNP, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team, is performing under the scope of their respective licensure; and

E. As part of the Provider release form, the potential Provider must agree to release all MA records pertaining to sanctions and/or settlement to the PH-MCO and the Department.

F. The Department will recoup from the PH-MCO any and all payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by the PH-MCO in a manner that is not consistent with the Provider's licensure. In addition, the PH-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.

G. The PH-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the PH-MCO's credentialing practices.

H. Any economic profiles used by the PH-MCOs to credential Providers should be adjusted to adequately account for factors that influence utilization independent of the Provider's clinical management, including Member age, Member sex, Provider case-mix and Member severity. The PH-MCO must report any utilization profile that it utilizes in its credentialing process and the methodology that it uses to adjust the profile to account for non-clinical management factors at the time and in the manner requested by the Department.

I. In the event that a PH-MCO renders an adverse credentialing decision, the PH-MCO must provide the affected Provider with a written notice of the decision. The notice should include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors. All credentialing decisions made by the PH-MCO are final and may not be appealed to the Department.

J. The PH-MCO must meet the following standards related to timeliness of processing new provider applications for credentialing.

1) The PH-MCO must begin its credentialing process upon receipt of a provider's credentialing application if the application contains all required information.

2) The PH-MCO may not delay processing the application if the provider does not have an MAID number that is issued by the DHS. However, the PH-MCO cannot complete its process until the provider has received its MAID number from DHS.

3) Provider applications submitted to the PH-MCO for credentialing must be completed within sixty (60) days of receipt of the application packet if the information is complete.

Standard IX: The PH-MCO's written UM program must contain policies and procedures that describe the scope of the program, mechanisms, information sources used to make determinations of medical necessity and in conjunction with the requirements in Exhibit H Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program.

A. The UM program must contain policies and procedures for Prospective, Concurrent, and Retrospective review determinations of medical necessity.

B. The UM program must allow for determinations of medical necessity that are consistent with the HealthChoices Program definition of Medically Necessary:

Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review or Retrospective Review basis, shall be documented in writing. The PH-MCO shall base its determination on medical information provided by the Member, the Member's family/care taker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Member. Medical necessity 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. Satisfaction of any one of the following standards will result in authorization of the service:

1) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability;

2) 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;

3) 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.

C. If the PH-MCO wishes to require Prior Authorization of any services, they must establish and maintain written policies and procedures for the Prior Authorization review process. Prior Authorization policies and procedures must:

1) Meet the HealthChoices Program's definition of Medically Necessary;

2) Contain timeframes for decision making or cross reference policies on time frames for decision making that meet requirements outlined in Section V.B, Prior Authorization of Services, of the Agreement.

3) Contain language or cross reference policies and procedures of notifying Members of adverse decisions and how to file a Complaint/Grievance/DHS Fair Hearing;

4) Comply with state/federal regulations;

5) Comply with HealthChoices RFP and other contractual requirements;

6) Specify populations covered by the policy;

7) Contain an effective date; and

8) Be received under signature of individuals authorized by the plan.

D. The PH-MCO must provide all Licensed Proprietary Products which include, but are not limited to: Interqual and Milliman. All Utilization Review Criteria and/or policies and procedures that contain Utilization Review Criteria used to determine medical necessity must:

1) Not contain any definition of medical necessity that differs from the HealthChoices definition of Medically Necessary;

2) Allow for determinations of medical necessity that are consistent with the HealthChoices Program definition of Medically Necessary;

3) Allow for the assessment of the individual's current condition and response to treatment and/or co-morbidities, psychosocial, environmental and/or other needs that influences care;

4) Provide direction to clinical reviewers on how to use clinical information gathered in making a determination to approve, deny, continue, reduce or terminate a service;

5) Be developed using a scientific based process;

6) Be reviewed at least annually and updated as necessary; and

7) Provide for evaluation of the consistency with which reviewers implement the criteria on at least an annual basis.

E. The PH-MCO must ensure that Prior Authorization and Concurrent review decisions:

1) Are supervised by a physician or Health Care practitioner with appropriate clinical expertise in treating the Member's condition or disease;

2) That result in a denial may only be made by a licensed physician;

3) Are made in accordance with established RFP time-frames for routine, urgent, or emergency care; and

4) Are made by clinical reviewers using the HealthChoices definition of medical necessity.

F. The PH-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, and medical supplies. The PH-MCO must have written policies and procedures that address how Members and Providers can make contact with the PH-MCO to receive instruction or Prior Authorization, as necessary

G. Additional Prior Authorization requirements can be found in Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program.

H. The PH-MCO must ensure that utilization records document efforts made to obtain all pertinent clinical information and efforts to consult with the prescribing Provider before issuing a denial based upon medical necessity.

I. The PH-MCO must ensure that sources of utilization criteria are provided to Members and Providers upon request.

J. The UM program must contain procedures for providing written notification to Members of denials of medical necessity and terminations, reductions and changes in level of care or placement, which clearly document and communicate the reasons for each denial. These procedures must:

1) Meet requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.

2) Provide for written notification to Members of denials, terminations, reductions and changes in medical services at least ten (10) days before the effective date.

3) Include notification to Members of their right to file a Complaint, Grievance or DHS Fair Hearing as outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.

K. The PH-MCO must agree to comply with the Department's utilization review monitoring processes, including, but not limited to:

1) Submission of a log of all denials issued using formats to be specified by the Department.
2) Submission of denial notices for review as requested by the Department
3) Submission of utilization review records and documentation as requested by the Department
4) Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.
5) Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department prior to implementation.

Standard X: The PH-MCO must have a mechanism in place for Provider Appeals/Provider Disputes related to the following:

A. Administrative denials including denials of Claims/payment issues, and payment of Claims at an alternate level of care than what was provided, i.e. acute versus skilled days. This includes the appeal by Health Care Providers of a PH-MCO's decision to deny payment for services already rendered by the Provider to a Member.

B. QM/UM sanctions

C. Adverse credentialing/recredentialing decisions

D. Provider Terminations

Standard XI: The PH-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM and UM program activities are documented and

reported to appropriate individuals within the PH-MCO for use in other management activities.

A. The QM and UM program must have procedures which describe how findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to individuals within the PH-MCO for use in conjunction with other related activities such as:

1) PH-MCO Provider Network changes;
2) Benefit changes;
3) Medical management systems (e.g., pre-certification); and
4) Practices feedback to Providers.

Standard XII: The PH-MCO must have written policies and procedures for conducting prospective and retrospective DUR that meet requirements outlined in Exhibit BBB(2), Drug Utilization Review Guidelines.

Standard XIII: The PH-MCO must have written standards for medical record keeping. The PH-MCO must ensure that the medical records contain written documentation of the medical necessity of a rendered, ordered or prescribed service.

A. The PH-MCO must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for medical records that promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

B. Medical record standards must meet or exceed medical record keeping requirements contained in 55 Pa. Code Section 1101.51(d)(e) of the MA Manual and medical record keeping standards adopted by DOH.

C. Additional standards for patient visit data must, at a minimum, include the following:

1) History and physical that is appropriate to the patient's current condition;
2) Treatment plan, progress and changes in treatment plan;
3) Diagnostic tests and results
4) Therapies and other prescribed regimens;
5) Disposition and follow-up;
6) Referrals and results thereof;
7) Hospitalizations;
8) Reports of operative procedures and excised tissues; and
9) <u>All other aspects of patient care.</u>

D. The PH-MCO must have written policies and procedures to assess the content of medical records for legibility, organization, completion and conformance to its standards.

E. The PH-MCO must ensure access of the Member to his/her medical record at no charge and upon request. The Member's medical records are the property of the Provider who generates the record.

F. The Department and/or its authorized agents (i.e., any individual or corporation or entity employed, contracted or subcontracted with by the Department) shall be afforded prompt access to all Members' medical records whether electronic or paper. All medical record copies are to be forwarded to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. The Department is not required to obtain written approval from a Member before requesting the Member's medical record from the PCP or any other agency.

G. <u>Medical records must be preserved and maintained for a minimum of five years from expiration of the PH-MCO's contract. Medical records must be made available in paper form upon request.</u>

H. When a Member changes PCPs, the PH-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PCP within seven business days from receipt of the request. In emergency situations, the PH-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

I. When a Member changes PH-MCOs, the PH-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PH-MCO within seven business days from the effective date of enrollment in the gaining PH-MCO. In emergency situations, the PH-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

Standard XIV: The QM and UM program must demonstrate a commitment to ensuring that Members are treated in a manner that acknowledges their defined rights and responsibilities.

A. The PH-MCO must have a written policy that recognizes the following rights of Members:

1) To be treated with respect, and recognition of their dignity and need for privacy;

2) To be provided with information about the PH-MCO, its services, the practitioners providing care, and Members rights and responsibilities;

3) To be able to choose Providers, within the limits of the PH-MCO Network, including the right to refuse treatment from specific practitioners;

4) To participate in decision making regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions;

5) To have a Health Care Provider, acting within the lawful scope of practice, discuss Medically Necessary care and advise or advocate appropriate care with or on behalf of the Member including; information regarding the nature of treatment options; risks of treatment; alternative therapies; and consultation or tests that may be self-administered; without any restriction or prohibition from the PH-MCO;

6) To file a Grievance about the PH-MCO or care provided;

7) To file a DHS Fair Hearing appeal with the Department;

8) To formulate advance directives including:

   a) Written policies and procedures that meet advance directive requirements in accordance with 42 CFR 489, Subpart I

   b) Written policies and procedures concerning advance directives with respect to all adult Members receiving medical care by or through the PH-MCO

9) To have access to his/her medical records in accordance with applicable Federal and State laws and the right to request that they be amended or corrected as specified as in 45 CFR Section 164.526.

B. The PH-MCO must have a written policy that addresses Member's responsibility for cooperating with those providing health care services. This written policy must address Member's responsibility for:

1) Providing, to the extent possible, information needed by professional staff in caring for the Member; and

2) Following instructions and guidelines given by those providing health care services.

   Members shall provide consent to managed care plans, Health Care Providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For these purposes, Members will remain anonymous to the greatest extent possible.

C. The PH-MCO's policies on Member rights and responsibilities must be provided to all participating Providers.

D. Upon enrollment, Members must be provided with a written statement that includes information on the following:

1) Rights and responsibilities of Members;

2) Benefits and services included as a condition of membership, and how to obtain them, including a description of:

a) Any special benefit provisions (for example, co-payment, higher deductibles, rejection of Claim) that may apply to services obtained outside the system; and
b) The procedures for obtaining Out-of-Area Services;
c) Charges to Members if applicable;
d) Benefits and services excluded.
e) Provisions for after-hours, urgent and emergency coverage;
f) The PH-MCO's policy on referrals for specialty care;
g) PH-MCO Procedures for notifying, in writing, those Members affected by denial, termination or change in any benefit or service including denials, terminations or changes in level of care or placement;
h) Procedures for appealing decisions adversely affecting the Member's coverage, benefits or relationship to the PH-MCO;
i) Information about OMAP's Hotline functions;
j) Procedures for changing practitioners;
k) Procedures for disenrolling from the PH-MCO;
l) Procedures for filing Complaints and/or Grievances; DHS Fair Hearings; and
m) Procedures for recommending changes in policies and services.

E. The PH-MCO must have policies and procedures for resolving Member Complaints and Grievances that meet all requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Processes. These procedures must include mechanisms that allow for the review of all Complaints and Grievances to determine if quality of care issues exists and for appropriate referral of identified issues.

F. Opportunity must be provided for Members to offer suggestions for changes in policies and procedures.

G. The PH-MCO must take steps to promote accessibility of services offered to Members. These steps must include identification of the points of access to primary care, specialty care and hospital services. At a minimum, Members are given information about:

1) How to obtain services during regular hours of operation;

2) How to obtain after-hours, urgent and emergency care; and

3) How to obtain the names, qualifications, and titles of the Health Care Provider providing and/or responsible for their care.

H. Member information (for example, Member brochures, announcements, and handbooks) must be written in language that is readable and easily understood.

I. The PH-MCO must make vital documents disseminated to English speaking members available in alternate languages, upon request of the member. Documents may be deemed vital if related to the access of LEP persons to programs and services.

Standard XV: The PH-MCO must maintain systems, which document implementation of the written QM and UM program descriptions.

A. The PH-MCO must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM and UM programs.

B. The PH-MCO must adhere to all systems requirements as outlined in Section V.O.7, Management Information Systems, and Section VIII.B, Systems Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the HealthChoices Intranet.

C. The PH-MCO must adhere to all Encounter Data requirements as outlined in Section VIII.B.1, Encounter Data Reporting, of the Agreement.

EXHIBIT N(1)

STANDARD DENIAL NOTICE – COMPLETE DENIAL

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for service/item is:

Denied completely because**: *[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [*date*].

To continue getting services:
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint, grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision:

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could

harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(2)

STANDARD DENIAL NOTICE – PARTIAL APPROVAL OF REQUESTED SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for service/item is:

> Approved other than as requested as follows: **[Describe the level, frequency, and duration of service approved and the level, frequency, and duration of service denied.]**

The service or item is not approved as requested because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

This decision will take effect on [*date*].

To continue getting services:
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint, grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision:

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(3)

STANDARD DENIAL NOTICE – APPROVAL OF DIFFERENT SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for service/item is:

> Denied as requested, but the following service/item is approved: **[Describe the specific service/item approved, including the level, frequency, and duration of service.]**

A different service or item is approved because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

This decision will take effect on [*date*].

To continue getting services:
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint, grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;

- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision:

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(4)

STANDARD BENEFIT LIMIT EXCEPTION (BLE)
DENIAL NOTICE – COMPLETE DENIAL

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the benefit limit exception request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for benefit limit exception is:

Denied completely because***: [Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [*date*].

To continue getting services
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

INSTRUCTIONS FOR RECIPIENT FAIR HEARING REQUEST

If you have not yet received the service, you may ask for a Fair Hearing from the Department of Human Services. If you have already received the service, then you may ask for a fair hearing if your provider told you, before you got the service, that you would have to pay for the service if an exception was not granted. If your provider did not tell you that you might have to pay for the service, then the provider may not bill you for the service and you should not file an appeal**.**

Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

The provider may use the provider dispute process in the provider agreement with [PH MCO Name].

Request Criteria

You may request a copy of the benefit limit exception criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

INSTRUCTIONS FOR PROVIDER APPEAL

Providers may use the provider dispute resolution process as described in their provider contract with [PH MCO Name].

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(5)

STANDARD BENEFIT LIMIT EXCEPTION (BLE)
DENIAL NOTICE – PARTIAL APPROVAL OF REQUESTED SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the benefit limit exception request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for benefit limit exception is:

> Approved other than as requested as follows: **[Describe the level, frequency, and duration of service approved and the level, frequency, and duration of service denied.]**

The service or item is not approved as requested because: ***[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [*date*].

To continue getting services
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

INSTRUCTIONS FOR RECIPIENT FAIR HEARING REQUEST

If you have not yet received the service, you may ask for a Fair Hearing from the Department of Human Services. If you have already received the service, then you may ask for a fair hearing if your provider told you, before you got the service, that you would have to pay for the service if an exception was not granted. If your provider did not tell you that you might have to pay for the service, then the provider may not bill you for the service and you should not file an appeal**.**

Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

The provider may use the provider dispute process in the provider agreement with [PH MCO Name].

Request Criteria

You may request a copy of the benefit limit exception criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

INSTRUCTIONS FOR PROVIDER APPEAL

Providers may use the provider dispute resolution process as described in their provider contract with [PH MCO Name].

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(6)

STANDARD BENEFIT LIMIT EXCEPTION (BLE)
DENIAL NOTICE – APPROVAL OF DIFFERENT SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the benefit limit exception request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for benefit limit exception is:

> Denied as requested, but the following service/item is approved: **[Describe the specific service/item approved, including the level, frequency, and duration of service.]**

A different service or item is approved because: ***[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [*date*].

To continue getting services
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

INSTRUCTIONS FOR RECIPIENT FAIR HEARING REQUEST

If you have not yet received the service, you may ask for a Fair Hearing from the Department of Human Services. If you have already received the service, then you may ask for a fair hearing if your provider told you, before you got the service, that you would have to pay for the service if an exception was not granted. If your provider did not tell you that you might have to pay for the service, then the provider may not bill you for the service and you should not file an appeal**.**

Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings

P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

The provider may use the provider dispute process in the provider agreement with [PH MCO Name].

Request Criteria

You may request a copy of the benefit limit exception criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a

complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

INSTRUCTIONS FOR PROVIDER APPEAL

Providers may use the provider dispute resolution process as described in their provider contract with [PH MCO Name].

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT Q

SAMPLE MODEL AGREEMENT

This sample model Agreement is illustrative only and is designed for use by the county children and youth agencies, but can be adapted by other community agencies. Letters of Agreement must contain the information found in Exhibit S, Written Agreements Between PH-MCO and Service Providers.

[COUNTY AGENCY]/OFFICE

HEALTH SERVICES COORDINATION AGREEMENT

This County Office Health Services Coordination Agreement is entered into and effective this _____ day of _____, _____, by and between [Plan], a corporation, and the [County Agency] for _____ County, and the _____ Office of _____ County, Pennsylvania (collectively [County Agency]).

WHEREAS, [Plan], a licensed health maintenance organization in the Commonwealth of Pennsylvania, has entered into an agreement with the Pennsylvania Department of Human Services ("DHS") to furnish Medical Assistance-covered services ("covered services") to Medical Assistance (MA) recipients under the [Plan] Medical Assistance product (MA product"), in accordance with the Commonwealth's Medical Assistance programs, and in accordance with the agreements between [Plan] and DHS ("MA Agreements"); and

WHEREAS, [Plan] and [County Agency] wish to ensure that Medical Assistance recipients who are children in substitute care ("MA covered persons"), and served by the parties, receive the necessary and appropriate covered services; and

WHEREAS, since covered services can be delivered more efficiently and more timely if [County Agency] and [Plan] coordinate the identification and treatment of MA covered persons, DHS requires that [Plan] enter into agreements with county agencies] and county offices to set forth the terms on which they will coordinate the delivery of covered services to MA covered persons; and

WHEREAS, the parties explicitly acknowledge, understand and agree that the common purpose of this cooperative relationship is to ensure that access to covered services and the quality of covered services provided will not be diminished or compromised because of an MA covered person's placement in substitute care.

NOW, THEREFORE, in consideration of the mutual covenants and premises, and for other good and valuable consideration, and intending to be legally bound, the parties agree as follows:

1.0 DEFINITIONS

For the purposes of this Agreement, the following terms shall have the meanings set forth below:

1.1 **Covered Services** means those health care services MA covered persons are entitled to receive under the state and federal law. It also means those services that a PH-MCO is required to provide under its agreement with the Department of Human Services to MA covered persons.

1.2 **DOH** means the Pennsylvania Department of Health.

1.3 **DHS** means the Pennsylvania Department of Human Services.

1.4 **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person 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.

1.5 **EPSDT** means the Early and Periodic Screening, Diagnosis, and Treatment Program that provides medical services for individuals under the age of 21 administered under the Medical Assistance Program.

1.6 **MA Covered Person** means: (1) any Medical Assistance recipient that (a) is under the age of 18; or (b) over the age of 18 up to age 21 and under the jurisdiction of [County Agency] care and custody; and (2) for whom [Plan] and [County Agency] have agreed to coordinate the provision of covered services.

1.7 **Medical Assistance (MA)** means 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 Title 62, Chapter 1, Article 4 of the Pennsylvania Statutes and regulations promulgated thereunder.

1.8 **MA Agreements** means the contracts between [Plan] and DHS under any of Pennsylvania's Medical Assistance managed care programs, including DHS's HealthChoices Program, pursuant to which [Plan] arranges for the provision of certain services covered by Medical Assistance to MA covered persons.

1.9 **MA Product** means [Plan's] Medical Assistance HMO product.

1.10 **MA Recipient** means an individual eligible to receive services under Pennsylvania's MA Program, including the HealthChoices Managed Care Program, and is enrolled in the MA product.

1.11 **Medically Necessary** means that condition or procedure defined as medically necessary by DHS as delineated in DHS's HealthChoices Agreement between the [Plan] and DHS.

1.12 **PID** means the Pennsylvania Insurance Department.

Terms not defined hereinabove shall be given the meanings ascribed to them in the MA Agreements or the RFP.

2.0 MUTUAL [PLAN] AND [COUNTY AGENCY] OBLIGATIONS RELATIVE TO COORDINATION OF CARE

2.1 The parties, and their liaisons where applicable agree to communicate with the MA covered person's Primary Care Physicians (PCPs), coordinate services, exchange relevant enrollment and individual health-related information and services needs of MA covered persons, including the institution of a process to monitor such activity, and a process to monitor the quality management and utilization management responsibilities of each party.

2.2 The parties agree to develop policies, within 60 days of the effective date, on referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, continuity of care, and other treatment issues necessary for optimal health and disease prevention, including policies on coordination of specialized service plans for MA covered persons with special health needs.

2.3 The parties agree to interact with the PCPs for prompt treatment and coordination of care.

2.4 The parties agree to jointly monitor the quality of the covered services delivered.

2.5 The parties agree to work cooperatively to establish programmatic responsibility for each MA covered person.

2.6 The parties agree to serve on interagency teams, when requested by either of the parties hereto.

2.7 The parties agree to cooperate in the coordination of covered services with the applicable Behavioral Health Managed Care Organizations in the HealthChoices Zone (HC Zone), including Pharmacy Coordination, to the extent permitted by law**.**

2.8 Where the parties have identified an issue, the parties mutually agree to undertake intensive outreach efforts to MA covered persons identified as needing covered services.

2.9 To assure the effectiveness of this Agreement and the services provided hereunder, the parties will review the Agreement for accuracy at least [insert time frame] or, if necessary, more often. Additionally, the parties agree to set up a

forum to discuss opportunities to assess training needs, consultation, and sharing of information between the parties to facilitate the cost-effective use of resources. The parties also agree to meet [insert time frame], or as requested by either party, to resolve any outstanding issues existing between them.

2.10 The parties agree to assist, when appropriate, in the development of an adequate provider network to serve special needs populations.

2.11 The parties agree to develop and implement a work plan to address issues or actions so as to bring said issues and actions into compliance with the term(s) of this Agreement.

2.12 The parties agree to adhere to the Americans with Disabilities Act, as amended, and the Rehabilitation Act of 1973.

2.13 The parties agree to collaborate on identifying and reducing the frequency of fraud, abuse, over use, under use, and inappropriate or unnecessary medical care.

2.14 The parties will work cooperatively to develop processes to ensure that:

(i) The [County Agency] caseworker will contact a participating provider or attempt to contact the PCP, when the [County Agency] caseworker can identify the PCP, when admission or discharge physical examinations are required due to the initial placement or discharge of an MA covered person or if the MA covered person is relocated. When it is not possible to contact the PCP, the [County Agency] shall coordinate with the plan's Special Needs Unit to arrange to use other providers within the [Plan's] network. In cases of suspected abuse, [County Agency] shall contact the appropriate medical provider for the examination without having to obtain prior approval from the PCP or [Plan]. If the enrollment of the MA recipient cannot be determined at the time the exam is required, the exam may be performed in an emergency room or through a provider affiliated with [County Agency]. Within 24 hours, or as soon as it can be reasonably determined that the MA recipient is eligible for the MA Product and eligible to be an MA covered person, [County Agency] will notify [Plan's] Special Needs Unit and/or the PCP in order that necessary follow-up care can be coordinated.

(ii) Information related to suspected abuse cases obtained from a PCP or [Plan] provider, including diagnostic tests, is shared with [County Agency].

(iii) Physical assessments needed by the MA covered persons entering emergency shelters are being performed within the time frames established by law. The same procedure set forth in 2.14(i) above applies.

(iv) Medically necessary home health services are being provided to MA covered persons in medical foster care.

(v) [County Agency] will be notified by [Plan] of denial of services to MA covered persons, including explicit steps on how to file an appeal, which has the right to file, and how denials will be processed.

2.15 [Plan] and [County Agency] will work together to determine the post-discharge needs of any MA covered person placed in substitute care, and to develop a care plan that will maintain continuity of care through the MA covered person's transition from substitute care to home.

2.16 [Plan] and [County Agency] will work together to develop policies and procedures on the identification of individuals who have the authority to represent MA covered persons to request PCP selections and changes; receive MA covered person information including identification cards, MA covered person notices, or filing MA covered person complaints, grievances or appeals on behalf of the MA covered persons.

2.17 [Plan] and [County Agency] will work together to develop and implement joint education and training programs related to requirements of both. This training will be provided to [County Agency] caseworkers, staff, or private agencies and [Plan's] Special Needs Unit staff and participating providers throughout the implementation of HealthChoices and as specific needs are identified.

2.18 [Plan] and [County Agency] will cooperate in the identification of opportunities for improvement of processes or procedures identified in this Agreement and the need for additional processes or procedures. At a minimum, representatives from [Plan] and [County Agency] will meet to discuss identified opportunities and to establish a work plan to address those issues. This process will be coordinated through the designated contact persons.

2.19 [Plan] shall provide to [County Agency] at [County Agency's] address set forth hereinafter, any notification that [Plan] is required to provide to MA covered persons, in lieu of providing it to MA covered persons, and [County Agency] shall then be obligated to provide any such notification to MA covered persons, and MA covered persons' caretaker, provider, or guardian.

2.20 [County Agency] and [Plan] shall cooperate with each other and shall share medical information for children entering placement who are covered persons and if appropriate.

3.0. [PLAN] OBLIGATIONS

3.1 [Plan] will be responsible for the payment of physical health services as set forth in the RFP, including eye care, dental care, hearing exams, and immunizations. [Plan] shall not be obligated to pay for medical services currently covered by Fee-For-Service Medical Assistance and for which [County Agency] contracts directly with providers of medical care. [Plan] shall not be obligated to pay for medical services for children who are not MA covered persons. Medical services provided to children who are currently being evaluated for Medicaid eligibility

shall be paid for by DHS under Fee-For-Service Medical Assistance programs. [Plan] shall not be obligated to pay for inpatient hospital days that are not a medical necessity, as determined by [Plan], including the situation where [County Agency] is in the process of placing the child in a foster or similar home and is having difficulty doing so. [Plan] shall not be obligated to pay for psychological evaluations for any purpose whatsoever.

3.2 [Plan] shall be responsible to provide or arrange for the provision of medically necessary covered services to any MA covered person upon his or her discharge from substitute care to his/her family or other primary caretaker (i.e. legal guardian), provided that the MA covered person is discharged to a location in the HC Zone.

3.3 [Plan] has a Special Needs Unit that will deal, in a timely manner, with issues relating to MA covered persons with special needs.

3.4 [Plan] shall identify a contact person for coordination with [County Agency] and further shall define the roles and responsibilities of the contact person to address mass change situations such as enrollment and incorrect PCP designations, which affect all MA covered persons, and individual requirements such as emergency physical exams, PCP selections or change, or EPSDT screens that are due.

3.5 For MA covered persons with complex medical needs, the designated contact person at [Plan's] Special Needs Unit will coordinate requests for specialists to serve as PCP with the contact person at [County Agency]. The procedures will include a timeline for submission of requests, tracking of requests, and decisions on requests. The procedures will include the selection of an accessible PCP until a decision has been provided. If the request has been denied, any request for a change in PCP will be coordinated with the [County Agency] contact person.

3.6 [Plan] shall coordinate notification and scheduling of EPSDT screens that are due with the [County Agency] contact person or the appropriate foster parent if [County Agency] notifies [Plan's] Special Needs Unit of the foster parent. [Plan] shall provide [County Agency] with EPSDT data on MA covered persons on a mutually agreed upon reporting, time frame, and format.

3.7 [Plan] shall provide [County Agency] with its provider directories when they are produced on no less than an annual basis.

3.8 [Plan's] Special Needs Unit shall provide information in writing to [County Agency] describing [Plan's] operations, including the manner in which [County Agency] may contact [Plan] regarding benefit coverage rules and access to additional information or resources on behalf of an MA covered person placed in substitute care.

3.9 [Plan's] Special Needs Unit staff shall provide education to [County Agency] staff on the [Plan's] requests for accessing medically necessary services.

3.10 All denials by [Plan] of requests for services shall be provided to [County Agency] via telefax and regular mail.

4.0 [COUNTY AGENCY'S] OBLIGATIONS

4.1 Within four months after the implementation of this Agreement, and, at a minimum, quarterly as new providers are identified by [County Agency], [County Agency] shall provide to [Plan] the names of the health care providers [County Agency] uses for exams on an annual basis.

4.2 [County Agency] shall identify a contact person to [Plan], and further shall define the roles and responsibilities of the contact person, to address mass change situations such as enrollment, which affect all MA covered persons, and individual requirements such as emergency physical exams, PCP selection or change, or EPSDT screens which are due.

4.3 [County Agency] will attempt to determine a Medical Assistance recipient's eligibility including physical health plan enrollment by utilizing DHS's Eligibility Verification System (EVS). If EVS is not available in the [County Agency] office, [County Agency] will secure an EVS terminal or educate staff on how to contact DHS to verify eligibility.

4.4 [County Agency] shall arrange for the provision of any medically necessary physical health services by [Plan] contract providers unless the situation is an emergency. [County Agency] will arrange for the provision of any EPSDT screening exams, immunizations, tests or follow-up medical care with [Plan's] Special Needs Unit or PCP. [Plan] shall consider all DHS-required EPSDT services covered services as set forth in DHS's EPSDT guidelines.

4.5 [County Agency] shall advise [Plan] of all new placements or relocations of MA recipients within 15 days or as soon as it can be determined that the recipient is an MA covered person. [County Agency] will coordinate PCP selection or change with [Plan's] Special Needs Unit contact person upon notification of the MA covered person's need to timely access to a PCP.

4.6 [County Agency] will notify [Plan] within 15 days of new placements, changes in placement, or removals from placement of an MA covered person.

4.7 As appropriate, [Plan's] Special Needs Unit will contact [County Agency's] Managed Care Unit [or its equivalent] to request assistance in gathering medical information on the MA covered person. The medical information can include that collected as part of the [County Agency's] intake function or obtained from past medical records. The [County Agency's] Managed Care Unit and the Special Needs Unit [or its equivalent] will work together to obtain the necessary medical information and to share this information with [Plan's] participating provider as appropriate.

4.8 [County Agency] will assist in obtaining required consent-to-treat documents from the MA covered person's parent, legal guardian, or through the court system, if necessary.

4.9 [County Agency] will require any private contracted agencies to cooperate with [Plan]. [County Agency] will require each private contracted agency to identify a contact person to [Plan's] Special Needs Unit designated contact person. [County Agency] will coordinate training and education of private contracted agencies with [Plan].

5.0 SPECIAL NEEDS UNIT

5.1 [County Agency] shall notify [Plan's] Special Needs Unit of the planned transition for the MA covered person within 15 days of discharge from substitute care. Included in these arrangements will be the transfer of all relevant medical information/records to a [Plan] PCP to which the MA covered person will be assigned if different from the current PCP.

5.2 As part of the joint [County Agency] and [Plan] discharge planning, and based on the individual needs of the MA covered person, the [County Agency] case worker and the [Plan's] Special Needs Unit will identify those MA covered persons who could benefit from Special Needs Unit case management. [Plan] case managers will cooperate with the PCP and the [County Agency] caseworker in the development of an appropriate care plan. The [Plan] case manager will assist in the coordination of services required to meet the needs of the MA covered person including any non- MA covered services.

5.3 In the event that [Plan] does not receive notice of an MA covered person's discharge from substitute care until after the discharge has occurred, a care coordinator from [Plan's] Special Needs Unit will be assigned to the case upon [Plan's] receipt of such notification. This care coordination will then work with the MA covered person's PCP and a [County Agency] Managed Care Unit, or its equivalent liaison, to make appropriate arrangements for the MA covered person's care.

6.0 DATA COLLECTION/REPORTING/SHARING

6.1 The parties agree to develop procedures on the collection of information on the covered services delivered, which information shall be shared with DHS upon request.

6.2 The parties agree to develop provisions for the notification of reportable conditions experienced by any MA covered persons to the appropriate regulatory agency as required by law.

6.3 The parties agree to share necessary data to ensure delivery of appropriate covered services.

7.0 COORDINATION OF CARE

If an MA covered person is placed by [County Agency] outside the HC services area, the [County Agency] contact person will notify the DHS County Assistance Office. DHS shall disenroll the MA covered person from [Plan]. The MA covered person will then either be enrolled in another HealthChoices service area or covered by the Fee-For-Service Medical Assistance Program. The [County Agency] contact person will notify [Plan's] Special Needs Unit contact person of the placement outside of the HC service area. [Plan] and [County Agency] will coordinate the transfer of the medical information to the new HealthChoices health plan or selected PCP.

8.0 CONFIDENTIALITY

8.1 The parties recognize and acknowledge that performance of this Agreement may result in the disclosure to the other party of trade secrets, proprietary information, and confidential information (collectively referred to as "Confidential Information"). The non-disclosing party agrees that it and its employees, representatives, and agents shall treat confidential information as strictly confidential and shall: (i) protect the confidential information from unauthorized use or disclosure either directly or indirectly, and keep it confidential; (ii) use the confidential information only for purposes related to this Agreement; (iii) not disclose or otherwise permit any third person or party access to the confidential information without prior written authorization by the disclosing party; and (iv) limit disclosure to necessary individuals and ensure that individuals exposed to confidential information are advised of its confidential nature and their obligations hereunder.

8.2 This Section, (8.0 Confidentiality) shall survive termination of this Agreement. The parties agree that the breach or prospective breach of this provision will cause irreparable harm of which money damages may not be adequate. The parties agree that in addition to any other remedies, the non-breaching party shall be entitled to injunctive or other equitable relief to restrain the breach hereof.

9.0 MEDICAL RECORDS

9.1 The parties agree to obtain the appropriate releases necessary to share clinical information and provide health records to each other as requested, consistent with all applicable laws.

9.2 The parties agree to maintain the confidentiality of all covered persons' medical records in accordance with all applicable state and federal laws.

9.3 DHS and/or its authorized agents shall be afforded prompt access to all MA covered persons' medical records whether electronic or paper. All medical

record copies are to be forwarded to the requesting party within 15 calendar days of such request and at no expense to the requesting party. DHS is not required to obtain written approval from an MA covered person before requesting the MA covered person's medical record from the parties or any other agency.

10.0 EMERGENCY CARE

[County Agency] has the right to proceed in an emergency without obtaining prior authorization from [Plan]. An emergency will not require an authorization at any time. [County Agency] shall contact the PCP to authorize urgent care or any follow-up care related to the emergency.

11.0 TERM AND TERMINATION

11.1 This Agreement shall become effective on the later of the effective date set forth above or DHS's approval thereof, and shall continue in effect until Date, or until the earlier termination of the HealthChoices MA Agreement. This Agreement shall renew upon the mutual consent of the parties and the renewal of the HealthChoices MA Agreement for a term consistent with the HealthChoices MA Agreement.

11.2 Either party may terminate this Agreement for cause by giving the other party and DHS 90 days written notice of a breach of this Agreement. Any such termination shall be effective on the date stated in the notice of termination unless the other party cures the breach prior to the expiration of the 90-day notice period. In the event the breach is cured to the reasonable satisfaction of the other party, the Agreement shall not be so terminated, and DHS shall be notified of the same.

11.3 This Agreement may also be terminated by mutual agreement of both parties with notice to DHS, and by either party upon 120 days advance written notice to the other party and DHS.

12.0 IMPLEMENTATION AND REVIEW OF AGREEMENT

The parties will jointly develop an implementation plan for the coordination of covered services and will appoint representatives who will meet regularly to carry out such plan. To assure the effectiveness of this Agreement and the services to be provided hereunder, the parties will review the Agreement at least once each year, or more often if necessary.

13.0 DISPUTE RESOLUTION

Any controversy, dispute, or disagreement arising out of or relating to the Agreement, or breach thereof, that cannot be resolved at the meetings described in Section 2.9 above,

shall first be mediated, which shall be conducted in [enter appropriate county] County, Pennsylvania, in accordance with the American Health Lawyers' Association Alternative Dispute Resolution Service Rules of Procedure. In the event the parties cannot resolve their differences through mediation, the parties shall have the right to undertake proceedings in a court of proper jurisdiction. No regulatory order or requirement of DOH shall be subject to such mediation.

14.0 MISCELLANEOUS

14.1 **Compliance with Federal and State Laws.** Throughout the term of this Agreement, it shall be each party's responsibility to maintain compliance with all state and federal laws and regulations that affect its respective operations and the furnishing of covered services under this Agreement.

14.2 **Assignment.** This Agreement shall not in any manner be assigned, delegated, or transferred by either party without the prior written consent of the other party, provided, however, that [Plan] may assign this Agreement to another party that controls, is controlled by, or is under common control with [Plan].

14.3 **Notices.** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and if such notice relates to a modification to this Agreement or the MA product, it shall be sent by certified mail, return receipt requested, to the parties at the addresses set forth below, or personally delivered, delivered by facsimile, or regular or overnight mail. If mailed by regular mail, any such notice shall be deemed given on the fifth day following the date of mailing.

If to [Plan]
[Address]
[Fax #]

If to [County Agency]
_____ County _____ Agency
[Address]
Attention: _____

14.4 **Relationship of Parties.** The relationship between [Plan] and [County Agency] is that of independent contractors and neither shall be considered an agent or representative of the other for any purpose.

14.5 **Non-Exclusivity.** [County Agency] may enter into independent contracts with any payor or participate in other organizations that have purposes identical or similar to the purposes of [Plan].

14.6 **No Third Party Beneficiaries.** This Agreement shall be construed to give rights and place obligations solely upon the parties to this Agreement.

14.7 **Section Headings.** The headings and captions in this Agreement are for ease of reference only and shall not affect in any way the meaning or interpretation of this Agreement.

14.8 **Severability/Invalid Provisions.** The provisions of this Agreement are independent of and separate from each other. If any one provision is determined to be invalid or unenforceable, it shall not render any other provision invalid or unenforceable.

14.9 **Waiver/Compliance with Terms.** Waiver of any part of this Agreement shall not be considered a waiver of any other part of this Agreement. Failure to insist upon strict compliance with any terms of this Agreement (by way of waiver or breach) by either party hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.

14.10 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania and all applicable federal laws.

14.11 **Inconsistencies.** In the event of any inconsistency between the provisions of this Agreement and the provisions of any MA Agreement or the RFP, or any exhibit thereto, the provisions of the HealthChoices MA Agreement or the RFP, respectively, shall govern.

14.12 **Entire Agreement and Amendments.** This Agreement, and all attachments and amendments hereto, constitute the entire understanding and agreement of the parties hereto and supersede any prior written or oral agreement pertaining to the subject matter hereof. This Agreement may be amended by the parties upon the written consent of both parties and DHS. In the event the parties are unable to agree to the content or the wording of an amendment, the proposed amendment and the facts related thereto shall be conveyed to DHS for guidance and direction on how to proceed.

IN WITNESS WHEREOF, the parties have caused their duly authorized representatives to affix their signatures to this Agreement as of the date written above.

_____County [County Agency]	[Plan]
By: _____	By: _____
Title: _____	Title: _____
Witness:	Witness:
By: _____	By: _____

Title: _____

Date: _____

[County/Agency] Primary Contact:

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

Title: _____

Date: _____

[Plan] Primary Contact

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

[County/Agency] Office

By: _____

Title: _____

Witness:

By: _____

Title: _____

Date: _____

Exhibit V - Telephonic Psychiatric Consultation Team Services

The HealthChoices MCO has the responsibility to coordinate the care of children who require therapeutic interventions and medication to treat mental health conditions especially those children in foster care. In order to improve the quality of care for children that require psychotropic mediation, the MCO will contract with a telephonic Psychiatric Consultation Team (PCT) that will provide real time telephonic consultative services to PCPs and other prescribers of psychotropic medications for children (referred to as PCPs throughout this document). **The MCO will work with all other BH and PH-MCOs within the HC region to collaboratively choose one PCT team for each HC region.**

The PCT must consist of a team of staff including one (1) full-time equivalent child psychiatrist, one (1) full-time equivalent behavioral health therapist, and one (1) full-time equivalent care coordinator.

Qualifications and key responsibilities for team staff are listed below:

(i) **Child Psychiatrist**. The full-time equivalent position of child psychiatrist may consist of one or more individuals as follows- child psychiatrists must be Board certified or Board eligible and skilled in psychopharmacology. At least one child psychiatrist shall be on call providing continuous coverage from 9:00 a.m. to 5:00 p.m., Monday through Friday, and shall at all times while on call carry a pager and/or cell phone and be accessible to a caller within thirty (30) minutes. The on-call team member shall not be engaged in any activity from which he/she cannot be interrupted within thirty (30) minutes. A child psychiatrist team member shall make an on-site visit to high volume participating PCPs defined by the MCOs in the HC region at least once per year. One child psychiatrist will be designated as the PCT's lead medical director with responsibility to assure consistent quality of care, convene periodic team meetings, assure team productivity and timely regional coverage of PCPs, and participate in quarterly meetings with all BH and PH MCOs within the HC region.

(ii) **Behavioral Health Therapist**. The one (1) full-time equivalent position of behavioral health therapist may consist of one or more individuals as follows: licensed clinical social workers ("LCSW"), licensed mental health counselor, or licensed psychologists. The behavioral health therapist team member's activities must be limited to consultative or short-term transitional care. The therapist(s) must be knowledgeable of local behavioral health resources and work as a team with the care coordinator to match a specific youth/family with the most appropriate and available community resource.

(iii) **Care Coordinator**. The care coordinator supports the team members by coordinating and maintaining schedules, managing registration and billing of patients requiring face-to-face visits, arranging appointments with local behavioral health

providers and oversees collection of any encounter data. The care coordinator must be in constant contact with the BH and PH MCOs.

The PCT will perform consultative services and provider outreach services as described below.

Consultation Services. The PCT will be available at all times between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding Provider's holidays), to PCPs and other designated providers in the HC region to provide immediate consultations by telephone concerning children and adolescent behavioral health matters. In the event that PCT is unable to consult with the PCP at the time of the PCP's initial inquiry, the PCT shall respond to the PCP within thirty (30) minutes of PCP's initial inquiry call. The telephone consultation will result in one of the following outcomes dependent upon the needs of the PCP's patient and patient's family- resolution of the PCP's inquiry to the satisfaction of the PCP; referral to the PCT care coordinator to assist the family in accessing routine local behavioral health services with such referral stating the average anticipated wait time for visits; referral to PCT's child psychiatrist for an acute psychopharmacological or diagnostic consultation within two (2) weeks or as agreed with the patient's family; or referral to the PCT's social worker to provide diagnostic consultation and/or transitional face-to-face care or telephonic support to the patient and family until the family can access routine local behavioral health services.

The PCT shall maintain an appropriate clinical setting for its staff to care for patients needing face-to-face consultative or transitional services.

The PCT shall maintain records on all consultations and maintain a single designated telephone number with paging ability or PCT person answering the telephone for PCPs to access consultation services.

For all encounters requiring the care coordinator to assist the family with access to routine local behavioral health services, the PCT will follow up with the family to ascertain whether the appointment was made and continue to assist the family as appropriate if the appointment was not made. The care coordinator will contact the BH-MCO to make it aware of any barriers to timely care.

The PCT will send to PCPs a written or electronic record of all face-to-face visits including results of any follow up contacts within 48 hours of the visit. The PCT is encouraged to provide verbal feedback to the PCP from all face-to-face visits requiring follow up. The PCT will also send to PCPs a written or electronic record of all telephonic care coordination encounters including results or any follow up contact within 48 hours of encounter.

The PCT will generate quarterly reports detailing the activity of participating PCPs and identifying which PCPs are not utilizing the service. The PCT will outreach to engage PCPs who are not utilizing the service. This may include but is not limited to outreach

by telephone, e-mail, continuing education sessions, or visits to the office. The quarterly reports will detail the number of telephonic and face to face encounters, the number of unique recipients using the service, the number referred for additional services with community BH providers, the number of recipients who showed up for referred services, the number of unique members discussed with the BH-MCO, and the number of unique members discussed with the PH MCO.

Provider outreach services

The PCT will sequentially contact PCPs and other targeted prescribers of psychotropic medications in the HC Region to inform them of the PCT program and encourage them to participate. The PCT will provide PCPs in the HC Region with training and behavioral health continuing education at PCP offices on how to access and use the consultation program, orientation to community behavioral health services, and guidelines for prescribing and monitoring side effects of common psychotropic medications.

EXHIBIT X

HEALTHCHOICES PH-MCO GUIDELINES FOR ADVERTISING, SPONSORSHIPS, AND OUTREACH

I. Overview

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 this exhibit.

II. HealthChoices Outreach Procedures

HealthChoices (HC) Managed Care Organizations (MCOs) must adhere to the following guidelines and all the requirements specified in Section V.F.2, PH-MCO Outreach Materials, and V.F.3, PH-MCO Outreach Activities, of the Agreement when submitting outreach materials, policies and procedures to the Department.

A. Submission of PH-MCO Outreach Material

Purpose: To obtain Department approval of new or revised outreach materials, plans or procedures.

Objectives:

1. To assure that PH-MCO outreach materials are accurate.

2. To prevent the PH-MCO from distributing outreach materials that mislead, confuse or defraud either the Member or the Department.

Process:

1. The PH-MCO submits outreach materials to the Department for prior approval using the HealthChoices Educational Materials Approval Request form (form attached).

2. The Department's contract monitoring Core Team will review and forward to the PH-MCO a preliminary response within thirty (30) calendar days from date of receipt of the request form.

   Exception: Should the materials require comments or approval from offices outside the Department contract monitoring Core Team, the turnaround time would be as soon as possible.

3. The PH-MCO will submit a final copy of the outreach materials to the Department contract monitoring Core Team for a final written approval prior to circulating the materials.

4. The Department review agency will forward a final written approval to the PH-MCO within ten (10) business days.

5. Outreach material usage:

   a. Direct outreach materials will be used only by the HealthChoices Independent Enrollment Assistance Program personnel after final written approval is received by the PH-MCO from the Department.

   b. Indirect outreach materials, i.e. advertisements, may be utilized immediately after final written approval is received by the PH-MCO from the Department.

B. Criteria for Review of PH-MCO Outreach Material

Purpose: To assure that printed materials, advertising, promotional activities and new Member orientations coordinated through the HealthChoices Independent Enrollment Assistance Program are designed to enable the Medical Assistance consumer to make an informed choice.

Objectives:

1. To assure that the information complies with all federal and state requirements.

2. To determine if the information is grammatically correct and appropriate for Pennsylvania's Medical Assistance population.

3. To ensure that outreach materials are accurate and do not mislead, confuse, or defraud the Member or the Department with the assertion or statement that the Member must enroll in the PH-MCO in order to obtain Medical Assistance benefits, or in order to not lose Medical Assistance benefits.

4. To ensure that there are no assertions or statements that the PH-MCO is endorsed by CMS, the Federal or State government, or similar entity.

Process:

1. Receive a written overall outreach plan annually if the PH-MCO anticipates participation in outreach activities. Requests for specific indirect advertising must be submitted thirty (30) calendar days in advance for written Department approval.

2. Determine if approval is necessary from other offices.

3. Review the information with the following criteria:

   a. Is the PH-MCO identified?
   b. Does the information comply with all federal and state regulations?
   c. Is the information presented in grammatically correct, precise, appropriate and unambiguous language, easily understood by the target audience (i.e., age and language) and does it avoid the use of industry jargon?
   d. Is the information fair, relevant, accurate and not misleading or disparaging to competitors?
   e. Can the information be easily understood by a person with a sixth grade education?
   f. Does the information include symbols or pictures that are discriminating because of race, color, age, religion, sex, national origin, physical handicap or otherwise? and
   g. Does the information create a negative image of the traditional Fee-for-Service system?

4. The Department will forward a final written response to the PH-MCO within ten (10) business days.

C. HC PH-MCO Participating In or Hosting an Event

The PH-MCO may submit requests to sponsor or participate in health fairs or community events; the request should demonstrate that the PH-MCO will participate in such fairs or events through activities, including approved outreach activities that are primarily health-care related. The PH-MCO must receive advance written approval from the Department prior to the event date. All requests must be submitted to the Department at least thirty 30 calendar days in advance of the event, on the forms which are included as part of this attachment.

Purpose: To clarify for PH-MCOs that Pennsylvania laws and regulations prohibit certain kinds of offers or payments to consumers as inducements or incentives for consumers to use the PH-MCO's services.

Objectives:

1. To provide amenities that create an environment that is comfortable and convenient for Recipients but is not offered as an artificial outreach inducement or incentive.

2. To eliminate fraudulent, abusive and deceptive practices that may occur as incentives or inducements to obtain specific covered services from the PH-MCO.

Process:

1. The PH-MCO must submit a request, using the applicable HealthChoices PH-MCO Outreach Approval Request Form or the HealthChoices Education Materials Request Form, to the appropriate Department review agency to host an event thirty (30) calendar days in advance of the event (see attached). Should the event require approval from other offices, the approval process may extend beyond thirty (30) calendar days.

2. The Department review agency considers the request confidential information.

D. PH-MCO Outreach Request Form

1. HealthChoices PH-MCO Outreach Approval Request Form

E. Health Education Materials Request Form

1. HealthChoices Educational Materials Approval Request Form

HEALTHCHOICES EDUCATIONAL MATERIALS APPROVAL FORM

PH-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject:

_____

Who:

_____

What:

_____

When:

_____

Where:

_____

Any Fees:

_____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

DHS USE ONLY:

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

HEALTHCHOICES PH-MCO OUTREACH APPROVAL FORM

PH-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject:

_____

Who:

_____

What:

_____

When:

_____

Where:

_____

Any Fees:

_____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

DHS USE ONLY:

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

EXHIBIT Z
AUTOMATIC ASSIGNMENT

Any Consumer who does not select a physical health-managed care organization (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 an equal 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%.

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.

EXHIBIT BB

PH-MCO RECIPIENT COVERAGE DOCUMENT

This Recipient Coverage Document (RCD) includes descriptions of policies supported by the Department of Human Services (Department) data systems and processes. In cases in which policies expressed in this document conflict with another provision of the Managed Care Organization's (PH-MCO) Agreement, the Agreement will take precedence.

PH-MCO coverage as detailed in this document does not imply coverage under a BH-MCO. Refer to the BH-MCO RCD for behavioral health coverage guidelines.

The Department will provide sufficient information to the PH-MCO in order for it to reconcile PH-MCO membership data and amounts paid to and recovered from the PH-MCO. The Department will only pay capitation to one plan per recipient per month.

Coverage Rules

A PH-MCO is responsible for a Member if coverage is determined by applying the general rules found in any of paragraphs A, B, or C below, subject to exceptions and clarifications found in paragraphs D, E, F, and G.

Refer to the HealthChoices Intranet site "HealthChoices" for additional information on Recipient coverage, clarifications, examples, and membership Enrollment/disenrollment procedures.

A. Responsibility to Provide MA Benefits. - Unless otherwise specified, the PH-MCO is responsible to provide Medical Assistance (MA) benefits to Members in accordance with eligibility information included on the Monthly Membership File and/or the Daily Membership File, which is provided by the Department to each PH-MCO.

B. Membership Files/Coverage Dates/Eligibility. - Daily and Monthly Membership Files containing information and changes that apply to their Members are provided to each PH-MCO. The PH-MCO is responsible to provide services for each PH-MCO Member identified on the Daily or Monthly Membership File from the first day of the calendar month or the PH-MCO coverage start date, whichever is later, through the last day of the calendar month, or the PH-MCO end-date, if any. The Department will pay the PH-MCO from the first day of coverage in a month through the last day of the calendar month. PH-MCO coverage dates beyond the last day of the month in which the Daily or Monthly Membership File is created are preliminary information that is subject to change.

Members who become ineligible for MA will retain their PH-MCO selection for six months. These Members will become the responsibility of the same PH-MCO if

they regain MA eligibility during that six-month period, as long as their category of assistance and geographic location are valid for that PH-MCO. Upon regaining eligibility, their PH-MCO effective date will be their eligibility begin date or the date Client Information System (CIS) is updated with their coverage, whichever is later.

C. Benefit Packages. - 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 Qualification Code. In cases where the Member benefits are determined by the benefit package, the most comprehensive package is to be honored. For example, if a Member has the most comprehensive package on the first of the month but changes to a lesser level package during the month, he/she should receive the higher level of benefits for the entire month. If a Member has a lesser level benefit package at the beginning of the month but changes to higher level during the month, he/she should receive the higher-level benefits effective the first day of coverage under the higher level through the end of that month regardless of whether the category/program status code combination resulting in the higher level of benefits is valid for PH-MCO Enrollment. Refer to the Daily and Monthly Membership Files to determine increased benefits during a month.

D. Exceptions and Clarifications. - The Department will recover Capitation payments made for Members for whom it has been determined that the PH-MCO was not responsible to provide services.

The PH-MCO will not be responsible and will not be paid when the Department notifies the PH-MCO of Members for whom they are not responsible.

1. Errors in PH-MCO coverage identified from any source must be reported to the Department within forty-five (45) days of receipt of the Daily Membership File in order for changes to be considered.

   If a Recipient is enrolled in an PH-MCO in error, that PH-MCO is responsible to cover the Recipient until the Department is notified and the correction is applied to the CIS eligibility record.

   If at the time of notification to the Department, the Recipient was disenrolled in error from an PH-MCO and the Recipient is enrolled in a different PH-MCO, the Recipient will be reenrolled in the previous PH-MCO effective the first of the next month. However, if at the time of notification the Recipient is covered by FFS, the Recipient will be reenrolled into the same PH-MCO effective the day following notification to the Department.

2. If CIS shows an exemption code or a facility/placement code that precludes PH-MCO coverage, the Recipient will not be enrolled in a PH-MCO.

3. If CIS shows Fee-For-Service (FFS) coverage that coincides with PH-MCO coverage, the Member may use either coverage and there will be no monetary adjustment between the Department and the PH-MCO. (This is subordinate to #7 below.)

4. If a PH-MCO has actual knowledge that a Member is deceased, and if such Member shows on either the Monthly Membership or the Daily Membership file as active, the PH-MCO is required to notify the County Assistance Office (CAO) and the Department. The Department will recover Capitation payments made for up to eighteen (18) months after the service month in which the date of death occurred.

5. The Department will recover Capitation payments for Members who were later determined to be ineligible for PH-MCO coverage or who were placed in settings that result in the termination of PH-MCO coverage by the Department. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (i.e. today's date is 9/18/11 and central office staff end date managed care coverage 9/30/10 – payments are recouped for 10/10 through 9/11. See Section F for examples of placements that result in termination of coverage).

6. A newborn is the responsibility of the PH-MCO that covered the mother on the newborn's date of birth. Where CIS does not reflect this, the PH-MCO must notify the Department to correct coverage. The Department will generate Capitation payments as appropriate. Limitations in Sections E-2 and E-3 applicable to the mother will apply to the newborn.

   Exception #1: If mother is in a PH-MCO and C&Y assumes custody of the newborn at birth and places the child in a county within the same HC zone as the mother, the child's coverage will mirror the mother's PH-MCO coverage.

   Exception #2: If mother is in a PH-MCO and C&Y assumes custody of the newborn at birth and places the child in a county outside of the same HC zone where the mother resides, the child will be FFS until auto assignment or selected PH-MCO is effective in the new HC County.

7. Movement out of a PH-MCO's service area does not necessarily eliminate the PH-MCO's responsibility to provide MA benefits. It is the PH-MCO's

responsibility to inform the CAO of the address change upon receipt of information that a Member is residing outside the PH-MCO service area.

8. Pursuant to the rules outlined in the RCD, a lack of MA eligibility indicated on CIS for a certain date does not necessarily eliminate the PH-MCO's responsibility to provide MA benefits. (Refer to Section E, Coverage During Inpatient Hospital Stays, for rules regarding the PH-MCO's responsibility for hospital stays when a Recipient loses MA eligibility during the stay.)

9. Dual Eligibles who are enrolled in Medicare Part D, and who turn 21 years of age will be identified by the Department on the first Friday of each month, and will be disenrolled from the PH-MCO, effective the end of the month in which the Department identifies that the Member turned 21 years of age. In addition, newly identified Dual Eligibles age 21 and over will be disenrolled the end of the month following the month in which Medicare Part D is posted to their eligibility record. The PH-MCO remains responsible for these Members through the disenrollment date.

10. The Department reserves the right to intercede in requests for expedited enrollments when Medically Necessary. The Department's determination for the expedited enrollment will be final. The Capitation rate will be retroactively adjusted for each PH-MCO based on the effective date of the expedited enrollment.

11. A Member who is attending a college or university in a state other than Pennsylvania remains the responsibility of the PH-MCO. However, at the sole discretion of the Department, the Member may be disenrolled from the PH-MCO and enrolled in FFS. The Department will take into consideration such factors as distance from Pennsylvania, the intensity and duration of medically required services, whether the PH-MCO has a business presence nearby, etc.

E. Change in PH-MCO Coverage During Inpatient Hospital Stays. - When an MA Recipient has managed care coverage during part of a hospital stay, payment responsibility is as documented in Section E, Coverage During Inpatient Hospital Stays.

Note: One or more of the rules documented in the following sections may apply during a hospital stay.

RULE: E-1.	
Condition	**A Recipient who is covered by FFS when admitted to a hospital assumes PH-MCO coverage while still in the hospital.**
PH-MCO	As of the begin date of PH-MCO coverage, the PH-MCO is responsible for physician,

Coverage Responsibility	DME and all other covered services not included in the hospital bill.
MA FFS Coverage Responsibility	The FFS program is responsible for the hospital bill through the date of discharge. Note: If the Recipient is discharged from the initial hospital to another hospital (acute or rehabilitation) after the PH-MCO begin date, FFS is only responsible for the stay in the initial hospital through the date of discharge. The PH-MCO is responsible for the stay in the subsequent hospital upon admission.

RULE: E-2.	
Condition	**A Recipient who is covered by a PH-MCO when admitted to a hospital loses PH-MCO coverage and assumes FFS coverage while still in the hospital.**
PH-MCO Coverage Responsibility	The PH-MCO is responsible for the hospital stay with the following exceptions. EXCEPTION #1: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is the first day of the month, the PH-MCO is financially responsible for the stay through the last day of that month. Example: If a Recipient covered by the PH-MCO is admitted to a hospital on June 21 and the FFS coverage begin date is July 1, the FFS program assumes payment responsibility for the stay on August 1. The PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is any day other than the first day of the month, the PH-MCO is financially responsible for the stay through the last day of the following month. Example: If a Recipient covered by a PH-MCO is admitted to a hospital on June 21 and the FFS program coverage begin date is July 15, the FFS program assumes payment responsibility for the stay on September 1. The PH-MCO program remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	Starting with the FFS begin date, FFS is responsible for physician, DME and other bills not included in the hospital bill. EXCEPTION #1: The FFS program is financially responsible for the stay beginning on the first day of the next month. EXCEPTION #2: The FFS program is financially responsible for the stay beginning on the first day of the month following the next month.

RULE: E-3.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital transfers to another PH-MCO while still in the hospital.**
PH-MCO Coverage Responsibility	The losing PH-MCO is responsible for the hospital stay with the following exceptions. Starting with the gaining PH-MCO's begin date, the gaining PH-MCO is responsible for the physician, DME and all other covered services not included in the hospital bill. EXCEPTION #1: If the Recipient is still in the hospital on the gaining PH-MCO

	coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 1, the gaining PH-MCO assumes payment responsibility for the stay on August 1. The losing PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the gaining PH-MCO coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is any day other than the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the following month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The losing PH-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

RULE: E-4a.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses and <u>regains MA eligibility while in the hospital (Recipient is not discharged)</u>, resulting in a break in PH-MCO coverage. The Department's Division of Managed Care Systems Support (DMCSS) becomes aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.**
PH-MCO Coverage Responsibility	DMCSS will reopen the Recipient's PH-MCO coverage retroactive to the day it was end-dated on CIS and adjust the Capitation payment accordingly. The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services. Example: • A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22 and regains it on April 9 retroactive to March 22. The PH-MCO coverage on CIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new PH-MCO begin date of April 9. On April 25, DMCSS becomes aware of the situation. • Because DMCSS is aware of the loss of MA eligibility within the month following the month in which it was lost, DMCSS reopens the PH-MCO coverage retroactive to April 1, the day after the PH-MCO end-date is posted on CIS (March 31). The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services.

MA FFS Coverage Responsibility	There would be no FFS coverage in this example.

RULE: E-4b.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Recipient is not discharged), resulting in a break in PH-MCO coverage. DMCSS does not become aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.**
PH-MCO Coverage Responsibility	Example: Same as in RULE: E-4a except, because DMCSS is not aware of the break in PH-MCO coverage by the end of the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on CIS (March 31). The PH-MCO is only responsible to cover the Recipient through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4c.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility while in the hospital (Recipient is not discharged). The Recipient regains MA eligibility retroactively after the month following the month in which the MA eligibility was ended, regardless of when DMCSS became aware of the action.**
PH-MCO Coverage Responsibility	Example: • A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient regains MA eligibility on May 15 retroactive to March 22. The PH-MCO coverage on CIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new begin date of May 15. • Because the MA eligibility was not reopened within the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on CIS (March 31). The PH-MCO is only responsible to cover the Recipient through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4d.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility while in the hospital. The Recipient is discharged from the hospital after the month in which the MA eligibility was lost but before the MA eligibility is regained by the Recipient and reopened retroactively, regardless of when DMCSS became aware of the situation.**

PH-MCO Coverage Responsibility	Example: • A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient is discharged from the hospital April 3. The Recipient regains MA eligibility on April 22 retroactive to March 22. The PH-MCO coverage on CIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new begin date of April 22. • Because the Recipient was discharged from the hospital before the MA eligibility was reopened, which resulted in a 3-day period of FFS coverage on CIS, DMCSS does not reopen the PH-MCO coverage retroactive to April 1. The PH-MCO is only responsible for the stay through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4e.	
Condition	**A hospitalized Recipient never regains MA eligibility.**
PH-MCO Coverage Responsibility	If the Recipient is never determined retroactively eligible for MA, the PH-MCO is only responsible to cover the Recipient through the end of the month in which MA eligibility ended.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Recipient has not regained MA eligibility.

F. Other Causes for Coverage Termination and Involuntary Disenrollment. - If a condition described in the following sections occurs, the PH-MCO must notify the Department. In accordance with Department's disenrollment guidelines, DMCSS will take action to disenroll the Member. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (i.e. today's date is 9/18/11 and central office staff end date managed care coverage 9/30/10 – payments are recouped for 10/10 through 9/11).

If a Recipient is placed in a setting listed in these sections, and is under FFS prior to the PH-MCO's begin date, PH-MCO coverage will be voided and adjustments will be processed for any Capitation payments made.

The PH-MCO must notify the Department within sixty (60) days following the satisfaction of the Department's disenrollment guidelines in order for DMCSS to end-date the member's enrollment. Failure on the part of the PH-MCO to notify DMCSS within the sixty (60) days **will** result in the end-date being delayed, thereby extending the PH-MCO's responsibility for covering the Recipient. The PH-MCO should not hold and then later submit the notifications.

RULE: F-1.	
Condition	**A. A Member is admitted to a Nursing Facility (MA provider type/specialty codes 03/31 – County Nursing Facility, 03/30 – Nursing Facility, 03/382 – Hospital Based Nursing Facility, and 03/040 – Certified Rehab Agency) including a Medicare certified Nursing Facility.** **B. A Member who is covered by a PH-MCO when admitted to a Nursing Facility transfers to another PH-MCO or to FFS during the thirty (30) day period.** **C. A Member is admitted to an out of state Nursing Facility (regardless of who places the Member in the facility).** **D. A Member transfers from a Nursing Facility to the Pennsylvania Department of Aging (PDA) Waiver Program, or from the PDA Waiver Program to a Nursing Facility.** **E. A member is admitted to a Veteran's Home (MA provider type/specialty 03/042).**
PH-MCO Coverage Responsibility	**A.** The PH-MCO is responsible for payment for up to thirty (30) days of nursing home care (including hospital reserve or bed hold days) and for notifying the Department in accordance with the Department's disenrollment guidelines if a Member is admitted to a Nursing Facility. • A Member is disenrolled thirty (30) days following the admission date to the Nursing Facility provided that the Member has not been discharged from the Nursing Facility to a community placement. Example: A Member is admitted to a Nursing Facility on July 1. The Member is disenrolled from Managed Care effective July 30. PH-MCO is responsible for Member's services through July 30. The thirty (30) day period includes any hospitalizations or transfers between Nursing Facilities during the thirty (30) days. If a Member is hospitalized during the thirty (30) day period and has not been discharged from the hospital by the end of the thirty (30) days, the PH-MCO is responsible for the hospital stay as described in Section E, Coverage During Inpatient Hospital Stays chart, of the RCD. **B.** The PH-MCO at the time of the admission is responsible for thirty (30) days of nursing home care and for notifying the Department in accordance with the Department's disenrollment guidelines. If a Member becomes hospitalized during the thirty (30) day period and remains hospitalized at the end of the thirty (30) days, the PH-MCO at the time of admission to the Nursing Facility is responsible for the hospital stay as described in Section E, Coverage During Inpatient Hospital Stays , of the RCD. **C.** The PH-MCO is not responsible for Members who are placed in a Nursing Facility outside of Pennsylvania. A Member who is placed in an out of state Nursing Facility is disenrolled from the PH-MCO the day before the admission date. **D.** If a Member transfers from a Nursing Facility to the PDA Waiver Program, or from the PDA Waiver Program to a Nursing Facility, before the 30th consecutive day of PH-MCO responsibility, the thirty (30) day count of PH-MCO responsibility will include the total combined days consecutively enrolled in both the PDA Waiver or in the Nursing Facility, which includes hospital or bed hold days. **E**. The PH-MCO is not responsible for Members who are admitted to a Veteran's Home. A Member who is admitted to a Veteran's Home is disenrolled from the PH-MCO the day before the admission date.

MA FFS Coverage Responsibility	FFS is financially responsible for nursing home care effective on the 31st day following admission to the Nursing Facility. **A.** FFS is responsible as described in Section E, Coverage During Inpatient Hospital Stays, of the RCD. **B.** FFS is responsible as described in Section E, Coverage During Inpatient Hospital Stays, of the RCD. **C.** FFS is not responsible for coverage in an out of state Nursing Facility.

RULE: F-2.	
Condition	**A Member is enrolled in the PDA Waiver.**
PH-MCO Coverage Responsibility	The PH-MCO is responsible for the first thirty (30) days. If a Member transfers from a Nursing Facility to the PDA Waiver Program, or from the PDA Waiver Program to a Nursing Facility, before the 30th consecutive day of PH-MCO responsibility, the thirty (30) day count of PH-MCO responsibility will include the total combined days consecutively enrolled in both the PDA Waiver or in the Nursing Facility, which includes hospital or bed hold days. A Member enrolled in the PDA Waiver is disenrolled from the PH-MCO after thirty (30) days of service.
MA FFS Coverage Responsibility	FFS coverage is effective on the thirty-first (31st) day.

RULE: F-3.	
Condition	**A Member is admitted to a State Facility (MA Provider Type/Specialty Codes 01/23 - Public Psychiatric Hospital and 03/37 - State LTC Unit located at State Mental Hospitals).**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for Members in a state facility. A Member admitted to a state facility is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: F-4.	
Condition	**A Member is incarcerated in a Penal Facility, Correctional Institution (including work release), or Youth Development Center.**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility. The Member is disenrolled from the PH-MCO effective the day before incarceration in the facility or institution.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility,except for inpatient hospital services.
NOTE:	This rule is based upon section 392.2 of the MA Eligibility Handbook which states,

	"For purposes of MA eligibility, other than eligibility for inpatient hospital services, the needs of an inmate in a correctional institution are the responsibility of the governmental authority exercising administrative control over the facility."

RULE: F-5.	
Condition	**A Member is placed in a Juvenile Detention Center (JDC).**
PH-MCO Coverage Responsibility	During the first thirty five (35) days of a Member's placement in a JDC, the PH-MCO is responsible for all covered services that are provided to the Member ***outside*** of the JDC site. A Member who is placed in a JDC is disenrolled from the PH-MCO after thirty five (35) days.
MA FFS Coverage Responsibility	Services provided to the Member ***on-site*** at the JDC during the first thirty five (35) days will be covered under the MA FFS Program. FFS coverage is effective on the 36th day.

RULE: F-6.	
Condition	**A Member becomes eligible for the Health Insurance Premium Payment Program (HIPP).**
PH-MCO Coverage Responsibility	A Member determined to be HIPP eligible (Employer Group Health Plan) is disenrolled from the PH-MCO. Additionally, HIPP eligible MA Members are prevented from enrolling in PH-MCOs.
MA FFS Coverage Responsibility	FFS benefits with HIPP insurance coverage begin the day after the disenrollment date.

RULE: F-7.	
Condition	**A Member is enrolled in the Living Independence for the Elderly Program (LIFE) (MA ProviderType/Specialty Code 07/70 – LIFE)** **LIFE is Pennsylvania's managed care demonstration for Nursing Facility eligibles. It provides for long term care needs of frail elderly Recipients who wish to remain independent in their community but require intensive, integrated primary and psychosocial care to do so.**
PH-MCO Coverage Responsibility	A Member enrolled in LIFE is disenrolled from the PH-MCO effective the day before the begin date of LIFE.
MA FFS Coverage Responsibility	LIFE Coverage begins the day after the disenrollment date.

G. Other Facility Placement Coverage. - Refer to the following sections for rules concerning PH-MCO coverage of Recipients placed in other facilities.

RULE: G-1.	
Condition	**A Member is admitted to a state ICF-MR (MA Provider Type/Specialty Code 03/38 – State Mental Retardation Center).**
PH-MCO Coverage Responsibility	A Member admitted to a state ICF-MR is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: G-2.	
Condition	**A Member is admitted to a private ICF-MR/ICF-ORC (MA Provider Type/Specialty Code 03/32 – ICF/MR 8 Beds or Less, 03/33 – ICF/MR 9 Beds or More, and 03/39 – ICF/ORC).**
PH-MCO Coverage Responsibility	A Member admitted to a private ICF-MR or an ICF-ORC facility will continue to be covered by their selected PH-MCO for all covered physical health services with the exception of those services that the ICF-MR or ICF-ORC has historically and customarily provided to residents of the facility or those services that are covered under the facilities per diem payment. • The residential/treatment costs that are the responsibility of the ICF-MR or ICF-ORC under its agreement with DHS are not the responsibility of the BH-MCO. All other Behavioral Health Services are the responsibility of the BH-MCO.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs. DHS will make direct payments to the ICF-MR or ICF-ORC facility to cover room, board, MR-specific non-MA services, and physical and behavioral health services to the extent these services have been customarily and historically provided to residents of the facility.

RULE: G-3.	
Condition	**A. A Member is admitted to a JCAHO approved Residential Treatment Facility (RTF) (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital).** **B. A Member is admitted to a non-JCAHO approved Residential Treatment Facility (RTF)** (MA Provider Type/Specialty Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified)**.**
PH-MCO Coverage Responsibility	**A.** With the exception of Children in Substitute Care who are placed in residential facilities by another government agency that has responsibility for these children, a Member placed in a JCAHO approved RTF (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital) remains covered by their selected PH-MCO for all covered physical health services. • The BH-MCO is responsible for the residential/treatment costs. **B.** A Member placed in a non-JCAHO approved RTF (MA Provider Type/Specialty

	Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified) remains covered by their selected PH-MCO for all covered physical health services. • The BH-MCO is responsible for the MA per diem. The Room & Board per diem can be the responsibility of the BH-MCO, Children and Youth or another agency depending on medical necessity and who places the Recipient.
MA FFS Coverage Responsibility	**A.** FFS is responsible for the residential/treatment costs. **B.** FFS is responsible for the facility's per diem payment.

RULE: G-4.	
Condition	**A Member is admitted to an Extended Acute Psychiatric Care Hospital (MA Provider Type/Specialty Code 01/18 – Extended Acute Psych Inpatient Unit)..**
PH-MCO Coverage Responsibility	A Member admitted to an extended acute psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. • If the Recipient is placed in the facility by the BH-MCO, then the BH-MCO is responsible for the residential/treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

RULE: G-5.	
Condition	**A Member is admitted to an Inpatient Private Psychiatric Facility (MA Provider Type/Specialty Code 01/11 – Private Psychiatric Hospital and 01/22 – Private Psychiatric Unit).**
PH-MCO Coverage Responsibility	A Member admitted to a private psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. • The BH-MCO is responsible for the residential/treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

EXHIBIT CC

DATA SUPPORT FOR PH-MCOs

Each PH-MCO will be required to connect to the Department's network for the purpose of on-line inquiries, Intranet access and file transfers. Specifications and limited technical assistance will be made available. No information made available to the PH-MCO is to be used for any purpose other than supporting their program under HealthChoices. Access to the Department's network will continue for the functions not included under PROMISe™.

The PH-MCOs will be required to adhere to Department requirements and HIPAA transactions. Each PH-MCO will need to be certified through PROMISe™ prior to implementing any data exchange. The Department will provide training on the use and interpretation of information found on the system.

DHS INQUIRY ACCESS:

1. Client Information System (CIS)

   The Department will make available to each PH-MCO access to the Department's CIS database. This database provides eligibility history, demographic information, and TPL information to support the PH-MCO in meeting their obligations.

2. HealthChoices Intranet

   The Department will make available to each PH-MCO access to the Department's HealthChoices Intranet.

3. DHS Internet

   Each PH-MCO will have access to the Department's Internet at www.dhs.pa.gov.

PROMISe™ INQUIRY ACCESS:

1. Eligibility Verification System (EVS)

   All PH-MCOs will be provided access to EVS. EVS can be used to verify eligibility, MCO coverage and TPL information. Access will be via the following methods:

   - Toll-free via an Automated Voice Response System (AVRS);
   - Dial-up access to a Bulletin Board System (BBS)/Modem;
   - Toll free via Provider Electronic Solutions software or point of service (POS) device;
   - Internet; and
   - Direct line.

2. On-Line Inquiry

   Access to the following online screens will be made available to the PH-MCOs:

   - Provider
   - Reference
   - Recipient Eligibility Verification
   - Claims
   - Prior Authorization

DATA FILES:

Following are the descriptions of the data files that will be provided to the PH-MCO by the EAP Contractor, or by the Department.; the data files that the PH-MCO will be required to submit to the EAP Contractor or the Department; and the files that the EAP Contractor will be required to provide to the Department. Additional files may be made available upon request. File layouts and schedules can be found on the HealthChoices Intranet Site.

FILES AND REPORTS PROVIDED TO THE PH-MCO:

NAME	PURPOSE	FREQUENCY
834 Daily Membership File	HIPAA compliant file of any change affecting a Member's demographic, eligibility and enrollment data and TPL information for that day.	Daily
834 Monthly Membership File	HIPAA compliant file containing one record for each recipient who is both MA and managed care eligible at some point in the following month as of the date that the file is generated.	Monthly
Weekly Enrollment/ Alert Reconciliation file	File of the disposition of each record submitted on the Weekly Enrollment/Alert File of enrollments and alerts.	Weekly
Pending Enrollment File	File from the EAP contractor that provides the PH-MCOs with pre-enrollment data.	Weekly
Response to the Automated Provider Directory	A response file (from the EAP) to the Automated Provider Directory that is posted each time a file has been processed.	Weekly
ARM 568 Report File	Report file of CIS eligibility statistics by county/district	Monthly-Optional
DHS Casualty Encounter Data File Request	TPL file of Recipients for every PH-MCO where TPL needs adjudicated encounter claims information.	Daily - Urgent Weekly - Non-urgent

NAME	PURPOSE	FREQUENCY
PH-MCO Electronic Resource Error File	TPL file of records returned by DHS due to errors.	Weekly
CMS Drug Product Data File	Listing of CMS approved drugs covered by Medicaid	Quarterly
Response to PCP File	Report of records returned by PROMISe due to error.	Weekly
Procedure Code Extract	The Procedure Code File contains five files within the zip file: Modifier Max Fee, Procedure Code, Provider Type, Restricted and Related.	Monthly
Diagnosis Code File	Diagnosis Code file to assist in the coding of Claims and Encounter Data	Monthly
820 Capitation Payment File	HIPAA compliant file reflecting Capitation payments and adjustments processed for eligible Recipients.	Monthly
835 Remittance Advice File	HIPAA compliant file of all maternity care Claims that paid or rejected, as well as gross adjustments that processed.	Weekly
MCO Payment Summary File	Summary file of capitation payments by county group, rate cell and date of service up to 36 months	Monthly
36-Month Summary File	A summary file of all Capitation payments by county group, rate cell, and date of service for the last 36 months.	Monthly
List of Active and Closed Providers (PRV-415)	File of enrolled MA Providers in Pennsylvania and the surrounding states and providers closed within the last 90 days.	Monthly
List of Active and Closed Providers (PRV-414)	File of enrolled MA Providers in Pennsylvania and the surrounding states and providers closed within the last 90 days.	Weekly
NPI Crosswalk File (PRV-430)	File of providers that registered their NPI number with the Department.	Weekly
Special Indicator File (PRV435)	File of provider/service locations and special indicators to identify those providers eligible for the enhanced payments.	Weekly
PH-MCO Provider Error Report (PRM640)	Report of PH-MCO Provider records returned by DHS due to error.	Monthly
Daily EDI Claims	Summary report providing EDI encounter	Daily

NAME	PURPOSE	FREQUENCY
Submission Statistics	totals sent to the PROMISe™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the day.	
Weekly EDI Claims Submission Statistics	Summary report providing EDI encounter totals sent to the PROMISe™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the week.	Weekly
Monthly EDI Claims Submission Statistics	Summary report providing EDI encounter totals sent to the PROMISe™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the month.	Monthly
Record Accept/Reject Report	Report sent from the translator in response to incoming HIPAA transaction files from the PH-MCOs.	Daily/After Each Submission
U277	HIPAA transaction generated from PROMISe™ at the end of each processing day, providing a limited data set of all accepted, suspended, and rejected encounters during that Business Day's processing.	Daily
NCPDP Response	HIPAA transaction generated from PROMISe™ providing a limited data set of all accepted and rejected drug encounters per file submission.	Daily
Record Accept/Reject File	Flat file sent from the translator in response to incoming HIPAA transaction files from the PH-MCOs.	Daily
Monthly Rejected Encounter Activity Report	Report sent to the PH-MCOs providing a summary/counts of all encounters remaining uncorrected in the suspense database at a given month's end.	Monthly
997 BES Report	Provided by the BES Translator. Sent to the Submitter when the entire file is rejected for invalid HIPAA formats.	Daily
FFS Pharmacy Files	Pharmacy data from FFS to the physical health and behavioral health plans.	Weekly
Reapplication File	File of recipients who have MA reapplication and SAR (Semi Annual Reporting) due dates that are 90 days in advance of the run date.	Monthly

NAME	PURPOSE	FREQUENCY
Quarterly Network Provider File	File of network providers returned to the MCO	Quarterly
TPL Monthly File	This file provides the MCOs with TPL information from DHS's TPL database specific to their members.	Monthly
Service History Data Files	Files containing service history data (FFS and encounters) for enrolled members from the DHS data warehouse.	Weekly

FILES PROVIDED BY THE PH-MCO:

NAME	PURPOSE	FREQUENCY
PH-MCO Network Provider file (PRV640)	File provided listing all Providers within the Network to serve Members.	Monthly
PCP File	File provides the PCP assignments for all Members.	Weekly
837P - Maternity Care	HIPAA compliant file of Claims for each PH-MCO where the PH-MCO was responsible for the Recipient on the newborn's date of birth.	Daily
PH-MCO Casualty Claims File	TPL file of adjudicated Claims for Recipients on DHS casualty claims file.	Weekly, sometimes daily
PH-MCO Recovery Flagging File	TPL file provides DHS with a list of encounters on which the PH-MCO intends to pursue recovery.	Monthly/Weekly
PH-MCO Reconciliation File	TPL file provides DHS with a list of encounters on which the PH-MCO has realized a recovery, been denied by the third party, or has abandoned recovery activity.	Monthly/Weekly
PH-MCO Electronic Resource File	TPL file provides the PH-MCOs with a process to send both new and updated resource referrals electronically in batch format to DHS for update to the TPL file.	Weekly

NAME	PURPOSE	FREQUENCY
837P, 837I, 837D, NCPDP	HIPAA compliant file submitted by the PH-MCO providing the Department with Encounter Data for all PH-MCO Recipients.	As Scheduled
NCPDP Supplemental File	A file containing supplemental data for NCPDP transactions used for the purpose of drug rebate dispute resolution.	Monthly
Weekly Enrollment/ Alert File	File provided to notify the Department of return mail, newborns not on CIS, a Member's pregnancy not reflected on CIS, or a deceased Recipient with no Date of Death reflected on CIS.	Weekly
Automated Provider Directory File	File contains information on all Providers in the Network for the PH-MCO. The information will be used by the EAP contractor for their Electronic (Online) Provider Directory.	Weekly
PH/BH Pharmacy File	Pharmacy data from the physical health plans to the behavioral health plans	Submission based on schedule developed by the PH-MCO (at least twice per month.)
Insure Kids Now—Dental Provider Data File	A quarterly file provided by the MCOs to DHS containing select information about their Dental Providers.	Quarterly

EXHIBIT DD

PH-MCO MEMBER HANDBOOK

The PH-MCO must ensure that the Member handbook contains written information regarding Member rights and protections and is written at no higher than a sixth grade reading level. The PH-MCO must provide a Member handbook in the appropriate prevalent language, or alternate format, to all members within five (5) business days of being notified of a Member's enrollment, but no sooner than five (5) business days before the 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. Upon request, the PH-MCO must provide a hard copy version of the Member handbook to the Member.

At a minimum, the Member handbook shall include:

1. Information about the PH-MCO, its services, the practitioners providing care, and Member's rights and responsibilities.

2. Role of the PCP in directing and managing care and as patient advocate.

3. Information on the role of the Enrollment Assistance Program and how to access services, including but not limited to what services they provide to the Member and contact information.

4. Description of services which should include assistance with changing PH-MCOs, PCPs and the right to request an updated Provider directory.

5. How to access after-hour, non-emergency care.

6. Description of the PH-MCO ID card and the ACCESS card and their uses.

7. Statement that no balance billing allowed.

8. Information about co-payments, service limits, and the exception process.

9. An explanation of the Member's financial responsibilities for payment of services provided by a Non-participating Provider, when service is provided by a Provider without Prior Authorization, or when care rendered is not covered by the PH-MCO.

10. An explanation that prescriptions for medications that are written by non-participating providers (whether or not they are presented at a participating or non-participating pharmacy) will be the member's responsibility with the following exceptions:

- 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.

11. Information that the Member is not liable for payment of covered services provided in the event that a Pennsylvania Medical Assistance participating Health Care Provider does not receive payment from the PH-MCO.

12. Rights of the Member regarding confidentiality of their medical records.

13. Rights of the Member to request and receive a copy of his or her medical records and to request that they be corrected or amended as specified in 45 CFR part 164.524 and 164.526.

14. Rights of members to receive information regarding cost of care.

15. Information on the availability of and how to access or receive assistance in accessing, at no cost to the Member, oral interpretation services for all services provided by the PH-MCO for all non-English languages.. The PH-MCO must make 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.

16. Availability of and information on how to access or receive assistance in accessing, at no cost to the Member, communication methods including TTY and relay services and materials in an alternate format such as Braille, audio tape, large print, compact disc (CD), DVD, computer diskette, and/or electronic communication including how the PH-MCO will arrange for providing these alternate format Member materials.

17. Table of contents.

18. Information about choosing and changing PCPs.

19. Information about choosing a primary dentist, if applicable.

20. Information on how to request a specialist as a PCP or a standing referral to a specialist.

21. Information on availability of specialists.

22. Information about what to do when family size, address or phone number changes.

23. Information regarding appointment standards.

24. Information regarding MA Members' rights and PH-MCOs' responsibilities per Section 1867 of the Social Security Act.

25. A description of all available contract services, including how to access those services, and an explanation of any service limitations or exclusions from coverage, including an explanation that limitations and most exclusions do not apply to Members under the age of 21, specific instructions on how transportation is provided, and a notice stating that the PH-MCO will be liable only for those services that are the responsibility of the PH-MCO.

26. A description of the services not covered 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.

27. Information on how to request guidelines, including utilization review and clinical practice guidelines.

28. An explanation of the procedures for obtaining benefits, including self-referred services, services requiring Prior Authorization and services requiring a referral.

29. How to contact Member Services, the Special Needs Unit (HealthChoices only) and the Maternal Health/EPSDT Coordinator and a description of their functions.

30. Information regarding the Complaint, Grievance and DHS Fair Hearing processes, as set forth in the Physical Health Member Handbook Template for Complaints, Grievances and Fair Hearings, and the right to interim relief within the relevant time frames of the process (55 Pa. Code Section 275.4(d).

31. How to contact the Clinical Sentinel Hotline. Please reference Managed Care Ops Memo # 09/2009-018 for required template language guidelines.

32. An explanation of how to obtain a list of all available PCPs, specialists, pharmacies, and providers of ancillary services, upon request, in the appropriate alternate format or language.

33. What to do in case of an Emergency Medical Condition and instructions for receiving advice on care in case of an emergency. The Member handbook should instruct members to use the emergency medical services (EMS) available and/or activate EMS by dialing 9-1-1 in a life-threatening situation.

34. How to obtain emergency transportation and Medically Necessary transportation. Provide the names and telephone numbers for county MATP providers.

35. EPSDT standard services and information regarding Early Intervention services, including dental services that fall under EPSDT. PH-MCOs must update their handbooks to reflect increased access for application of topical fluoride varnish by CRNPs and physicians.

36. How and where to access behavioral health, family planning and vision services.

37. Information on how to obtain prescription drugs, including information on the PH-MCO's formulary and how to request a copy.

38. Information on what to do regarding out of county/out of state moves.

39. Contributions the member can make towards his/her own health.

40. Information regarding pregnancies which conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant. The concept of remaining with the same PH-MCO for the entire pregnancy will be advocated.

41. Notification that the selection of certain PCP sites may result in medical residents, nurse practitioners and physicians assistants providing care to Members.

42. Information regarding the availability of second opinions and when and how to access them.

43. Information regarding the right to receive services from an Out-of-Network Provider when the PH-MCO cannot offer a choice of two qualified specialists, and an explanation of how to request authorization for out-of-network services and how to appeal a Denial of Services.

44. Information on the availability and process for accessing MA Out-of-Plan Services which are not the responsibility of the PH-MCO, but are available to Members.

45. Information regarding the Women's, Infants' and Children (WIC) Program and how to access the Program.

46. Information regarding HIV/AIDS programs and how to access them.

47. Information on Tobacco Cessation Programs and how to access them.

48. Information on "Advance Directives" (durable health care power of attorney and living wills) for adult Members including:
    a. The description of State law, if applicable
    b. The process for notifying the Member of any changes in applicable State law as soon as possible, but no later than ninety (90) days after the effective date of the change
    c. Any limitation the PH-MCO has regarding implementation of advanced directives as a matter of conscience
    d. The process for Members to file a Complaint concerning noncompliance with the advanced directive requirements with the PH-MCO and the State survey and certification agency
    e. How to request written information on advance directive policies.

49. A statement that all Members will be treated with respect and due consideration for his or her dignity and privacy.

50. A statement that Members may receive, from a Health Care Provider, information on available treatment options and alternatives, presented in a manner appropriate to Member's condition and ability to understand.

51. A statement that Members have the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

52. A statement that Members are guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

53. A statement that Each Member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the PH-MCO and its Providers or the State agency treat the Member.

54. Explanation of PH-MCO's and DHS's Recipient Restriction Program including how to request a DHS Fair Hearing regarding a restriction action and how to request a change of pharmacy or Provider.

55. The Department's MA Provider Compliance Hotline number and explanatory statement.

EXHIBIT GG

COMPLAINT, GRIEVANCE AND DHS FAIR HEARING PROCESSES

A. General Requirements

1. All Complaint, Grievance and DHS Fair Hearing policies and procedures must receive prior written approval by the Department.

2. The PH-MCO may not charge Members a fee for filing a Complaint or Grievance at any level of the process.

3. The PH-MCO must have written policies and procedures for registering, responding to and resolving Complaints and Grievances (at all levels) as they relate to the MA population. These policies and procedures must be made available upon request.

4. The PH-MCO must maintain written documentation of each Complaint and Grievance and the actions taken by the PH-MCO.

5. The PH-MCO must ensure that Members have access to all relevant documentation pertaining to the subject of the Complaint or Grievance.

6. The PH-MCO must have a data system to process, track and trend all Complaints and Grievances.

7. The PH-MCO must ensure that there is a link between the Complaint and Grievance processes and the Quality Management and Utilization Management programs.

8. The PH-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements in this Exhibit.

9. PH-MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training and experience to make an informed and impartial determination regarding issues assigned to them.

10. The PH-MCO may not use the time frames or procedures of the Complaint and Grievance process to avoid the medical decision process or to discourage or prevent the Member from receiving Medically Necessary care in a timely manner.

11. The PH-MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/TDD for telephone inquiries and Complaints and Grievances from Members who are hearing impaired; Braille; tape; or computer disk; and other commonly accepted alternative forms of communication. PH-MCO employees who receive

telephone Complaints and Grievances should also be made aware of the speech limitation of some Members with disabilities so they can treat these individuals with patience, understanding, and respect.

12. The PH-MCO must provide Members with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Member. This includes:

    - Providing qualified sign language interpreters for Members who are severely hearing impaired;
    - Providing information submitted on behalf of the PH-MCO at the Complaint or Grievance review in an alternative format accessible to the Member filing the Complaint or Grievance. The alternative format version should be supplied to the Member at or before the review, so the Member can discuss and/or refute the content during the review; and
    - Providing personal assistance to Members with other physical limitations in copying and presenting documents and other evidence.

13. The PH-MCO must provide language interpreter services when requested by a Member, at no cost to the Member.

14. The PH-MCO must offer Members the assistance of a PH-MCO staff member throughout the Complaint and Grievance processes at no cost to the Member.

15. The PH-MCO must ensure that anyone who participates in making the decision on a Complaint or Grievance was not involved in any previous level of review or decision-making.

16. The PH-MCO must notify the Member when the PH-MCO fails to decide a first level Complaint or first level Grievance within the timeframes specified in this Exhibit, using the template supplied by the Department (Exhibit GG(1)) on the HealthChoices Intranet. This notice must be mailed one day following the date the decision was to be made (day 31).

17. The PH-MCO must notify the Member when it denies payment 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 using the template supplied by the Department (Exhibit GG(11)). This notice must be mailed to the Member on the day the decision was made to deny payment.

18. The PH-MCO must notify the Member when it denies payment after a service has been delivered because the service/item provided is not a covered benefit for the Member, using the template supplied by the Department (Exhibit GG(12)). This notice must be mailed to the Member on the day the decision is made to deny payment.

19. The PH-MCO must notify the Member when it denies payment after a service has been delivered because the PH-MCO determined that the service was not

Medically Necessary, using the template supplied by the Department (Exhibit GG(13)). This notice must be mailed to the Member on the day the decision is made to deny payment.

20. The PH-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances (at all levels) at one location within each of its zones of operation. If a Member requests an in-person review, the PH-MCO must notify the Member of the location of the review and who will be present at the review using the template supplied by the Department (Exhibit GG(14)).

21. The PH-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.

B. Complaint Requirements

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 Insurance Department of the Commonwealth, including but not limited to:

i. a denial because the requested service/item is not a covered benefit; or

ii. a failure of the PH-MCO to meet the required timeframes for providing a service/item; or

iii. a failure of the PH-MCO to decide a Complaint or Grievance within the specified timeframes; or

iv. 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

v. 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.

1. First Level Complaint Process

a. A PH-MCO must permit a Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a Complaint either in writing or orally. Oral requests must be committed to writing by the PH-MCO if not confirmed in writing by the Member and must be provided to the Member or the Member's representative for signature. The signature may be obtained at any point in

the process, and failure to obtain a signed Complaint may not delay the Complaint process. If the Complaint disputes the failure of the PH-MCO to decide a Complaint or Grievance within the specified timeframes; challenges the failure to meet the required timeframes for providing a service/item; disputes a denial made for the reason that a service/item is not a covered benefit; disputes a denial of payment after the service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Member, the Member must file a Complaint within forty-five (45) days from the date of the incident complained of or the date the Member receives written notice of the decision. For all other Complaints, there is no time limit for filing a Complaint.

b. The PH-MCO must provide Members with a toll free number to file a Complaint, request information about the Complaint process, and ask any questions the Member may have about the status of a Complaint.

c. If a Member files a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the Complaint, if the Complaint is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

d. Upon receipt of the Complaint, the PH-MCO shall send the Member and Member's representative, if the Member has designated one, an acknowledgment letter using the template supplied by the Department (Exhibits GG(2a) and GG(2b)).

e. The first level Complaint review for Complaints **not involving** a clinical issue shall be performed by a first level Complaint review committee, which shall include one or more employees of the PH-MCO who were not involved in any previous level of review or decision making on the issue that is the subject of the Complaint.

f. The first level Complaint review for Complaints **involving** a clinical issue shall be performed by a first level Complaint review committee, which shall include one or more employees of the PH-MCO who were not involved in any previous level of review or decision making on the issue that is the subject of the Complaint. The Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the Complaint.

g. The Member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The

PH-MCO shall be flexible when scheduling the review to facilitate the Member's attendance. The Member shall be given at least seven (7) days advance written notice of the review date using the template supplied by the Department (Exhibits GG(14a) and GG(14b)). If the Member cannot appear in person at the review, an opportunity to communicate with the first level Complaint review committee by telephone or videoconference must be provided. The Member may elect not to attend the first level Complaint meeting but the meeting must be conducted with the same protocols as if the Member was present.

h. If a Member requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review will be held and the other members of the first level Complaint review committee must participate in the review through the use of videoconferencing.

i. The first level Complaint review committee shall complete its review of the Complaint as expeditiously as the Member's health condition requires, but no more than thirty (30) days from receipt of the Complaint, which may be extended by fourteen (14) days at the request of the Member.

j. The first level Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.

k. The PH-MCO must send a written notice of the first level Complaint decision, using the template supplied by the Department (Exhibit GG(3a)), to the Member, Member's representative, if the Member has designated one, service provider and prescribing PCP, if applicable, within five (5) Business Days from the first level Complaint review committee's decision.

l. The Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for a second level Complaint review ("second level Complaint") within forty-five (45) days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

m. If the Complaint disputes the failure of the PH-MCO to provide a service/item or to decide a Complaint or Grievance within specified time frames or disputes a denial made for the reason that a service/item is not a covered benefit, or disputes a denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Member, the Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's first level Complaint decision.

2. **Second Level Complaint Process**

a. Upon receipt of the second level Complaint, the PH-MCO shall send the Member and Member's representative, if the Member has designated one, an acknowledgment letter using the template supplied by Department (Exhibit GG(4)).

b. If a Member files a second level Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the second level Complaint, if the second level Complaint is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the PH-MCO's first level Complaint decision.

c. The second level Complaint review shall be performed by a second level Complaint review committee made up of three (3) or more individuals who were not involved in any previous level of review or decision-making on the matter under review.

d. At least one-third of the second level Complaint review committee may not be employees of the PH-MCO or a related subsidiary or affiliate.

e. A committee member who does not personally attend the second level Complaint review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.

f. The Member must be provided the opportunity to appear before the second level Complaint review committee. The PH-MCO shall be flexible when scheduling the second level Complaint review to facilitate the Member's attendance. The Member shall be given at least fifteen (15) days advance written notice of the review date using the template supplied by the Department (Exhibits GG(14a) and GG(14b)). If the Member cannot appear in person at the second level Complaint review, an opportunity to communicate with the second level Complaint review committee by telephone or videoconference must be provided. The Member may elect not to attend the second level Complaint meeting but the meeting must be conducted with the same protocols as if the Member was present.

g. If a Member requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review will be held and the other members of the second level Complaint review committee must participate in the review through the use of videoconferencing.

h. The decision of the second level Complaint review committee must be based solely on the information presented at the review.

i. The second level Complaint review committee shall complete the second level Complaint review within forty-five (45) days from the PH-MCO's receipt of the Member's second level Complaint.

i. Testimony taken by the second level Complaint review committee (including the Member's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.

j. The PH-MCO must send a written notice of the second level Complaint decision, using the template supplied by the Department (Exhibit GG(5)) to the Member, Member's representative, if the Member has designated one, service Provider and prescribing Provider, if applicable within five (5) Business Days from the second level Complaint review committee's decision.

k. The Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an external review of the second level Complaint decision with either the Department of Health or the Insurance Department within fifteen (15) days from the date the Member receives the written notice of the PH-MCO's second level Complaint decision.

l. If the second level Complaint disputes the failure of the PH-MCO to provide a service/item or to decide a Complaint or Grievance within specified time frames or disputes a denial made for the reason that a service/item is not a covered benefit, or disputes a denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Member, the Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's second level Complaint decision.

3. **External Review of Second Level Complaint Review Decision**

a. If a Member files a request for an external review of a second level Complaint decision to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the external review, if the request for external review is hand-

delivered or post-marked within ten (10) days from the mail date on the written notice on the PH-MCO's second level Complaint decision.

b. Upon the request of either the Department of Health or the Insurance Department, all records from the first level review and second level review shall be transmitted to the appropriate department by the PH-MCO within thirty (30) days from the request in the manner prescribed by that department. The Member, the Health Care Provider or the PH-MCO may submit additional materials related to the Complaint.

c. The Department of Health and the Insurance Department will determine the appropriate agency for the review.

4. **Expedited Complaint Process**

a. The PH-MCO must conduct expedited review of a Complaint at any point prior to the second level Complaint decision, if a Member or Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, provides the PH-MCO with a certification from his or her Provider that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular Complaint process. This certification is necessary even when the Member's request for the expedited review is made orally. The certification must include the Provider's signature.

b. A request for an expedited review of a Complaint may be filed either in writing, by fax or orally. Oral requests must be committed to writing by the PH-MCO. The Member's signature is not required.

c**.** Upon receipt of an oral or written request for expedited review, the PH-MCO must inform the Member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

d. If the Provider certification is not included with the request for an expedited review, the PH-MCO, must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three (3) Business Days of the Member's request for expedited review, the PH-MCO shall decide the Complaint within the standard timeframes as set forth in this Exhibit. The PH-MCO must make a reasonable effort to give the Member prompt oral notice that the Complaint is to be decided within the standard timeframe and send a written notice within two (2) days of the decision to deny expedited review, using the template supplied by the Department (Exhibit GG(6b)).

e. If a Member files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Member

has been receiving on the basis that the service/item is not a covered benefit, the Member must continue to receive the disputed service/item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

f. Complaints requiring expedited review must be reviewed by a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review. The members of the Complaint review committee may not have been involved in any previous level of review or decision-making on the issue under review. The licensed physician must decide the Complaint.

g. The PH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if the Member has designated one, and the Member's Health Care Provider within either forty-eight (48) hours of receiving the Provider certification or three (3) Business Days of receiving the Member's request for an expedited review, whichever is shorter. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one, and the Member's Health Care Provider within two (2) days of the decision using the template supplied by the Department (Exhibit GG(6a)).

h. The PH-MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.

i. The Member, or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an expedited external Complaint review with the PH-MCO within two (2) Business Days from the date the Member receives the PH-MCO's expedited Complaint decision.

j. The PH-MCO shall follow Department of Health guidelines relating to submission of requests for expedited external reviews.

k. The PH-MCO must ensure that punitive action is not taken against a Provider who either requests expedited resolution of a Complaint or supports a Member's request for expedited review of a Complaint.

l. The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's expedited Complaint decision.

C. Grievance Requirements

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.

1. **First Level Grievance Process**

   a. A PH-MCO shall permit a Member or the Member representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a Grievance either in writing or orally. Oral requests must be committed to writing by the PH-MCO if not confirmed in writing by the Member and must be provided to the Member for signature. The Member's signature may be obtained at any point in the process, and failure to obtain a signed Grievance may not delay the Grievance process. Members will be given forty-five (45) days from the date the Member receives the written notice to file a Grievance.

   b. The PH-MCO must provide Members with a toll free number to file a Grievance, request information about the Grievance process, and ask questions the Member may have about the status of a Grievance.

   c. A Member who files a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the Grievance, if the Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

   d. Upon receipt of the Grievance, the PH-MCO shall send the Member and Member's representative, if the Member has designated one, an acknowledgment letter using the template supplied by the Department (Exhibit GG(7)).

   e. A Member who consents to the filing of a Grievance by a Health Care Provider may not file a separate Grievance. The Member retains the right to rescind consent throughout the Grievance process upon written notice to the PH-MCO and the Provider.

   f. In order for the Provider to represent the Member in the conduct of a Grievance, the Provider must obtain the written consent of the Member. A Provider may obtain the Member's written permission at the time of treatment. A Provider may NOT require a Member to sign a document

authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

i. The name and address of the Member, the Member's date of birth and identification number;

ii. If the Member is a minor, or is legally incompetent, the name, address and relationship to the Member of the person who signed the consent;

iii. The name, address and PH-MCO identification number of the Provider to whom the Member is providing consent;

iv. The name and address of the PH-MCO to which the Grievance will be submitted;

v. An explanation of the specific service/item for which coverage was provided or denied to the Member to which the consent will apply;

vi. The following statement: "The Member or the Member's representative may not submit a Grievance concerning the services/items listed in this consent form unless the Member or the Member's representative rescinds consent in writing. The Member or the Member's representative has the right to rescind consent at any time during the Grievance process.";

vii. The following statement: "The consent of the Member or the Member's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the second level review process.";

viii. The following statement: "The Member or the Member's representative, if the Member is a minor or is legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The Member or the Member's representative understands the information in the Member's consent form."; and

ix. The dated signature of the Member, or the Member's representative, and the dated signature of a witness.

g. The first level Grievance review shall be performed by the first level Grievance review committee, which shall include one or more employees of the PH-MCO who was not involved in any previous level of review or decision making on the subject of the Grievance.

h. The first level Grievance review committee shall include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the Grievance.

i. The Member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The PH-MCO shall be flexible when scheduling the review to facilitate the Member's attendance. The Member shall be given at least seven (7) days advance written notice of the review date using the template supplied by the Department (Exhibits GG(14a) and GG(14b)). If the Member cannot appear in person at the review, an opportunity to communicate with the first level Grievance review committee by telephone or videoconference must be provided. The Member may elect not to attend the first level Grievance meeting but the meeting must be conducted with the same protocols as if the Member was present.

j. If a Member requests an in-person first level Grievance review, at a minimum, a member of the first level Grievance review committee must be physically present at the location where the first level Grievance review will be held and the other members of the first level Grievance review committee must participate in the review through the use of videoconferencing.

k. The first level Grievance review committee shall complete its review of the Grievance as expeditiously as the Member's health condition requires, but no more than thirty (30) days from receipt of the Grievance, which may be extended by fourteen (14) days at the request of the Member.

l. The first level Grievance review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Grievance record.

l. The PH-MCO must send a written notice of the first level Grievance decision, using the template supplied by the Department (Exhibit GG(3b)), to the Member, Member's representative, if the Member has designated one, service Provider and prescribing PCP, if applicable, within five (5) Business Days from the first level Grievance review committee's decision.

m. The Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for a second level Grievance review ("second level Grievance") within forty-five (45) days from the date the Member receives the written notice of the PH-MCO's first level Grievance decision.

n. The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's first level Grievance decision.

2. **Second Level Grievance Process**

a. Upon receipt of the second level Grievance, the PH-MCO shall send the Member and the Member's representative, if the Member has designated

one, an acknowledgment letter using the template supplied by the Department (Exhibit GG(8)).

b. A Member who files a second level Grievance to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the second level Grievance, if the second level Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the PH-MCO's first level Grievance decision.

c. The second level Grievance review shall be performed by a second level Grievance review committee made up of three (3) or more individuals who were not involved in any previous level of review or decision making to deny coverage or payment for the requested service/item. At least one-third of the second level Grievance review committee may not be employees of the PH-MCO or a related subsidiary or affiliate.

d. The second level Grievance review committee shall include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review.

e. The Member must be provided the opportunity to appear before the second level Grievance review committee. The PH-MCO shall be flexible when scheduling the second level review to facilitate the Member's attendance. The Member shall be given at least fifteen (15) days advance written notice of the review date using the template supplied by the Department (Exhibits GG(14a) and GG(14b)). If the Member cannot appear in person at the second level review, an opportunity to communicate with the second level Grievance review committee by telephone or videoconference must be provided. The Member may elect not to attend the second level Grievance meeting but the meeting must be conducted with the same protocols as if the Member was present.

f. If a Member requests an in-person second level Grievance review, at a minimum, a member of the second level Grievance review committee must be physically present at the location where the second level Grievance review will be held and the other members of the second level Grievance review committee must participate in the review through the use of videoconferencing.

g. The decision of the second level Grievance review committee must be based solely on the information presented at the review.

h. The second level Grievance review committee shall complete the second level Grievance review within forty-five (45) days from receipt of the Member's second level Grievance.

i. Testimony taken by the second level Grievance review committee (including the Member's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Grievance record.

j. The PH-MCO must send a written notice of the second level Grievance decision, using the template supplied by the Department (Exhibit GG(9)), to the Member, Member's representative, if the Member has designated one, service Provider and prescribing Provider, if applicable, within five (5) Business Days of the second level Grievance review committee's decision.

k. The Member or Member representative, which may include the Member's Provider, with proof of the Member's written authorization for a representative to be involved and/or act on the Member's behalf, may file a request with the PH-MCO for an external review ("external Grievance review") of the second level Grievance decision by a certified review entity appointed by the Department of Health. The request must be filed within fifteen (15) days from the date the Member receives the written notice of the PH-MCO's second level Grievance decision.

l. The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's second level Grievance decision.

3. **External Review of Second Level Grievance Decision:**

a. All requests for external Grievance review are processed through the PH-MCO. The PH-MCO has the responsibility to follow the protocols established by the Department of Health in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Member, Member's representative, if the Member has designated one, service Provider and prescribing Provider.

b. A Member who files a request for an external Grievance review to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is hand delivered or post-marked within ten (10) days of the mail date on the written notice of the PH-MCO's second level Grievance decision.

c. Within five (5) Business Days of receipt of the request for an external Grievance review, the PH-MCO shall notify the Member, the Member's representative, if the Member has designated one, or the Health Care Provider, and the Department of Health that the request for external Grievance review has been filed.

d. The external Grievance review shall be conducted by a certified review entity (CRE) not directly affiliated with the PH-MCO.

e. Within two (2) Business Days from receipt of the request for an external Grievance review, the Department of Health randomly assigns a CRE to conduct the review. The PH-MCO and assigned CRE entity will be notified of this decision.

f. If the Department of Health fails to select a CRE within two (2) Business Days from receipt of a request for an external Grievance review, the PH-MCO may designate a CRE to conduct a review from the list of CREs approved by the Department of Health. The PH-MCO may not select a CRE that has a current contract or is negotiating a contract with the PH-MCO or its Affiliates or is otherwise affiliated with the PH-MCO or its Affiliates.

g. The PH-MCO must forward all documentation regarding the decision, including all supporting information, a summary of applicable issues and the basis and clinical rationale for the decision, to the CRE conducting the external Grievance review. This transmission of information must take place within fifteen (15) days from receipt of the Member's request for an external Grievance review.

h. Within fifteen (15) days from receipt of the request for an external Grievance review by the PH-MCO, the Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may supply additional information to the CRE conducting the external Grievance review for consideration. Copies must also be provided at the same time to the PH-MCO so that the PH-MCO has an opportunity to consider the additional information.

i. Within sixty (60) days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review shall issue a written decision to the PH-MCO, the Member, the Member's representative and the Provider (if the Provider filed the Grievance with the Member's consent), that includes the basis and clinical rationale for the decision. The standard of review shall be whether the service/item was Medically Necessary and appropriate under the terms of the PH-MCO's contract.

j. The external Grievance decision may be appealed by the Member, the Member's representative, or the Health Care Provider to a court of competent jurisdiction within sixty (60) days from the date the Member receives notice of the external Grievance decision.

4. **Expedited Grievance Process**

a. The PH-MCO must conduct expedited review of a Grievance at any point prior to the second level Grievance decision, if a Member or Member representative, with proof of the Member's written authorization for a representative to be involved and/or act on the Member's behalf, provides the

PH-MCO with a certification from his or her Provider that the Member's life, health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. This certification is necessary even when the Member's request for the expedited review is made orally. The certification must include the Provider's signature.

b. A request for expedited review of a Grievance may be filed either in writing, by fax or orally. Oral requests must be committed to writing by the PH-MCO. The Member's signature is not required.

c. The expedited review process is bound by the same rules and procedures as the second level Grievance review process with the exception of time frames, which are modified as specified in this section.

d. Upon receipt of an oral or written request for expedited review, the PH-MCO must inform the Member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

e. If the Provider certification is not included with the request for an expedited review, the PH-MCO, must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three (3) Business Days of the Member's request for expedited review, the PH-MCO shall decide the Grievance within the standard timeframes as set forth in this Exhibit. The PH-MCO must make a reasonable effort to give the Member prompt oral notice that the Grievance is to be decided within the standard timeframe and send a written notice within two (2) days of the decision to deny expedited review, using the template supplied by the Department (Exhibit GG(6b)).

f. A Member who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

g. Review of Grievances must be performed by a Grievance review committee that includes a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate providers may participate in the review. The members of the Grievance review committee may not have been involved in any previous level of review or decision-making on the subject of the Grievance. The licensed physician must decide the Grievance.

h. The PH-MCO must issue the decision resulting from the expedited review in

person or by phone to the Member, the Member's representative, if the Member has designated one, and the Member's Provider within either forty-eight (48) hours of receiving the Provider certification, or three (3) Business Days of receiving the Member's request for an expedited review, whichever is shorter. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one, and the Member's Health Care Provider within two (2) days of the decision using the template supplied by the Department (Exhibit GG(10)).

i. The Member, or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an expedited external Grievance review with the PH-MCO; within two (2) Business Days from the date the Member receives the PH-MCO's expedited Grievance decision.

j. The PH-MCO shall follow Department of Health guidelines relating to submission of requests for expedited external reviews.

k. The PH-MCO must ensure that punitive action is not taken against a Provider who either requests expedited resolution of a Grievance or supports a Member's request for expedited review of a Grievance.

l. The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's expedited Grievance decision.

D. Department's Fair Hearing Requirements

DHS Fair Hearing: A hearing conducted by the Department of Human Services, Bureau of Hearings and Appeals or its subcontractor.

1. Department's Fair Hearing Process

a. Members do not have to exhaust the Complaint or Grievance process prior to filing a request for a DHS Fair Hearing.

b. The Member or the Member's representative may request DHS Fair Hearings within thirty (30) days from the mail date on the initial written notice of decision and within thirty (30) days from the mail date on the written notice of the PH-MCO's first or second level Complaint or Grievance notice of decision for any of the following:

i) the denial, in whole or part, of payment for a requested service/item if based on lack of Medical Necessity;

ii) the denial of a requested service/item on the basis that the service/item is not a covered benefit;

iii) the denial or issuance of a limited authorization of a requested service/item, including the type or level of service/item;

iv) the reduction, suspension, or termination of a previously authorized service/item;

v) the denial of a requested service/item but approval of an alternative service/item;

vi) the failure of the PH-MCO to provide services/items in a timely manner, as defined by the Department;

vii) the failure of the PH-MCO to decide a Complaint or Grievance within the timeframes specified in this Exhibit.

viii) the denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

ix) the denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Member.

c. The request for a DHS Fair Hearing must include a copy of the written notice of decision that is the subject of the request. Requests must be sent to:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

d. A Member who files a request for a DHS Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for a DHS Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

e. Upon receipt of the request for a DHS Fair Hearing, the Department's Bureau of Hearings and Appeals or a designee will schedule a hearing. The Member and the PH-MCO will receive notification of the hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the Member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

f. The PH-MCO is a party to the hearing and must be present. The PH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Department's decision is based solely on the evidence presented at the hearing. The failure of the PH-MCO to

participate in the hearing will not be reason to postpone the hearing.

g. The PH-MCO must provide Members, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.

h. If the Bureau of Hearings and Appeals has not taken final administrative action within ninety (90) days of the receipt of the request for a DHS Fair Hearing, the PH-MCO shall follow the requirements at 55 Pa. Code 275.4 regarding the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process, the time limit for final administrative action will be extended by the length of the delay attributed to the Member (55 Pa. Code 275.4).

i. The Bureau of Hearings and Appeals' adjudication is binding on the PH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on the PH-MCO.

2. **Expedited Fair Hearing Process**

a. A request for an expedited DHS Fair Hearing may be filed by the Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, with the Department either in writing or orally.

b. Members do not have to exhaust the Complaint or Grievance process prior to filing a request for an expedited DHS Fair Hearing.

c. An expedited DHS Fair Hearing will be conducted if a Member or a Member's representative provides the Department with written certification from the Member's Provider that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular DHS Fair Hearing process. This certification is necessary even when the Member's request for the expedited Fair Hearing is made orally. The certification must include the Provider's signature. The Provider may also testify at the DHS Fair Hearing to explain why using the usual timeframes would place the Member's health in jeopardy.

d. A Member who files a request for an expedited Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for an expedited Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

e. Upon the receipt of the request for an expedited Fair Hearing, the

Department's Bureau of Hearings and Appeals or a designee will schedule a hearing.

f. The PH-MCO is a party to the hearing and must participate in the hearing. The PH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The failure of the PH-MCO to participate in the hearing will not be reason to postpone the hearing.

g. The PH-MCO must provide Member, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.

h. The Bureau of Hearings and Appeals has three (3) Business Days from the receipt of the Member's oral or written request for an expedited review to process final administrative action.

i. The Bureau of Hearings and Appeals adjudication is binding on the PH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on the PH-MCO.

E. Provision of and Payment for Services/Items following Decision

1. If the PH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny, limit, or delay services/items that were not furnished during the Complaint, Grievance or DHS Fair Hearing process, the PH-MCO must authorize or provide the disputed services/items promptly and as expeditiously as the Member's health condition requires. If the PH-MCO requests reconsideration from the Secretary of Human Services, the PH-MCO must authorize or provide the disputed services/items pending reconsideration unless the PH-MCO requests a stay of the Bureau of Hearings and Appeals decision and the stay is granted.

2. If the PH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny authorization of services/items, and the Member received the disputed services/items during the Complaint, Grievance or DHS Fair Hearing process, the PH-MCO must pay for those services/items.

EXHIBIT GG(1)

NOTICE FOR FAILURE OF PH-MCO TO MEET COMPLAINT OR GRIEVANCE TIMEFRAMES

[Date Notice Mailed (1 day after the date the decision was to be made)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your **[Complaint] [Grievance]** About **[Issue]**

Dear **[Member Name]**:

[PH-MCO Name] has not decided your **[complaint] [grievance]** about **[identify subject of complaint/grievance]**, filed on **[date]**, within **[number that is fewer than 30 days]** days, as required. We expect to be able to decide the **[complaint] [grievance]** by **[date]**.

If you are unhappy that **[MCO Name]** has not decided your **[complaint] [grievance]** within **[#]** days of receiving it, you can do one or both of the following:

File a Complaint

You may file a complaint with **[PH-MCO Name]** about the delay in deciding your **[complaint] [grievance]**. You must file the complaint **within 45 days from the date you get this notice.**

A decision will be made on your complaint no later than **[30, unless PH-MCO will be using a shorter time frame to decide 1st level complaints]** days from when we receive it.

To file a complaint:

- Call **[PH-MCO Name] at [Phone #/Toll-free TTY #]**;
- Fax [PH-MCO Fax #]; **or**
- Send your complaint to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing complaint]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider, if BBA complaint or grievance]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the [complaint] [grievance] you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(2a)

1ST LEVEL COMPLAINT ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your Complaint About ***[Complaint Issue]***

Dear **[Member Name]**:

[PH-MCO Name] received your complaint about **[identify subject of complaint]** on **[date of receipt]**.

The First Level Complaint Process

A committee of one or more **[PH-MCO Name]** staff who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your complaint. You may also send information that you have about your complaint to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**. Please note, for videoconference you must contact the PH-MCO within 10 days of this notice. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

If you think your issue is really a grievance and should not be treated as a complaint, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, Pennsylvania 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

If you need more information on what a grievance is, you can read your Member handbook or call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #].**

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your complaint is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your complaint is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

,cc: **[Member Representative, if designated]**
[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my complaint is described correctly.

_____ _____

Member's or Member's Representative Signature Date

EXHIBIT GG(2b)

FAILURE TO PROVIDE SERVICE(S)/ITEM(S) IN A TIMELY MANNER ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID#: *********

Subject: Your Complaint About **[*Complaint Issue*]**

Dear **[Member Name]**:

[PH-MCO Name] received your complaint on **[date of oral complaint]** that you did not receive your **[type of services/items]** in the time you should have received them.

The First Level Complaint Process

A committee of one or more **[PH-MCO Name]** staff who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your complaint. You may also send information that you have about your complaint to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #] within ten days from the date on this letter.** You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

To ask for an early decision

If your doctor or dentist believes that waiting **[30, unless PH-MCO will be using a shorter time frame to decide 1st level complaints]** days to get a decision could harm your health, you may ask that your complaint be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**; **OR**
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO Fax #]** explaining why taking **[30, unless PH-MCO will be using a shorter time frame to decide 1st level complaints]** days to decide your complaint could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

The Fair Hearing Process

At any point before **[PH-MCO Name]** makes its decision, you may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this letter**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this letter.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;

- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Get Help with Complaints or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your complaint is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your complaint is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: **[Member Representative, if designated]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you made with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my complaint is described correctly.

_____ _____

Member's or Member's Representative Signature Date

EXHIBIT GG(3a)

1ST LEVEL COMPLAINT DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the first level complaint decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Complaint

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the first level complaint review committee has decided that **[state decision in detail]**.

The reasons for this decision are:

[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If unable to make a decision because of insufficient information, identify all additional information needed to render decision.]

[PH-MCO: Include the following paragraph only if the complaint challenges a denial because the service/item is not a covered benefit.]

To continue getting services:
If you have been receiving the services/items that are being reduced, changed, or denied and you file a second level complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Second Level Complaint

You may file a second level complaint with **[PH-MCO Name]** **within 45 days from the date you get this notice.** A decision will be made on your second level complaint no

later than **[45, unless the PH-MCO will be using a shorter time frame to decide 2nd level complaints]** days from when we receive it.

To file a second level complaint:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; **or**
- Send your complaint to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing complaint]

[PH-MCO: Include the following paragraph on expedited complaints only if the complaint is about the failure to provide services/items in a timely manner or denial of service/item as not a covered benefit.]

To ask for an early decision

If your doctor or dentist believes that waiting **[45, unless the PH-MCO will be using a shorter time frame to decide 2nd level complaints]** days to get a decision could harm your health, you may ask that your complaint be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; **OR**
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO Fax #]** explaining why taking **[45, unless PH-MCO will be using a shorter time frame to decide 2nd level complaints]** days to decide your complaint could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

[PH-MCO: Include the following paragraphs on Fair Hearings and Expedited Fair Hearings only if the complaint is about one of the following: Failure to provide services/items in a timely manner; failure to decide a complaint or grievance within 30 days; or denial of service/item as not a covered benefit (whether prior authorization or payment denial); or denial because the service/item was provided without authorization by a non-MA enrolled provider.]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[PH-MCO: Include this last item only for complaints challenging a denial because service/item is not a covered benefit or because the service/item was provided without authorization by a non-MA provider.]**

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

Get Help with Complaints or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider, if BBA complaint]**
[Member representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(3b)

1ST LEVEL GRIEVANCE DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the date of the first level grievance decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Grievance

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your grievance about **[issue]**, received on **[date]**.

Based on a review of all information provided, the first level grievance review committee has decided that **[state decision in detail]**.

The reasons for this decision are:
[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]

To continue getting services:
If you have been receiving the services/items that are being reduced, changed, or denied and you file a second level grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Second Level Grievance

You may file a second level grievance with **[PH-MCO Name]** **within 45 days from the date you get this notice.** A decision will be made on your second level grievance no later than **[45, unless PH-MCO will be using a shorter time frame to decide 2nd level grievances]** days from when we receive it.

To file a second level grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**
- Fax **[PH-MCO Fax #]**; **or**
- Send your grievance to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing grievance]

❖ **<u>To ask for an early decision</u>**

If your doctor or dentist believes that waiting **[45, unless the PH-MCO will be using a shorter time frame to decide 2nd level grievances]** days to get a decision could harm your health, you may ask that your grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; **OR**
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax#]**;

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO Fax #]** explaining why taking **[45, unless the PH-MCO will be using a shorter time frame to decide 2nd level grievances]** days to decide your grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **<u>within 30 days from the date on this notice</u>**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

❖ **To ask for an early decision**

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Request Criteria

You may ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

Get Help with Grievances or Fair Hearings

If you need help filing a grievance or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your grievance or Fair Hearing, or with filing your grievance or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(4)

2ND LEVEL COMPLAINT ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your Second Level Complaint About ***[Complaint Issue]***

Dear **[Member Name]**:

[PH-MCO Name] received your second level complaint about **[identify subject of complaint]** on **[date of receipt]**.

The Second Level Complaint Process

A committee of three or more people, including at least one person who does not work for **[PH-MCO Name]**, who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 45 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your complaint. You may also send information that you have about your complaint to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**. Please note, for videoconference you must contact the PH-MCO within 10 days of this notice. You may also bring a family member, friend, lawyer or other person to help you. We will send you another letter at least 15 days before the date of the complaint review, telling you the place, date and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

Get Help with Complaints, or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your second level complaint is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your second level complaint is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: **[Member Representative, if designated]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my second level complaint is described correctly.

_____ _____

Member's or Member's Representative Signature Date

EXHIBIT GG(5)

2ND LEVEL COMPLAINT DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the second level complaint decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Second Level Complaint

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your second level complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the second level complaint review committee has decided that **[state decision in detail]**.

The reasons for this decision are: **[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If unable to make a decision because of insufficient information, identify all additional information needed to render decision.]**

[PH-MCO: Include the following paragraph only if the complaint challenges a denial because the service/item is not a covered benefit.]

To continue getting services:
If you have been receiving the services/items that are being reduced, changed, or denied and you file a request for an external review or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING

Request an External Review

You may ask for an "external review" of the second level complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department **within 15 days from the date you get this notice**.

Send your request to one of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, Pennsylvania 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

Pennsylvania Insurance Department
Bureau of Customer Service
1321 Strawberry Square
Harrisburg, PA 17120
Telephone: 1-877-881-6388

Your request for external review by either Department must include the following information:

- Your (the Member's) name, address, and daytime telephone number;
- Your (the Member's) **[PH-MCO Name]** identification number;
- **[PH-MCO Name]'**s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

[PH-MCO: Include the following paragraphs on Fair Hearings and Expedited Fair Hearings only if the complaint is about one of the following: Failure to provide services/items in a timely manner; failure to decide a complaint or grievance within 30 days; or denial of service/item as not a covered benefit (whether prior authorization or payment denial); or denial because the service/item was provided without authorization by a non-MA enrolled provider.]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;

- A copy of the original denial notice, if available. **[PH-MCO: Include this last item only for complaints challenging a denial because a service/item is not a covered benefit or because the service/item was provided without authorization by a non-MA provider.]**

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision within 90 days from when it receives your request.

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

  The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

[PH-MCO: Choose one of the following two paragraphs, depending on whether Fair Hearing paragraphs are included in notice:]

To get help with a request for external review or Fair Hearing

- If you need help filing a request for an external review, call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]** and **[PH-MCO Name]** will assign a staff person who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a Fair Hearing, you may call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

OR

To get help with a request for external review

If you need help filing a request for external review, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your request for external review or with filing your request for external review, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider, if BBA complaint]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(6a)

EXPEDITED COMPLAINT DECISION NOTICE

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: "Expedited" Decision About Your Complaint

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the review committee has decided that **[state decision in detail].**

The reasons for this decision are:
[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If unable to make a decision because of insufficient information, identify all additional information needed to render decision.]

[PH-MCO: Include the following paragraph only if the complaint challenges a denial because the service/item is not a covered benefit.]

To continue getting services
If you have been receiving the services/items that are being reduced, changed, or denied and you file a second level complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

Request an Expedited External Review

You may ask for an "expedited external review" of the complaint decision from the Pennsylvania Department of Health. You must ask for the external review **within 2 business days from the date you get this notice.**

To ask for an expedited external review:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; **or**
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax #]**;
- Send your request to **[PH-MCO Name]** at the following address:

[PH-MCO Address for requesting external review]

Request a Fair Hearing

To ask for an early decision

You may ask for a Fair Hearing from the Department of Welfare. If your doctor or dentist still believes that the usual time frame for deciding a Fair Hearing (between 60 and 90 days) could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[PH-MCO: include this last item only for complaints challenging a denial because service/item is not a covered benefit.]**

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program

Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

To get help with a request for external review or Fair Hearing

If you need help filing a request for an external review or Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your request for external review or Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(6b)

NOTICE OF FAILURE TO RECEIVE PROVIDER CERTIFICATION FOR AN EXPEDITED COMPLAINT OR GRIEVANCE

[Date Notice Mailed (no more than 2 days after date of decision to deny expedited review)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Request for "Expedited" **[complaint][grievance]**

Dear **[Member Name]**:

[PH-MCO Name] received your **[complaint] [grievance]** about **[identify subject of complaint/grievance]**, on **[date]** and your request to have the **[complaint] [grievance]** decided more quickly than the usual **[30, unless the PH-MCO will be using a shorter time frame to decide 1st level complaints/grievances]**-day time frame. As we told you when you filed your **[complaint] [grievance]**, in order for your **[complaint] [grievance]** to be decided more quickly, your **[doctor] [dentist]** needed to send us a signed, written statement that taking the usual amount of time to decide the **[complaint] [grievance]** could harm your health. **[PH-MCO Name]** also asked your **[doctor] [dentist]** for this statement.

[PH-MCO Name] has not received your **[doctor's] [dentist's]** statement, so your **[complaint] [grievance]** will be decided within the usual time frame of **[30, unless the PH-MCO will be using a shorter time frame to decide 1st level complaints/grievances]** days from when we first got your **[complaint] [grievance]**.

[PH-MCO: Choose one of the following two paragraphs:]

The First Level Complaint Process

A committee of one or more **[PH-MCO Name]** staff who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

OR

The First Level Grievance Process

A committee of one or more **[PH-MCO Name]** staff, that includes a licensed doctor, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the "grievance review." A decision will be made by **[date that is no more than 30 days from receipt of the grievance]**. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the **[complaint] [grievance]** process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your **[complaint] [grievance]**. You may also send information that you have about your **[complaint] [grievance]** to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the **[complaint] [grievance]** review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #] within ten days from the date on this notice**. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

[PH-MCO: For complaints, include the following paragraphs on Fair Hearings and Expedited Fair Hearings only if the complaint is about one of the following: Failure to provide services/items in a timely manner; failure to decide a complaint or grievance within 30 days; or denial of service/item as not a covered benefit (whether prior authorization or payment denial); or denial because the service/item was provided without authorization by a non-MA enrolled provider. Include the paragraphs for all grievances.]

The Fair Hearing Process

You may also ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice.** Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[PH-MCO: Include this last item for complaints challenging a denial because service/item is not a covered benefit or because the service/item was provided without authorization by a non-MA provider, and for all grievances.]**

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**

[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the [complaint] [grievance] you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(7)

1ST LEVEL GRIEVANCE ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your Grievance About ***[Grievance Issue]***

Dear **[Member Name]**:

[PH-MCO Name] received your grievance about **[identify subject of grievance]** on **[date of receipt]**.

The First Level Grievance Process

A committee of one or more **[PH-MCO Name]** staff, that includes a licensed doctor, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the "grievance review." A decision will be made by **[date that is no more than 30 days from receipt of the grievance]**. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your grievance. You may also send information that you have about your grievance to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #].** Please note, for videoconference you must contact the PH-MCO within 10 days of this notice. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

If you think your issue is really a complaint and should not be treated as a grievance, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, Pennsylvania 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

If you need more information on what a complaint is, you can read your Member handbook or call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #].**

Get Help with Grievances or Fair Hearings

If you need help filing a grievance or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance or Fair Hearing, or with filing your grievance or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your grievance is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your grievance is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my grievance is described correctly.

_____ _____

Member's or Member's Representative Signature Date

EXHIBIT GG(8)

2ND LEVEL GRIEVANCE ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your Second Level Grievance About ***[Grievance Issue]***

Dear **[Member Name]**:

[PH-MCO Name] received your second level grievance about **[identify subject of grievance]** on **[date of receipt].**

The Second Level Grievance Process

A committee of three or more people, which includes a licensed doctor, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the "grievance review." A decision will be made by **[date that is no more than 45 days from receipt of the grievance]**. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your grievance. You may also send information that you have about your grievance to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #].** Please note, for videoconference you must contact the PH-MCO within 10 days of this notice. You may also bring a family member, friend, lawyer or other person to help you. We will send you another letter at least 15 days before the date of the grievance review, telling you the place, date and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

Get Help with Grievances or Fair Hearings

If you need help filing a grievance or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance or Fair Hearing, or with filing your grievance or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your second level grievance is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your second level grievance is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my second level grievance is described correctly.

_____ _____

Member's or Member's Representative Signature Date

EXHIBIT GG(9)

2ND LEVEL GRIEVANCE DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the date of the second level grievance decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Second Level Grievance

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your second level grievance about **[issue],** received on **[date]**.

Based on a review of all information provided, the second level grievance review committee has decided that **[state decision in detail]**.

The reasons for this decision are:
[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]

To continue getting services
If you have been receiving the services/items that are being reduced, changed or denied and you file a request for an external review or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING

Request an External Review

You may ask for an "external review" of the second level grievance decision **within 15 days from the date you get this notice.** An external review is a review by a licensed doctor who does not work for **[PH-MCO Name].**

Your request for an external review must be sent to the following address:

[PH-MCO Address for requesting external review]

A decision will be issued within 60 days from when we receive your request.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision within 90 days from when it receives your request.

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Request Criteria

You may ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

To get help with a request for external review or Fair Hearing

If you need help filing a request for external review or Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your request for external review or Fair Hearing, or with filing your request for external review or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/ Toll-free TTY #].

EXHIBIT GG(10)

EXPEDITED GRIEVANCE DECISION NOTICE

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: "Expedited" Decision About Your Grievance

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your grievance about **[issue]**, received on **[date]**.

Based on a review of all information provided, the review committee has decided that **[state decision in detail]**.

The reasons for this decision are:
[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]

To continue getting services
If you have been receiving the services/items that are being reduced, changed, or denied and you file a request for an external review or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

Request an Expedited External Review

You may ask for an "expedited external review" of the grievance decision. An external review is a review by a licensed doctor who does not work for **[PH-MCO Name].** You must ask for the external review **within two business days from the date you get this notice**. A decision will be issued within five business days from when we receive your request.

To ask for an external review:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax#]; or**

- Send your request to **[PH-MCO Name]** at the following address:

[PH-MCO Address for requesting external review]

Request a Fair Hearing

To ask for an early decision

You may ask for a Fair Hearing from the Department of Human Services. If your doctor or dentist still believes that the usual time frame for deciding a Fair Hearing (between 60 and 90 days) could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a Fair Hearing from the Department of Human Services. The request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see you Member handbook for more details).

Request Criteria

You may ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

To get help with a request for external review or Fair Hearing

If you need help filing a request for external review or Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your request for external review or Fair Hearing, or with filing your request for external review or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(11)

NOTICE FOR PAYMENT DENIAL BECAUSE THE SERVICE(S)/ITEM(S) WAS PROVIDED WITHOUT AUTHORIZATION BY A PROVIDER NOT ENROLLED IN THE PENNSYLVANIA MEDICAL ASSISTANCE PROGRAM

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Member Name
Address
City, State Zip

Member ID: ********

Dear **[Member Name]**:

[PH-MCO Name] has reviewed the request for payment from **[provider's name]** for **[identify specific service/item]**, which you received on **[date]**. Your provider's request for payment has been denied because **[provider's name]** is not enrolled in the Pennsylvania Medical Assistance Program and did not ask **[PH-MCO Name]** for approval to provide the service/item to you.

[PROVIDER'S NAME] MAY BILL YOU FOR THIS SERVICE/ITEM.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

File a Complaint

You may file a complaint with **[PH-MCO Name]** **within 45 days from the date you get this notice.** A decision will be made on your complaint no later than **[30, unless the PH-MCO will be using a shorter time frame to decide 1st level complaints]** days from when we receive it.

To file a complaint:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; **or**
- Send your complaint to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing complaint]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice.** Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You may appear in person or by telephone at both the complaint review and the Fair Hearing, and you may bring a family member, friend, lawyer or other person to help you.

If you file a complaint or a request for a Fair Hearing, you may ask to see any information relevant to this decision by sending a written request for the information to the following address:

[PH-MCO Address for records information]

Get Help with Complaints or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(12)

NOTICE FOR PAYMENT DENIAL BECAUSE THE SERVICE(S)/ITEMS(S) WAS NOT A COVERED BENEFIT FOR THE MEMBER

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Member Name
Address
City, State Zip

Member ID: *********

Dear **[Member Name]**:

[PH-MCO Name] has reviewed the request for payment from **[Provider's name]** for **[identify specific service/item]**, which you received on **[date**]. Your Provider's request for payment has been denied. The service/item you received is not a covered benefit because:

___ It is not covered under the Medical Assistance Program; **OR**

___ It is not part of your benefit package.

___ The **[Provider Name]** is not in **[PH-MCO Name]** Provider network and provided the service without **[PH-MCO Name]** authorization.

[PROVIDER'S NAME] MAY BILL YOU FOR THIS SERVICE/ITEM ONLY IF [PROVIDER'S NAME] TOLD YOU THAT THE SERVICE/ITEM WAS NOT COVERED FOR YOU BEFORE YOU GOT THE SERVICE/ITEM.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

File a Complaint

You may file a complaint with **[PH-MCO Name] within 45 days from the date you get this notice.** A decision will be made on your complaint no later than **[30, unless PH-MCO will be using shorter time frame to decide 1st level complaints]** days from when we receive it.

To file a complaint:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**
- Fax **[PH-MCO Fax #]**; **or**
- Send your complaint to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing complaint]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You may appear in person or by telephone at both the complaint review and the Fair Hearing, and you may bring a family member, friend, lawyer or other person to help you.

If you file a complaint or a request for a Fair Hearing, you may ask to see all information relevant to this decision by sending a written request for the information to the following address:

[PH-MCO Address for records information]

Get Help with Complaints or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(13)

NOTICE FOR DENIAL OF PAYMENT AFTER A SERVICE(S) HAS BEEN DELIVERED BECAUSE THE EMERGENCY ROOM SERVICE(S) WAS NOT MEDICALLY NECESSARY

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Member Name
Address
City, State Zip

Member ID: *********

Dear **[Member Name]**:

[PH-MCO Name] has reviewed the request for payment from **[Provider's name]** for **[identify specific service]**, which you received on **[date]**. Your Provider's request for payment has been denied.

The service you received was not Medically Necessary because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

[PROVIDER'S NAME] MAY NOT BILL YOU FOR THIS SERVICE. YOU CAN SHOW THIS NOTICE TO [PROVIDER'S NAME] IF [PROVIDER'S NAME] SENDS YOU A BILL.

Sincerely,

[PH-MCO Name]

cc: **[Provider]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(14a)

IN-PERSON (FIRST/SECOND LEVEL) (COMPLAINT/GRIEVANCE) REVIEW TEMPLATE

Date Letter Mailed (For first level complaints or grievances must be at least 7 days prior to the review date. For second level complaints or grievances must be at least 15 days prior to the review date.)

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your [**complaint/grievance**] about **[Issue]**

Dear **[Member Name]**:

[PH-MCO Name] received your request for an in-person review of your (**first/second level**) **(complaint/grievance**) about **[identify subject of complaint]**.

The review will be held at [**Location of Review; including address**] on [**Date**] at [**Time**]. This location is physically accessible for persons with disabilities. IF APPLICABLE, INCLUDE THE FOLLOWING: We have included with this letter directions to the location of the review and information on parking. When you arrive for the review, please inform the [**Staff person, front desk, receptionist**] and they will direct you to the meeting room where the review will take place.

If you wish to cancel, need to reschedule the in-person review, or have decided to participate by telephone instead, please contact [**PH-MCO Name**] as soon as possible by calling Member Services at [**insert Member Services Number**] If you do not appear at the scheduled date and time the review will go on without you.

At your review the (**first/second level) (complaint/grievance)** Committee **[member/members]** who will be physically present will be [**insert titles and committee role; if licensed physician include specialty**]. IF NOT ALL MEMBERS WILL BE PRESENT ENTER THE FOLLOWING: Other Committee **[member/members]** who will take part in the review will participate by secure video-conference include [**insert titles and committee role; if licensed physician include specialty**].IF THE LICENSED PHYSICIAN IN THE SAME OR SIMILAR SPECIALITY WILL NOT BE PRESENT OR PARTICIPATING BY VIDEOCONFERENCE ENTER THE FOLLOWING: **[insert title and specialty]** will participate by telephone.

You can have someone you know represent you or act on your behalf during the in-person review of your **(first/second level) (complaint/grievance**). If you decide to have someone represent you or act for you and you have not already told **[PH-MCO Name]**, tell **[PH-MCO Name]** in writing the name of that person and how we can reach him or her. This should be sent to: [Name, address, fax #].

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your **(complaint/grievance)**. You can do that by calling: You may also send information that you have about your **(complaint/grievance)** before the in-person review to **[PH-MCO Name, address, fax #].** If you are unable to send the information before the in-person review, bring the information with you to the in-person review and **[PH-MCO Name]** will [**scan/fax**] the information to any members of the review panel who will not be physically present at the review before the start of the committee review.

If you have any questions about this notice please contact me [**insert name**] at [**enter phone number**]

Sincerely,

[STAFF NAME]

[PH-MCO Name]

cc: **[Member Representative, if designated]**
[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the (**first/second level**) (**complaint/grievance**) you filed with **[PH-MCO Name]**. It is available in other languages and formats by calling **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**.

EXHIBIT GG(14b)

GENERAL (FIRST/SECOND LEVEL) (COMPLAINT/GRIEVANCE) REVIEW TEMPLATE

Date Letter Mailed (For first level complaints or grievances, member must be given at least 7 days advance notice of the review date. For second level complaints or grievances, member must be given at least 15 days advance notice of the review date.)

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your [**first/second**] level [**complaint/grievance**] review

Dear **[Member Name]**:

[PH-MCO Name] received your request for a review regarding **[identify the subject of the complaint/grievance]**.

The meeting to review your **[first/second]** level **[complaint/grievance]** will be held at:

[time of committee meeting] on **[date of committee meeting]** at
[location of the meeting]

You can have someone you know represent you or act on your behalf during the review. If you or your representative wishes to participate in the review, please contact [**PH-MCO name**] **as soon as possible** by calling Member Services at [**PH-MCO Member Services Number**]. If you or your representative are not available at the scheduled date and time and you or your representative wish to participate in the review, **[PH-MCO name]** will reschedule the review. You may attend the meeting by phone, in person, or by videoconference (if available). If you decide not to attend the review meeting, it will not affect the review committee's decision.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your **(complaint/grievance)**. If you want to see any information relevant to your **(complaint/grievance)**, call **[Phone #/Toll-free TTY #]**.

You may also send information that you have about your **(complaint/grievance)** before the review to:

[PH-MCO Name
Complaint/grievance Address]
or faxed to the following number: **[PH-MCO complaint/grievance fax #].**

If you have any questions about this notice, please contact [**PH-MCO**] at [**PH-MCO phone #**].

Sincerely,

[STAFF NAME]

[PH-MCO Name]

cc: **[Member Representative, if designated]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the (**first/second level**) (**complaint/grievance**) you filed with **[PH-MCO Name]**. It is available in other languages and formats by calling **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**.

EXHIBIT NN

SPECIAL NEEDS UNIT

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 ongoing physical, developmental, emotional, or behavioral conditions, including, but not limited to, HIV/AIDS, Children in Substitute Care, and Intellectual Disabilities/developmental disabilities. Examples of factors in the determination of a Member with a Special Need(s) include, but are not limited to, the following:

- Require care and/or services of a type or amount that is beyond what is typically required;
- Require extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve the level of functioning for the individual;
- May require that primary care be managed by a specialist, due to the nature of the condition;
- May incur higher morbidity without intervention and coordination in the care of the individual;
- Require care and/or services that necessitate coordination and communication among Network Providers and/or Out-of-Network Providers;
- Require care and/or services that necessitate coordination and collaboration with public and private community services organizations outside the PH-MCO;
- Require coordination of care and/or services between the acute inpatient setting and other facilities and Community Providers;
- Result in the Member requiring assistance to schedule or make arrangements for appointments or services, including arranging for transportation to and from appointments;
- Result in the need for language, communication, or mobility accommodations; or
- Result in the need for a Member to be accompanied or assisted while seeking or receiving care by an individual who may act on the Member's behalf.

The PH-MCO will be required to develop, train, and maintain a unit within its organization structure whose primary responsibility will be to deal, in a timely manner, with issues relating to Members with Special Needs. This unit will be headed by a Special Needs Coordinator who must have access to and periodically consult with the Medical Director. The staff members of this unit will work in close collaboration with the Special Needs Section (SNS) operated by the Department and the Enrollment Assistance Program contractor’s Special Needs contact person. The Department

expects the PH-MCO's Special Needs Unit to be staffed by individuals with either a medical and/or social services background, in sufficient number to initiate a response to a Member's inquiry within two (2) Business Days or sooner in urgent situations. The Department expects the core staff members of the Special Needs Unit to be responsible primarily for the functions and operations associated with the unit. The Department also expects that at times the Special Needs Unit staff will have access to the resources of other departments within the PH-MCO to supplement the Special Needs Unit in assisting Members with Special Needs. The PH-MCO must show evidence of their access to and use of individuals with expertise in the treatment of Members with Special Needs to provide consultation to the Special Needs Unit staff, as needed.

The PH-MCO shall use knowledgeable and independent organizations such as consumer groups, disability advocacy groups, Special Needs consumers, the Department of Health District Offices and the DOH's Special Kids Network (http://www.portal.state.pa.us/portal/server.pt/community/special_kids_network/14205) for Children with Special Needs, when providing training to its Special Needs Unit staff, whenever possible.

The primary purpose of the Special Needs Unit is to ensure that each Member with Special Needs receives access to appropriate primary care, access to specialists trained and skilled in the needs of the Member, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the Member's condition or circumstance, including pharmaceuticals and DME, and access to needed community services. The Special Needs Unit must have a direct link to the Utilization Management functions of the PH-MCO and have input into the case review process. The PH-MCO must have procedures in place that ensure the proactive identification of and outreach to Members with Special Needs who may not self-identify as having a Special Need.

Special Needs Unit Functions and Requirements

The staff of the PH-MCO Special Needs Unit will ensure the receipt of care and/or services by acting as the PH-MCO case manager for each Member with an identified Special Need. The case manager will be responsible for coordinating the delivery of all services for which the Member is eligible under the PH-MCO benefit package. In the event that a Member is not satisfied with PH-MCO performance in any area, the Special Needs Unit case manager will be responsible for facilitating dispute resolution and for informing the Member of the Complaint, Grievance, and DHS Fair Hearing mechanisms that are available. Members with Special Needs will be assigned to a particular Special Needs Unit case manager and will have ready access to their Special Needs Unit case manager as long as they are enrolled in the PH-MCO. Members with Special Needs are permitted to change case managers as needed during their enrollment. The PH-MCO must be able to demonstrate that its staff will perform the following functions:

- Conduct necessary training for all PH-MCO staff to acquaint them with the purpose and function of the Special Needs Unit and the need to coordinate within departments to serve Members with Special Needs.

- Ensure coordination between the PH-MCO and other health, education, and human services systems.

- Ensure adherence to state and federal laws, regulations, Departmental agreements and court requirements relating to individuals with Special Needs.

- A contact within the Special Needs Unit must be designated to act as a liaison with Office of Medical Assistance Program's Special Needs Section and the Enrollment Assistance Program contractor's Special Needs contact person. The Department expects the PH-MCO to develop an appropriate automated process to operationalize the information on Special Needs individuals supplied by the Enrollment Assistance Program contractor.

- Sufficient telephone and alternative communication channels must be established to allow ready and timely interactions between the PH-MCO Special Needs Unit Coordinator and case managers and the Office of Medical Assistance Programs, the Enrollment Assistance Program contractor, Members with Special Needs, Providers (Network and Out-of-Network) servicing Members with Special Needs and involved agencies.

- Ensure appropriate arrangements are made to effectively assist Members with Special Needs who speak languages other than English, which include interpreter services and translation of documents, in accordance with the RFP and Agreement requirements. In addition, efforts must be made to match Members with communication barriers due to disability or linguistic background with Providers with whom they can effectively communicate.

- Serve on interagency teams upon request by a Member or their family to facilitate and coordinate delivery of Physical Health Services contained in treatment plans for children and/or adults including, but not limited to, Individual Family Service Plans, Individual Educational Plans, Individual Habilitation Plans, and Individual Behavioral Health Treatment Plans.

- Special Needs Unit case managers must have a working knowledge of Children and Adolescent Support Services Program (CASSP), included in Children, Youth and Family Oriented Services and the Community Support Program (CSP) principles, included in Adult Recovery Oriented Services and principles of drug and alcohol treatment.

- Ensure cooperation of the PH-MCO's Provider Network. Special Needs Unit case managers must facilitate communication and coordinate service delivery between primary care, specialty, ancillary, and behavioral health Providers to ensure Member's timely and uninterrupted access to care.

- Assist in the development of adequate Provider Networks, such as pediatric specialists, to serve Special Needs populations. Special Needs Unit case managers must assist and support Members with Special Needs in making an informed choice between Providers of equivalent services within the network. When adequate network

capacity does not exist to allow for choice between network Providers of equivalent services, case managers must facilitate and coordinate services rendered by Out-of-Network Providers.

- Conduct necessary training for PCPs to assist them in providing services to diverse populations including the identification of the PH-MCO's Special Needs Unit contact persons.

- Provide ongoing coordination with PCPs to continually serve Special Needs population's Members.

- Attend ad hoc meetings, workgroups, etc., hosted by the Department that require mandatory attendance by Special Needs Unit staff.

- Attend public/community sponsored meetings with the Department's representative(s) at the discretion of the PH-MCO.

- If the PH-MCO chooses to subcontract any of the Special Needs Unit functions, the PH-MCO must maintain accountability by assigning responsibility for oversight of the subcontract to a senior executive within the organization.

The Special Needs Unit will track, analyze, report, and, when appropriate, develop plans of correction around quality activities for indicators including, but not limited to, Special Needs Unit access measures; PCP access measures; specialist access measures; ancillary services' access measures; and Complaints, Grievances, and DHS Fair Hearings by Members with Special Needs. The Special Needs Unit coordinator will be responsible for the submission of the quarterly reports to the Office of Medical Assistance Programs' Special Needs Section on specified indicators in a format to be determined by the Department. The PH-MCO must submit the report to the Department within thirty (30) calendar days from the end of the quarter being reported. In addition, the PH-MCO will develop, implement, and maintain a targeted Quality Management component focused on Members with Special Needs that is integrated into the Quality Management/Utilization Management Program as outlined in Exhibit M(1), Quality Management and Utilization Management Program Requirements.

EXHIBIT PP

PROVIDER MANUALS

The PH-MCO shall develop, distribute prior to implementation and maintain a Provider manual. In addition, the PH-MCO and/or PH-MCO Subcontractors will be expected to distribute copies of all manuals and subsequent policy clarifications and procedural changes to participating Providers following advance written approval of the documents by the Department. Provider manuals must be updated to reflect any program or policy change(s) made by the Department via MA Bulletin within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the MA Bulletin, whichever is later, when such change(s) affect(s) information that the PH-MCO is required to include in its provider manual, as set forth in this Exhibit. The Provider manual must include, at a minimum, the following information:

A. A description of the case management system and protocols;

B. A description of the role of a PCP as described in Section II, Definitions, and Section V.S.3, Primary Care Practitioner (PCP) Responsibilities, of the Agreement;

C. Information on how Members may access specialists, including standing referrals and specialists as PCPs;

D. A summary of the guidelines and requirements of Title VI of the Civil Rights Act of 1964 and its guidelines, and how Providers can obtain qualified interpreters familiar with medical terminology;

E. Contact information to access the PH-MCO, DHS, advocates, other related organizations, etc;

F. A copy of the PH-MCO's Formulary, Prior Authorization, and Program Exception process;

G. Contact follow-up responsibilities for missed appointments;

H. Description of role of Special Needs Unit and how to refer patients;

I. Description of drug and alcohol treatment available and how to make referrals;

J. Complaint, Grievance and DHS Fair Hearing information;

K. Information on Provider Disputes;

L. PH-MCO policies, procedures, available services, sample forms, and fee schedule applicable to the Provider type;

M. A full description of covered services, listing all applicable services under the Medical Assistance Fee-for-Service Program;

N. Billing instructions;

O. Information regarding applicable portions of 55 PA Code, Chapter 1101, General Provisions;

P. Information on self-referred services and services which are not the responsibility of the PH-MCO but are available to Members on a Fee-for-Service basis;

Q. Provider performance expectations, including disclosure of Quality Management and Utilization Management criteria and processes;

R. Information on procedures for sterilizations, hysterectomies and abortions (if applicable);

S. Information about EPSDT screening requirements and EPSDT services, including information on the dental referral process);

T. A description of certain Providers' obligations, under law, to follow applicable procedures in dealing with Members on "Advance Directives" (durable health care power of attorney and living wills). This includes notification and record keeping requirements;

U. Information on ADA and Section 504 of the Rehabilitation Act of 1973, other applicable laws, and available resources related to the same;

V. A definition of “Medically Necessary” consistent with the language in the Agreement;

W. Information on Member confidentiality requirements;

X. Information regarding school-based/school-linked services in this HealthChoices zone; and

Y. The Department’s MA Provider Compliance Hotline (formerly the Fraud and Abuse Hotline) number and explanatory statement.

Z. Explanation of Contractor’s and DHS’s Recipient Restriction Program.

AA. Information regarding written translation and oral interpretation services for Members with LEP and alternate methods of communication for those requesting communication in alternate formats.

BB. List and scope of services for referral and Prior Authorization.

The PH-MCO is required to provide documented training to its Providers and their staffs and to Subcontractors, regarding the contents and requirements of the Provider manuals.

EXHIBIT XX
ENCOUNTER DATA SUBMISSION REQUIREMENTS
And
PENALTY APPLICATIONS

The submission of timely and accurate encounter data is critical to the Commonwealth's ability to establish and maintain cost effective and quality managed care programs. Consequently, the requirements for submission and metrics for measuring the value of the data for achieving these goals are crucial.

- CERTIFICATION REQUIREMENT

  All MCOs must be certified through PROMISe prior to the submission of live encounter data. The certification process is detailed at: https://dpwintra.dpw.state.pa.us/HealthChoices/custom/program/encounter/promise/documents/encounter_updated_certification_process_for_promise_v1.0_to_dpw_ph.doc

- SUBMISSION REQUIREMENTS

  Timeliness:

  With the exception of pharmacy encounters, all MCO approved encounters and those specified MCO denied encounters must be approved in PROMISe by the last day of the third month following the month of initial MCO adjudication. Pharmacy encounters must be submitted and approved in PROMISe within 30 days following the MCO adjudication.

  Metric: During the sixth months following the month of the initial PROMISe adjudication, the encounters will be analyzed for timely submission of encounters.

  - Failure to achieve PROMISe approved/paid status for 98% of all MCO paid/approved and specified MCO denied encounters by the last day of the third month following initial MCO adjudication may result in a penalty.
  - Any encounter corrected or initially submitted after the last day of the third month following initial MCO adjudication may be subject to a penalty.

  Accuracy and Completeness:

  Accuracy and completeness are based on the consistency between encounter information submitted to the Commonwealth and information for the same service maintained by the MCO in their claims/service history data base.

  Metric: Accuracy and completeness will be determined through a series of analyses applied to MCO claims history data and encounters received and processed through PROMISe. This analysis will be done at least yearly but no more than twice a year and consist of making a comparison between an encounter sample and what is found in MCO claims history. A sample may also be drawn from the MCO service history and compared against encounters processed through PROMISe.

Samples will be drawn proportionally based on the MCO financial expenditures for each transaction type submitted during the review period. Each annual or semi-annual analysis will be based on a statistically valid sample of no less than 200 records.

- PENALTY PROVISION

  Timeliness

  - Failure to comply with timeliness requirements will result in a sanction of up to $10,000 for each program month.

  Completeness and Accuracy

  - Errors in accuracy or completeness that are identified by the Department in an annual or semi-annual analysis will result in sanctions as follows. An error in accuracy or completeness or both, in one sample record, counts as one error.

Percentage of the sample that includes an error	Sanction
Less than 1.0 percent	None
1.0 – 1.4 percent	$4,000
1.5 – 2.0 percent	$10,000
2.1 - 3.0 percent	$16,000
3.1 – 4.0 percent	$22,000
4.1 – 5.0 percent	$28000
5.1 – 6.0 percent	$34,000
6.1 – 7.0 percent	$40,000
7.1 – 8.0 percent	$46,000
8.1 – 9.0 percent	$52,000
9.1 – 10.0 percent	$58,000
10.1 percent and higher	$100,000

Rev. 1-1-16

EXHIBIT AAA (1)

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

The PH-MCO must consider the following in establishing and maintaining its Provider Network:

- The anticipated MA enrollment,
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the PH-MCO,
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted MA services,
- The number of Network Providers who are not accepting new MA patients, and
- The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

The PH-MCO must ensure that its Provider Network is adequate to provide its Members in this HealthChoices Zone with access to quality Member care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the PH-MCO must supply geographic access maps using Member level data detailing the number, location and specialties of their Provider Network to the Department in order to verify accessibility of Providers within their Network in relation to the location of its Members. The Department may require additional numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The PH-MCO must also have a process in place which ensures that the PH-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The PH-MCO must make all reasonable efforts to honor a Member's choice of Providers who are credentialed in the Network. Additionally, the PH-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire HealthChoices Zone in which the PH-MCO operates if providers exist:

a. PCPs

Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available.

Members may, at their discretion, select PCPs located further from their homes.

b. Pediatricians as PCPs

Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (30 minutes Urban, 60 minutes Rural).

c. Specialists

i. For the following provider types, the PH-MCO must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

General Surgery	Cardiology
Obstetrics & Gynecology	Pharmacy
Oncology	Orthopedic Surgery
Physical Therapy	General Dentistry
Radiology	

ii. For the following provider types, the PH-MCO must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the HealthChoices Zone:

Oral Surgery	Urology
Nursing Facility	Neurology
Dermatology	Otolaryngology

iii. For all other specialists and subspecialists, the PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.

d. Hospitals

Ensure at least one (1) hospital within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice within the HealthChoices Zone.

e. Special Health Needs

Ensure the provision of services to persons who have special health needs or who face access barriers to health care. If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the

particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services. For children with special health needs, the PH-MCO must offer at least two (2) pediatric specialists or pediatric sub-specialists.

f. Anesthesia for Dental Care

For Members needing anesthesia for dental care, the PH-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay out of Network.

g. Rehabilitation Facilities

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this HealthChoices Zone.

h. CNMs / CRNPs, Other Health Care Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. The PH-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

i. Qualified Providers

The PH-MCO must limit its PCP Network to appropriately qualified Providers. The PH-MCO's PCP Network must meet the following:

- Seventy–five to one hundred percent (75-100%) of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics; and

- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal

medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

j. Members Freedom of Choice

The PH-MCO must demonstrate its ability to offer its Members freedom of choice in selecting a PCP. At a minimum, the PH-MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Recipients. For the purposes of this section, a full-time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Members to the panel. The number of Members assigned to a PCP may be decreased by the PH-MCO if necessary to maintain the appointment availability standards.

k. PCP Composition and Location

The PH-MCO and the Department will work together to avoid the PCP having a caseload or medical practice composed predominantly of HC Members. In addition, the PH-MCO must organize its PCP Sites so as to ensure continuity of care to Members and must identify a specific PCP or PCP group for each Member. The PH-MCO may apply to the Department for a waiver of these requirements. The Department may waive these requirements for good cause demonstrated by the PH-MCO. The PH-MCO will comply with the program standards regarding PCP assignment as set forth in Section V.Q. of the Agreement, Assignment of PCPs.

l. FQHCs / RHCs

The PH-MCO must include in its Provider Network every FQHC and RHC that are willing to accept PPS rates as payment in full and are located within the operational HealthChoices Zones in which the PH-MCO has an agreement. If the PH-MCO's primary care Network includes FQHCs and RHCs, these sites may be designated as PCP sites.

m. Medically Necessary Emergency Services

The PH-MCO must comply with the provisions of Act 112 of 1996 (H.B. 1415, P.N. 3853, signed July 11, 1996), the Balanced Budget Reconciliation Act of 1997 and Act 68 of 1998, the Quality Health Care

Accountability and Protection Provisions, 40 P.S. 991.2101 et seq. pertaining to coverage and payment of Medically Necessary Emergency Services. The definition of such services is set forth herein at Section II of this Agreement, Definitions.

n. ADA Accessibility Guidelines

The PH-MCO must inspect the office of any PCP or dentist who seeks to participate in the PH-MCO's Provider Network (excluding offices located in hospitals) to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

The PH-MCO must submit quarterly reports to the Department, in a format to be specified by the Department, on the results of the inspections.

If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the PH-MCO's Provider Network provided that the PCP or dentist: 1) requests and is determined by the PH-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within six (6) months after the PH-MCO identified the barrier.

The PH-MCO must document its efforts to determine architectural accessibility. The PH-MCO must submit this documentation to the Department upon request.

o. Laboratory Testing Sites

The PH-MCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number in accordance with CLIA 1988. Those laboratories with certificates of waiver will provide only the eight (8) types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The PCP must provide all required demographics to the laboratory when submitting a specimen for analysis.

p. PH-MCO Discrimination

The PH-MCO must not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within

the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph must not be construed to prohibit a PH-MCO from including Providers only to the extent necessary to meet the needs of the organization's Members or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the PH-MCO.

q. Declined Providers

If the PH-MCO declines to include individual Providers or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision.

r. Second Opinions

The PH-MCO must provide for a second opinion from a qualified Health Care Provider within the Network, at no cost to the Member. If a qualified Health Care Provider is not available within the Network, the PH-MCO must assist the Member in obtaining a second opinion from a qualified Health Care Provider outside the Network, at no cost to the Member, unless co-payments apply.

2. Appointment Standards

The PH-MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

a. General

PCP scheduling procedures must ensure that:

i. Emergency Medical Condition cases must be immediately seen or referred to an emergency facility.

ii. Urgent Medical Condition cases must be scheduled within twenty-four (24) hours.

iii. Routine appointments must be scheduled within ten (10) Business Days.

iv. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.

v. The PH-MCO must provide the Department with its protocol for ensuring that a Member's average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical need. The Member must be informed of scheduling time frames through educational outreach efforts.

vi. The PH-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room visits.

b. Persons with HIV/AIDS

The PH-MCO must have adequate PCP scheduling procedures in place to ensure that an appointment with a PCP or specialist must be scheduled within seven (7) days from the effective date of Enrollment for any person known to the PH-MCO to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the Member is already in active care with a PCP or specialist.

c. Supplemental Security Income (SSI)

The PH-MCO must make a reasonable effort to schedule an appointment with a PCP or specialist within forty-five (45) days of Enrollment for any Member who is an SSI or SSI-related consumer unless the Member is already in active care with a PCP or specialist.

d. Specialty Referrals

For specialty referrals, the PH-MCO must be able to provide for:

i. Emergency Medical Condition appointments immediately upon referral.

ii. Urgent Medical Condition care appointments within twenty-four (24) hours of referral.

iii. Scheduling of appointments for routine care within fifteen (15) business days for the following specialty provider types:

Otolaryngology	Orthopedic Surgery
Dermatology	Pediatric Allergy & Immunology
Pediatric Endocrinology	Pediatric Gastroenterology
Pediatric General Surgery	Pediatric Hematology
Pediatric Infectious Disease	Pediatric Nephrology
Pediatric Neurology	Pediatric Oncology
Pediatric Pulmonology	Pediatric Rehab Medicine
Pediatric Rheumatology	Pediatric Urology
Dentist	

iv. Scheduling of appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.

e. Pregnant Women

Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members as follows:

i. First trimester — within ten (10) Business Days of the Member being identified as being pregnant.

ii. Second trimester — within five (5) Business Days of the Member being identified as being pregnant.

iii. Third trimester — within four (4) Business Days of the Member being identified as being pregnant.

iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the PH-MCO or maternity care Provider, or immediately if an emergency exists.

f. EPSDT

EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations.

The PH-MCO must distribute quarterly lists to each PCP in its Provider Networks which identify Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in this Exhibit, or Members who have not complied with EPSDT periodicity and immunization schedules for children. The PH-MCO must contact such Members, documenting the reasons for noncompliance and documenting its efforts for bringing the Members' care into compliance.

3. Policies and Procedures for Appointment Standards

The PH-MCO will comply with the program standards regarding service accessibility standards that are set forth in this Exhibit and in Section V.S. of the Agreement, Provider Agreements.

The PH-MCO must have written policies and procedures for disseminating its appointment standards to all Members through its Member handbook and through other means. In addition, the PH-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The PH-MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

4. Compliance with Access Standards

a. Mandatory Compliance

The PH-MCO must comply with the access standards in accordance with this Exhibit and Section V.S of the Agreement, Provider Agreements. If the PH-MCO fails to meet any of the access standards by the dates specified by the Department, the Department may terminate this Agreement.

b. Reasonable Efforts and Assurances

The PH-MCO must make reasonable efforts to honor a Member's choice of Providers among Network Providers as long as:

i. The PH-MCO's agreement with the Network Provider covers the services required by the Member; and

ii. The PH-MCO has not determined that the Member's choice is clinically inappropriate.

The PH-MCO must provide the Department adequate assurances that the PH-MCO, with respect to this HealthChoices Zone, has the capacity to serve the expected Enrollment in this HealthChoices Zone. The

PH-MCO must provide assurances that it will offer the full scope of covered services as set forth in this Agreement and access to preventive and primary care services. The PH-MCO must also maintain a sufficient number, mix and geographic distribution of Providers and services in accordance with the standards set forth in this Exhibit and Section V.S of the Agreement, Provider Agreements.

c. PH-MCO's Corrective Action

The PH-MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a termination action or other sanction by the Department, the PH-MCO will be given the opportunity to institute a corrective action plan. The PH-MCO must submit a corrective action plan to the Department for approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the PH-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the PH-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the PH-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the PH-MCO must submit a revised corrective action plan within fifteen (15) days of notification. If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the PH-MCO, in accordance with Section VIII.H. of the Agreement, Sanctions. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in this Agreement.

EXHIBIT BBB

OUTPATIENT DRUG SERVICES

1. General Requirements

a. The PH-MCO must cover all Covered Outpatient Drugs listed on the Center for Medicare and Medicaid Services (CMS) Quarterly Drug Information File when determined to be Medically Necessary, unless otherwise excluded from coverage. (See 2. Coverage Exclusions below for exclusions.) This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers enrolled in the MA program, and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.

b. The PH-MCO must provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C.A. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature.

c. Unless financial responsibility is otherwise assigned, all Covered Outpatient Drugs are the payment responsibility of the Member's PH-MCO. The only exception is that the behavioral health managed care organization (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.

d. All Covered Outpatient Drugs must be dispensed through PH-MCO Network Providers. This includes Covered Outpatient Drugs prescribed by both the PH-MCO and the BH-MCO Providers.

e. Under no circumstances will the PH-MCO permit the therapeutic substitution of an outpatient drug by a pharmacist without explicit authorization from the licensed prescriber.

f. All proposed pharmacy programs and drug utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. must be submitted to the Department for review and approval prior to implementation.

g. The PH-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Outpatient Drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will,

i. Apply, regardless of whether the Covered Outpatient Drug is provided as an outpatient drug benefit or as a "medical benefit" incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).

ii. Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-reviewed medical literature, and FFS guidelines to determine medical necessity of drugs that require prior authorization in the MA FFS Program, when designated by the Department.

h. The PH-MCO must agree to adopt the same guidelines to determine medical necessity of selected drugs or classes of drugs as those adopted by the MA FFS Program when designated by the Department by publication of Managed Care Operations Memoranda (MC OPS Memos).

i. 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 also comply with the procedures outlined in MA Bulletin 99-03-13 and MA Bulletin # 99-96-01. The PH-MCO policy and procedures for continuity of care for outpatient drugs, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the PH-MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to outpatient drugs that the member was prescribed before enrolling in the PH-MCO.

2. **Coverage Exclusions**

a. In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. 1396r-8, the PH-MCO must exclude coverage for any drug marketed by a drug company (or labeler) who does not participate in the Medicaid Drug Rebate Program. The PH-MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide rebates to the Medicaid agency. This requirement does not apply to vaccines, compounding materials, certain vitamins and minerals or diabetic supplies.

b. The PH-MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

c. The PH-MCO must exclude coverage of noncompensable drugs in accordance with 55 PA Code §1121.54.

3. Formularies and Preferred Drug Lists (PDLs)

a. The PH-MCO may use a Formulary or a Preferred Drug List (PDL). All drugs must be Covered Outpatient Drugs.

b. The Formulary or PDL must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee.

c. The Formulary or PDL must meet the clinical needs of the MA population. The Formulary or PDL must include a range of drugs in each therapeutic drug class represented. The Department reserves the right to determine if the Formulary or PDL meets the clinical needs of the MA population. .

d. The Formulary or PDL must be clinically based. Only those drugs that do not have a significant, clinically meaningful therapeutic advantage, in terms of safety, effectiveness, or clinical outcomes, over other drugs included in the Formulary or PDL, may be designated as non-formulary or non-preferred.

e. The PH-MCO must make a satisfactory written explanation of the reason(s) for designating a drug as non-formulary or non-preferred available to the Department upon request.

f. The PH-MCO must allow access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy), in accordance with Prior Authorization of Services Section V. B.1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program.

g. The PH-MCO must receive written approval from the Department of the Formulary or PDL, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred, prior to implementation of the Formulary or PDL and the requirements.

h. The PH-MCO must submit all Formulary or PDL changes (other than additions) and deletions to the Department for review and written approval prior to implementation.

i. The PH-MCO must submit written notification of any Formulary or PDL additions to the Department within fifteen (15) days of implementation.

j. The Formulary or PDL must be re-submitted for Department review and approval annually.

k. The PH-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Outpatient Drug either by addition to the Formulary or PDL, or through prior authorization, within 10 days from their availability in the marketplace.

4. Prior Authorization of Outpatient Drugs

a. The PH-MCO may require Prior Authorization (includes step therapy) as a condition of coverage or payment for a Covered Outpatient Drug provided that:

i. 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

ii. 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 instructs the pharmacist to dispense either a:

a) Fifteen (15) day supply if the prescription qualifies as an Ongoing Medication, 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 DHS Fair Hearing request has not been filed, or

b) A seventy-two (72) hour supply of a new medication.

b. 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.

c. 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.

d. In such an event, the PH-MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber.

e. If the PH-MCO denies the request for prior authorization, the PH-MCO must issue a written denial notice, using the appropriate Outpatient Drug Denial Notice template listed on the Department Intranet, within twenty-four (24) hours of receiving the request for prior authorization.

f. If the Member files a Grievance or DHS Fair Hearing request from a denial of an Ongoing Medication, the PH-MCO must authorize the medication until the Grievance or DHS Fair Hearing request is resolved.

g. 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.

h. The PH-MCO must establish and maintain written prior authorization policies, procedures, and guidelines to determine Medical Necessity of Covered Outpatient Drugs that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred.

i. The PH-MCO must comply with the requirements for Prior Authorization of Services, Section V. B. 1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and receive written approval from the Department prior to implementation.

j. The PH-MCO must submit additions, changes and deletions to Prior Authorization (including Step Therapy) policies, procedures and any associated medical necessity guidelines for Department review and written approval prior to implementation.

5. Provider and Member Notification

The PH-MCO must have policies and procedures for notification to Providers and Members of changes to the Formulary or PDL and Prior Authorization requirements.

a. Written notification for changes to the Formulary or PDL and Prior Authorization requirements must be provided to all affected Providers and Members at least thirty (30) days prior to the effective date of the change.

b. The PH-MCO must provide all other Providers and Members written notification of changes to the Formulary or PDL and Prior Authorization requirements upon request.

c. The PH-MCO also must generally notify Providers and Members of Formulary or PDL and Prior Authorization changes through Member and Provider newsletters, its web site, or other regularly published media of general distribution.

6. PH-MCO Pharmacy & Therapeutics (P&T) Committee

a. The P&T Committee membership must include physicians, including a minimum of two (2) behavioral health physicians, pharmacists, MA program consumers and other appropriate clinicians. MA program consumer representative membership must include the following:

   i. One (1) physical health consumer representative. The physical health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, or a physical health consumer advocate designated by consumers enrolled in the PH-MCO to represent them.

   ii. One (1) behavioral health consumer representative. The behavioral health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, a behavioral health consumer advocate, or a family member designated by consumers enrolled in the PH-MCO to represent them.

b. The PH-MCO must submit a P&T Committee membership list for Department review and approval upon request.

c. When the P&T Committee addresses specific drugs or entire drug classes requiring medical expertise beyond the P&T Committee membership, specialists with knowledge appropriate to the drug(s) or class of drugs being addressed must be added as non-voting, ad hoc members.

d. The minutes from each PH-MCO P&T Committee meeting must be posted for public view on the PH-MCO's website within 30 days of the date of the meeting at which the minutes are approved. Minutes will include vote totals.

7. Pharmacy Provider Network - Any Willing Pharmacy

The PH-MCO must contract on an equal basis with any pharmacy qualified to participate in the MA Program that is willing to comply with the PH-MCO's payment rates and terms and to adhere to quality standards established by the PH-MCO as required by 62 P.S. 449.

The provisions for any willing pharmacy apply if the PH-MCO Subcontracts with specialty pharmacies, or designates specific network pharmacies as the preferred provider(s) of specialty drugs(s). PH-MCOs are required to contract on an equal basis with any pharmacy qualified to participate in the MA program that is willing to accept the same payment rate(s) as the preferred provider(s) of specialty drugs and comply with the same terms and conditions for quality standards and reporting as the preferred provider(s) of specialty drugs.

Subcontracts and agreements with specialty pharmacies and network pharmacies designated to serve as preferred providers of specialty drugs must be submitted to the Department for advance written approval.

8. **Pharmacy Rebate Program**

Under the provisions of Section 1927 of the Social Security Act 42 U.S.C.A. 1396r-8, drug companies that wish to have their products covered through the MA Program (both FFS and managed care) must sign an agreement with the federal government to provide rebates to the State. The Affordable Care Act (ACA) provides for federal drug rebates for drugs paid for by the PH-MCOs.

a. In order to ensure full compliance with the provisions of the ACA, PH-MCOs must report the necessary encounter data in order for the Department to invoice drug manufacturers for rebates for all Covered Outpatient Drugs. This includes physician-administered drugs, drugs dispensed by 340B covered entities or contract Pharmacies, and drugs dispensed to PH-MCO members with private or public pharmacy coverage and the PH-MCO provided secondary coverage.

b. The PH-MCO must report all outpatient drug information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by the Department.

The PH-MCO may negotiate its own market share rebates for pharmaceutical products with drug companies.

If the PH-MCO fails to submit Outpatient Drug Encounter Data when invoiced to manufacturers for rebate, at least 90% are collectable within 90 calendar days of invoicing by the Commonwealth a sanction of $25,000 per quarter shall be imposed until the PH-MCO reaches the 90% threshold.

9. Outpatient Drug Encounters

a. The PH-MCO shall submit all Outpatient Drug Encounters to the Department within 30 days of the adjudication date of the claim to the MCO for payment.

b. The PH-MCO shall provide all Outpatient Drug Encounter data and supporting information as specified below for the Department to collect rebates through the Medicaid Drug Rebate Program. For all Outpatient Drug Encounter data including pharmacy point-of-sale (NCPDP), physician-administered drugs (837P), outpatient hospital drugs (837I), and drugs dispensed by 340B covered entities and contract pharmacies, the following data elements are required:

   i. Valid NDC for the drug dispensed.

      1. The PH-MCO shall also include the HCPCS code associated with the NDC for all 837P and 837I encounters where payment was made by the MCO based on the HCPCS code and HCPCS code units.

      2. The PH-MCO shall also include the diagnosis codes associated with the NDC for all 837P and 837I encounters where payment was made by the PH-MCO based on the HCPCS code and HCPCS code units.

   ii. Valid NDC units for the drug dispensed

      1. The MCO shall also include the HCPCS units associated with the NDC for all 837P and 837I encounters where payment was made by the MCO based on the HCPCS code and HCPCS code units.

   iii. Actual paid amount by the MCO to the provider for the drug dispensed.

   iv. Actual TPL amount paid by the Member's primary pharmacy coverage to the provider for the drug dispensed.

   v. Actual copayment paid by the Member to the provider for the drug dispensed.

   vi. Actual dispensing fee paid by the MCO to the provider for the drug dispensed.

   vii. The billing provider's:

      1. NPI and/or Medical Assistance Identification Number

      2. Full address and phone number associated with the NPI

   viii. The prescribing provider's:

      1. NPI and/or Medical Assistance Identification Number

      2. Full address and phone number associated with the NPI

ix. The date of service for the dispensing of the drug by the billing provider.

x. The date of payment by the PH-MCO to the provider for the drug.

xi. Any other data elements identified by the Department to invoice for drug rebates.

c. The PH-MCO shall edit and validate claim transaction submissions and Outpatient Drug Encounter data for completeness and accuracy in accordance with claim standards such as NCPDP. The actual paid amount by the PH-MCO to the dispensing provider must be accurately submitted on each Outpatient Drug Encounter to the Department.

d. The PH-MCO shall ensure that the NDC on all Outpatient Drug Encounters is appropriate for the HCPCS code based on the NDC and units billed. The NDC must represent a drug that was available to the physician in an outpatient setting for administration.

e. The Department will review the Outpatient Drug Encounters and remove applicable 340B covered entity encounters from the drug rebate invoicing process.

i. The Department does not recognize 340B contracted pharmacies as 340B providers and will not remove encounters billed by contract pharmacies from the rebate invoicing process.

f. The PH-MCO shall meet Outpatient Drug Encounter Data accuracy requirements by submitting PH-MCO paid Outpatient Drug Encounters with no more than a 3% error rate, calculated for a month's worth of Encounter submissions. The Department will monitor the PH-MCO's corrections to denied Encounters by random sampling performed quarterly and over the term of this Agreement. The PH-MCO shall have corrected and resubmitted 75% of the denied Encounters for services covered under this Agreement included in the random sample within 30 calendar days of denial

g. If the PH-MCO fails to submit Outpatient Drug Encounter data within timeframes specified, the Department shall assess civil monetary penalties upon the PH-MCO. These penalties shall be $2,000 for each calendar day that the Outpatient Drug Encounter data is not submitted. The Department may waive these sanctions if it is determined that the PH-MCO was not at fault for the late submission of the data.

Drug Utilization Review (DUR) Program

The PH-MCO must provide a DUR Program to assure that prescriptions are appropriate, Medically Necessary and not likely to result in adverse medical outcomes, and to enhance the quality of patient care by educating prescribers, pharmacists and Members.

a. Prospective Drug Utilization Review (Pro-DUR)

i. The PH-MCO must provide for a review of drug therapy before each prescription is filled or delivered to a member at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.

ii. The PH-MCO must provide for counseling of members receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

b. Retrospective Drug Utilization Review (Retro-DUR)

i. The PH-MCO must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and members.

ii. The PH-MCO shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.

iii. The PH-MCO shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.

The PH-MCO must submit an annual report on the operation of its Pennsylvania Medicaid Drug Utilization Review (DUR) program in a format designated by the Department. The format of the report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational

interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

c. Drug Utilization Review Board (DUR Board)

The Department maintains a DUR Board that reflects the structure of the health care delivery model that includes both a managed care and a fee-for-service delivery system. Each PH-MCO and BH-MCO is required to include a representative to serve as a member of the DUR Board. The DUR Board is a standing advisory committee that recommends the application of predetermined standards related to Pro-DUR, Retro-DUR, and related administrative and educational interventions designed to protect the health and safety of the MA program recipients. The Board reviews and evaluates pharmacy claims data and prescribing practices for efficacy, safety, and quality against predetermined standards using nationally recognized drug compendia and peer reviewed medical literature as a source. The Board recommends appropriate utilization controls and protocols including prior authorization, automated prior authorization, system edits, guidelines to determine medical necessity, generic substitution, and quantity limits for individual medications or for therapeutic categories.

10. Pharmacy Benefit Manager (PBM)

The PH-MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions in Section XIII: Subcontractural Relationships, and has received advance written approval by the Department. The standards for Network composition and adequacy for outpatient drug services includes the requirements for any willing pharmacy as described above. The PH-MCO must indicate the intent to use a PBM, identify the proposed PBM Subcontract and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly or in part by a PH-MCO, retail pharmacy Provider, chain drug store or pharmaceutical manufacturer, the PH-MCO must submit a written description of the assurances and procedures that will be put in place under the proposed PBM Subcontract, such as an independent audit, to assure confidentiality of proprietary information. These assurances and procedures must be submitted and receive advance written approval by the Department prior to initiating the PBM Subcontract. The Department will allow the continued operation of existing PBM Subcontracts while the Department is reviewing new contracts.

11. Requirements For PH-MCO and BH-MCO Interaction and Coordination of Outpatient Drug Services

a. BH-MCO prescribing Providers must comply with the PH-MCO requirements for utilization management of outpatient behavioral health drugs.

b. The BH-MCO will be required to issue an initial list of BH-MCO Providers to the PH-MCO, and quarterly updates that include additions and terminations. Should the PH-MCO receive a request to dispense medication prescribed by 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. Payment for inpatient pharmaceuticals during a BH admission is the responsibility of the BH-MCO and is included in the hospital charge.

d. The PH-MCO may deny payment of a claim for a Covered Outpatient Drug prescribed by a BH-MCO Provider only if one of the following occurs:

    i. The drug is not being prescribed for the treatment of substance abuse/dependency/ addiction or mental illness and any side effects of psychopharmacological agents. Those drugs are to be prescribed by the PH-MCO's PCP or specialists in the Member's PH-MCO Network.

    ii. The prescription has been identified as a case of Fraud, Abuse, or gross overuse, or the dispensing pharmacist determined that taking the medication either alone or along with other medications that the Member may be taking, would jeopardize the health and safety of the Member.

e. The PH-MCO must receive written approval from the Department of the policies and procedures for the PH-MCO and BH-MCO to:

    i. When deemed advisable, require consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records.

    ii. Timely resolve disputes which arise from the payment for or use of drugs, including a mechanism for timely, impartial mediation when resolution between the PH-MCO and BH-MCO does not occur.

    iii. Share independently developed Quality Management/Utilization Management information related to outpatient drug services, as applicable.

    iv. Collaborate in adhering to a drug utilization review program approved by the Department. Collaborate in identifying and reducing the frequency of patterns of Fraud, Abuse, gross overuse, inappropriate or medically unnecessary care among physicians, pharmacists and Members associated with specific drugs.

f. The PH-MCO must send data files, via the Department's file transfer protocol (FTP), containing records of detailed outpatient drug services as provided to individual enrollees of the BH-MCOs contracted with the Department. 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

EXHIBIT CCC

PHYSICAL HEALTH MCO (PH-MCO) 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 PH-MCO's Provider Agreements must include the following provisions:

a. A requirement that the PH-MCO must not exclude or terminate a Provider from participation in the PH-MCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

b. A requirement that the PH-MCO must not exclude a Provider from the PH-MCO's Provider Network because the Provider advocated on behalf of a Member for Medically Necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable Health Care Provider practicing according to the applicable legal standard of care.

c. A provision that prohibits the Provider from denying services to an Recipient during the MA FFS eligibility window prior to the effective date of the PH-MCO Enrollment.

d. Notification of the prohibition and sanctions for submission of false Claims and statements.

e. The definition of Medically Necessary as defined in Section II of this Agreement, Definitions.

f. A requirement that the PH-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member including; information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

g. A requirement that the PH-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or nontreatment.

h. A requirement that the PH-MCO cannot terminate a contract or employment with a Health Care Provider for filing a Grievance on a Member's behalf.

i. A clause which specifies that the agreement will not be construed as requiring the PH-MCO to provide, reimburse for, or provide coverage of, a counseling or referral service if the Provider objects to the provision of such services on moral or religious grounds.

j. A requirement securing cooperation with the QM/UM Program standards outlined in Exhibit M(1) of this Agreement, Quality Management and Utilization Management Program Requirements.

k. A requirement for cooperation for the submission of 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.

l. A continuation of benefits provision which states that the Provider agrees that in the event of the PH-MCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the PH-MCO's Members, including Members in an inpatient setting, through the period for which the Capitation has been paid.

m. A requirement that the PCPs who serve Members under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another Network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Member's PCP medical record. For details on access requirements, see Exhibit AAA(1), AAA(2) or AAA(3) of this Agreement, Provider Network Composition/Service Access, as applicable.

n. A requirement that PCPs who serve Members under the age of twenty-one (21) report Encounter Data associated with EPSDT screens, using a format approved by the Department, to the PH-MCO within ninety (90) days from the date of service.

o. A requirement that PCPs contact new Members identified in the quarterly Encounter lists who have not had an Encounter during the first six (6) months of Enrollment, or who have not complied with the scheduling requirements outlined in the RFP and this Agreement. The PH-MCO must require the PCP to contact Members identified in the quarterly Encounter lists as not complying with EPSDT periodicity and immunization schedules for children. The PCP must be required to identify to the PH-MCO any such Members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such notification to the site by the PH-MCO. The PCP must also be

required to document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards. PCPs shall be required to contact all Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in Exhibit AAA(1), AAA(2), or AAA(3) of this Agreement, Appointment Standards, as applicable, to arrange appointments.

p. A requirement that the PH-MCO include in all capitated Provider Agreements a clause which requires that should the Provider terminate its agreement with the PH-MCO, for any reason, that the Provider provide services to the Members assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.

q. A requirement that ensures each physician providing services to Members eligible for Medical Assistance under the State Plan to have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act.

r. Language which requires the Provider to disclose annually any Physician Incentive Plan or risk arrangements it may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no Substantial Financial Risk between the PH-MCO and the physician or physician group.

s. A requirement for cooperation with the PH-MCO's and DHS's Recipient Restriction Program.

t. A requirement that health care facilities and ambulatory surgical facilities develop and implement, in accordance with P.L.154, No. 13 known as the Medical Care Availability and Reduction of Error (Mcare) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures for the detection, control and prevention of Health Care-Associated Infections.

u. A provision that the PH-MCO's Utilization Management (UM) Departments are mandated by the Department to monitor the progress of a member's inpatient hospital stay. This must be accomplished by the PH-MCO's UM department receiving appropriate clinical information from the hospital that details the member's admission information, progress to date, and any pertinent data within two (2) business days from the time of admission. The PH-MCOs providers must agree to the PH-MCO's UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the PH-MCO's Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the PH-MCO must receive all clinical information

on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

v. Requirements regarding coordination with Behavioral Health Providers (if applicable):

- Comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written member consents to disclose confidential medical records.

- Make referrals for social, vocational, education or human services when a need for such service is identified through assessment.

- Provide health records if requested by the Behavioral Health Provider.

- Notify BH Provider of all prescriptions, and when deemed advisable, check with BH Provider before prescribing medication. Make certain BH clinicians have complete, up-to-date record of medications.

- Be available to the BH Provider on a timely basis for consultations.

w. The PH-MCO must require that participating ER staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for the county.

The PH-MCO may not enter into a Provider Agreement that prohibits the Provider from contracting with another PH-MCO or that prohibits or penalizes the PH-MCO for contracting with other Providers.

The PH-MCO must make all necessary revisions to its Provider Agreements to be in compliance with the requirements set forth in this section. Revisions may be completed as Provider Agreements become due for renewal provided that all Provider Agreements are amended within one (1) year of the effective date of this Agreement with the exception of the Encounter Data requirements which must be amended immediately, if necessary, to ensure that all Providers are submitting Encounter Data to the PH-MCO within the time frames specified in Section VIII.B.1 of this Agreement, Encounter Data Reporting.