Copy-ID:		GRANT Number:	SAP 4100060537

PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

GRANT AGREEMENT AMENDMENT #8

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

AWARD TO:

NAME AND ADDRESS:	Mail Final Agreement to:
Yvette Bright, President and CEO Vista Health Plan, Inc. 1901 Market Street Philadelphia, PA 19103 TELEPHONE NUMBER: 215-241-2056	Laura Herzog Director PA Compliance and Regulatory Affairs Keystone First, AmeriHealth Caritas, & AmeriHealth Northeast Health Plans 200 Stevens Drive Philadelphia, PA 19113 ebaumgartner@amerihealthcaritas.com Lherzog@amerihealthcaritas.com

FEDERAL I.D. NUMBER: [redacted]

HEALTHCHOICES NEW WEST PHYSICAL HEALTH AGREEMENT
No. 4100060537 Amendment #8

THIS Amendment to Grant Agreement No. 4100060537 (the "Amendment") is made this 8th day of August, 2017 by and between the Commonwealth of Pennsylvania, acting through its Department of Human Services (the "Department") and Vista Health Plan, Inc., a Pennsylvania corporation with its principal place of business at 1901 Market Street, Philadelphia, Pennsylvania 19103 (the "PH-MCO").

W I T N E S S E T H:

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

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

WHEREAS, the Department desires to amend 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, 2017, Appendix 3a ACA Health Insurance Providers Fee (dated March 22, 2016) is replaced with the attached Appendix 3a, ACA Health Insurance Providers Fee (dated January 15, 2017).
b. Effective January 1, 2017, Appendix 3b Explanation of Capitation Payments (dated April 11, 2016) is replaced with the attached Appendix 3b Explanation of Capitation Rates (dated January 9, 2017).
c. Effective January 1, 2017, Appendix 3c Home Nursing Risk Sharing Arrangement (dated February 23, 2016) is replaced with the attached Appendix 3c Home Nursing Risk Sharing Arrangement (dated January 9, 2017).
d. Effective December 31, 2016, Appendix 3d Risk Corridor (dated November 9, 2015) is removed.
e. For services provided on or after January 1, 2017, Appendix 3f Capitation Rates (Prepared on March 23, 2016) is replaced with the attached Exhibit 3f Capitation Rates (Prepared on January 11, 2017).

f. Effective January 1, 2017, Appendix 3g Overview of Methodologies for Rate Setting and Determination of Risk Sharing Withhold Amounts (dated November 8, 2015) is replaced with the attached Appendix 3g Overview of Methodologies for Rate Setting and Determination of Risk Sharing Withhold Amounts (dated January 10, 2017).
g. Effective January 1, 2017, Appendix 3h, Medical Loss Ratio Reporting and Remittance Requirements (dated November 27, 2016) is added as a new appendix.
h. Effective January 1, 2017, Appendix 3k High Cost Risk Pool (dated April 5, 2016) is replaced with the attached Appendix 3k High Cost Risk Pool (dated January 9, 2017).
i. Effective January 1, 2017, Appendix 3m Gross Receipts Tax (dated July 17, 2015) is replaced with the attached Appendix 3m MCO Assessment (dated January 15, 2017).
j. Effective January 1, 2017, Appendix 3m-1 MCO Assessment (dated March 26, 2016) is removed.
k. Effective January 1, 2017, Appendix 5 Specialty Drug Risk Sharing and Quality Risk Pools (dated March 26, 2016) is replaced with the attached Appendix 5 Specialty Drug Risk Sharing and Quality Risk Pools (dated March 29, 2017).
l. Effective January 1, 2017, Appendix 14 APR/DRG Adjustment Inpatient Acute Care Services (dated March 26, 2016) is replaced with the attached Appendix 14 APR/DRG Adjustment Inpatient Acute Care Services (dated January 9, 2017).
m. Effective January 1, 2017, the following exhibits are replaced: Exhibit A, Exhibit B(1), Exhibit B(2), Exhibit B(3), Exhibit E(1), Exhibit M(1), Exhibit M(2), Exhibit M(4), Exhibit O, Exhibit CC, Exhibit DD, Exhibit GG, Exhibit KK, Exhibit LL, Exhibit NN, Exhibit OO, Exhibit PP, Exhibit WW, and Exhibit BBB.
n. Effective January 1, 2017, the following exhibits are added: Exhibit G and Exhibit DDD.

2. The attached Appendix 3a, Appendix 3b, Appendix 3c, Appendix 3f, Appendix 3g, Appendix 3h, Appendix 3k, Appendix 3m, Appendix 5, Appendix 14, Exhibit A, Exhibit B(1), Exhibit B(2), Exhibit B(3), Exhibit E(1), Exhibit G, Exhibit M(1), Exhibit M(2), Exhibit M(4), Exhibit O, Exhibit CC, Exhibit DD, Exhibit GG, Exhibit KK, Exhibit LL, Exhibit NN, Exhibit OO, Exhibit PP, Exhibit WW, Exhibit BBB, and Exhibit DDD 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
Yvette Bright, President and CEO

SIGNATURE
PRINT OR TYPE NAME AND TITLE

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

Program Deputy Secretary
Teresa M. Allen 5-11-17
SIGNATURE

Secretary
SIGNATURE

MAY 1 2 2017

COMPTROLLER OPERATIONS

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

AMOUNT	SOURCE	APPROPRIATION SYMBOL	PROGRAM

Karen Leavitt 8/8/2017
SIGNATURE COMPTROLLER OPERATIONS

Approved as to Legality and Form:

OFFICE OF LEGAL COUNSEL
DEPARTMENT OF HUMAN SERVICES
6/16/17

DEPUTY ATTORNEY GENERAL
OFFICE OF ATTORNEY GENERAL
(when required) 7-28-17

DEPUTY GENERAL COUNSEL
OFFICE OF GENERAL COUNSEL
(when required)
6/30/17

HEALTHCHOICES PHYSICAL HEALTH AGREEMENT

BETWEEN

COMMONWEALTH OF PENNSYLVANIA

AND

VISTA HEALTH PLAN, INC.

HEALTHCHOICES AGREEMENT

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SECTION I: INCORPORATION OF DOCUMENTS

A. Operative Documents

The RFP, which is attached hereto as Appendix 1, and the Proposal, is attached hereto as Appendix 2, are incorporated herein and are made part of this Agreement. With regard to the governance of such documents, it is agreed that:

1. In the event that any of the terms of this Agreement conflict with, or are inconsistent with the terms of the RFP, the terms of this Agreement shall govern;

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

3. In the event that any of the terms of the RFP conflict with, or are inconsistent with 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)

The Department will issue MC OPS Memos via the HealthChoices Intranet to provide clarifications to requirements pertaining to

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

2. HealthChoices Intranet

To access the HealthChoices Intranet, the PH-MCO must have established connectivity with DHS.

In addition to the MCO-OPS Memos, 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 systems notices.

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 agreement obligations (including 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.

Actuarily Sound Capitation Rate — Actuarially sound Capitation rates are projected to provide reasonable, appropriate and attainable costs that are required under the terms of the contract and for the operation of the Primary Contractor for the time period and the population covered under the terms of the contracts, and such Capitation rates are developed in accordance with the requirement in 42 CFR §438.4(b).

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; and
- 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 MA MCOs in the relevant Agreement year and meet the standards of the Actuarial Standards Board.

Actuary — An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

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

Advanced Directives — A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Affiliate — Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization ("Person"), controlling, controlled by or under common control with the PH-MCO or its parent(s), whether such 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) are Affiliates. 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.

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

Ambulatory Surgical Center — A facility licensed by the Department of Health which provides outpatient surgical treatment. The term does not include individual or group practice offices of private physicians or dentists, unless the

offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.

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 — The single local agency designated by the PDA 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 — An entity, operated by county government or licensed by the Commonwealth as a risk-bearing HMO or PPO, which manages the purchase and provision of Behavioral Health Services under an agreement with the Department.

Behavioral Health Rehabilitation Services 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 Services — Mental health and substance abuse services which are provided by the BH-MCO.

Behavioral Health Services Provider — A Provider, practitioner, or vendor/supplier which contracts with a BH-MCO to provide Behavioral Health Services or ordering or referring those services, and is legally authorized to do so by the Department under the HealthChoices Behavioral Health Program.

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

Capitation — A payment the Department makes periodically to a PH-MCO on behalf of each Member enrolled under the Agreement and based on the actuarially sound rate for the provision of services under the State Plan. The Department makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

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 & Medicaid Services — 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 DOH and PID 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 — A professional nurse licensed in the Commonwealth of Pennsylvania who is certified by the State Board of Nursing 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 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 RTFs for Children.

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 — The Department's database of Recipients. The data base contains demographic and eligibility information for all Recipients.

Community HealthChoices — Community HealthChoices is a new initiative that will use managed care organizations to coordinate physical health care and long-term services and supports (LTSS) for older persons, persons with physical disabilities, and Pennsylvanians who are dually eligible for Medicare and Medicaid (dual eligible).

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 PH-MCO, which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with the DOH or the PID of the Commonwealth, including but not limited to:

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

The term does not include a Grievance.

Comprehensive Risk Contract — *A* risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:
(1) Outpatient hospital services (2) Rural health clinic services (3) Federally Qualified Health Center (FQHC) services (4) Other laboratory and X-ray services (5) Nursing facility (NF) services (6) Early and periodic screening, diagnostic, and treatment (EPSDT) services (7) Family planning services (8) Physician services (9) Home health services.

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 — 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 — A brand name drug, a generic drug, or an 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 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 CIS that is transmitted to the PH-MCO on state work days. This 834 Daily File includes TPL information and is transmitted via the Department's MIS 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. Deliverables include, but are not limited to: operational policies and procedures, letters of agreement, Provider Agreements, Provider reimbursement methodology, coordination agreements, reports, tracking systems, required files, QM/UM documents, and referral systems.

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 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 Bureau of Hearings and Appeals.

Drug Efficacy Study Implementation — Drug products that have been classified as less-than-effective by the FDA.

Dual Eligible — An individual who is eligible to receive services through both Medicare and the MA Program.

Durable Medical Equipment — Equipment furnished by a supplier or a home health agency that meets the following conditions: (a) can withstand repeated use (b) effective with respect to items classified as durable medical equipment after January 1, 2012, has an expected life of at least three years (c) is primarily and customarily used to serve a medical purpose (d) generally is not useful to an individual in the absence of an illness or injury (e) is appropriate for use in the home.

Early and Periodic Screening, Diagnosis and Treatment — 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 — 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, TPR, 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 Member, regardless of whether it has an associated Claim.

Encounter Data — A record of any Encounter, including Encounters reimbursed through Capitation, Fee-for-Service, or other methods of compensation regardless of whether payment is due or made.

Enrollee — A Medicaid beneficiary who is currently enrolled in a PH-MCO.

Enrollee Encounter Data — The information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between the State and a PH-MCO that is subject to the requirements of 42 CFR §438.242 and 42 CFR §438.818.

Enrollment — The process by which a Member's coverage by a PH-MCO is initiated.

Enrollment Assistance Program — The program that provides Enrollment Specialists to assist Recipients in selecting a PH-MCO and PCP and in obtaining information regarding HealthChoices Physical, Behavioral Health Services, Community HealthChoices long-term services and supports 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.

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

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 — 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 independent, external review body to perform an annual review of the quality of services furnished by MCOs, 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.

Federally Qualified Health Maintenance Organization (HMO) — An HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

Federally Qualified Health Center — 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 — 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 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. It includes any act that constitutes fraud under applicable Federal or State law.

Generally Accepted Accounting Principles — 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 Agreement and operational issues and works within the PH-MCO and with the Department to facilitate compliance, solve problems, and implement corrective action.

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 BLE.
This term does not include a Complaint.

Health Care-Acquired Condition — A condition occurring in any inpatient hospital setting, identified as a Hospital Acquired Condition by the Secretary of Health and Human Services for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act; other than Deep Vein Thrombosis/Pulmonary Embolism 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;
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, public health dental hygiene practitioner, pharmacist or an individual accredited or certified to provide behavioral health services.

Health Insuring Organization (HIO) — a county operated entity, that in exchange for capitation payments, covers services for beneficiaries: (1) through payments to, or arrangements with, providers; (2) under a comprehensive risk contract with the State; and (3) meets the following criteria: (i) first became operational prior to January 1, 1986; or (ii) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of

the Omnibus Budget Reconciliation Act of 1990 and section 205 of the Medicare Improvements for Patients and Providers Act of 2008).

Health Maintenance Organization — 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 MA Recipients in Pennsylvania.

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.

Hospice Services — A comprehensive set of services described in 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

Hospital Outpatient Care — Care in a hospital that usually doesn't require an overnight stay Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that: (1) Are furnished to outpatients; (2) Are furnished by or under the direction of a physician or dentist; and (3) Are furnished by an institution that—(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and (ii) Meets the requirements for participation in Medicare as a hospital; and (4) May be limited by a Medicaid agency in the following manner: the Department may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State.

Immediate Need — A situation in which, in the professional judgment of the dispensing registered pharmacist or prescriber, the dispensing of a 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.

Incentive Arrangement — Any payment mechanism under which a PH-MCO may receive additional funds over and above the Capitation rate it was paid for meeting targets specified in the Agreement.

Indian — An individual, defined at 25 U.S.C. § 1603(c), 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 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 — 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.

Interagency Team for Adults — A multi-system planning team consisting of the individual, family members, legal guardian, advocates, county mental health/intellectual-developmental disability and/or drug and alcohol case managers, PCP, treating specialists, residential or day service Providers and any other participants 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.

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, 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.

Intermediate Care Facility for the Intellectually Disabled and Other Related Conditions — 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 or her maximum capacity.

Juvenile Detention Center — 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 JDC).

Limited English Proficient — Enrollees or potential enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English, may be eligible to receive language assistance for a particular type of service, benefit or encounter.

Lock-In — Recipients determined to be involved in fraudulent activities or identified as abusing services provided under the MA Program who are restricted to a specific Provider(s) to obtain all of his or her services in an attempt to ensure appropriately managed care.

Long-Term Services and Supports — Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed Care Organization — An entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is: (1) Federally qualified HMO that meets the advance directives requirements of 42 CFR §489 Subpart I; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.and (ii) Meets the solvency standards of 42 CFR § 438.116.

Managed Care Program — A managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.

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 — 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.

Material Adjustment — An adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the Capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

Medicaid Eligibility Determination Automation — Part of the CIS that automates the determination of Medicaid eligibility.

Medical Assistance — 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 — A non-emergency medical transportation service provided to eligible persons who need to make trips to and 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 that is compensable under the MA Program and if it meets any one of the following standards:

- The service, item, procedure or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

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

- The service, item, procedure or level of care 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.

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 PH 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), including intrapartum, postpartum and gynecological care.

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

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

Network Provider — any provider, group of providers, or entity that has a network provider agreement with a PH-MCO or a Subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with a PH-MCO. A network provider is not a Subcontractor by virtue of the network provider agreement.

Non-participating Provider — A Health Care Provider, either not enrolled in the Pennsylvania MA Program or not participating in the PH-MCO's Network, which provides medical services or supplies to Members.

Nonrisk Contract — A contract between the State and a PIHP or PAHP under which the contractor (1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR §447.362 and (2) May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

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 — Department phone lines designed to address and facilitate resolution of issues encountered by Recipients and their advocates or Providers according to PH-MCO policies and procedures.

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 or prescriber, and that has been used by the Member without a gap in treatment. If a 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.

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 PDA.

Other Provider-Preventable Condition — 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, or
  - Surgical or other invasive procedure performed on the wrong patient.

Other Related Conditions — 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 Member's HealthChoices Zone;

- The health of the Member would be endangered if the Member returned to his or her HealthChoices Zone for needed services;

- The Provider is located outside the Member's HealthChoices Zone, but regularly provides medical services to Members at the request of the PH-MCO; or

- The needed medical services are not available in the Member's 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 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.

Overpayment — Any payment made to a Network Provider by a PH-MCO or its Subcontractor to which the Network Provider is not entitled to under Title XIX of the Act or any payment to a PH-MCO or its Subcontractor by a State to which the PH-MCO is not entitled to under Title XIX of the Act.

Pass-Through Payment — Any amount required by the Department to be added to the contracted payment rates, and considered in calculating the actuarially sound Capitation rate, between the PH-MCO and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the Agreement; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of 42 CFR §438.6 for services and enrollees covered under the Agreement; a subcapitated payment arrangement for a specific set of services and enrollees covered under the Agreement; GME payments; or FQHC or RHC wrap around payments.

Patient Centered Medical Home — This model of care includes key components such as: whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care.

Pennsylvania Open Systems Network — 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 IRM Standards.

Physical Health Managed Care Organization — 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 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 MA 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.

Potential Enrollee — A Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM, or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM or PCCM entity.

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 P&T Committee.

Premium — An amount to be paid for an insurance policy.

Prepaid Ambulatory Health Plan — An entity that: (1) Provides services to enrollees under contract with the Department, and on the basis of Capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.

Prepaid Inpatient Health Plan — An entity that: (1) Provides services to enrollees under contract with the Department, and on the basis of Capitation

payment, or other payment arrangements that do not use State Plan payment rates; (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.

Prescription Drugs — Simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are: (1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; (2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and (3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Primary Care — All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Case Management — A system under which: (1) A primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or (2) A PCCM entity contracts with the State to provide a defined set of functions.

Primary Care Case Management Entity (PCCM entity) — An organization that provides any of the following functions, in addition to primary care case management services, for the State: (1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line, (2) Development of enrollee care plans, (3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program, (4) Provision of payments to FFS providers on behalf of the State, (5) Provision of enrollee outreach and education activities, (6) Operation of a customer service call center, (7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement, (8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers, (9) Coordination with behavioral health systems/providers, (10) Coordination with long-term services and supports systems/providers.

Primary Care Case Manager (PCCM) — means a physician, a physician group practice or, at State option, any of the following: (1) A physician assistant, (2) A nurse practitioner, (3) A certified nurse-midwife.

Primary Care Practitioner — A specific physician, physician group or a CRNP operating under the scope of his or 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 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 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 — Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

Provider Agreement — A 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 determination by the PH-MCO, with regard to:

- 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 — A condition that meets the definition of a health care-acquired condition or other provider-preventable condition as defined in 42 CFR §447.26(b).

Provider Reimbursement and Operations Management Information System electronic (PROMISe™) — The Department's current claims processing and management system that supports the FFS and MA Managed Care delivery programs.

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

Rate Cell — A set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the Capitation rate and making a Capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the Agreement.

Rating Period — A period of twelve (12) months selected by the Department for which the actuarially sound Capitation rates are developed and documented in the rate certification, submitted to CMS as required by 42 CFR §438.7(a).

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

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

Rehabilitative Services — This includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

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 Party — An 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 Agreement with the Department.

Residential Treatment Facility — A facility licensed by the Department 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.

Revenue [for the purposes of the Equity requirement calculation] — The total gross Direct Business Premiums, for all Pennsylvania lines of business, reported in Schedule T, "Premiums and other Considerations," of the PID report.

Risk Based Capital — 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 with PID, divided by the Authorized Control Level Risk-based Capital figure.

Risk Contract — A contract between the State, an MCO, PIHP, or PAHP under which the contractor: (1) Assumes risk for the cost of the services covered under the contract, and (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Risk Corridor — A risk sharing mechanism in which the Department and PH-MCOs may share in profits and losses under the Agreement outside of a predetermined threshold amount.

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 Health Center.

Short Procedure Unit — A unit of a hospital organized for the delivery of ambulatory surgical, diagnostic or medical services.

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

Start Date — The first date on which the PH-MCO is operationally responsible and financially liable for the provision of Medically Necessary services to Members.

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 — A 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..

Subcontractor — An individual or entity that has a contract a PH-MCO that relates directly or indirectly to the performance of the PH-MCO's obligation under its contract with the Department. A network provider is not a Subcontractor by virtue of the network Provider Agreement with the MCO, PIHP, or PAHP.

Sustained Improvement — Improvement in performance documented through continued measurement of quality indicators after the performance project, study, or quality initiative is complete.

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 Program — A case management program for Recipients who are diagnosed with AIDS or symptomatic HIV.

Third Party Liability — An individual entity or program's (e.g. Medicare) other than the PH-MCO financial responsibility for all or part of a Member's health care expenses.

Third Party Resource — 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 TPR include: government insurance programs such as Medicare or CHAMPUS; 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 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 upon hospital discharge to children who require intensive medical care for an extended period of time to allow for the caregiver to be trained in the care of the child.

Urgent Care Services — Services furnished to an individual who requires services to be furnished within twenty-four (24) hours in order to avoid the likely onset of an emergency medical condition.

Urgent Medical Condition — An illness, injury or severe condition which under reasonable standards of medical practice, should 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 services that are necessary to avoid a delay in hospital discharge or hospitalization.

Utilization Management — 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.

Value Based Purchasing Strategies — A model which aligns more directly to the quality and efficiency of care provided, by rewarding providers for their measured performance across the dimensions of quality.

VBP strategies for the HealthChoices Program may include, but not be limited to gain sharing contracts, risk contracts, episodes of care payments, bundled payments, and contracting with Centers of Excellence and Accountable Care Organizations.

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.

Waste — The overutilization of services or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions, but rather misuse of resources.

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.
ASC — Ambulatory Surgical Center.
BFM — Bureau of Fiscal Management.
BH — Behavioral Health.
BHA — Bureau of Hearings and Appeals.
BH-MCO — Behavioral Health Managed Care Organization.
BLE — Benefit Limit Exception.
BMCO — Bureau of Managed Care Operations.
BPI — Bureau of Program Integrity.
CAHPS — Consumer Assessment of Healthcare Providers and Systems.
CAO — County Assistance Office.
CBCM — Community Based Care Management
CEO – Chief Executive Officer.
CFO — Chief Financial Officer.
CHAMPUS — Civilian Health and Medical Program of the Uniformed Services.
CHC — Community HealthChoices.
CHS — Contract Health Services.
CIS — Client Information System.
CLIA — Clinical Laboratory Improvement Amendment.
CLPPP — Childhood Lead Poisoning Prevention Program.
CME — Continuing Medical Education.
CMS — Centers for Medicare and Medicaid Services.
CNM — Certified Nurse Midwife.
COB — Coordination of Benefits.
CRNP — Certified Registered Nurse Practitioner.
CSP — Community Support Program.
DEA — Drug Enforcement Agency.
DESI —Drug Efficacy Study Implementation.
DHHS — U.S. Department of Health and Human Services.
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.
ED — Emergency Department.
EHR — Electronic Health Record.
EMS — Emergency Medical Services.

EOB — Explanation of Benefits.
EPLS — The Excluded Parties List System.
EPSDT — Early and Periodic Screening, Diagnosis and Treatment.
EQR — External Quality Review.
EQRO — External Quality Review Organization.
EVS — Eligibility Verification System.
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.
HHS-OIG — U.S. Department of Health and Human Services-Office of Inspector General.
HIO — Health Insuring Organization.
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.
ICP — Integrated Care Program.
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 on Accreditation of Healthcare Organizations.
JDC — Juvenile Detention Center.
LEIE — HHS-OIG List of Excluded Individuals and Entities.
LEP — Limited English Proficiency.
LTSS — Long-term Services and Supports.
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.
NPPES — National Plan and the Provider Enumeration System.
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.
OUD-COE — Opioid Use Disorder Centers of Excellence.
P&T — Pharmacy & Therapeutics.
PAHP — Prepaid Ambulatory Health Plan.
PARP — Prior Authorization Review Panel.
PBM — Pharmacy Benefit Manager.
PCP — Primary Care Practitioner.
PCCM — Primary Care Case Manager.
PCMH — Patient Centered Medical Home.
PDA — Pennsylvania Department of Aging.
PDL — Preferred Drug List.
PERT — Program Evaluation and Review Technique.
PH — Physical Health.
PHDHP — Public Health Dental Hygiene Practitioners.
PH-MCO — Physical Health Managed Care Organization.
PHS — Public Health Service.
PID — Pennsylvania Insurance Department.
PIHP — Prepaid Inpatient Health Plan.
PIP — Physician Incentive Plan.
PIPs — Performance Improvement Projects.
PMPM — Per Member, Per Month.
POSNet — Pennsylvania Open Systems Network.
PPC — Provider Preventable Condition.
PPS — Prospective Payment System.
PROMISe™ — Provider Reimbursement (and) Operations Management Information System electronic (format).

PSMI — Persistent Serious Mental Illness.
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 Centers.
RPAA — Risk Pool Allocation Amount.
RTF — Residential Treatment Facility.
SAM — System for Award Management.
SAP — Statutory Accounting Principles.
SNU — Special Needs Unit.
SPU — Short Procedure Unit.
SSADMF — Social Security Administration's Death Master File.
SSI — Supplemental Security Income.
SUD — Substance Use Disorder.
TANF — Temporary Assistance for Needy Families.
TCM — Targeted Case Management.
TPL — Third Party Liability.
TPR — Third Party Resources.
TTY — Text Telephone Typewriter.
UM — Utilization Management.
URCAP — Utilization Review Criteria Assessment Process.
VBP — Value Base Purchasing.
WBE — Women's Business Enterprise.
WIC — Women, 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. 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 is responsible for all taxes and withholdings 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 will indemnify the Department for any taxes, penalties or interest imposed upon the Department by such taxing authority or other governmental agency.

B. Nature of Agreement

The PH-MCO must arrange for the provision of medical and related services to Members through qualified Providers in accordance with the this Agreement. In administering the HealthChoices Program, the PH-MCO must comply fully with 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 MCOs operating in the HealthChoices Program and may, during the term of this Agreement, enter into agreements with additional qualified MCOs who meet all established agreement, licensing and readiness review requirements.

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 may not

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 and is required to screen all Health Care Providers (both individual and entities), at the time of hire or contracting; and thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in federal health care programs.

B. Specific to MA Program

The PH-MCO will participate in the MA Program, will arrange for the provision of those medical and related services essential to the medical care of its Members, and will 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 will 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 C.F.R. Parts 431 through 481 and 45 C.F.R Parts 74, 80, and 84, and the Department regulations as specified in Exhibit A, 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, 42 U.S.C. §§2000d et seq. and 2000e et seq.; Title IX of the Education Amendments of 1972, 20 U.S.C. §§1681 et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§701 et seq.; the Age Discrimination Act of 1975, 42 U.S.C. §§6101 et seq.; the Americans with Disabilities Act, 42 U.S.C. §§12101 et seq.; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Health Information Technology for Economic and Clincal Health (HITECH) Act; the HIPAA Privacy Rule and the HIPAA Security Rule, 45 CFR. Parts 160, 162, and 164 (HIPAA Regulations); the Pennsylvania Human Relations Act of 1955, 71 P.S. §§941 et seq.; Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. §§991.2102 et seq.; and Drug and Alcohol Use and Dependency Coverage Act 106 of 1989, 40 P.S. §§908-1 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. The PH-MCO must comply with all applicable laws, regulations, and policies of the Pennsylvania DOH and the PID.

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

4. The PH-MCO and its Subcontractors must respect the conscience rights of individual Providers, 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 provide health care services on moral or religious grounds as outlined in 40 P.S. §901.2121 and §991.2171; 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.

5. 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.

6. 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.

7. The PH-MCO must comply with all applicable Federal regulations, including 42 C.F.R. §§438.726 and 438.730 describing conditions under which CMS may deny payments for new enrollees.

8. The PH-MCO must comply with all applicable Federal regulations pertaining to provider screening and enrollment, including but not limited to 42 CFR §§455.414 and 455.432.

9. The PH-MCO is required under 42 CFR §455.436 to check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents, and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management, the Social Security Administration's Death Master File (SSADMF), the National Plan and the Provider Enumeration System upon enrollment and re-enrollment; and check the LEIE and EPLS no less frequently than monthly. The PH-MCO is required to check the SSADMF at the time of initial enrollment and re-enrollment as well as providers, owners, agents, and managing employees against the LEIE and EPLS on a monthly basis.

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, Regulations, Policies and Procedures

The PH-MCO will comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in the MA Program.

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

The PH-MCO will comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in the MA 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:

- 42 U.S.C. §1396b(t)

as amended and as it meets the requirements of 42 U.S.C. §1395w-4(o) and Title XIII, section 13001, known as 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 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, the PH-MCO must provide In-Plan Services in the amount, duration and scope set forth in the MA FFS Program and be based on the Recipient's benefit package, unless otherwise specified by the Department. The PH-MCO must provide services that 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.

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 PH-MCO may not deny personal care services for members under the age of 21 based on the Member's diagnosis or because the need for personal care services is the result of a cognitive impairment. The personal care services 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.

The PH-MCO may not deny 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 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 required to establish a Program Exception process, reviewed and approved by the Department, whereby a Provider may request coverage for items or services, which are included in the Member's benefit package but are not currently listed on the MA Program Fee Schedule. The PH-MCO must also apply the program exception process 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 are described in 55 Pa. Code §1150.63.

4. Expanded Services

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

MCO is notified, in writing, by the Department, to discontinue the expanded service.

In order for information about expanded services to be included in any Member information provided by the PH-MCO, the PH-MCO must make the expanded services available 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 service. Such services 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 services and must simultaneously amend all written materials describing its covered services or Provider Network. A change in covered services includes any reduction in services or a substantial change to the Provider Network.

5. Referrals

The PH-MCO must 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

The PH-MCO may not require referrals from a PCP for certain services. A Member may self-refer for vision, dental care, obstetrical and gynecological (OB/GYN) services, providing the Member obtains the services within the Provider Network. A Member may access chiropractic services in accordance with the process set forth in MA Bulletin 15-07-01, and physical therapy services 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 Prior Authorization to manage the utilization of Family Planning Services. The PH-MCO may not restrict the right of a Member to choose a Health Care Provider for Family Planning Services and must make such services available without regard to marital status, age, sex or parenthood. 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, Family Planning Services Procedures. The PH-MCO must pay for Out-of-Network Services.

The PH-MCO must provide Members with direct access to OB/GYN services and 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.

The PH-MCO must permit Members to select a Network Provider, including nurse midwives, to obtain maternity and gynecological care without prior approval from a PCP. This includes selecting a Network 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 Member is pregnant and 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 services as set forth in the agreements between the Department and the BH-MCOs in effect at the same time as this Agreement, as outlined in Exhibit U, 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.

9. EPSDT Services

The PH-MCO must comply with the requirements regarding EPSDT services as set forth in Exhibit J, 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 must comply with the program standards regarding Emergency Services that are set forth in Exhibit K, Emergency Services.

The PH-MCO must comply with the provisions of 42 U.S.C. §1396u-2(b)(2), 28 Pa. Code §9.672, 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.

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.

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 FFS Program.

- Health Care Providers may initiate the necessary intervention to stabilize an Emergency Medical Condition of a Member 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 is 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 may not:

- track, trend and profile emergency department 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 department usage.

11. Post-Stabilization Services

The PH-MCO must cover Post-Stabilization Services, as defined in 42 CFR §438.114.

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 a Network Provider.

The PH-MCO must cover Post-Stabilization Services without authorization, and regardless of whether the Member obtains the services within or outside its Provider Network if any of the following situations exist:

a. 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.

b. 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.

c. The Post-Stabilization Services were not pre-approved by the PH-MCO because the Provider could not reach the PH-MCO request pre-approval for the Post-Stabilization Services.

d. 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 Network physician with privileges at the treating hospital assumes responsibility for the Member's care;

b. A Network 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 provide Members under evaluation as possible victims of child abuse or neglect and who present for physical examinations for determination of abuse or neglect, with 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 emergency department staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for Members under the care of the county Children and Youth Agency. 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 Member 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 42 C.F.R. §§418.1 et seq.

The Department will not enroll those Recipients in the Department's Hospice Program who were not previously enrolled in the HealthChoices Program. If a Member is determined eligible for the Department's Hospice Program after being enrolled in the PH-MCO, the PH-MCO remains responsible for the Member.

14. Organ Transplants

The PH-MCO will pay for transplants to the extent that the MA FFS Program pays for such transplants. When Medically Necessary, the MA FFS program currently covers the following transplants: 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 must provide 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 MATP. A complete description of MATP responsibilities can be found in Exhibit L, Medical Assistance Transportation Program.

16. Waiver Services/State Plan Amendments

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

The PH-MCO must provide for 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 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 Members with SUD. These health homes will be focused on identifying, initiating treatment, and referring pregnant Members 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.

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. Members are disenrolled from HealthChoices thirty

(30) days following the admission date to a 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.

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

The Department will not enroll Recipients who are placed into a Nursing Facility and who were not previously enrolled in the HealthChoices Program or individuals who enter a Nursing Facility and are then determined eligible for MA in the HealthChoices Program. If an individual leaves the Nursing Facility to reside in the HealthChoices Zone covered by this Agreement and is then determined eligible for Enrollment into the HealthChoices Program, the individual will 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 on the HealthChoices Intranet.

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.

19. Environmental Lead Testing

The PH-MCO must provide for necessary comprehensive environmental lead investigations as part of covered blood lead treatment services. The PH-MCO must contract with the necessary number of MA-enrolled Comprehensive Lead Investigation Providers to ensure access to this service in all HealthChoices zones in which the PH-MCO operates.

B. Prior Authorization of Services

1. General Prior Authorization Requirements

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. The PH-MCO 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, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and Exhibit M(1), Quality Management and Utilization Management Program Requirements. The Department will consider Prior Authorization policies and procedures approved under previous HealthChoices agreements approved under this Agreement. The PH-MCO's submission of new or revised policies and procedures for PARP review and approval shall not act to void any existing, previously approved policies and procedures. 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.

The Department may subject Prior Authorization Denials issued under unapproved Prior Authorization policies to Retrospective Review and reversal and may impose sanctions and/or require corrective action plans in the event that the PH-MCO improperly implements any Prior Authorization policy or procedure or implements such policy or procedure without Department approval.

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 templates N(1), N(2), (N)3, and N(7) found on the HealthChoices Intranet site. In addition, the PH-MCO must make the notice available in accessible formats for individuals with visual impairments and for persons with limited English proficiency. If 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 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 notice of denial to the Member.

For Children in Substitute Care, the PH-MCO must send notices to the County Children and Youth Agency with legal custody of the 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 legal 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. 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.

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

2. Time Frames for Notice of Decisions

a. The PH-MCO must process each request for Prior Authorization of a service and notify the Member 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 (2) Business Days after the decision is made. The PH-MCO may make notification of coverage approvals via electronic notices as 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, N(7) Request for Additional Information Letter on the HealthChoices Intranet site.

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 PH-MCO must make the decision to approve or deny the service based upon the available information and notify the Member 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 PH-MCO must make the decision to approve or deny a covered service or item 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 (18^{th}) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, the PH-MCO must hand deliver the notice to the Member, or the request is automatically approved.

e. If the Member is currently receiving a requested service and the PH-MCO decides to deny the Prior Authorization request, the PH-MCO must mail the written notice of denial at least (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. The PH-MCO is not required to provide advance notice when it has factual information on the following:

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

The PH-MCO must comply with the requirements of Exhibit BBB 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), and MA Bulletin 99-03-13 Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations to provide for continuity of Prior Authorized Services.

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 §9.684 and 31 Pa. Code §154.15. 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 must coordinate care for its Members. The PH-MCO must provide for seamless and continuous coordination of care across a continuum of services for the Member with a focus on improving health care outcomes. The continuum of services may include the In-Plan comprehensive service package, out-of-plan services, 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
- Residential Treatment Facility
- Acute Psychiatric Facilities
- Extended and Extended Acute Psychiatric Facilities
- Non-Hospital Residential Detoxification, Rehabilitation, and Half-Way House Facilities for Drug/Alcohol Dependence/ Addiction

- AAA/OPTIONS Assessment and Pre-admission Screening Requirements
- PDA Waiver
- Juvenile Detention Centers
- Children in Substitute Care Transition
- Adoption Assistance for Children and 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
- Home-and Community-Based Waiver Program for Nursing Facility Applicants with Other Related Conditions
- Home-and Community-Based Waiver for Attendant Care Services
- Home-and Community-Based Waiver for Persons with Intellectual Disabilities
- COMMCARE Waiver for Persons with a Primary Diagnosis of Acquired Brain Injury
- Children in Residential Facilities
- Home-and Community-Based Waiver for Persons with Autism

The PH-MCO must provide the necessary related services for Members in facilities as described in Exhibit O, Description of

Facilities and Related Services. Out-of-Plan Services are described in Exhibit P, Out-of-Plan Services. Recipient coverage rules are outlined in Exhibit BB, PH-MCO Recipient Coverage Document.

1. Coordination of Care/Letters of Agreement

The PH-MCO must coordinate the comprehensive in-plan package with entities providing Out-of-Plan Services. To facilitate the efficient administration of the Medical Assistance Program, to enhance the treatment of Members who need Out-of-Plan services and 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), Juvenile Probation Offices (refer to Sample Model Agreement, Exhibit Q), and BH-MCOs (refer to Exhibit R, Coordination with BH-MCOs). In Addition, the PH-MCO must 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 determine whether to waive strict compliance with this requirement.

All written coordination documents developed and maintained by the PH-MCO must have advance written approval by the Department and must be reviewed and, if necessary, revised at least annually by the PH-MCO. Coordination documents must be available for review by the Department upon request.

The PH-MCO must obtain the Department's prior written approval of all written coordination documents entered into between a service provider and the PH-MCO. These coordination documents must contain, but should not be limited to, the provisions outlined in Exhibit S, Written Coordination Agreements Between PH-MCO and Service Providers, and must be submitted for final Department review and approval at least thirty (30) days prior to the operational date of Agreement. Under no circumstances may these coordination documents contain a definition of Medically Necessary other than the definition found in this Agreement.

2. PH-MCO and BH-MCO Coordination

To facilitate the efficient administration of the Medical Assistance Program, to enhance the treatment of Members who need both physical health and BH services, the PH-MCO must develop and implement written agreements with each BH-MCO in the PH-MCO's zone(s) 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 are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services.

The HealthChoices Program requirements covering BH Services are outlined in Exhibit U, Behavioral Health Services. The PH-MCO must work in collaboration with the BH-MCOs through participation in joint initiatives to improve overall health outcomes of its Members and those activities that are prescribed by the Department. These joint initiatives must include at a minimum:

a. Information exchange including the BH utilization data provided by the Department to control avoidable hospital admissions, readmissions and emergency department usage for Members with PSMI and/or substance abuse disorders.

b. Development of specific coordination mechanisms to assess and, where appropriate, reduce the use of psychotropic medications prescribed for children, especially those in substitute care.

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

a. The PH-MCO will, and the Department will require BH-MCOs to agree, to submit to a binding independent arbitration process in the event of a dispute between the PH-MCO and a BH-MCO concerning their respective obligations under this Agreement and the Behavioral HealthChoices agreement. 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. Exhibit BBB contains additional requirements specific to Outpatient Drug Services.

3. Disability Advocacy Program

The PH-MCO must cooperate with the Department's Disability Advocacy Program that provides assistance to Members in applying for SSI 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 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 does 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(s) 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 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 broker to assist Recipients in choosing a PH-MCO and PCP. The PH-MCO must develop such materials for the HealthChoices Program 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. 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:

a. 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 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:

- 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.

The PH-MCO must obtain from the Department advance written approval of any advertising placed in mass media for any reason by the PH-MCO.

c. The PH-MCO may participate in or sponsor health fairs or community events. The Department may set limits on contributions and/or payments made to non-profit groups in connection with health fairs or community events and requires advance written approval 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. The PH-MCO may offer items of little or no intrinsic value (i.e., trinkets with promotional PH-MCO logos)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 services in excess of those required by the Department, and is permitted to feature such expanded services in approved outreach materials. All such expanded services are subject to advance written approval by the Department and must meet the requirements of Section V.A.4., Expanded Services.

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 Member 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 Department may review any and all outreach activities and advertising materials and procedures used by the PH-MCO, including all outreach activities, advertising materials, and corporate initiatives that are likely to reach MA Recipients. In addition to any other sanctions, the Department may impose monetary or restricted Enrollment sanctions should the PH-MCO be found to be using unapproved outreach materials or engaging in unapproved outreach practices. The Department may suspend all outreach activities and the completion of applications for new Members. Such suspensions may be imposed for a period of up to sixty (60) days from notification by the Department to the PH-MCO citing the violation.

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

k. The PH-MCO must not, under any conditions use the Department's 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 this Agreement.

l. 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, 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.

Upon a Member’s request, the PH-MCO must provide, at no cost to Members, oral interpretation services in the requested language or sign language interpreter services to meet the needs of the Members. These services must also include all services dictated by federal requirements for translation services designated to the

PH-MCO providers if the provider is unable or unwilling to provide these services.

The PH-MCO must make all vital documents disseminated to English speaking Members available in alternative languages, upon request of a Member. Documents may be deemed vital if related to the access to programs and services and may include informational material. Vital documents include but are not limited to Provider Directories and Member Handbooks. 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.

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, 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 broker. 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 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 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, gender identity, 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, Services for New Members, and Exhibit BB, PH-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 MA 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, Alerts.

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 PH-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 HealthChoices 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.

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 HealthChoices 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 this file within 24 hours of receipt.

The PH-MCO must reconcile this file against its internal membership information and notify the Department of any discrepencies within thirty (30) Business Days.

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. Policies and procedures must be approved 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(s) covered by this Agreement,

the PH-MCO from which the Member disenrolled remains 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 its 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 use 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, upon the new Member's effective Enrollment date in the PH-MCO. If a Special Need is indicated, the PH-MCO must 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 including the assignment of a Special Needs or Care Management case manager as appropriate.

The PH-MCO must comply with access standards as required in Exhibit AAA(1), AAA(2), or AAA(3), as applicable, 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
- How to register a Complaint, file a Grievance or request a DHS Fair Hearing, and
- Information on the existence and function of the SNU and how to contact it, if necessary.

The PH-MCO must obtain the Department advance written approval of these policies and procedures.

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; or at the request of the Department.

14. PH-MCO Identification Cards

The PH-MCO must issue its own identification card to 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. The PH-MCO must notify all Members 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 provide that the Member handbook is written at no higher than a sixth grade reading level and includes, 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 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.

16. Provider Directories

The PH-MCO must make available directories for all types of Network Providers, 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 broker with an updated electronic version of its 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:

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

- Assisting Members with making appointments and obtaining services, including interpreter services, as needed.

- Assisting with arranging transportation for Members through the MATP. See Section V.A.15., Transportation and Exhibit L, 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 require that all such inquiries are addressed by clinical personnel acting within the scope of their licensure to practice a health-related profession.

The PH-MCO must forward all calls received by the Member services area in which the caller requests the Special Needs Unit to the SNU. In the event the call is received beyond the hours of availability of the SNU, The PH-MCO's SNU must allow the Member to leave a message. The SNU must return the call as soon as possible but no longer than two (2) business days from the receipt of the call.

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 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. The PH-MCO must document all calls and if the caller is

not satisfied, the PH-MCO must refer the call 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:

- Provides for a dedicated phone line for its Members.

- Provide for necessary translation and interpreter assistance for LEP Members.

- 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, Intellectual/Developmental Disabilities, Dual Eligibles, etc.

The PH-MCO must establish and maintain a Health Education Advisory Committee that includes Members 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

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. 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, Complaint, Grievance, and DHS Fair Hearing Processes. The PH-MCO must use the required templates to inform Members regarding decisions and the process. Templates GG(1) through GG(14) are available on the HealthChoices Intranet site.

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 DOH regulations (28 Pa. Code Chapter 9), PID regulations (31 Pa. Code CHs. 154 and 301) and 42 C.F.R. §431.200 et seq. The PH-MCO must also comply with 55 Pa. Code Chapter 275 regarding DHS Fair Hearing Requests and 42 C.F.R. §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. 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.

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 DOH 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 DOH'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 BHA for those cases when a Member has requested a DHS Fair Hearing, unless requesting reconsideration by the Secretary of the Department. 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' Grievance and Appeals Coordinator for review and resolution.

J. OMAP Hotlines

The PH-MCO will 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 Agreements 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 BHA. Additionally, the Department's BHA 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. 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 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 provide:
  - 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 Agreement. The PH-MCO must provide to the Department a copy of the DOH correspondence granting operating authority in each county covered by this 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.

- 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 SNU, QM Department and UM Department. The Medical Director and his/her staff/consultant physicians must devote sufficient time to the PH-MCO to provide 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 management and serves on the PH-MCO P&T Committee.

- A full-time 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 HealthChoices Program.

N. Other Administrative Components

The PH-MCO must provide for 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 Agreement requirements.

- A QM Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant with past experience or education in QM systems. The Department may consider other advanced degrees relevant to QM 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 UM systems. The Department may consider other advanced degrees relevant to UM 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 MA. 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 will notify the Department within thirty (30) days of a change in the SNU Coordinator.

- 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. 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 Agreement 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 Agreement.

- A designated HEDIS Project Manager who acts as the point person with the Department and the Department's EQR contractor.

The PH-MCO must have all staff that has appropriate training, education, experience and orientation to fulfill the requirements of the position. The PH-MCO must update job descriptions for each of the positions 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, Standard 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 in the Agreement. 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, 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 have an administrative office within each HC Zone covered by this Agreement. The Department may grant exceptions to this requirement 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 DOH and PID.

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 key personnel must be accessible.

1. Recipient Restriction Program

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

The PH-MCO will maintain a Recipient Restriction Program to interface with the Department's Recipient Restriction Program, will 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 must obtain approval from the Department prior to implementing a restriction, including approval of written policies and procedures and correspondence to Members. The PH-MCO's process must include:

- Designating a Recipient Restriction Coordinator within the MCO to manage processes.
- 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 to Member of proposed restriction, at least ten days in advance, 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 CAO.
- 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 a MCO, 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. 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

2. 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 is responsible for compliance with the Agreement, including:

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 for services rendered to Members by such Provider that has not been paid within sixty (60) days after the later of (i) the determination by the subcontractor that the claim is payable, and (ii) the exercise by the provider and the completion of all levels of the available provider appeals process of the subcontractor for a claim that was, and continues to be, incorrectly denied, rejected or not adjudicated by the subcontractor. Notwithstanding the foregoing, the PH-MCO shall not have such an obligation to a provider under this section in the event the Department has failed to make payment of amounts due and owing to the PH-MCO, where such amounts past due equal or exceed one percent of the revenue received by the PH-MCO in the prior calendar year from the Department under this or any other HealthChoices Agreement. Any such obligation of the PH-MCO to a provider under this section shall be considered satisfied if payment thereof is made by the subcontractor.

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.

In accordance with Exhibit D, the PH-MCO must submit for prior approval subcontracts 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.

3. Records Retention

The PH-MCO will comply with the program standards regarding records retention, which are set forth in federal and state law and regulations and 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 ten (10) 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 or other location determined by the Department, 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 investigations. In the event records requested by the state or federal government for the purposes of fiscal audits or fraud and/or abuse investigations, the PH-MCO must provide copies of the records to the Department in the timeframe designated. The retention requirements in this section do not apply to DHS-generated Remittance Advices.

4. Fraud and Abuse

The PH-MCO must develop a written compliance plan that contains the following elements described in 42 CFR §438.608(a)(1)(i-vii) and CMS publication "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" found on the CMS internet and that includes the following:

- Written policies, procedures, and standards of conduct that articulate the PH-MCO's commitment to comply with all Federal and State standards related to MA 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 PH-MCO employees.
- Effective lines of communication between the compliance officer and PH-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, Waste and Abuse Unit

The PH-MCO must establish a Fraud, Waste and Abuse Unit comprised of experienced Fraud, Waste and Abuse reviewers as required in 42 CFR §438.608(a)(1)(vii). This Unit must have the primary purpose of preventing, detecting, investigating, referring, and reporting suspected Fraud, Waste and Abuse that may be committed by Network Providers, Members, Caregivers, Employees, or other third parties with whom the PH-MCO contracts. If the PH-MCO has multiple lines of business, the Fraud, Waste and Abuse Unit is required to have an investigator to Member ratio of at least one investigator per 60,000 members devoted to the HealthChoices Program's Fraud, Waste and Abuse activities. The Department will make the final determination regarding whether or not the PH-MCO is in compliance with these requirements.

b. Written Policies

The PH-MCO must create and maintain written policies and procedures for the prevention, detection, investigation, reporting and referral of suspected Fraud, Waste and Abuse, including any and all fraud and abuse policies delineated under state and or federal mandate including but not limited to 42 CFR §438.608(a)(1)(i).

c. Access to Provider Records

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

d. Audit Protocol

The PH-MCO must inform all Network Providers of the Pennsylvania MA Provider Self Audit Protocol which allows Providers to voluntarily disclose overpayments or improper payments of MA funds. This includes, but is not limited to

inclusion in the provider handbooks. The PH-MCO must provide written documentation that this action has been completed.

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

e. Procedure for Identifying Fraud, Waste and Abuse

The PH-MCO's policies and procedures must also contain the following:

i. A description of the methodology and standard operating procedures used to identify and investigate Fraud, Waste and Abuse, including a method for verifying with Members whether services billed by providers were received, and to recover overpayments or otherwise sanction Providers as required by 42 CFR §§438.608(a)(5) and 438.608(d)(1)(i-iv). Policies and procedures must also include provisions for payment suspension to a network provider for which the State determines that there is a credible allegation of fraud as required in 42 CFR §§455.23 and 438.608(a)(8).

ii. A description of specific controls in place for Fraud, Waste 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.

f. Referral to the Department

The PH-MCO must establish a policy for referral of suspected Fraud, Waste and Abuse to the Department as required in 42 CFR §438.608(a)(7). A standardized referral process is outlined in Exhibit KK of this Agreement, Reporting Suspected Fraud, Waste and Abuse to the Department, to expedite information for appropriate disposition.

g. Education Plan

The PH-MCO must create and disseminate written materials for the purpose of educating its employees, managers, Providers, Subcontractors and Subcontractors' employees

about health care Fraud laws, the PH-MCO's policies and procedures for preventing and detecting Fraud, Waste and Abuse and the rights of employees to act as whistleblowers as required in 42 CFR §438.608(a)(1)(iv).

h. 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 on an annual basis.

i. Prior Department Approval

The Fraud, Waste 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, Waste 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.

j. Duty to Cooperate with Oversight Agencies

The PH-MCO and its employees must cooperate fully with oversight agencies responsible for Fraud, Waste and Abuse detection, investigation, and prosecution activities. Such agencies include, but are not limited to, the Department's BPI, Governor's Office of the Budget, Office of Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, the DHHS Office of Inspector General, CMS, the United States Attorney's Office/ Justice Department and the Federal Bureau of Investigations.

Such cooperation must include providing access to all necessary case information, computer files, and appropriate staff. In addition, such cooperation will include participating in periodic Fraud, Waste and Abuse training sessions, meetings, and joint reviews of subcontracted Providers or Members.

k. Hotline Information

The PH-MCO must distribute the Department's toll-free MA Provider Compliance Hotline number and accompanying explanatory statement to its Members and Providers through its Member and Provider handbooks. The explanatory statement needs to include at a minimum the following information:

i. *Recipient Fraud*: Someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assitance (LIHEAP), child care, medical assistance, or other public benefits AND that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS card, trafficking SNAP benefits or taking advantage of the system in any way.

ii. *Provider Fraud*: Billing for services not rendered, billing separately for services in lieu of an available combination code; misrepresentation of the service/supplies rendered (billing brand named for generic drugs; upcoding to more expensive service than was rendered; billing for more time or units of service than provided); altering claims, submission of any false data on claims, such as date of service, provider or prescriber of service, duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; billing for used items as new.

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.

l. 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 a Provider Agreement is subsequently suspended or terminated from participation in the MA or Medicare Programs. Upon notification from the Department that a Network Provider is suspended or terminated from participation in the MA or Medicare Programs, the PH-MCO must immediately act to terminate the Provider from its Network. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

The PH-MCO is required to check the SSADM, and NPPES at the time of initial enrollment and re-enrollment as well as providers, owners, agents, and managing employees against the HHS-OIG LEIE, the EPLS on the SAM, and the PA Medicheck list on a monthly basis as required in 42 CFR §455.436.

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 of a person described above.

"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 Network Provider or Subcontractor is subsequently suspended, terminated or voluntarily withdraws from participation in the MA program as a result of suspected or confirmed Fraud, Waste 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, Guidelines for Sanctions Regarding Fraud, Waste 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.

m. Sanctions

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

n. Subcontracts

i. The PH-MCO will require that all Network Providers and all Subcontractors take such actions as are necessary to permit the PH-MCO to comply with the Fraud, Waste and

Abuse requirements listed in this Agreement as well as federal regulations including but not limited to 42 CFR §438.608.

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 4a. – 4h. above, of this Agreement relating to Fraud, Waste and Abuse.

iii. The PH-MCO will require, via its Provider Agreement, that Network Providers comply with MA regulations and any enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions.

o. Fraud, Waste and 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 BPI, 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.

p. Provider Reviews and Overpayment Recovery

- The PH-MCO shall audit, review and investigate Providers within its network. The PH-MCO shall recover any overpayments directly from its Network Providers for audits, reviews or investigations conducted solely by the PH-MCO.
    - The PH-MCO will void encounters for those claims involving full recovery of the payment and adjust encounters for partial recoveries.
    - All voids and adjustments to encounters will be reported to the Department's BPI.
    - The PH-MCO must notify BPI in writing before it recovers overpayments or improper payments related to Fraud, Abuse or Waste of Medical Assistance.

- The Department has the right to audit, review and investigate MA Providers within the PH-MCO's network.

    - The Department developed a vetting process to coordinate audits, reviews or investigations of the PH-MCO's Network Providers to avoid duplication of effort.
    - Through the vetting process, the PH-MCO must provide information to BPI including, but not limited to the PH-MCO's claims history, policies/procedures, provider contracts, provider review history, complaints and payment methodology.
    - The PH-MCO must provide this information within thirty (30) calendar days of the Department's request. The PH-MCO must respond to Urgent requests within forty-eight (48) hours.
    - The PH-MCO can not initiate a review of a Network Provider after the Department advises the PH-MCO of an open review or investigation by the Department, its designee, or another state or federal agency, without written Departmental authorization to proceed.
    - The Department will inform the PH-MCO and the Provider(s) of its preliminary and final findings related to BPI's review of the PH-MCOs Network Providers.

- Overpayment recoveries resulting from audits, reviews or investigations initiated by the Department, that are not part of mutually agreed upon joint investigation, will be recouped from the PH-MCO.

- The PH-MCO must recoup overpayments resulting from audits, reviews or investigations conducted independently by the Department, from its Network Provider after the PH-MCO receives notice of the final findings from the Department.

    - The Department will deduct the restitution demanded from a future payment to the PH-MCO after 45 days from the mail date of the Department's notice of final determination.
    - The PH-MCO must submit a corrective action plan to the Department, upon request, to resolve any Network Provider's regulatory violations identified through the Department's, its vendor's, or other designee's audit, review or investigation.

- The Department may require the PH-MCO to withhold payment to a Network Provider or to initiate a pre-payment review as a result of law enforcement reviews and activities or the Department's audits, reviews or investigations as required in 42 CFR §§438.608(a)(8) and 455.23.

- The PH-MCO will monitor claims to a provider during a payment suspension, and report on a monthly basis in writing to BPI the amount of funds withheld to the provider during the payment suspension. If the provider is subsequently convicted, these funds will be adjusted from the capitated payments.

- Joint reviews, audits or investigations between the PH-MCO, the Department or its designee 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 after payment of any required contingency fee to the vendor.

5. Management Information Systems

The PH-MCO must have a comprehensive, automated and integrated health 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/appii/index.htm .

a. The PH-MCO must have at a minimum the following components to its MIS or the capability to link to other systems containing this information: Membership, Provider, Claims processing, 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 its 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-MCO must ensure that each provider service location is enrolled and active with Medical Assistance. In addition, the PH-MCO must maintain all service locations in their own system. The PH-MCO 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-MCO must ensure that providers enrolled in their network 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, including electronic mail, to meet the requirements of this Agreement.

j. The PH-MCO must have the capability to electronically transfer data files with the Department and the EAP broker. 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 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 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 60 days prior to the change. The PH-MCO must include a work plan detailing recovery effort and use of parallel system testing.

r. The PH-MCO must be able to accept and generate HIPAA compliant transactions as required in the ASC X12 Implementation Guides.

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 must 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 the List of Active and Closed Providers (PRV-414 and/or PRV-415) file to meet the obligation to maintain valid PROMISe™ Provider IDs; Managed Care Affiliations (PRV-640Q) file to meet the obligation to provide updates on the MCO Provider File (PRV-640); and NPI Crosswalk (PRV-430) file to provide all NPI records active with the Department. 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.

v. In addition to the PH-MCO reconciling the 834 daily and monthly membership files against its internal membership information as referenced in Section V.F.10 of this Agreement, the PH-MCO must also reconcile the 820 capitation payment file against its internal membership information, and report any discrepancies to the Department with thirty (30) days.

6. Department Access and Availability

Upon request by the Department, the PH-MCO must provide 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;
- One (1) telephone which has speaker phone capabilities;
- One (1) personal computer and printer with on-line access to the PH-MCO's MIS;

The PH-MCO must provide the Department with 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

1. Establishment of Special Needs Unit

a. The PH-MCO must develop, train, and maintain a SNU within its organizational structure to deal with issues relating to Members with Special Needs. The purpose of the SNU is to ensure that all Members with special needs are able to receive all necessary services and supports in a timely manner. The SNU must also assist each member with a special need with access to services and information relevant to their special condition or circumstance. The SNU must proactively identify and outreach

to members with special needs to provide these services and information. These services will include all those needed by a member with special needs to address their condition or circumstance and will include but not be limited to all functions and requirements as stated in Exhibit NN, Special Needs Unit. The PH-MCO must employ or execute agreements with experts in the treatment of Special Needs to provide consultation to the SNU staff as needed.

b. The PH-MCO must comply with the Department's non-categorical definition as determined by the requirements outlined in Exhibit NN, Special Needs Unit.

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

d. The PH-MCO must require that outpatient case management services for Members 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.

e. If the PH-MCO provides Case Management Services to Members under the age of twenty-one (21) through the SNU, the PH-MCO must require 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.

f. In addition to other telephone and alternative communication channels, it is required that a dedicated Special Needs hotline be established and maintained as a toll free direct dial access to the Special Needs Unit. This hotline shall be staffed by Special Needs Staff members during normal business hours, Monday through Friday and in sufficient numbers that calls are answered in a timely manner, with no longer than a one minute wait time, or provision made to call the member back within one hour following the initial call.

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, Other Administrative Components.

3. Responsibilities of Special Needs Unit Staff

a. The PH-MCO will require that staff members employed within the SNU 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, Coordination of Care Entities.

b. The staff members of this unit must work in close collaboration with the Bureau of Managed Care Operations Special Needs Unit (BMCO SNU) and the EAP broker's SNU contact person.

c. The PH-MCO must have SNU staff that is qualified to perform the functions outlined in Exhibit NN, 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. 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 honor a Member's selection of a PCP through the EAP broker upon commencement of PH-MCO coverage. If the PH-MCO is not able to honor the selection, the PH-MCO must follow the guidelines described further under this provision.

- The PH-MCO may 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 honor upon commencement of the PH-MCO coverage, the Member's selection. 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, 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 Member 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 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. The PH-MCO must distribute copies of the Provider manual in a manner that makes them easily accessible to all Network 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 workplan to the Department that outlines its plans to educate and train Network Providers. The format for this workplan will be designated by the Department through its Operations Reporting requirements found on the HealthChoices Intranet. This training plan can be done in conjunction with the SNU training requirements as outlined in Exhibit NN, 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 LEP 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 QM process.

i. Identifying and making referrals to the PH-MCO SNU.

j. Guidance to providers on the process to submit materials to the PH-MCO to make utilization review and Prior authorization review decisions about members. Submitted materials may include but not be limited to letters of medical necessity.

k. Information to providers on the complaint, grievance and appeal process including but not limited to expectations should a provider represent a member at a grievance review.

l. Information on PIP such as the Provider Pay for Performance (P4P) outlined in Exhibit B(3) and how providers may benefit from participation in these programs.

The PH-MCO may submit an alternate Provider training and education workplan should the PH-MCO wish to combine its activities with other PH-MCOs operating in the HealthChoices Zones covered by this Agreement or wish to develop and

implement new and innovative methods for Provider training and education. However, this alternative workplan must have advance written approval by the Department. Should the Department approve an alternative workplan, 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 workplan.

3. Panel Listing Requirements

The PH-MCO is required to give its Network Providers panel listings of Members who receive EPSDT services. The PH-MCO must provide electronic panel listings at the request of a 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 each HealthChoices Zone covered by this Agreement. 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 must 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, PH-MCO Provider Agreements.

2. Cultural Competency

Both the PH-MCO and Network 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 Responsibilities

The PH-MCO must have written policies and procedures for ensuring 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. At a minimum, the PH-MCO Network PCP are responsible for:

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 will 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.

The PH-MCO must have adequate Network capacity of qualified specialists to act 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 require 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. Hospital Related Party

The Department requires that a PH-MCO that is a Related Party to a Hospital or system must insure that the Related Party is 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 prohibit Network Providers from intentionally segregating 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.

The PH-MCO must require all Network Providers to be enrolled in the Commonwealth's MA Program and possess an active PROMISe™ Provider ID for each location in which they provide services for the PH-MCO. In addition, the PH-MCO must be able to store and utilize the PROMISe™ Provider ID and NPI stored in PROMISe™ for each location.

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

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

9. Twenty-Four Hour Coverage

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

10. Opioid Use Disorder Centers of Excellence

The Department will implement twenty OUD-COEs in the Physical Health Program throughout the Commonwealth. This initiative will increase the capacity to care for those seeking treatment for OUD, as well as increase the overall quality of care. The PH-MCO must

comply with the Department's OUD-COE requirements specified in Exhibit G Opioid Use Disorder Centers of Excellence.

T. QM and UM Program Requirements

1. Overview

The PH-MCO must comply with the Department's QM and 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) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The PH-MCO must comply with the Quality Management/Utilization Management Reporting Requirements 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 will 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 PH-MCOs that meet quality goals. Information regarding MCO Pay for Performance Programs may be found in Exhibit B(1), HealthChoices MCO Pay for Performance Program. Information regarding the Provider Pay for Performance Program may be found in Exhibit B(3), HealthChoices Provider Pay for Performance Program.

5. QM/UM Program Reporting Requirements

The PH-MCO must 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.

6. Delegated Quality Management and Utilization Management Functions

The PH-MCO may not structure compensation or payments to individuals or entities that conduct Utilization Management activities 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 will 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 Chapter 105; and 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information).

The PH-MCO must require its Network Provider offices and sites have 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) will 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.

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

The Department will provide financial incentives to the PH-MCOs and BH-MCOs for the ICP Program. The Department expects the ICP Program to improve the quality of healthcare and reduce expenditures through enhanced coordination of care among PH-MCOs, BH-MCOs and providers. The targeted membership for this incentive program will be members with persistent serious mental illness (PSMI). Information regarding this incentive program is found in Exhibit B(2)-- PH-MCO and BH-MCO Integrated Care Plan Pay for Performance Program.

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 bear 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 the 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.

The Department may require the PH-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 PH-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 may 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

The PH-MCO must comply with all financial requirements included in this Agreement, in addition to those of the PID. As proof of financial responsibility and adequate protection against insolvency in accordance with 42 CFR §438.116, the following applies:

1. Risk Protection Reinsurance for High Cost Cases

If the PH-MCO is eligible for inclusion in the High Cost Risk Pool, for every HealthChoices Zone of operation, per Appendix 3k, then 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 PH-MCO must obtain reinsurance to 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 may 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, the PH-MCO must submit each annual agreement to the Department for prior written 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 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 PID; or

    iii. The net income as reported to the PID 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 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 PID report. This amount will be reduced by the PH-MCO's expenses relating to the following obligations: Health Insurance Provider's Fee and MCO Assessment.

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 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 and E. Financial Reports and Equity.

3. Risk Based Capital (RBC)

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, 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 PID 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 PID 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 are otherwise modified, such that after the transaction took place, a final determination is made that the PH-MCO was not in compliance with the Agreement 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 and reason for the change or termination and the name of the replacement auditor or actuary, if any. If the change or termination occurred as a result of a disagreement or dispute, the PH-MCO must disclose the nature of the disagreement or dispute.

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 an assessment of more than twenty (20) percent, which equal or exceed current liabilities.

- If an assessment for conversion of long-term investments is applicable, only the value net of the assessment 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. Assessments

In addition to the Department's general assessment authority specified in Section VIII.H of this Agreement, Assessments, if the PH-MCO fails to comply with the requirements of Section VII.A, the Department will take any or all of the following actions:

- Discuss fiscal plans with the PH-MCO's management;

- Suspend payments or a portion of payments for Members enrolled until CMS or the Department is satisfied that the reason for the imposition of the Assessment 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; and/or

- Terminate this Agreement upon forty-five (45) days written notice, in accordance with Section X of this Agreement, Termination and Default.

8. DSH/GME Payment for Disproportionate Share Hospitals Graduate Medical Education

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.

9. Member Liability

In accordance with 42 CFR §438.106, the PH-MCO must provide that Members are not held 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 fails to receive payment from the Department.

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 fails 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 Member enrolled in the PH-MCO, for the first day in the month the Member is enrolled in the PH-MCO and for each subsequent day, through and including the last day of the month.

iii. If a PH-MCO Member is enrolled into a CHC MCO, the Department will pay capitation to the PH-MCO only through the day prior to the CHC begin date.

iv. The Department will not make a Capitation payment for a Member 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.

v. The Department will 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.

vi. Upon notice to the PH-MCO, and for those months specified by the Department, by the fifteenth (15th) of each month, the Department will make a Capitation payment 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.

vii. Unless paragraph vi. Above applies, by the fifteenth (15th) of each month, the Department will make a Capitation payment 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 21 of the same year.

b) Any Capitation payment that would otherwise be payable in the month of June will be payable by July 7 of the same year.

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

viii. 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 Members for up to eighteen (18) months after the service month for which payment was made.

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 MA 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.

3. Program Changes

Amendments, revisions, or additions to the MA 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 Members, 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 Recipients 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

Sound 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, or any other Appendix that specifies rates to reflect change in an Assessment, Premium Tax, Gross Receipts Tax, or similar tax.

The rates in Appendix 3f, Capitation Rates 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. Acceptance of Actuarially Sound Rates

By executing the Agreement, the PH-MCO has reviewed the rates as set forth in the Rate Appendices in this Agreement, Capitation Rates, and accepts the rates for the relevant Agreement period.

D. Claims Processing Standards, Monthly Report and Assessments

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.

The PH-MCO must adjudicate every Claim entered into the PH-MCO's computer information system that is not a Rejected Claim. The PH-MCO must maintain an electronic file of Rejected Claims, inclusive of a reason or reason code for rejection. The PH-MCO must deny a claim for a Recipient who was not a MCO Member as of the date of service at the time of processing of the claim and must notify the Provider.

The amount of time required to adjudicate a paid Claim is computed by comparing the date the Claim is 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 is received with the date the denial notice was created or the transmission date of an electronic denial notice. The PH-MCO must mail checks not later than three (3) Business Days from the check date and make electronic payments 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. Assessments

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 timeliness. For example, the Department shall utilize the monthly report that is due January 5th, to determine Claims processing timeliness for Claims received in the previous August. The Department shall utilize the monthly report that is due February 5th, to determine Claims processing timeliness for Claims received in the previous September. The Department shall utilize the monthly report that is due March 5th, to determine Claims processing timeliness for Claims received in the previous October, and so on.

All Claims received during the month, for which an assessment is being computed, that have not been adjudicated at the time the assessment 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 assessment amount.

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

a. Inpatient Claims.

b. Claims other than inpatient and drug.

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.

The Department will reduce the assessments in the charts below by one-third if the PH-MCO has 25,000-50,000 Members and by two-thirds if the PH-MCO has less than 25,000 Members.

The total assessment 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 assessments for the current month is greater than zero (0) but less than $10,000.

CLAIMS ADJUDICATION MONTHLY ASSESSMENT CHART

The Department will compute assessments as for failure to adjudicate inpatient Claims and Claims other than inpatient or pharmacy.

Percentage of Clean Claims Adjudicated in 30 Days	Assessment
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	Assessment
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	Assessment
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 PIP requirements included under 42 CFR §§ 422.208 and 422.210, which apply to Medicaid managed care under 42 CFR §438.6(h).

b. PH-MCOs are only permitted to operate PIPs 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. PH-MCOs must provide information specified in the regulations to the Department and CMS, upon request. In addition, PH-MCOs must provide the information on their PIPs to any Member, upon request. PH-MCOs that have PIPs 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. PH-MCOs that have PIPs 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 ability to access services.

d. PH-MCOs must provide the following disclosure information concerning its PIPs to the Department prior to approval of the contract:

- whether referral services are included in the PIP,
- 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 Members 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 apply, the PH-MCOs must provide the survey results.

e. The PH-MCO must provide the disclosure information specified in 1.d. above to the Department annually, unless the Department has provided the PH-MCO with notice of suspension of this requirement.

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. Payment for Services Provided by In-Network Providers

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.

4. Payments for Out-of-Network Providers

a. The PH-MCO must make timely payments to Out-of-Network Providers for Medically Necessary, covered services when:

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

ii. Services were Prior Authorized;

iii. It is determined by the Department, after a hearing, that the services should have been authorized; or

iv. 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.

b. The PH-MCO is not financially liable for:

i. Services rendered to treat a non-emergency condition in a hospital emergency department (except to the extent required elsewhere in law), unless the services were Prior Authorized; or

ii. Prescriptions presented at Out-of-Network Provider pharmacies that were written by Non-participating providers or Out–of-Network Providers unless:

- the Non-participating Provider or Out-of-Network provider arrangements were approved in advance by the PH-MCO and any prior authorization requirements (if applicable) were met;
- the Non-participating Provider or Out-of-Network Provider prescriber and the pharmacy are the Member's Medicare providers; or
- the Member is covered by a third party carrier and the Non-participating or Out-of-Network Provider 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 §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 FFS Prospective Payment System (PPS) rate(s), as determined by the Department. Beginning on or after December 1, 2016, the PH-MCO must also make a payment separate from the PPS rate(s) to any FQHC that has opted–in to the Alternative Payment Methodology for inpatient deliveries and/or deliveries in the FQHC setting. 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. The PH-MCO must pay all FQHCs and/or RHCs in the Network for eligible visits regardless of whether the FQHC and/or RHC is the Member's primary care physician. This requirement applies to any Subcontractor of the PH-MCO, as required by Section V.O.2.

6. Financial Obligations when the Agreement has 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. Value Based Purchasing

a. Goals

The PH-MCO must enter into arrangements with Providers that incorporate value based purchasing strategies such as:

i. Provider pay for performance programs

ii. Patient Centered Medical Homes (PCMH)
iii. Shared savings contractual arrangements
iv. Bundled or global payment arrangements
v. Full risk or Accountable Care Organization payment arrangements

The financial goals for the VBP strategies for each calendar year are based on a percentage of the PH-MCO's expenditures to the medical portion of the risk adjusted capitation and maternity revenue without consideration of risk sharing risk pools, P4P or other revenue or revenue adjustments. For the purpose of this requirement, Capitation revenue is gross of premiums for risk sharing or risk pool arrangements without adjustment for risk sharing or risk pool results. The PH-MCO must achieve the following percentages through VBP arrangements:

- Calendar year 2017 – 7.5% of the medical portion of the capitation and maternity care revenue must be expended through VBP strategies. The 7.5% may be from any combination of the five (5) strategies listed.

- Calendar year 2018 – 15% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP strategies. At least 50% of the 15% must be from a combination of strategies ii. through v.

- Calendar year 2019 – 30% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP. At least 50% of the 30% must be from a combination of strategies iii. through v.

b. Reporting

The Department will measure compliance through required reports that have been accepted by the Department. By January 1 of each calendar year, the PH-MCO must submit its proposed VBP plan to the Department that outlines and describes its plan for compliance in that calendar year. The Department will review and provide feedback on the plan to the PH-MCO. By the last work day of every quarter, the PH-MCO must submit a progress report.

By June 30 of the subsequent calendar year, the PH-MCO must submit a report on accomplishments from the prior year. This annual report must include a listing of the VBP arrangements by provider; and an explanation of each arrangement; and the dollar amount spent for medical services provided during the previous

year through these arrangements. The dollar amounts that qualify toward meeting the VBP goals are as follows:

i. Provider pay for performance programs – dollar value of performance (bonus) payments and direct payments made to the Provider for Members attributed to the provider's panel during the calendar year.

ii. Patient Centered Medical Homes – dollar value of any PCMH payments, performance (bonus) payments, direct payments made to the provider and total medical costs, incurred by the PH-MCO for Members of the provider's panel during the time period of the calendar year the member was attributed to the provider's panel.

iii. Shared savings contractual arrangements – dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the PH-MCO for Members of the provider's panel during the time period of the calendar year the Member was attributed to the provider's panel.

iv. Bundled or global payment arrangements – dollar value of bundled payments made to providers.

v. Full risk or Accountable Care Organization payment arrangements – dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the PH-MCO for Members of the provider's panel inclusive of any previous (bonus) payments during the time period of the calendar year the Member was attributed to the provider's panel.

c. New Agreements

If a new PH-MCO Agreement is executed and effective during a calendar year, the reporting requirements are applicable to the calendar year that crosses Agreements, and the Department will determine compliance for the complete calendar year.

d. Assessment

This section provides for an assessment against the PH-MCO's revenue if an annual goal is not met.

Not later than 60 calendar days after receipt from the PH-MCO of the annual Report on VBP accomplishments, the Department will notify the PH-MCO of its determination about compliance with the goal for the preceding year. The PH-MCO may provide a response within 30 calendar days. After considering the response from the PH-MCO, if any, the Department will notify the PH-MCO of its final determination of compliance. If the determination results in a finding of non-compliance, the Department will reduce the next monthly capitation payment by an amount equivalent to one (1) percent of the capitation it paid to the PH-MCO for December of the prior calendar year.

If the PH-MCO fails to provide a timely and adequate report on VBP accomplishments, the Department may determine that the PH-MCO is not compliant with the goal of the preceding year.

e. Data Sharing

The PH-MCOs must provide timely and actionable data to its providers participating in VBP arrangements. This data should include, but is not limited to, the following:

- Identification of high risk patients;
- Comprehensive care gaps inclusive of gaps related to quality metrics used in the VBP arrangement; and
- Service utilization and claims data across clinical areas such as inpatient admissions, non-inpatient facility (SPU/ASC), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.

8. 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.

9. Financial Responsibility for Dual Eligibles

Dual Eligibles age 21 and older who the Department has confirmed are enrolled in Medicare Part D will not participate in HealthChoices and 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 provide a Member who is Dual Eligible access to a Medicare product or service from the Medicare Provider of his or her choice. The PH-MCO must 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.

10. Financial Responsibility for transitioning CHC Members

This paragraph applies only to the PH-MCO's responsibility to provide benefits to a recipient whose county of record is a county in which Community HealthChoices has not been implemented. The PH-MCO's responsibility to provide benefits to a recipient ends on the thirtieth (30^{th}) consecutive day of a stay in a nursing facility.

This section applies only to the PH-MCO's responsibility to provide benefits to a member whose county of record is a county in which CHC has been implemented.

a. Residence in a nursing facility is not cause for disenrollment from the PH-MCO.

b. If CIS provides a CHC start date, and if the PH-MCO's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an

earlier date in the month of the CHC start date or a later date, the last day of the PH-MCO's responsibility to provide benefits is the date prior to the CHC start date. This applies regardless of whether the CHC start date is before or after the thirtieth consecutive day of a stay in a nursing facility covered by the PH-MCO.

c. If the recipient is not determined financially eligible for LTSS, the PH-MCO will not be responsible to pay the nursing facility for any day after the thirtieth consecutive day the recipient is in the nursing facility and is a member of this PH-MCO. This exemption from responsibility to pay the nursing facility will continue unabated if the recipient is admitted to a hospital and returns to the nursing facility. It is acceptable for the PH-MCO to decline to accept or approve nursing facility claims for days after the thirtieth consecutive day the recipient is in the nursing facility until notice is received of a determination of financial eligibility for LTSS.

11. Telephonic Psychiatric Consultation Team Services

The PH-MCO will provide documentation on the expenditure of the funds.

12. Confidentiality

The Department may from time to time 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 FFS 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 Agreement 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.

13. Audits

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

14. Restitution for Overpayments

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.

F. Third Party Liability

The PH-MCO must comply with the TPL procedures defined by Section 1902(a)(25) of the Social Security Act, 42 U.S.C. 1396a(a)(25) implemented by the Department. Under this Agreement, the TPL responsibilities of the Department will be allocated between the Department and the PH-MCO.

1. Cost Avoidance Activities

a. The PH-MCO will have primary responsibility for cost avoidance through the COB relative to federal and private health insurance-type resources including, but not limited to, Medicare, private health insurance, ERISA plans, and Workers Compensation. Except as provided in subparagraph b., the PH-MCO must attempt to avoid initial payment of Claims, whenever possible, where federal or private health insurance-type resources are available. The number of claims cost avoided by the MCO's claims system should be reported in Financial Report #8A, “Claims 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.

b. The PH-MCO and its Subcontractors must pay, and then chase 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.

c. The PH-MCO may not deny or delay approval of otherwise covered treatment or services based upon TPL considerations. The PH-MCO may neither unreasonably delay payment nor deny payment of claims unless the existence of TPL is established at the time the claim is adjudicated.

2. Post-Payment Recoveries

a. 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. Other resources include, but are not limited to recoveries from personal injury claims, liability insurance, first-party automobile medical insurance and accident indemnity insurance.

b. The Department's Division of TPL retains the sole and exclusive right to investigate, pursue, collect, and retain all Other Resources. 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 Member and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The PH-MCO may neither 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 calendar 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 60 calendar

days to return all casualty funds to the Department using the established format.

The PH-MCO must pursue, collect and retain recoveries of a claim involving Workers' Compensation.

c. 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.

d. 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.

e. 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 assessments against the PH-MCO.

f. 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.

3. Health Insurance Premium Payment Program

The HIPP Program pays for employment-related health insurance for Recipients when it is determined to be cost effective.

4. Requests for Additional Data

The PH-MCO must provide, at the Department's request, information not included in the Encounter Data submissions that may be necessary for the administration of TPL activity. The PH-MCO must provide this information within fifteen (15) calendar days of the Department's request. The PH-MCO must respond to Urgent requests within forty-eight (48) hours. The Department may request information such as individual medical records for the express purpose of determining TPL for the services rendered.

5. Accessibility to TPL Data

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

6. Third Party Resource Identification

The PH-MCO must supply to the Department's TPL Division Third Party Resources identified by the PH-MCO or its Subcontractors, which do not appear on the Department's TPL database, within two weeks of its receipt by the PH-MCO must be supplied to the Department's TPL Division by the PH-MCO. In addition to newly identified resources, the PH-MCO must provide information on coverage for other household members, addition of a coverage type, changes to existing resources, including termination of coverage and changes to coverage dates 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. 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 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. Unless the verification notification is requested on the last business day of the week, then the PH-MCO must respond by the close of business that day to avoid a potential access to care issue for the Member.

The PH-MCO must use the Department's verification systems (EVS) and secured services on the internet (previously known as 'POSNet') to identify insurance information the recipients have on file. If there is additional or different insurance information the PH-MCO or their Subcontractors must communicate the information as directed above.

7. Estate Recovery

The Department's Division of TPL is solely responsible for administering the Estate Recovery Program.

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 data submitted to the Department as required by 42 C.F.R. §438.604, whether in written or electronic form. The PH-MCO must submit certification concurrently with the certified data and the certification of accuracy, completeness and truthfulness of the data must be based on the knowledge, information and belief of the CEO, CFO or an individual who has delegated authority to sign for, and who reports directly to the CEO or CFO.

The PH-MCO will 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 required electronica files and data.

Exhibit CC, Data Support for PH-MCOs, provides a listing of 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. The PH-MCO shall only submit Encounter Data for Members 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 needed 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 the Department intends to implement regarding Encounter Data.

a. Data Format

The PH-MCO must submit Encounter Data to the Department using established protocols.

The PH-MCO must provide Encounter Data files 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

Providers must submit claims to the PH-MCO within one hundred eighty (180) days after the date of service.

The PH-MCO may include a requirement for more prompt submissions of Claims or Encounter Data 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 Data except pharmacy transactions must be submitted by the PH-MCO and determined acceptable by the Department on or before the last calendar day of the third month after the payment or adjudication calendar month in which the PH-MCO paid or adjudicated the Claim. Pharmacy transactions must be submitted and approved in PROMISe™ within 30 days following the adjudication date.

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

Encounter Data that deny due to Department edits will be 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 timeframes 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, format specifications and submission schedule for the Encounter File as provided by the Department.

iv. Response Files

The PH-MCO Encounter Data system must have a mechanism in place to receive and process the U277 and NCPDP response files; and to store the PROMIS*e*™ ICN associated with each processed Encounter Data 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 Health Care Providers, including Subcontractors, are submitted accurately and timely as Encounters to the Department and that demonstrates denied Encounters are resolved and 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 Sanctions

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 will request the PH-MCO submit a Corrective Action Plan when areas of noncompliance are identified.

The Department may assess financial sanctions as provided in Exhibit XX, Encounter Data Submission Requirements and Sanctions, based on the identification of instances of non-compliance.

e. Data Validation

The PH-MCO will 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, an independent, external review organizations or both.

In addition, the PH-MCO must validate files sent to them when requested.

f. Secondary Release of Encounter Data

The Department owns all Encounter Data recorded to document services rendered to Recipients. Access to this data is provided to the PH-MCO and its agents for the sole purpose of operating the HealthChoices Program. 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 must submit a complete, accurate and timely monthly file containing supplemental data for NCPDP transactions used for the purpose of drug rebate dispute resolution. The PH-MCO must submit the file 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. Unless the verification notification is requested on the last business day of the week, then the PH-MCO must respond by the close of business that day to avoid a potential access to care issue for their member. 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 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 to 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 confirm 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. The PH-MCO must comply with the file submission requirements found on HealthChoices Intranet under File Specifications and File Schedules, *Eligibility Verification System/PCP File*.

4. Provider Network

The PH-MCO must provide a file to the Department's PROMISe™ contractor of its entire Provider Network, including its Subcontractors.

The PH-MCO must provide this file monthly. The PH-MCO must confirm 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. The PH-MCO must comply with the file submission requirements found on HealthChoices Intranet under File Specifications and File Schedules, Provider Files.

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 confirm the information is consistent with all requirements specified by the Department on the HealthChoices Intranet under the File Specifications and File Schedules, *Enrollment/Disenrollment Files*.

6. Maternity Care

The PH-MCO must submit a maternity care claim 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 confirm the information is consistent with all requirements specified by the Department on the HealthChoices Intranet under the File Specifications and File Schedules, *Maternity Care Files*.

C. Operations Reporting

The PH-MCO must submit 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, CMS has imposed specific reporting requirements related to the 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 the required 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 PH-MCO must include information for all situations where a Provider action caused an overpayment to occur and must identify cases under review (including approximate dollar amounts), Providers terminated due to Medicare/Medicaid preclusion, overpayments recovered and cost avoidance issues related to identifying and/or identified fraud, waste, and abuse (42 CFR 438.608(a)(2).

The PH-MCO must comply with all requirements regarding Operations Report format and timeframes provided on the DHS/PH-MCO DocuShare Reporting pages and the HealthChoices Intranet at Managed Care Program/*Program Information-Reporting Requirements.*

D. Financial Reports

The PH-MCO will submit such reports as specified by the Department to assist the Department in assessing the PH-MCO's financial viability and 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 on the HealthChoices Intranet at Managed Care Program/*Program Information-Reporting Requirements*.

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 (2nd) 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, 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, 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 the Department by the fifth (5th) calendar day of the second (2nd) 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.

If the PH-MCO fails to submit a timely, accurate fully compliant Claims processing report, The Department may impose the following assessments: up to $200 per calendar day for the first ten (10) calendar days from the date that the report is due and up to $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. Sanctions 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 this Agreement 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 MA 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 Department, Members, potential Members, or Health Care Providers.

   - Fails to comply with requirements for PIPs as set forth in 42 CFR §§422.208 and 422.210.

   - Fails to comply with the Agreement requirements pertaining to Program Integrity and Fraud, Waste and Abuse.

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

   The Department may impose sanctions as may be applicable for noncompliance with the requirements under this Agreement, failure to meet applicable requirements of the Social Security Act and 42 CFR Subpart I. The sanctions which may be imposed will depend on the nature and severity of the noncompliance, which the Department, in its reasonable discretion, will determine as follows:

a. Imposing civil monetary penalties of a minimum of $1,000.00 per calendar 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;

f. Termination of the Agreement: The Department may terminate a PH-MCO Agreement and enroll its Members in another PH-MCO or provide MA benefits through other options included in the State plan.

2. Where this Agreement provides for a specific sanction, the Department may, at its discretion, apply the specific sanction provided for the noncompliance or apply any of the general sanctions set forth in this section. Specific sanctions contained in this Agreement include the following:

a. Claims Processing: Sanctions related to Claims processing are provided in Section VII D. of this Agreement, Claims Processing Standards, Monthly Reports and Sanctions.

b. Report or File Reports, 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, the Department may reduce a subsequent payment to the PH-MCO. 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 PMPM 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 Sanctions related to the submission of Encounter Data are set forth in Section VIII.B, Systems Reports, and Exhibit XX, Encounter Data Submission Requirements and Sanctions.

d. Marketing: The sanctions for engaging in unapproved marketing practices are described in Section V.F.3, 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), 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 of 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.

g. Outpatient Drug Encounters: Sanctions for non-compliance with outpatient drug encounter data timeliness is set forth in Exhibit BBB, 9. Outpatient Drug Encounters.

I. Non-Duplication of Financial Penalties

The Department will not assess duplicate financial sanctions for non-compliance where financial sanctions have already been issued.

SECTION IX: REPRESENTATIONS AND WARRANTIES OF THE PH-MCO

A. Accuracy of Proposal

The PH-MCO warrants that all information submitted to the Department in or with the Proposal is true, accurate and complete in all material respects. The PH-MCO agrees that these representations are continuing ones, and that the PH-MCO must 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 Proposal submission, 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 and 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) calendar days of any change or addition. The PH-MCO agrees that any failure to comply with this provision in any material respect, or making of any misrepresentation which would cause the PH-MCO 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 will report to the Department, as well as the DOH and PID, 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, its Affiliates or Related Parties. 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 intent of Suspension, debarment or exclusion of PH-MCO, PH-MCO's parent(s), or any Affiliate or Related Party of either, by any state or the federal government;

2. Suspension or intent of Suspension, debarment or exclusion of a director, officer, partner or person with beneficial ownership of more than five percent (5%) of the PH-MCO's Equity.

3. Notice of an intent to suspend, debar or exclude issued by any state or the federal government to PH-MCO, PH-MCO's parent(s), any Affiliate or Related Party of either, any individuals with employment, consulting or other arrangements that are material and significant; 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.

SECTION X: TERMINATION AND DEFAULT

A. Termination by the Department

In conjunction with termination provisions in Section 18 of Exhibit D, Standard 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 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 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 16 Default of Exhibit D, Standard Terms and Conditions for Services,

a. An act of theft or Fraud against the Department, any state agency, or the Federal Government;or

b. An adverse material change in circumstances as described in Section IX.C, Disclosure of Change in Circumstances.

3. Termination Due to Unavailability of Funds/Approvals

In addition to Section 18.b of Exhibit D, Standard 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 FFP in all or part of the cost hereof for covered services;

b. Notification of the 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 PID or DOH 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 Member 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, 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 or expiration, 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 coordinate the continuation of care prior to termination or expiration for Members who are undergoing treatment for an acute condition.

3. Submission of Invoices

Upon termination or expiration, 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 no later than forty-five (45) days from the effective date of termination or expiration. 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. Termination Requirements

In addition to the termination requirements specified in this section, the PH-MCO must also provide the Department with all outstanding Encounter Data. If either the Department or the Contractor provides written notice of termination, the Department will withhold ten percent (10%) of one (1) month's Capitation payment. Once the Department determines that the Contractor has substantially complied with the requirements in this section, the Department will pay the withheld portion of the Capitation payment to the PH-MCO. The Department will not unreasonably delay or deny a determination that the PH-MCO has substantially complied. The Department will share with the PH-MCO the determination on substantial compliance by the first (1st) day of the fifth (5th) month after the Agreement ends. If the Department determines that the PH-MCO has not substantially complied, the Department will share a subsequent determination by the first (1st) day of each subsequent month.

D. Transition at Expiration or Termination of Agreement

If the PH-MCO and the Department have not entered into a new Agreement for any of the HealthChoices Zones covered by this Agreement, the Department will develop a transition plan. During the transition period, the PH-MCO must cooperate with any subsequent PH-MCO and the Department. As part of the transition plan, the Department will define the program information and the working relationship between the PH-MCOs. 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 PH-MCO is responsible for the costs relating to the transfer of materials and responsibilities as a normal part of doing business with the Department.

The PH-MCO must provide necessary information to a PH-MCO and 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 XI: 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.3, Records Retention.

2. The PH-MCO will submit to the Department or to the Secretary of Health and Human Services or their designees, within thirty-five (35) calendar 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 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 will include the requirements set forth in Section XII, Subcontractual Relationships, in all contracts it enters with Subcontractors under the HealthChoices Program.

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.3, 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.3, Records Retention.

The PH-MCO must provide Members' medical records, subject to this Agreement, to the Department or designee within twenty (20) Business Days of the Department's request. The PH-MCO must mail copies of such records 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, federal agencies or their designees. 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, 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 retention period, the PH-MCO, at its own expense, must send copies of the requested records to the requesting entity within thirty (30) calendar days of such request.

SECTION XII: SUBCONTRACTUAL RELATIONSHIPS

A. Compliance with Program Standards

With the exception of Provider Agreements, the PH-MCO will comply with the procedures set forth in Section V.O.2, Contracts and Subcontracts and in Exhibit II, Required Contract Terms for Administrative Subcontractors.

Prior to the award of a contract or Subcontract, the PH-MCO must disclose to the Department in writing information on 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 as required by 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), Quality Management and Utilization Management Program Requirements using the denial notice templates provided on the HealthChoices Intranet site. In addition, the PH-MCO must including in its contracts or Subcontracts that cover the provision of medical services to the PH-MCO’s Members the following provisions:

1. A requirement for the submission of all Encounter Data for services provided within the time frames required in Section VIII, 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 which provides the Department with 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, Definitions.

6. If applicable, adherence to the standards for Network composition and adequacy in the Subcontracts.

7. Compliance with the requirements of Section V.B.1, General Prior Authorization Requirements for Subcontracts for utilization review services.

8. A transition plan for Subcontracts with an entity to provide any information systems This transition plan must include information on how the data, including all historical Claims and service data shall be converted and made available to a new Subcontractor.

   The PH-MCO must make all necessary revisions to its Subcontracts to be in compliance with the requirements set forth in Section XIII.A, Compliance with Program Standards. The PH-MCO must make revisions 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 comply with Encounter Data to the PH-MCO within the time frames specified in Section VIII.B, Systems Reports.

B. Consistency with Regulations

The PH-MCO agrees that its agreements with all Subcontractors must be consistent, as may be applicable, with DOH regulations governing HMO Contracting with Integrated Delivery Systems at 28 Pa. Code §§ 9.721 – 9.725 and PID regulations at 31 Pa. Code §§ 301.301 – 301.314.

SECTION XIII: CONFIDENTIALITY

A. The PH-MCO agrees to comply with applicable federal and state laws regarding the confidentiality of medical information, as it more fully set forth below. The PH-MCO must also cause that each of its Subcontractors comply with such applicable laws. To facilitate the efficient administration of the Medical Assistance Program and to enhance the treatment of Members requiring behavioral health or other services not the responsibility of the PH-MCO, the PH-MCO shall receive all information relating to the health status of its Members, by the exchange of data and other such mechanisms the Department may approve. To further integrate and coordinate health care for Members who need behavioral health services that are not the responsibility of the PH-MCO, the PH-MCO shall disclose to the BH-MCO all information relating to the health of its Members, by the exchange of data and such other mechanisms as the Department may approve.

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 will be liable for any state or federal fines, financial penalties, or damages levied upon the Department for a breach of confidentiality due to the conduct of the PH-MCO in relation to the PH-MCO's systems, staff, or other area of responsibility.

C. The PH-MCO will return all data and material obtained in connection with this Agreement and the implementation thereof, including confidential data and material, at the Department's request. The PH-MCO is prohibited from using material for any purpose after the expiration or termination of this Agreement.

D. To facilitate the efficient administration of the Medical Assistance Program and to enhance the treatment of Members who need behavioral health or other services that are not the responsibility of the PH-M CO, the PH-MCO may receive all information relating to the health status of its Members, including treatment information, by the exchange of data

and other such mechanisms as the Department approves, in accordance with applicable federal and state confidentiality laws.

SECTION XIV: INDEMNIFICATION AND INSURANCE

A. Indemnification

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 XV: 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, who will make a determination in writing of his or her interpretation and will send the same to the PH-MCO within thirty (30) calendar days of the PH-MCO's written request. That interpretation shall be final, conclusive, and binding on the PH-MCO, and unreviewable in all respects unless the PH-MCO within twenty (20) calendar days of its receipt of said interpretation, delivers a written appeal to the Secretary of the Department. 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) calendar 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 XVI.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
Commonwealth Tower, 6th Floor
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 BHA in accordance with 67 Pa.C.S. §§101 – 106 and 55 Pa. Code Chapter 41.

SECTION XVI: 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 any federally funded health care program, the PH-MCO must promptly notify the Department, in writing, of such suspension or termination.

The PH-MCO shall not make any payment 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 a federally funded health care 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 XV 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. 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
Commonwealth Tower, 6th Floor
P.O. Box 2675
Harrisburg, Pennsylvania 17105

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
625 Forster Street
Harrisburg, Pennsylvania 17120
Attention: Chief Counsel

To the PH-MCO – PH-MCO Information, name and address.

F. 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.

G. Headings

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

H. 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.

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 revenue 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 revenue 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 Allowance 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 revenue and 50% of the next $25 million of premium revenue. 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 premium revenues 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 premium revenues 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 premium revenues produce 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..

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

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 Allowance 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 Allowance 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.

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

If the MCO is subject to the HIPF but had no HIPF obligation in the current fee year, a settlement amount representing the amount paid to the MCO in the data year for the HIPF on the prior year's settlement amount will be determined. The amount for Vista is $3,796,577 and will be deducted from a payment within 15 days after the execution of this agreement.

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 Rate Cells 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 Rate Cell and one Rate Region 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. MCO Assessment Amount

The Base Capitation Rates include an MCO Assessment Amount. The MCO Assessment Amount is the amount included in the Base Capitation Rates for the MCO Assessment fee inclusive of a multiplier that accounts for the PH-MCO's responsibility to pay the MCO Assessment fee for partial member months. As an example, the MCO Assessment Amount for January 2017 is $13.64 ($13.48 MCO Assessment x 1.0117 multiplier).

D. Contracted Rate Less Applicable Exclusions

For each MCO in a Zone, the following calculation will be made for each Rate Cell and Rate Region:

	Base Capitation Rate Net of HIPF Allowance
MINUS	Home Nursing Risk Sharing Allowance Amount
MINUS	High Cost Risk Pool Allowance Amount
MINUS	Specialty Drug Risk Sharing Allowance
MINUS	Hepatitis C Quality Risk Pool Allowance
MINUS	MCO Assessment Amount
EQUALS	Contracted Rate Less Applicable Exclusions.

E. Risk Adjusted Rate

The Risk Adjusted Rate applicable to this Agreement for this program month for this PH-MCO for this Rate Cell and Rate Region is the lowest Contracted Rate Less Applicable Exclusions calculated by the Department for any PH-MCO for this Rate Cell and Rate Region for this program month multiplied by the applicable RAR MCO Plan Factor issued by the Department for this PH-MCO.

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.

F. 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 Allowance that are not subject to risk adjustment.

If the Contracted Rate Less Applicable Exclusions is higher than the lowest Contracted Rate Less Applicable Exclusions that the Department has calculated for this Rate Cell and Rate Region for the applicable program month among all PH-MCOs that operate in this Zone, the difference is referred to as Amount A.

This is calculated as follows.

	Risk Adjusted Rate
PLUS	Amount A (if applicable)
PLUS	Home Nursing Risk Sharing Allowance Amount
PLUS	High Cost Risk Pool Allowance Amount
PLUS	Specialty Drug Risk Sharing Allowance
PLUS	Hepatitis C Quality Risk Pool Allowance
PLUS	MCO Assessment Amount
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.

G. 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.

H. 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.

I. Newly Eligible

For purposes of this Appendix, 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.

APPENDIX 3c

HOME NURSING RISK SHARING ARRANGEMENT

The terms of this appendix are effective January 1, 2017.

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

I. Arrangement Years

A. Arrangement Years are equivalent to calendar years. Exception: If the PH-MCO does not operate a HealthChoices program in a zone under this or any other HealthChoices Agreement throughout the complete calendar year, then the Arrangement Year consists of the portion of the year in which the PH-MCO operates the program. 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 operates a HealthChoices program in each 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 in the event of a conflict in terms.

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, the PH-MCO is responsible for the first $5,000 (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 eighty percent (80.0%) of Covered Services (net of third party liability/other insurance) submitted by the PH-MCO that are greater than $5,000.

IV. Home Nursing Risk Sharing Allowance Amounts

A. The Home Nursing Risk Sharing Allowances are an obligation of the PH-MCO to the Department. Home Nursing Risk Sharing Allowance Amounts effective January 2017 are specified in Appendix 3f.

B. The Department will determine the Home Nursing Risk Sharing Allowance Amount obligation by multiplying the Home Nursing Risk Sharing Allowance by the applicable Member Months.

C. Each Home Nursing Risk Sharing payment paid by the Department will be net of the PH-MCO's uncollected Home Nursing Risk Sharing Allowance Amount obligation through the same quarter. If the PH-MCO's uncollected Home Nursing Risk Sharing Allowance 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 Allowance 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 Allowance Amount obligation for the same month.

V. Data Source

A. The Department will use PROMISe-approved encounter data to identify those claims eligible for risk sharing, 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.

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

VI. Payment to the PH-MCO

The Department will notify the PH-MCO of an initial settlement for the current Arrangement Year by October 31 of the subsequent year. The Department will notify the PH-MCO of a final settlement for the current Arrangement Year by March 31 of the 2nd subsequent year. Within thirty days of the notice date, the Department will initiate any applicable payment/adjustment to the PH-MCO.

Vista Health Plan, Inc. Capitation Rates - Effective January 1, 2017 - June 30, 2017

Northwest		Capitation Payment Rate Calculation						Applicable Allowance Amounts				
Rate Region 1 - Crawford, Erie, Forest, Mercer, Venango and Warren counties	**Maternity Care Payment with HIPF Allowance**	**Base Capitation Rate with HIPF Allowance**	**HIPF Allowance**	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**High Cost Risk Pool Allowance**	**Specialty Drug Risk Sharing Allowance**	**Hepatitis C Quality Risk Pool Allowance**	**Provider Pay for Performance**	**Community Based Care Management**
TANF-MAGI < 2 Months		$2,746.92	$108.90	$2,638.02	TBD	TBD	TBD	$6.71	N/A	N/A	$1.00	$0.65
TANF-MAGI 2-11.999 Months		$284.66	$11.28	$273.38	TBD	TBD	TBD	$6.71	N/A	N/A	$1.00	$0.65
TANF-MAGI Ages 1-20		$172.34	$6.83	$165.51	TBD	TBD	TBD	$6.71	$0.18	$0.02	$1.00	$0.65
TANF-MAGI Ages 21+		$320.55	$12.71	$307.84	TBD	TBD	TBD	$6.71	$2.88	$0.36	$1.00	$0.65
SSI-HH-Other Disabled		$891.74	$35.38	$856.36	TBD	TBD	TBD	$49.24	$17.88	$1.73	$1.00	$0.65
Breast and Cervical Cancer		$2,589.94	$102.79	$2,487.15	$2,487.15	$2,487.15	TBD	$49.24	N/A	N/A	$1.00	$0.65
Newly Eligible Women Ages 19 to 44		$357.21	$14.17	$343.04	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Women Ages 45 to 64		$654.61	$25.97	$628.64	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Men Ages 19 to 44		$288.93	$11.46	$277.47	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Men Ages 45 to 64		$710.37	$28.18	$682.19	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Maternity Care	$8,060.72		$320.00	$7,740.72								
Rate Region 2 - Cameron, Clarion, Clearfield, Elk, Jefferson, McKean and Potter counties	**Maternity Care Payment with HIPF Allowance**	**Base Capitation Rate with HIPF Allowance**	**HIPF Allowance**	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**High Cost Risk Pool Allowance**	**Specialty Drug Risk Sharing Allowance**	**Hepatitis C Quality Risk Pool Allowance**	**Provider Pay for Performance**	**Community Based Care Management**
TANF-MAGI < 2 Months		$3,222.50	$127.75	$3,094.75	TBD	TBD	TBD	$6.71	N/A	N/A	$1.00	$0.65
TANF-MAGI 2-11.999 Months		$263.79	$10.46	$253.33	TBD	TBD	TBD	$6.71	N/A	N/A	$1.00	$0.65
TANF-MAGI Ages 1-20		$180.41	$7.15	$173.26	TBD	TBD	TBD	$6.71	$0.18	$0.02	$1.00	$0.65
TANF-MAGI Ages 21+		$367.48	$14.58	$352.90	TBD	TBD	TBD	$6.71	$2.88	$0.36	$1.00	$0.65
SSI-HH-Other Disabled		$964.37	$38.26	$926.11	TBD	TBD	TBD	$49.24	$17.88	$1.73	$1.00	$0.65
Breast and Cervical Cancer		$2,589.94	$102.79	$2,487.15	$2,487.15	$2,487.15	TBD	$49.24	N/A	N/A	$1.00	$0.65
Newly Eligible Women Ages 19 to 44		$357.21	$14.17	$343.04	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Women Ages 45 to 64		$654.61	$25.97	$628.64	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Men Ages 19 to 44		$288.93	$11.46	$277.47	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Men Ages 45 to 64		$710.37	$28.18	$682.19	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Maternity Care	$7,644.88		$303.49	$7,341.39								

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 Allowance is defined in Appendix 3a.

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

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

Vista Health Plan, Inc. Capitation Rates - Effective July 1, 2017 - December 31, 2017

Northwest		Capitation Payment Rate Calculation						Applicable Allowance Amounts				
Rate Region 1 - Crawford, Erie, Forest, Mercer, Venango and Warren counties	**Maternity Care Payment with HIPF Allowance**	**Base Capitation Rate with HIPF Allowance**	**HIPF Allowance**	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**High Cost Risk Pool Allowance**	**Specialty Drug Risk Sharing Allowance**	**Hepatitis C Quality Risk Pool Allowance**	**Provider Pay for Performance**	**Community Based Care Management**
TANF-MAGI < 2 Months		$2,618.64	$108.96	$2,509.68	TBD	TBD	TBD	$6.71	N/A	N/A	$1.00	$0.65
TANF-MAGI 2-11.999 Months		$272.37	$11.35	$261.02	TBD	TBD	TBD	$6.71	N/A	N/A	$1.00	$0.65
TANF-MAGI Ages 1-20		$167.69	$6.90	$160.79	TBD	TBD	TBD	$6.71	$0.18	$0.02	$1.00	$0.65
TANF-MAGI Ages 21+		$308.77	$12.78	$295.99	TBD	TBD	TBD	$6.71	$2.88	$0.36	$1.00	$0.65
SSI-HH-Other Disabled		$861.18	$35.45	$825.73	TBD	TBD	TBD	$49.24	$17.88	$1.73	$1.00	$0.65
Breast and Cervical Cancer		$2,478.59	$102.86	$2,375.73	$2,375.73	$2,375.73	TBD	$49.24	N/A	N/A	$1.00	$0.65
Newly Eligible Women Ages 19 to 44		$344.83	$14.24	$330.59	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Women Ages 45 to 64		$630.86	$26.03	$604.83	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Men Ages 19 to 44		$279.31	$11.52	$267.79	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Men Ages 45 to 64		$684.44	$28.25	$656.19	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Maternity Care	$7,749.85		$320.00	$7,429.85								
Rate Region 2 - Cameron, Clarion, Clearfield, Elk, Jefferson, McKean and Potter counties	**Maternity Care Payment with HIPF Allowance**	**Base Capitation Rate with HIPF Allowance**	**HIPF Allowance**	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**High Cost Risk Pool Allowance**	**Specialty Drug Risk Sharing Allowance**	**Hepatitis C Quality Risk Pool Allowance**	**Provider Pay for Performance**	**Community Based Care Management**
TANF-MAGI < 2 Months		$3,072.29	$127.82	$2,944.47	TBD	TBD	TBD	$6.71	N/A	N/A	$1.00	$0.65
TANF-MAGI 2-11.999 Months		$252.31	$10.52	$241.79	TBD	TBD	TBD	$6.71	N/A	N/A	$1.00	$0.65
TANF-MAGI Ages 1-20		$175.39	$7.22	$168.17	TBD	TBD	TBD	$6.71	$0.18	$0.02	$1.00	$0.65
TANF-MAGI Ages 21+		$352.30	$14.64	$337.66	TBD	TBD	TBD	$6.71	$2.88	$0.36	$1.00	$0.65
SSI-HH-Other Disabled		$926.13	$38.33	$887.80	TBD	TBD	TBD	$49.24	$17.88	$1.73	$1.00	$0.65
Breast and Cervical Cancer		$2,478.59	$102.86	$2,375.73	$2,375.73	$2,375.73	TBD	$49.24	N/A	N/A	$1.00	$0.65
Newly Eligible Women Ages 19 to 44		$344.83	$14.24	$330.59	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Women Ages 45 to 64		$630.86	$26.03	$604.83	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Men Ages 19 to 44		$279.31	$11.52	$267.79	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Newly Eligible Men Ages 45 to 64		$684.44	$28.25	$656.19	TBD	TBD	TBD	$6.48	$3.53	$0.44	$1.00	$0.65
Maternity Care	$7,349.71		$303.49	$7,046.22								

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 Allowance is defined in Appendix 3a.

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

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

Vista Health Plan, Inc. Capitation Rates - Effective January 1, 2017 - December 31, 2017

Northwest	Home Nursing Risk Sharing Allowance									
	End date of this PH-MCO's responsibility to operate a program in this zone per this Agreement or any other HealthChoices Agreement.									
Rate Region 1 - Crawford, Erie, Forest, Mercer, Venango and Warren counties	**March 31, 2017**	**April 30, 2017**	**May 31, 2017**	**June 30, 2017**	**July 31, 2017**	**August 31, 2017**	**September 30, 2017**	**October 31, 2017**	**November 30, 2017**	**December 31, 2017 or None***
TANF-MAGI < 2 Months	$4.98	$5.28	$5.46	$5.58	$5.66	$5.73	$5.78	$5.82	$5.85	$5.88
TANF-MAGI 2-11.999 Months	$4.98	$5.28	$5.46	$5.58	$5.66	$5.73	$5.78	$5.82	$5.85	$5.88
TANF-MAGI Ages 1-20	$4.98	$5.28	$5.46	$5.58	$5.66	$5.73	$5.78	$5.82	$5.85	$5.88
TANF-MAGI Ages 21+	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SSI-HH-Other Disabled	$38.67	$41.35	$42.96	$44.04	$44.80	$45.38	$45.83	$46.19	$46.48	$46.72
Breast and Cervical Cancer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Newly Eligible Women Ages 19 to 44	$0.86	$0.92	$0.95	$0.98	$0.99	$1.01	$1.02	$1.02	$1.03	$1.04
Newly Eligible Women Ages 45 to 64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Newly Eligible Men Ages 19 to 44	$0.86	$0.92	$0.95	$0.98	$0.99	$1.01	$1.02	$1.02	$1.03	$1.04
Newly Eligible Men Ages 45 to 64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maternity Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rate Region 2 - Cameron, Clarion, Clearfield, Elk, Jefferson, McKean and Potter counties	**March 31, 2017**	**April 30, 2017**	**May 31, 2017**	**June 30, 2017**	**July 31, 2017**	**August 31, 2017**	**September 30, 2017**	**October 31, 2017**	**November 30, 2017**	**December 31, 2017 or None***
TANF-MAGI < 2 Months	$4.98	$5.28	$5.46	$5.58	$5.66	$5.73	$5.78	$5.82	$5.85	$5.88
TANF-MAGI 2-11.999 Months	$4.98	$5.28	$5.46	$5.58	$5.66	$5.73	$5.78	$5.82	$5.85	$5.88
TANF-MAGI Ages 1-20	$4.98	$5.28	$5.46	$5.58	$5.66	$5.73	$5.78	$5.82	$5.85	$5.88
TANF-MAGI Ages 21+	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SSI-HH-Other Disabled	$38.67	$41.35	$42.96	$44.04	$44.80	$45.38	$45.83	$46.19	$46.48	$46.72
Breast and Cervical Cancer	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Newly Eligible Women Ages 19 to 44	$0.86	$0.92	$0.95	$0.98	$0.99	$1.01	$1.02	$1.02	$1.03	$1.04
Newly Eligible Women Ages 45 to 64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Newly Eligible Men Ages 19 to 44	$0.86	$0.92	$0.95	$0.98	$0.99	$1.01	$1.02	$1.02	$1.03	$1.04
Newly Eligible Men Ages 45 to 64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maternity Care	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

TBD - To Be Determined

The amounts shown are not to be withheld from the capitation rate. The Home Nursing Risk Sharing Allowance is used to determine the MCO's Home Nursing Risk Sharing obligation as per Appendix 3c of the HealthChoices Agreement.

*** The PH-MCO's responsibility to operate a HC program in this zone continues after December 31, 2017**

APPENDIX 3g

OVERVIEW OF METHODOLOGIES FOR RATE SETTING AND DETERMINATION OF RISK SHARING PREMIUM ALLOWANCE 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
- Assess Data Credibility
- Include the Effect of Program/Policy Changes
- Project the FFS Base Data Forward
- Adjust the FFS Data to Reflect Managed Care Principles
- Add an Appropriate Non-Medical Loads

Summarize the FFS Claims and Eligibility Data — The Commonwealth of Pennsylvania (Commonwealth) provides summarized FFS claims and eligibility data for the recipients and services to be covered under the HealthChoices program. Normally, multiple 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/or 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.

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

Include the Effect of Program/Policy Changes — The Commonwealth occasionally changes the services, reimbursements, or populations covered under the HealthChoices program (e.g., an expansion of a new benefit or restructuring of a currently covered benefit). Material program changes are included in the capitation rates by either increasing or decreasing the FFS data by an appropriate adjustment.

Project the FFS Base Data Forward — The base data is then projected forward to the period for which the capitation rates are contracted. 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, but are not limited to:

major category of service, geographic area, or rate cell.

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

Add an Appropriate Non-Medical Load — After the base data has been trended to the appropriate period, and adjusted for program/policy changes, non-medical loads, including, but not limited to administrative and underwriting gain components, will be added to the medical claim cost component to determine the overall capitation rates applicable to each rate cell. The non-medical loads can be applied as a percentage of the total capitation rate (e.g., percent of premium revenue) and may or may not vary by rate cell, or other rating characteristic, depending on the structure of adjustments.

Add an amount for State/Federal Taxes/Assessments — The final capitation rate, after all other components have been completed, is further adjusted to reflect any legislatively mandated State/Federal taxes and/or assessments. These adjustments are typically applied as a percent of final premium revenue, after non-medical loads are accounted for, and is added to the 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,
- Include the Effect of Program/Policy Changes,
- Project the Managed Care Base Data Forward, and
- Add Appropriate Non-Medical 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/or 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, but not limited to, reinsurance, over- or under-reserving of unpaid claims, utilization and unit cost efficiency, risk class structure, 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 rate cell. This step may include the blending of managed care data for rate cells that are anticipated to reflect new rate cells. For example, the newly eligible rate cell is anticipated to reflect a blending of the traditional rate cells that will align with this new population.

Include the Effect of Program/Policy Changes — The Commonwealth occasionally

changes the services or populations covered under the HealthChoices program (e.g., an expansion of a new benefit or a restructuring of a currently covered benefit). Any new, material 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 an appropriate adjustment.

Project the Managed Care Base Data Forward — The aggregate base of managed care data is projected forward to the period for which the capitation rates are contracted. Trend factors are used to estimate the future costs and utilization of the services that the covered population would generate in the managed care program. These trend factors normally vary by, but not limited to: major category of service, geographic area, and/or rate cell.

Add Appropriate Non-medical Load — After the base data has been trended to the appropriate period, and adjusted for program/policy changes, a non-medical load will be added to the medical claim cost component to determine the overall capitation rates applicable to each rate cell. The non-medical load can be applied as a percentage of the total capitation rate (e.g., percent of premium revenue) and may or may not vary by rate cell and includes all administrative liabilities expected for the average health plan in the Commonwealth operating the program in an efficient manner.

Add an amount for State/Federal Taxes/Assessments — The final capitation rate, after all other components have been completed, is further adjusted to reflect any legislatively mandated State/Federal taxes and/or assessments. These adjustments are typically applied as a percent of final premium revenue, after non-medical loads are accounted for, and is added to the final capitation rate.

Optional Rate Update — In lieu of rebasing rates on newer experience base data, it is possible to update the prior year's rates for new, material program changes, trend and other adjustments following a similar process outlined above.

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

When updated 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 period

for which the new capitation rates are contracted. 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 major category of service and/or rate cell.

Include the Effect of New Program/Policy Changes (Track 1) — In Track 1, any new, material program/policy changes implemented by the Commonwealth or required by the federal government 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 an appropriate adjustment.

Summarize and Adjust the Managed Care Data (Track 2) — The more recent managed care data is collected from the MCOs, summarized, and analyzed to support rate setting. Adjustments (positive and/or 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, but not limited to, the collection of TPL/COB, over- or under-reserving of unpaid claims, reinsurance, rebates, 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 contracted. Trend factors may vary by major category of service, geographic area, or rate cell, 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 an appropriate adjustment. An additional non-medical amount can be 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 rate cells.

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

Add an amount for State/Federal Taxes/Assessments — The final capitation rate, after all other components have been completed, is further adjusted to reflect any legislatively mandated State/Federal taxes and/or assessments. These adjustments are typically applied as a percent of final premium revenue, after non-medical loads are accounted for, and is added to the 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.

DHS will provide documentation, upon request, that addresses the actuarial soundness of the rates.

V. Methodology to Determine Risk Sharing Amount(s)

The amount that is applicable to the risk sharing program is the portion of the capitation rates used to fund the risk sharing program based on an analysis of data (FFS 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 risk sharing amounts which may vary by rate cell. Since any one year may reflect unusual occurrences, when available, multiple years of information may be reviewed and combined together. Since the data is generally historical in nature and the risk sharing amounts are applicable to the future capitation rates, the data must be trended and adjusted as necessary to coincide with the period in which the rates are contracted. These trends are estimates of the future costs and utilization 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 risk sharing amount 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 premium allowances. 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, variously detailed by geographic rating area, by rate cell, and/or by category of 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 rate cell, and by service group.

- The cost base detailed by utilization, unit costs and PMPMs (as applicable), by rate cell and by category of 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 "best estimate" 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 rate cell and/or service category.

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

- Average utilization, unit cost and/or PMPM trend rates by rate cell 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, "best estimate," and upper end of the range of actuarially sound rates determined by the Commonwealth's actuaries for each rate cell.

- 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. DHS will provide the MCO, upon request, documentation 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 Amount(s) (Where Applicable)

The amount that is attributable to a risk pool is the portion of the capitation rates used to fund a High Cost Risk Pool (HCRP) 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 risk pool amounts which may vary by rate cell. Since any one (1) year may reflect unusual occurrences, when available, multiple years of information may be reviewed and combined together. Since the data is generally historical in nature and risk pool(s) are applicable to the future capitation rates, the data must be trended and adjusted as necessary to coincide with the period in which the rates are contracted. These trends are estimates of the future costs and utilization of services provided. Given the programs' narrow specificity of risk and high per recipient cost, total risk pool costs may fluctuate substantially from year to year.

APPENDIX 3h

Medical Loss Ratio Reporting and Remittance Requirements

This appendix establishes requirements for the PH-MCO's responsibility to calculate and report their medical loss ratio (MLR) to the Department consistent with the 2016 Medicaid/CHIP Managed Care Final Rule requirements at 42 CFR §438.8. This appendix also establishes a requirement for remittance to the Department.

The reporting requirements in this appendix apply to each PH-MCO by calendar year (CY), starting with CY2017. The reporting requirements apply collectively to all Agreements the PH-MCO has with the Department to operate Physical Health (PH) HealthChoices (HC) programs during a CY. The PH-MCO must provide one report inclusive of all zones, rating periods and Agreements within a CY. The PH-MCO must not include revenue or costs that are not specific to the PH HC program.

I. Timing

The PH-MCO must submit the annual MLR report to the Department by November 30 of the following year. Example: the CY2017 report is due November 30, 2018.

II. MLR Reporting Year

Consistent with 42 CFR §438.8, the MLR reporting year is a 12-month period that aligns with the Department's HealthChoices PH rating period. The Department's current, standard rating period is a 12-month calendar year.

III. Contents of Annual MLR Report

The PH-MCO is to submit their MLR report containing at least the information outlined herein for the current MLR reporting year, consistent with the requirements in 42 CFR §438.8(k) or subsequently modified by CMS. The Department reserves the right to request additional information and/or require the use of a MLR report template.

1. Total incurred claims
2. Expenditures on quality improving activities
3. Recoveries through fraud reduction
4. Expenditures on fraud reduction
5. Non-claim costs
6. Premium revenue
7. Premium related taxes, licensing, and regulatory fees
8. Methodologies for allocation of expenditures

9. Any credibility adjustment applied
10. The calculated MLR (including numerator and denominator)
11. Any remittance potentially owed to the Department
12. A comparison of the MLR report information to the PH-MCO's audited financial report(s).
13. The number of member months
14. A description of the aggregation method used to aggregate data for all Medicaid eligibility groups covered under this Agreement

IV. New HealthChoices PH-MCOs

The Department, at its discretion, may exclude a PH-MCO that did not previously have a HC Agreement from these requirements for the first year of the PH-MCO's HealthChoices operations. However, the new PH-MCO will be required to comply with these requirements during the next MLR reporting year even if the first year of operations was not a full 12 months. For example, if a PH-MCO is new on July 1, 2017, the Department may exclude the new PH-MCO from completing the CY 2017 MLR reporting year's report, but the new PH-MCO will be required to complete the subsequent CY 2018 MLR reporting year's report.

V. MLR Numerator and Denominator

Detail of what is included and how the MLR numerator and denominator are computed can be found in 42 CFR §438.8(e) and (f) respectively. The PH-MCO is expected to comply with any additional requirements, guidance or instructions released by CMS that relate to the computation of the MLR as required in 42 CFR §438.8.

VI. Aggregate Medicaid Eligibility Groups

The Department requires the PH-MCO's MLR and MLR report is to be calculated as one aggregate value representing all HealthChoices Medicaid/Title XIX rate cells/populations and rating regions/zones combined that are covered under the HealthChoices Physical Health Agreements.

VII. Credibility Adjustment

Per 42 CFR §438.8(h), the PH-MCO has the option of adding a credibility adjustment to their reported MLR if the PH-MCO has sufficient member months to be partially credible, but not enough member months to be fully credible. The credibility adjustment is required for any remittance calculations. CMS will publish the table of credibility adjustments to be used. Fully credible plans may not use a credibility adjustment.

VIII. Remittance

Per 42 CFR §438.8(c) the Department has chosen a minimum MLR of 85.00 percent (85.00%). Per 42 CFR §438.8(j) for the CY 2017 MLR reporting year, the Department will not require a remittance. For subsequent MLR reporting years, the Department requires remittance. Settlement of a remittance obligation will be

due 75 calendar days after the annual report due date.

IX. Attestation

The PH-MCO must provide an attestation of the accuracy of the information provided in their submitted MLR report as required in 42 CFR §438.8(n) and consistent with 42 CFR §438.606. The attestation is due on the report due date.

X. Sub-Regulatory Guidance and Capitation Adjustments

These requirements are subject to change as CMS releases sub-regulatory guidance. If there are retroactive capitation adjustments these MLR reports may need to be updated. For more information about MLR calculations, please see 42 CFR §438.8.

XI. Continuation

If CMS issues MLR regulation that revises or replaces the citations in this appendix, the revised or replacement citations will apply. If CMS terminates the MLR report requirement or remittance option, this Appendix will continue to apply and the requirements will be defined as applicable by the citations even though they are no longer in effect or replacement citations issued by CMS. The Department may choose to waive any or all requirements.

HC Agreements
CY 2017 Amendment
Updated January 9, 2017

APPENDIX 3k

HIGH COST RISK POOL

This appendix is effective January 1, 2017

Overview

The Department will establish, administer, and distribute funds from three quarterly High Cost Risk Pools (HCRP).

Each quarterly risk pool will be funded through High Cost Risk Pool Allowance Amounts (HCRPAA). HCRPAAs are contained in Appendix 3f and provide for different amounts by zone and Medicaid Eligible Group (MEG). 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 for all Members included in each risk pool 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 PH-MCOs, in whole or in part.

High Cost Risk Pool Quarters

A High Cost Risk Pool Quarter is defined as a calendar quarter unless the HealthChoices program period covered by this Agreement ends mid-quarter. In this event the last High Cost Risk Pool Quarter will begin on the first day of the next-to-last calendar quarter and end on the last day of the program period covered by this Agreement. Example: The program period covered by this Agreement ends May 31, 2017. The last High Cost Risk Pool Quarter begins January 1, 2017 and ends May 31, 2017.

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.

HCRP Threshold

The HCRP Threshold is $80,000.

PH-MCO Inclusion/exclusion

A PH-MCO will participate in a zone's 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 months during the High Cost Risk Pool Quarter; and

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

  The Department will deem this criterion to have been met if it was met by the PH-MCO or by a PH-MCO that operated in the same HealthChoices zone ("Previous PH-MCO") if one of the following criteria 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 zone's quarterly HCRP, then:

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

- The PH-MCO has no opportunity to receive a distribution from that zone's quarterly HCRP; and

- The PH-MCO will not be required to contribute to that quarterly zone's 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 HCRPs.

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.

Calculation of Quarterly Funds in each Zone's Risk Pools

After each quarter has ended, the Department will determine the sum of the PH-MCO's HCRPAA obligation for the quarter for each MEG, 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 will be the total amount allocated to each HCRP for that quarter.

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 2017 HCRP is January-December 2016.

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 previous HealthChoices Agreement with the PH-MCO 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. These steps will be separately applied for the risk pool for each MEG. 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.

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

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 for the zone covered by this Agreement:

	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 March 1 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 March 1 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.

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APPENDIX 5

SPECIALTY DRUG RISK SHARING AND QUALITY RISK POOLS

This Appendix is effective January 1, 2016.

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.

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 allowance amounts 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 re-price covered drugs with a third party liability insurance (TPL)

based on the lower of the PH-MCO paid amount after TPL or the price provided by the Department on the drug list.

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 allowance 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.

If the PH-MCO does not operate a HealthChoices program in a zone under this Agreement throughout the complete settlement quarter, then the settlement quarter consists of the portion of the quarter in which the PH-MCO operates the program under this Agreement.

Risk sharing allowance

Specialty drug risk sharing allowance amounts are specified in Appendix 3f.

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

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 this risk sharing arrangement within fifteen work days of the notification:

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

- The Department may reduce each subsequent monthly capitation payment by the PH-MCO's specialty drug risk sharing obligation for the same month and future months (if applicable).

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

allowance amounts specified in Appendix 3f. There will be separate risk pools for the traditional HealthChoices population and Medicaid expansion members. The semi-annual quality risk pool periods will be January-June and July-December of each year, with the following exceptions.

- If the MCO's responsibility to operate a HealthChoices program within a zone per this Agreement ends on a date after January 1 and before June 30, the semi-annual quality risk pool period will extend from January 1 through the last day the MCO is responsible to operate a HealthChoices program per this Agreement. Example: The MCO's responsibility to operate a HealthChoices program per this Agreement ends March 31, 2017. The semi-annual quality risk pool period extends from January 1, 2017 through March 31, 2017.

- If the MCO's responsibility to operate a HealthChoices program within a zone per this Agreement ends on a date after June 30 and before September 1, the semi-annual quality risk pool period will extend from January 1 through the last day the MCO is responsible to operate a HealthChoices program per this Agreement. Example: The MCO's responsibility to operate a HealthChoices program per this Agreement ends August 31, 2017. The semi-annual quality risk pool period extends from January 1, 2017 through August 31, 2017.

- If the MCO's responsibility to operate a HealthChoices program within a zone per this Agreement ends on a date after August 31 and before December 31, the semi-annual quality risk pool period will extend from July 1 through the last day the MCO is responsible to operate a HealthChoices program per this Agreement. Example: The MCO's responsibility to operate a HealthChoices program per this Agreement ends September 30, 2017. The semi-annual quality risk pool period extends from July 1, 2017 through September 30, 2017.

- This provides for a potential exception to the language above. If all of the other PH-MCOs that are responsible to operate a HealthChoices program within a zone per Agreements that became operational on the same effective date as this Agreement are responsible to operate a HealthChoices program within the same zone per the same Agreement through the same, later date than the last date that this PH-MCO is responsible to operate a HealthChoices program within this zone per this Agreement, then the semi-annual quality risk pool period will end as of the date it ends for all of the other PH-MCOs. Example: The Department ends all Agreements in this zone as of July 31, 2017, but this PH-MCO cancels its Agreement as of April 30, 2017. The semi-annual quality risk pool for this PH-MCO ends July 31, 2017.

The Department will use the Covered Hepatitis C Drugs and pricing methodology that are specified for 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 SVRs it has obtained that document undetectable Hepatitis C RNA at least twelve weeks following completion of therapy.

The Department will allocate each SVR to one risk pool. The quality risk pool will be determined by the last date of service for a covered drug. The Department will not utilize an SVR if it utilized an SVR 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 not accept an SVR from the PH-MCO if neither of the following criteria is met:

- The PH-MCO has not paid for a Hepatitis C drug for the recipient after June 30, 2015.
- The recipient is not currently enrolled with the PH-MCO.

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 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 and payment for covered drugs, the credit will be allocated as follows:
    - 20% of one credit for notification of the SVR and
    - 80% of one SVR 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 date. Claims with dates of service more than 24 months prior to the SVR date are excluded.
    - Example:
        - MCO A submitted the SVR.
        - 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. MCO B gets 40% of the credit for this SVR.
- 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 allowance amounts for the PH-MCO for this semi-annual period will be charged as part of the financial settlement. Allowance amounts 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 the notification.

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

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.

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 this risk pool arrangement within fifteen work days of the final notification:

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

- The Department may reduce each subsequent monthly capitation payment by the PH-MCO's quality risk pool obligation for the same and future months (if applicable).

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 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, 2017 through December 31, 2017	Northwest Rate Region 1 Crawford, Erie, Forest, Mercer, Venango and Warren counties	Northwest Rate Region 2 Cameron, Clarion, Clearfield, Elk, Jefferson, McKean and Potter counties
TANF-MAGI < 2 Months	$218.00	$253.35
TANF-MAGI 2-11.999 Months	$11.14	$6.72
TANF-MAGI Ages 1-20	$1.74	$1.74
TANF-MAGI Ages 21+	$4.63	$5.43
SSI-HH-Other Disabled	$17.76	$18.66
Breast and Cervical Cancer	$15.99	$15.99
Newly Eligible Women Ages 19 to 44	$4.23	$4.23
Newly Eligible Women Ages 45 to 64	$20.90	$20.90
Newly Eligible Men Ages 19 to 44	$5.23	$5.23
Newly Eligible Men Ages 45 to 64	$19.83	$19.83

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.

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." 1101.32(a)(2)	Coverage Variations, Expanded coverage EPSDT Coverage Variations, Expanded Coverage School Medical Program for Medically Needy school children
1101.33(a) "…If the applicant is determined to be eligible, the Department issues Medical Services Eligibility (MSE) cards that are effective from the first of the month through the last day of the month..."	Recipient Eligibility, Verification of Eligibility (issuance of card)
1101.33(b)	Recipient Eligibility, Services restricted to a single provider
1101.51(a)	Responsibilities, Ongoing responsibilities of providers, Recipient freedom of choice of providers
1101.61	Fees and Payments, Reimbursement policies.
1101.62	Maximum fees
1101.63(b)(1) through (10)	Payment in full, Copayments for MA services
1101.63(c)	Payment in full, MA deductible
1101.64(b) "…Payment will be made in accordance with established MA rates and fees."	Third-party medical resources, Persons covered by Medicare and MA
1101.65	Method of payment
1101.67	Prior Authorization (including timeframes for notice)
1101.68	Invoicing for services
1101.69	Overpayment – underpayment (related to providers)
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)
1121.54(10)	Drugs prescribed in conjunction with sex reassignment procedures or other noncompensable procedures. As directed in MAB 99-16-11, this is inconsistent with the Federal Final Rule, "Nondiscrimination in Health Programs and Activities", and will no longer be applied.
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.")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1123.56(a)(1) through (3)	Vision aids. (“Payment for eyeglasses is made only if the recipient is 20 years of age or younger and the eyeglasses have been one of the following...”)
1123.56(b)(1) through(3)	Vision aids. (“Payment for low vision aids is made only if the recipient is categorically needy or if the recipient is medically needy and the low vision aid has been one of the following...”)
1123.56(c)	Vision aids. (“Payment for eye prostheses will be made only if the recipient is categorically needy.”)
1123.57(a) and (b)	Hearing aids. (Relating to payment for hearing aids only if recipient is 20 years of age or younger and have been prescribed through the EPSDT program, and for repairs to hearing aids owned by the recipient when the invoice is accompanied by an itemized statement.)
1123.58(1) and (2)	Prostheses and orthoses.
1123.60(a) through (i)	Limitations on payments.
1123.61 (1) through (8) and (10)	Noncompensable services and items. (Relating to when payment will not be made. (9) is not excluded, as it relates to items prescribed or ordered by a practitioner who has been barred or suspended during an administrative action from participation in the MA Program.)
1123.62	Method of payment.
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-86-02, Durable Medical Equipment Warranties.	
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 05-87-02, Coverage of Motorized Wheelchairs, with the following exceptions: - requiring Prior Authorization at the State level. - Page 2, number 7.	
Managed care organizations are to adhere to the provisions of Medical Assistance Bulletin 1123-91-01, EPSDT – OBRA ’89 with the following exceptions: - Page 3 – Vision Services – the “age of 21” and the MA fee schedule do not apply. - Page 3 – Dental Services – the “age of 21” and the MA fee schedule do not apply. - Page 3 – Hearing Services – the “age of 21” and the MA fee schedule do not apply. - Page 3 – “and use of existing Medical Assistance Program Fee Schedule”	
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-85-02, Policy Clarification for Services Provided to Hospitalized Recipients Under the DRG Payment System.	
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1126, Ambulatory Surgical Center and Hospital Short Procedure Unit Services, with the following exceptions:	
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
1150.56b	Payment Policy for Observation Services
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 2017 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® 2017, 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 2017. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2017, 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 ten (10) HEDIS® 2017 and one (1) 2017 Pennsylvania Performance Measure (PAPM) as quality indicators (representing CY 2016 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 eleven (11) 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
9. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
10. Medication Management for People With Asthma 75%

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 half 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 twelve (12) (Eleven (11) quality indicators with Annual Dental Visit counted twice). The Department will make Benchmark Performance payouts for performance relative to the HEDIS® 2017 (CY 2016) 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.d.). If the PH-MCO's HEDIS 2017 (CY 2016) performance rate is below the 50th Percentile Benchmark, the Department will implement a -50% off-set. The Department will distribute the payouts according to the following criteria:

a. All HEDIS® Measures

- HEDIS® 2017 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
- HEDIS® 2017 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
- HEDIS® 2017 rate at or above the 50th percentile and below the 75th percentile benchmark: 25 percent of the measure value.
- HEDIS® 2017 rate below the 50th percentile benchmark: -50% 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 -50% off-set will be applied to double the Benchmark Performance measure value (as identified in Section A.1).

c. Medication Management for People With Asthma 75%

- HEDIS® 2017 rate at or above the 90th percentile benchmark: 100 percent of the measure value.
- No penalty

d. 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 half 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 twelve (12) (Eleven(11) 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 2017 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® 2016 (CY 2015) to HEDIS® 2017 (CY 2016).

  - ≥ 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® 2016 (CY 2015) to HEDIS® 2017 (CY 2016) and PAPM 2016 (CY 2015) to PAPM 2017 (CY 2016).

  - ≥ 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, 2017. 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 2016 and June 2017. 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 2016 and June 2017, the Department will make a payment only per the terms of the more recent Agreement.

The Maximum Program Payout amount will be equivalent to two (2.0) 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 2016 through June 2017.

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 2016 through June 2017.

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 2016 through December 2016, 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 settlements that have been processed by the Department as of October 31, 2017.

MINUS The PH-MCO's Home Nursing Risk Sharing Withhold Amount obligation for the program period January 2016 through December 2016, 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 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

   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 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

   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 2017; 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 2017; 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, 2017, then the Department will use the best estimate in place of the actual payment/reduction.

5. *Specialty Drug Risk Sharing Revenue (SDRS). For the purpose of this Exhibit, SDRS revenue is defined as follows; revenue paid or payable by the Department to the PH-MCO in accordance with the Agreement (Appendix 5) for the 2016 SDRS service quarters offset by the SDRS withholds in Appendix 3f of the Agreement. This includes only SDRS settlements that have been processed by the Department as of October 31, 2017.*

6. *Hepatitis C Quality Risk Pool Revenue (HepCRP). For the purpose of this Exhibit, HepCRP revenue is defined as follows; revenue paid or payable by the Department to the PH-MCO in accordance with the Agreement (Appendix 5) for the 2016 HepCRP settlement periods offset by the HepCRP withholds in Appendix 3f of the Agreement. This includes only HepCRP settlements that have been processed by the Department as of October 31, 2017.*

If the Department has a payment obligation to the PH-MCO pursuant to this Exhibit B(1), the Department will issue the payment by August 31, 2018.

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 2018 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 2017. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2017, 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) 2017 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**- Re-stratification shall be conducted on all members in the targeted SPMI population. 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 all inpatient hospital admissions and will coordinate discharge and follow-up. This includes at a minimum the individual's member identification, the date of inpatient admission and name of the acute care hospital. Additional information sharing is encouraged 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 2017 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 2017 for the PH-MCO. The funding will be allocated to each PH-MCO according to its overall percent of HealthChoices member months for CY 2017.

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 previous measurement year of 2016 (HEDIS/PAPM 2017) to the current measurement year of 2017 (HEDIS/PAPM 2018).

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.

If the Department has a payment obligation to the PH-MCO and BH-MCO pursuant to this Exhibit B(2), the Department will issue the payment by August 31, 2019.

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 per 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 per 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** ten (10) HEDIS Quality Measures (per HEDIS® 2017 Technical Specifications, Vol. 2), one (1) PA Performance Measure (PAPM) and one (1) Electronic Quality Measure:

HEDIS®

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 that must be based on preventive dental services. The incentives must be structured to pay defined minimal amounts to dentists for performing episodes of preventive care for new and established recipients in at least two age bands- (0-5 years and 6-20 years). The specific incentive model will be relatively uniform across the HealthChoices program. The incentive model will be determined by the Department in cooperation with all HealthChoices PH-MCOs.
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. Medication Management for People With Asthma 75%
10. Ambulatory Care – ED Visits

PAPM

1. Reducing Potentially Preventable Readmissions

Electronic Quality Measure

1. Payment for electronic submission of any mandatory 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 is required to develop and submit a proposal to the Department prior to implementing its QPP. PH-MCO must complete and submit proposals using Exhibit B(3)(b), the QPP Submission Template. Proposals are due no later than December 1, 2016 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 Exhibit B(3)(a), Provider P4P Submission Change form; and
9. Attestation from the Medical Director.

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

business on the last day of each calendar quarter. No other revisions to the QPP will be accepted.

D. 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. The Department has provided a Template on DocuShare with the format required for the QPP Effectiveness Report.

E. 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 is to be 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 hygiene practitioners (PHDHPs), 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. The PH-MCO will be required to implement a public health dental hygiene practitioner (PHDHP) program or a dental hygienist program under the direct supervision of a dentist using CBCM funding. The hygienists must spend the majority of their time performing direct patient preventive care.

G. 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.

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

I. 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, 2016** and must be submitted to the appropriate folder in Docushare using Exhibit 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, 2017 through December 31, 2017.
   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.

J. A PH-MCO's approved CBCM program will remain in effect until December 31 of each calendar year. The PH-MCO may only submit one quarterly revision for the Department's review and approval. The PH-MCO must complete and submit Exhibit B(3)(d), CBCM Proposal Change Form, that is available on Docushare. Changes must be submitted no later than close of business on the last day of each calendar quarter. No other revisions will be accepted.

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. 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.

C. 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. With approval by the Department, funds provided to the PH-MCO per this Exhibit for this year or a prior year may be used to support an initiative to improve access to care.
4. 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.
5. Payments for the CBCM program cannot exceed more than 110.0 percent (110.0%) of the approved budget, as identified in Section II.I.6 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.I.1 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.

2. The PH-MCO is required to meet the Department's reporting requirements for the submission of an annual analysis of the effectiveness of its approved QPP. The Department has provided a template to the PH-MCO with the requirements for completing this report.

B. Community Based Care Management

1. All PH-MCO must submit an analysis of their Comprehensive Care 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 Comprehensive Care Management 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).

Upon the request of the Department, the PH-MCO must submit a financial report with payment activity for all approved CBCM programs.

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 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.

8. The PH-MCO will report all identified provider-preventable conditions in the form and frequency detailed in the MCO Operations Reporting Requirements on Docushare.

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 G

OPIOID USE DISORDER CENTERS OF EXCELLENCE

General Information

OMAP will implement twenty Opioid Use Disorder Centers of Excellence (OUD-COE) through the physical health HealthChoices program. These Centers of Excellence will be buprenorphine/naltrexone prescribing physical health (PH) organizations. This initiative will increase the capacity to care for those seeking treatment for OUD, as well as increase the quality of care. Each OUD-COE will be given funding of $500,000 to perform the following requirements:

- deploying a community-based care management team,
- tracking/reporting aggregate outcomes,
- meeting defined referral standards for drug and alcohol as well as mental health counseling,
- reporting on standard quality outcomes, and
- participating in a learning network.

The majority of the OUD-COE payments will be for care management/coordination of individuals with OUD. The OUD-COE will be expected to provide clinical expertise to the wider provider community in a “hub and spoke” model of care. Each OUD-COE is expected to expand capacity to at least 300 new patients within 12 months. The OUD-COEs must collect and report quality outcomes to the HealthChoices MCOs and OMAP. OMAP will select the Centers of Excellence through an application process in consultation with the HealthChoices Managed Care Organizations (MCOs).

Specific requirements of MCO

The MCO must contract with all selected OUD-COEs within the regions in which they operate, unless the MCO demonstrates to OMAP’s satisfaction that the MCO is not able to reach a contractual agreement with the OUD-COE. The MCO must collaborate with each OUD-COE to coordinate care, collect aggregate quality measures, and develop a regional and statewide learning network.

A regional learning network will be developed with all MCOs and OUD-COEs in each HealthChoices region. All OUD-COEs and MCOs will participate and support a statewide learning network. They will also support a statewide telephonic peer to peer consultative service from an addiction specialist team to OUD providers within the COEs and their respective communities.

The MCO will work with the OUD-COE care management team to obtain written patient consent to share OUD related information that is compliant with state and federal laws and regulations. Once consent is obtained the MCO will work collaboratively with the appropriate behavioral health MCO to coordinate comprehensive services. The MCO will work with the COE to report all care management activity to OMAP through the operations 15 report. The MCO must develop value based payment models that reward high quality of care delivered within the OUD-COE. The MCO must assure each OUD-COE is compliant with the specific requirements listed below.

Specific requirements of COE's

General requirements.

- All OUD Centers of Excellence (OUD-COEs) organizations must be enrolled as a Medical Assistance provider.
- All OUD-COEs must attest that they will not charge Medical Assistance recipients cash for any OUD related services.
- All OUD-COEs must have and make use of an Electronic Health Record within 18 months of being designated an OUD-COE.
- It is highly recommended but not required that the OUD-COE obtain a patient centered medical home (PCMH) certification from an accredited organization within 18 months of being designated an OUD-COE.

Community based care management teams.

The OUD-COE must deploy a community based care management (CBCM) team that consists of licensed and unlicensed professionals. The CBCM team's activities must not overlap or be redundant to already existing reimbursed care management services. The care management team must work within their local community to accept warm hand offs of individuals with OUD from local emergency departments, state and county corrections facilities, and from primary care providers. They must also work with inpatient and outpatient residential drug and alcohol providers to assure individuals living with OUD transition from that level of care to the COE for ongoing engagement in treatment. The CBCM team will motivate and encourage individuals with OUD to stay engaged in both physical health and mental health treatments. They will facilitate recovery by helping individuals find stable housing, employment, and reestablishing family/community relationships. The CBCM team will be responsible for obtaining written consent for individuals with OUD for sharing pertinent information with the physical health and behavioral health MCOs.

Tracking/reporting access to care and quality outcomes.

Each COE must track and internally report, at a minimum, the following metrics at an individual and aggregate level. This is not meant to be a comprehensive list of quality outcome measures. These measures must be reported to OMAP and to each MCO at least semi-annually at an aggregate level.

- number of individuals initiated in treatment and engaged for 30, 60, 90,180, 365 days,
- number of individuals seen within 1 business day of referral,
- percent of individuals diagnosed and referred for mental health conditions,
- percent of individuals receiving drug and alcohol counseling,
- percent of individuals referred for comprehensive pain management treatment,
- percentage of individuals concomitantly taking benzodiazepines or prescription opiates,
- a time series survey for quality of life and movement towards recovery for each individual, and
- an annual validated patient satisfaction survey.

Participation in a learning network.

Each COE will be expected to use up to $15,000 of the funding for the following:

- participate in a learning network that will include OUD treatment operational implementation and complex case based learning similar to the New Mexico ECHO learning model,
- establish a peer to peer telephonic consultative model where an addiction specialist is available for rapid support and advice,
- collaborate with local primary care providers to educate about screening, referral and treatment for OUD, share best practices between COEs, and work with telemedicine psychiatry providers in rural areas to increase the referral for appropriate treatment of behavioral health conditions.

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, case 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 initiating the credentialing process if the provider does not have an MAID number that is issued by the Department. However, the PH-MCO cannot complete the credentialing process until the provider has received its MAID number from the Department.

3) Provider applications submitted to the PH-MCO for credentialing must be completed within sixty (60) days of receipt of the application packet if 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 time-frames outlined in the Agreement 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, Outpatient Drug Services.

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) All other aspects of patient care.

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. 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.

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.

3) 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 and 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.5, 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 M(2)

EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1902(a), (30), (c) 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. The requirements for EQR were further outlined in 42 CFR Parts 433 and 438; External Quality Review of Medicaid Managed Care Organizations; Final Rule issued on May 6, 2016. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members. "Quality", as it pertains to EQR, means the degree to which a PH-MCO maintains or improves the health outcomes of its Members through its structural and operational characteristics and through the provision of services. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight. The Department requires that the PH-MCOs:

A. Actively participate in planning and developing the measures to be utilized with the Department and the EQRO. The Medical Assistance Advisory Committee will be given an opportunity to provide input into the measures to be utilized.

B. Accurately, completely and within the required timeframe identify eligible Members to the EQRO.

C. Correctly identify and report the numerator and denominator for each measure.

D. Actively encourage and require Providers, including subcontractors, to provide complete and accurate Provider medical records within the timeframe specified by the EQRO.

E. Demonstrate how the results of the EQR are incorporated into the Plan's overall Quality Improvement Plan and demonstrate progressive improvements during the term of the contract.

F. Improve Encounter Data in an effort to decrease the need for extensive Provider medical record reviews.

G. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.

H. Ensure that data, clinical records and workspace located at the PH-MCO's work site are available to the independent review team and to the Department, upon request.

I. Participate in Performance Improvement Projects (PIPs) whose target areas are dictated by the Department to address key quality areas of focus for improvements. The PH-MCO will comply with the timelines as prescribed by the EQRO.

EXHIBIT M(4)

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

HEDIS is a set of standardized performance measures designed to reliably compare health plan performance. HEDIS performance measures are divided into five domains of care:

- Effectiveness of care,
- Access/availability of care,
- Experience of care (Adult and Child CAHPS),
- Utilization and Relative resource use, and
- Health plan descriptive information,

The Department requires that the PH-MCOs:

A. Must produce rates for all Medicaid reporting measures, with the exclusion of the behavioral health measures, unless otherwise specified by the Department.

B. Must follow NCQA specifications as outlined in the HEDIS Technical Specifications clearly identifying the numerator and denominator for each measure.

C. Must have all HEDIS results validated by an NCQA-licensed vendor. The Department currently contracts with an NCQA-licensed entity to validate the MCOs' HEDIS results used in public reporting. The MCO may utilize these validation results for other purposes such as pursuit of accreditation. The Department may at some future date relinquish the direct contracting of NCQA validation activities.

D. Must assist with the HEDIS validation process by the Department's NCQA licensed contractor.

E. Must demonstrate how HEDIS results are incorporated into the MCO's overall Quality Improvement Plan.

F. Must submit validated HEDIS results annually on June 15th unless otherwise specified by the Department.

Measures publicly reported in the HealthChoices Consumer Guide are based on the Department's NCQA-licensed organization's validated findings.

EXHIBIT M(4)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (Adult and Child) are subsets of HEDIS reporting required by the Department. For HEDIS, MCOs must contract with an NCQA-certified vendor to administer the survey according to the HEDIS survey protocol that is designed to produce standardized results. The survey is based on a randomly selected sample of Members from the MCO and summarizes satisfaction with the experience of care through ratings and composites.

In addition to the Adult survey, HEDIS incorporates a CAHPS survey of parental experiences with their child's care. The separate survey is necessary because children's health care frequently requires different Provider Networks and addresses different consumer concerns (e.g. child growth and development).

The HEDIS protocol for administering CAHPS surveys consists of a mail protocol followed by telephone administration to those not responding by mail. MCOs must contract with a certified vendor to administer both the Adult and Child CAHPS surveys. The MCO must generate a sample frame for each survey sample, and arrange for an NCQA-certified auditor to verify the integrity of the sample frame before the certified vendor draws the sample and administers the survey. The MCOs are also required to have the certified vendor submit Member level data files to NCQA for calculation of HEDIS CAHPS survey results. The Department requires that the MCOs:

A. Must conduct both an Adult and Child CAHPS survey using the current version of CAHPS.

B. Must include all Medicaid core questions in both surveys.

C. Must add the following supplemental dental care questions, one through three, from the Supplemental Items for Adult/Child Questionnaires to both the Adult and Child CAHPS surveys and questions four through seven to the Child CAHPS survey:

1. C1.In the last 6 months, did you get care from a dentist's office or dental clinic?
   1) Yes
   2) No

2. C2. In the last 6 months, how many times did you go to a dentist's office or dental clinic?
   1) None (If None, the Adult dental questions are complete. Thank you.)
   2) 1
   3) 2
   4) 3
   5) 4

6) 5 to 9
7) 10 or more

3. C3. We want to know your rating of all your dental care from all dentists and other dental providers in the last 6 months. Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate your dental care?

1) 0 Worst dental care possible
2) 1
3) 2
4) 3
5) 4
6) 5
7) 6
8) 7
9) 8
10) 9
11) 10 Best dental care possible

Additional Child CAHPS dental questions:

4. D1. In the last six months, did your child get care from a dentist's office or dental clinic?

1) Yes
2) No

5. D2. In the last six months, how many times did your child go to a dentist's office or dental clinic?

1) None
2) 1
3) 2
4) 3
5) 4
6) 5 to 9
7) 10 or more

6. D3. We want to know your rating of your child's dental care from all dentists and other dental providers in the last six months. How would you rate your dental care (on a scale of 0 to 10)?

1) 0 Worst dental care possible
2) 1
3) 2
4) 3
5) 4
6) 5
7) 6

8) 7
9) 8
10) 9
11) 10 Best dental care possible

7. D4. Which of the following would help your child see the dentist more often?
   1) Help with transportation to the dentist
   2) Reminders to visit the dentist
   3) More dentists to choose from
   4) More convenient office hours
   5) Dentists that speak my language
   6) Help in finding a dentist
   7) Better communication about benefits from my child's health plan
   8) Education about good dental care
   9) None of the above. My child sees the dentist as often as I like.
   10) Other (write in)

D. Must forward CAHPS data to the Department both electronically and hardcopy in an Excel file in the format determined by the Department.

E. Must submit validated CAHPS results annually on June 15th unless otherwise specified by the Department.

The Department annually releases an Ops Memo that contains detailed information regarding the submission of HEDIS and CAHPS.

EXHIBIT O

Description of Facilities and Related Services

Intermediate Care Facility For Individuals with Intellectual Disabilities And Other Related Conditions (ICF/ID/ORCs)

The PH-MCO is responsible to provide the full range of Physical Health Services to Members residing in private ICF/ID/ORC, except that the PH-MCO is not responsible to provide services to a Recipient to the extent services are covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCO.

Residential Treatment Facility (RTF)

The PH-MCO is responsible to provide the full range of Physical Health Services to Members residing in RTFs. The PH-MCO is not responsible to provide any services that are currently covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

Extended Acute Psychiatric Facility

The PH-MCO is responsible to provide the full range of physical health services to Members residing in extended acute psychiatric facilities. The PH-MCO is not responsible to provide any services that are currently covered under the facilities per diem payment. The PH-MCO is also not responsible to provide any services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

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

The PH-MCO is responsible to provide the full range of physical health services to Members admitted to non-hospital residential detoxification, rehabilitation and halfway house facilities for drug/alcohol dependence/addiction. The PH-MCO is not responsible to provide any services that are currently covered under the facilities per diem payment. The PH-MCO is also not responsible to provide any services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

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

An OPTIONS Assessment must be completed to assess an individual's need for Nursing Facility services. The PH-MCO must contact the county AAA to initiate the OPTIONS assessment. This must occur prior to a Member's admission to a Nursing Facility. The PH-MCO must abide by the decision of the OPTIONS assessment related to the need for Nursing Facility services. The PH-MCO is not responsible for providing or paying for the OPTIONS assessment.

The PH-MCO must also comply with pre-admission screening requirements contained in 42 U.S.C. Section 1396r(e)(7) and 42 CFR 483.100-483.138 regarding individuals with Mental Retardation/Other Related Conditions or mental illness.

Pennsylvania (PA) Aging Waiver

The PA Aging waiver targets individuals age 60 and older who require Nursing Facility services, but who can safely be served in a community setting. However, the costs for this care may not exceed 80% of the average cost of a Nursing Facility. Individuals wishing to enter the waiver program must meet the current financial waiver requirements (300% of the SSI federal benefit rate) and choose to receive services in their own home or other community settings.

The PA Aging waiver program is operated by the AAA in selected counties in the HealthChoices Zone. It is the responsibility of the AAA to notify the PH-MCO should one of their Members become eligible for the PA Aging waiver program. The PH-MCO will remain financially responsible for the Member and continue to provide medical services, including waiver program medical services, for 30 consecutive days from the date the Member becomes eligible for the PA Aging waiver services. However, the PH-MCO will not be responsible for non-medical PA Aging waiver services during this 30 consecutive day period. The Member will then be disenrolled from the PH-MCO.

The PH-MCO must coordinate all requested medical services with the AAA to ensure continuity, as well as quality of care and to avoid duplication of services.

Members Admitted to Juvenile Detention Centers (JDCs)

Any child receiving MA benefits will continue to receive those benefits during placement in a JDC. Children enrolled in a PH-MCO prior to placement at a JDC either inside or outside the HealthChoices Zone will continue to be covered by the PH-MCO from the date of placement for a maximum of 35 consecutive days. The child will be disenrolled from the PH-MCO after the 35th consecutive day of placement. During the 35 consecutive days, MA eligible services provided to the child on-site at the JDC will be covered under the Medical Assistance Fee-for-Service Program. Any services that are covered by the PH-MCO and provided outside of the JDC site are the responsibility of the PH-MCO. Should a child either be voluntarily disenrolled from a PH-MCO or become ineligible for enrollment due to a change in status, coverage of the child will remain consistent with enrollment

policies. If during the period of placement the child transfers from one PH-MCO to another, the child will receive benefits through the new PH-MCO from the new PH-MCO effective date through the 35th consecutive day of placement.

A child already residing in a JDC will not be permitted to newly enroll in a PH-MCO until after release from the JDC. All other applicable coverage rules will apply.
EPSDT screening results or other health care needs detected during the period of the JDC placement should be reported to the effective PH-MCO. Should a covered service be identified that cannot be provided at the JDC site, the JDC must contact the PH-MCO in order to arrange for the covered service to be provided.

Dual Eligibles (Medicare/Medicaid) under the age of twenty - one

Recipients, under the age of twenty-one who receive both Medicare as their primary health care coverage and Medicaid (MA) as a supplemental coverage, will be required to enroll in the HealthChoices Program and choose both a PH-MCO and PCP within the PH-MCO. See Section V.F., Member Enrollment and Disenrollment, of the Agreement for enrollment information into HealthChoices Zone.

Due to their Medicare eligibility, many of these recipients may require special assistance with the coordination of their Medicare/Medicaid benefits. Therefore, these dually eligible Recipients are classified as having Special Needs and should fall under the guidelines outlined in Section V.P., Special Needs Unit (SNU), of the Agreement.

Recipients who are dually eligible are not required to go to their PH-MCO for services that are covered by Medicare. If appropriate, Recipients who are Dual Eligible are required to comply with the PH-MCO's referral and authorization requirements if they have exhausted their Medicare benefit for a Medicare covered service.

The PH-MCO is responsible to provide prescriptions written by Medicare Providers for a Member as long as the Member goes to a pharmacy within the PH-MCO's Provider Network. Prescription coverage for Recipients who are dually eligible is subject to the PH-MCO's authorization protocols, with the exception of drugs covered by Medicare. In addition, the provisions outlined in Section V.B., Prior Authorization of Services, of this Agreement, will apply.

The PH-MCO's financial responsibility for Dual Eligibles is outlined in Section VII. of the Agreement.

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
List of Active and Closed Providers (PRV415)	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 (PRV414)	File of enrolled MA Providers in Pennsylvania and the surrounding states and providers closed within the last 90 days.	Weekly
NPI Crosswalk File (PRV430)	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
Provider Revalidation File (PRV720)	File of all open service locations with a revalidation date in the next 90 days, and expected closure dates.	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 via the Special Needs Unit Hotline 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. 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.

32. 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.

33. How to obtain emergency transportation and Medically Necessary transportation. Provide the names and telephone numbers for county MATP providers.

34. 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.

35. How and where to access behavioral health, family planning and vision services.

36. Information on how to obtain prescription drugs, including information on the PH-MCO's formulary and how to request a copy.

37. Information on what to do regarding out of county/out of state moves.

38. Contributions the member can make towards his/her own health.

39. 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.

40. Notification that the selection of certain PCP sites may result in medical residents, nurse practitioners and physicians assistants providing care to Members.

41. Information regarding the availability of second opinions and when and how to access them.

42. 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.

43. 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.

44. Information regarding the Women's, Infants' and Children (WIC) Program and how to access the Program.

45. Information regarding HIV/AIDS programs and how to access them.

46. Information on Tobacco Cessation Programs and how to access them.

47. 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.

48. A statement that all Members will be treated with respect and due consideration for his or her dignity and privacy.

49. 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.

50. A statement that Members have the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

51. 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.

52. 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.

53. 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.

54. The Department's MA Provider Compliance Hotline number and explanatory statement.

EXHIBIT GG

COMPLAINT, GRIEVANCE AND DHS FAIR HEARING PROCESSES

A. General Requirements

1. The PH-MCO must obtain the Department's prior written approval of all Complaint, Grievance and DHS Fair Hearing policies and procedures.

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 and must make these policies and procedures 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 provide Members with 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 have 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. The PH-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech

limitation of 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 require 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 required template. The PH-MCO must mail this notice 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 or item was provided without authorization by a Provider not enrolled in the Pennsylvania MA Program using the required template (template GG(11)). The PH-MCO must mail this notice 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 required template (template GG(12)). The PH-MCO must mail this notice 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 required template. The PH-MCO must mail this notice 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 required template (template 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.

22. The PH-MCO must use the templates (Template GG(1) through GG(14b)), which are available on the HealthChoices Intranet site.

B. Complaint Requirements

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. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member. The PH-MCO must provide the written confirmation 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 MA 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 any, an acknowledgment letter using the required template (templates GG(2a) or 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 required template (template GG(14a) or GG(14b)). If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity to communicate with the first level Complaint review committee by telephone or videoconference. 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 required template , to the Member, Member's representative, if any, 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 MA 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 any, an acknowledgment letter using the required template (template 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 required template (template GG(14a) or GG(14b)). If the Member cannot appear in person at the second level Complaint review, the PH-MCO must provide the opportunity to communicate with the second level Complaint review committee by telephone or videoconference. 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.

j. 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.

k. The PH-MCO must send a written notice of the second level Complaint decision, using the required template (template GG(5)) to the Member, Member's representative, if any, service Provider and prescribing Provider, if applicable within five (5) Business Days from the second 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 an external review of the second level Complaint decision with either the DOH or PID within fifteen (15) days from the date the Member receives the written notice of the PH-MCO's second level Complaint decision.

m. 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 MA 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 DOH or PID, the PH-MCO must transmit all records from the first level review and second level review to the requesting department 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 DOH and PID 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 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 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 required template (template 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 required template (template 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 DOH guidelines relating to submission of requests for expedited external reviews.

k. The PH-MCO may not take punitive action 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

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. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member and must provide the written confirmation 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 required template (template 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 may 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 required template (template GG(14a) or GG(14b)). If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity to communicate with the first level Grievance review committee by telephone or videoconference. 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.

m. The PH-MCO must send a written notice of the first level Grievance decision, using the required template (template 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.

n. 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.

o. 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 required template (template 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 required template (template GG(14a) or GG(14b)). If the Member cannot appear in person at the second level review, the PH-MCO must provide an opportunity to communicate with the second level Grievance review committee by telephone or videoconference. 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 required template (template 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 DOH. 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. The PH-MCO must process all requests for external Grievance review. The PH-MCO must follow the protocols established by the DOH 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 DOH 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, DOH randomly assigns a CRE to conduct the review. The PH-MCO and assigned CRE entity will be notified of this decision.

f. If DOH 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 DOH. 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. The PH-MCO must transmit this information 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 required template (template 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 required template (template 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 DOH guidelines relating to submission of requests for expedited external reviews.

k. The PH-MCO may not take punitive action 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

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 a 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 MA 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 BHA 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. BHA must issue final administrative action within ninety (90) days of the receipt of the request for a DHS Fair Hearing after the original denial or after the second (2nd) level denial. In the case where the Fair Hearing is requested after the first (1st) level denial, BHA must issue a decision within ninety (90) days of the receipt of the request for a PH-MCO complaint or grievance, not including the number of days the enrollee took to subsequently file 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.

i. BHA adjudication is binding on the PH-MCO unless reversed by the Secretary of DHS. 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 final administrative action 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 BHA 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. BHA 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. BHA adjudication is binding on the PH-MCO unless reversed by the Secretary of DHS. 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 BHA 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, the PH-MCO must authorize or provide the disputed services/items pending reconsideration unless the PH-MCO requests a stay of the BHA decision and the stay is granted.

2. If the PH-MCO or BHA 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 KK

REPORTING SUSPECTED FRAUD AND ABUSE TO THE DEPARTMENT

The following requirements are adapted from 55 PA Code §1101, General Regulations for the Medical Assistance Program, specifically 55 PA Code §1101.75(a) and (b), Provider Prohibited Acts, which are directly adapted from the 62 PS §1407, (also referred to as Act 105 of 1980, Fraud and Abuse Control Act) and Federal Regulations 42 CFR §§ 438.608(a)(7-8) and 455.23(a).The basis for Recipient referrals is 55 PA Code §1101.91 and §1101.92, Recipient Misutilization and Abuse and Recipient Prohibited Acts. For information on these regulations, go to http://www.pacode.com.

Reporting Requirements:

PH-MCOs are required to report to the Department any act by Providers/Recipients/Caregivers/Employees that may affect the integrity of the HealthChoices Program under the Medical Assistance Program. Specifically, if the PH-MCO suspects that either Fraud, Abuse or Waste (as discussed in Section V.O.6, Fraud and Abuse, of the Agreement) may have occurred, the PH-MCO must report the issue to the Department's Bureau of Program Integrity (BPI). The PH-MCO must have a process to notify BPI of any adverse actions and/or provider disclosures taken during the credentialing/re-credentialing process. Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review or suspend payments to avoid unnecessary expenditures during the review process.

PH-MCOs are also required to report quality issues to the Department for further investigation. Quality issues are those which, on an individual basis, affect the Recipient's health (e.g. poor quality services, inappropriate treatment, aberrant and/or abusive prescribing patterns, and withholding of Medically Necessary services from Recipient).

All Fraud, Abuse, Waste or quality referrals must be made within thirty (30) days of the identification of the problem/issue. The PH-MCO must send to BPI all relevant documentation collected to support the referral. Such information includes, but is not limited to, the materials listed on the "Checklist of Supporting Documentation for Referrals" located at the end of this exhibit. The Fraud and Abuse Coordinator, or the responsible party completing the referral, should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form to indicate the supporting documentation that is sent with each referral. A copy of the completed checklist and all supporting documentation should accompany each referral. Any egregious situation or act (e.g. those that are causing or imminently threaten to cause harm to a Member or significant financial loss to the Department or its agent) must be referred immediately to the Department's Bureau of Program Integrity for further investigation.

Failure to comply with the requirements of Exhibit KK will result in sanctions and or corrective action as stated in the HealthChoices Agreement. The Department must suspend all Medicaid payments to a provider after a determination that there is a credible allegation of fraud for which an investigation is pending against an individual or entity unless the Department has good cause not to suspend payments or to suspend payments

in part. (42 CFR 455.23 (a)). Upon notification from the Department of the imposition of a payment suspension, the PH-MCO, at a minimum, must also suspend payments to the provider.

The following processes are required for Provider/Caregiver and Employee referrals, unless prior approval is received from BPI. Reports must be submitted online using the PH-MCO Referral Form. The instructions and form templates are located athttps://dpwintra.dpw.state.pa.us/HealthChoices/custom/program/fraud/fraud.asp > Once completed, the form must be submitted electronically to BPI. The following information must be faxed to 717-772-4638 or mailed to the below address:

- Checklist of Supporting Documentation for Referrals, accessible on the PH-MCO Referral Form,
- A copy of the confirmation page which will appear after the "Submit" button is clicked, submitting the PH-MCO Referral Form, and
- All supporting documentation. Referrals will not be processed, but will be returned for further development if they are received without all supporting documentation.

Attn: Division Director
Department of Human Services
Bureau of Program Integrity - DPPC
P.O. Box 2675
Harrisburg, PA 17105-2675

All suspected member fraud, abuse and/or waste should be reported directly to the Bureau of Program Integrity's Recipient Restriction Section by the PH-MCO's Recipient Restriction Coordinator using the established restriction referral process.

In the event member fraud is suspected but the criteria for restriction is not met, the PH-MCO's Restriction Coordinator should forward all supporting documentation, including a narrative description of the alleged fraud, to the Department's Recipient Restriction Section.

All subsequent information should also be sent to the Recipient Restriction Section at:

Department of Human Services
Bureau of Program Integrity
Recipient Restriction Program
P.O. Box 2675
Harrisburg, PA 17105-2675
717-772-4627 (office)
717- 214-1200 (fax)

Checklist of Supporting Documentation for Referrals

- All referrals should have the confirmation page from online referral attached.
- Please check the appropriate boxes that indicate the supporting documentation included with your referral.

Example of materials for provider, caregiver or staff person referrals –

☐ confirmation page from online referral
☐ encounter forms (lacking signatures or forged signatures)
☐ timesheets
☐ attendance records of recipient
☐ written statement from parent, provider, caregiver, recipient or other individual that services were not rendered or a signature was forged
☐ progress notes
☐ internal audit report
☐ interview findings
☐ sign-in log sheet
☐ complete medical records
☐ résumé and supporting résumé documentation (college transcripts, copy of degree)
☐ credentialing file (DEA license, CME, medical license, board certification, Department of Health certification, Medicare certification)
☐ copies of complaints filed by members
☐ admission of guilt statement
☐ other: _____

Example of materials for pharmacy referrals –

☐ paid claims
☐ prescriptions
☐ signature logs
☐ encounter forms
☐ purchase invoices
☐ EOB's
☐ delivery slips
☐ licensing information
☐ other: _____

Example of materials for RTF referrals –

- ☐ complete medical records
- ☐ discharge summary
- ☐ progress notes from providers, nurses, other staff
- ☐ psychological evaluation
- ☐ other: _____

Example of materials for behavioral health referrals –

- ☐ complete medical and mental health record
- ☐ results of treatment rendered/ ordered, including the results of all lab tests and diagnostic studies
- ☐ summaries of all hospitalizations
- ☐ all psychiatric examinations
- ☐ all psychological evaluations
- ☐ treatment plans
- ☐ all prior authorizations request packets and the resultant prior authorization number
- ☐ encounter forms (lacking signatures or forged signatures)
- ☐ plan of care summaries
- ☐ documentation of treatment team or Interagency Service Planning Team meetings
- ☐ progress notes
- ☐ other: _____

Example of materials for DME referrals –

- ☐ orders, prescriptions, and/or certificates of medical necessity (CMN for the equipment)
- ☐ delivery slips and/or proof of delivery of equipment
- ☐ copies of checks or proof of copay payment by recipient
- ☐ diagnostic testing in the records
- ☐ copy of company's current licensure
- ☐ copy of the Policy and Procedure manual applicable to DME items
- ☐ other: _____

EXHIBIT LL

GUIDELINES FOR SANCTIONS REGARDING FRAUD, WASTE AND ABUSE

The Department recognizes its responsibility to administer the HealthChoices Program and ensure that the public funds which pay for this program are properly spent.

To maintain the integrity of the HealthChoices Program and to ensure that PH-MCOs comply with pertinent provisions and related state and federal policies, including rules and regulations involving Fraud, Waste and Abuse issues, the Department will impose sanctions on the PH-MCOs as deemed appropriate where there is evidence of violations involving Fraud, Waste and Abuse issues in the HealthChoices Program. To that end, program compliance and improvement assessments, including financial assessments payable to BPI, will be applied by BPI for the PH-MCO's identified program integrity compliance deficiencies. Note that the Department also retains discretion to impose additional remedies available under applicable law and regulations.

FRAUD, WASTE AND ABUSE ISSUES WHICH MAY RESULT IN SANCTIONS

The Department may impose sanctions, for non-compliance with Fraud, Waste and Abuse requirements which include, but are not limited to, the following:

A. Failure to implement, develop, monitor, continue and/or maintain the required compliance plan and policies and procedures directly related to the detection, prevention, investigation, referral or sanction of Fraud, Waste and Abuse by providers, caregivers, members or employees.

B. Failure to cooperate with reviews by oversight agencies or their designees, including the Department, Office of Attorney General, Office of Inspector General of the U.S. DHHS, and other state or federal agencies and auditors under contract to CMS or the Department 42 CFR §438.3(h).

C. Failure to adhere to applicable state and federal laws and regulations.

D. Failure to adhere to the terms of the HealthChoices Agreement, and the relevant Exhibits which relate to Fraud, Waste and Abuse issues.

E. If a PH-MCO fails to provide the relevant operating agency, upon its written request, encounter data, claims data and information, payment methodology, policies and/or other data required to document the services and items delivered by or through the PH-MCO to Members 42 CFR §438.604.

F. PH-MCO engaging in actions that indicate a pattern of wrongful denial of payment for a health-care benefit, service or item that the organization is required to provide under its agreement.

G. If a PH-MCO or associate fails to furnish services or to provide members a health benefit, service or item that the organization is required to provide under its Agreement 42 CFR § 438.700(b)(1).

H. PH-MCO engaging in actions that indicate a pattern of wrongful delay of at least for 45 days or a longer period specified in the Agreement (not to exceed 60 days) in making payment for a health-care benefit, service or item that the organization is required to provide under its Agreement.

I. Discriminating against Members or prospective Members on any basis including without limitation, age, gender, ethnic origin or health status 42 CFR §438.3(d)(3-4)

J. Credible allegations of fraud for which investigation is pending under the Medicaid program against an individual, a provider, or other entity 42 CFR §455.23(a)

K. PH-MCO failure to pay overpayments to DHS as identified through network provider audits, reviews, investigations conducted by BPI or its designee and other state and federal agencies.

RANGE OF SANCTIONS

The Department may impose any of the sanctions indicated in Section VIII.H. of the Agreement including, but not limited to, the following:

A. Preclusion or exclusion of the PH-MCO, its officers, managing employees or other individuals with direct or indirect ownership or control interest in accordance with 42 U.S.C. §1320a-7, 42 C.F.R. Parts 1001 and 1002; 62 P.S. §1407 and 55 Pa. Code §§1101.75 and 1101.77.

These sanctions may, but need not be, progressive. The Department's intends to maintain an effective, reasonable and consistent sanctioning process as deemed necessary to protect the integrity of the HealthChoices Program.

EXHIBIT NN

SPECIAL NEEDS UNIT

A member with Special Needs is based upon a non-categorical or generic definition of Special Needs. This definition will include but not be limited to key attributes of ongoing physical, developmental, emotional or behavioral conditions or life circumstance which may serve as a barrier to the member's access to care or services. Examples of members with Special Needs will include but not be limited to: Children with Special Health Care Needs including those requiring skilled or unskilled home shift care, Children in Substitute Care, those with limited English Proficiency, or special communication needs due to sensory deficits those with Physical and/or Intellectual/ Developmental Disabilities, those with HIV/AIDS, those with significant behavioral challenges, or members requiring transportation assistance. Examples of factors in the determination of a member with 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.

- Require assistance in discharge planning from an inpatient or long term care setting to ensure the member will receive services in the least restrictive environment possible.

- Any condition, event or life circumstance that as a result inhibits a member's access to any necessary service or support needed to address their medical condition or maintain their current level of functioning.

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 BMCO SNU 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 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 and assisting in that process as needed or requested. Members with Special Needs determined to have ongoing needs for assistance 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 including County Children and Youth Services Offices and Juvenile Justice Offices.

- 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 the BMCO SNU staff and the Enrollment Assistance Program contractor's Special Needs contact person. The PH-MCO must 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.

- Appropriate arrangements must be made to effectively assist Members with Special Needs who speak languages other than English 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) and the Community Support Program (CSP) principles 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.

- Conduct necessary training for all PH-MCO providers to acquaint them with the purpose and function of the Special Needs Unit and identify a contact within the Special Needs Unit as a direct contact for any provider to refer a member with special needs for assistance.

- Provide assistance to any member needing help in filing a Complaint, Grievance, or Fair hearing, and serve in an advocacy role to assist the member in obtaining any information necessary from any PH-MCO provider in support of a Complaint, Grievance or DHS Fair Hearing.

- Provide assistance to any member needing additional help to access the Department's Medical Assistance Transportation Program.

- Provide assistance to any member needing help transitioning from a pediatric to an adult provider. In the case of defined medically fragile members transitioning

between the ages of 18 and 21, identify such individuals and assist them in transition to adult providers as required, and maintain them in Case Management until the transition is completed.

- For members receiving home shift care services, provide assistance in the member's transition from EPSDT services into Home and Community Based Waivers and adult systems of support, by actively participating in the Department's Resource Facilitation Team process.

- For members receiving home shift care, provide assistance with discharge planning for all members transitioning from inpatient settings including Pediatric Long Term care settings to ensure the member is transiting not only to the least restrictive environment possible, but to ensure that the environment and supports are in place in the new setting prior to any discharge occurring. Provide all necessary oversight including home or site visits with family or other caregivers to ensure adequate supports are in place for a safe discharge.

- Conduct face-to-face case management activities with members for whom telephonic case management has proven ineffective, and desired goals have not been attained. Utilize and interphase with community based care management staff to maintain a person-centered approach and to ensure that member-specific needs are being met.

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 OO

COORDINATION OF CARE ENTITIES

Examples of coordination of care entities are listed below. This list is not inclusive of all coordination of care entities.

- HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs)
- County Office of Drug and Alcohol Programs
- Bureau of Drug and Alcohol Programs (BDAP)
- Office of Children, Youth, and Families (OCYF)
- County Children and Youth Agencies
- Office of Developmental Programs (ODP)
- County Intellectual Disability (ID) Agencies and County ID Health Care Coordination Units
- Intermediate Care Facility Providers
- Office of Mental Health and Substance Abuse Services (OMHSAS)
- Office of Long Term Living (OLTL)
- County Mental Health Agencies
- PA. Department of Health's Community Health District Offices
- County and Municipal Health Departments
- Special Kids Network and Regional Offices
- Childhood Lead Poisoning Prevention Projects (CLPPPs)
- School Districts and Intermediate Units
- School Based Health Centers
- Juvenile Detention Centers
- Juvenile Probation Offices
- Area Agency on Aging (AAA)
- Community Service Organizations
- Public Health Entities
- Consumer Advocacy Groups
- WIC Agencies, Head Start Agencies, and Family Centers
- Public Housing Authorities

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 via the Special Needs Unit hotline and listing of the SNU hotline number;

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 WW

HEALTHCHOICES AUDIT CLAUSE

AUDITS

Annual Agreement Audits

The PH-MCO shall cause, and bear the costs of, an annual Agreement audit to be performed by an independent, licensed Certified Public Accountant. The Agreement audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The Agreement audit shall be digitally submitted to OMAP, BFM, Division of Financial Analysis and Reporting via the E-FRM system no later than June 30 after the Agreement year is ended.

If circumstances arise in which the Commonwealth or the PH-MCO invoke the contractual termination clause or determine the Agreement will cease, the Agreement audit for the period ending with the termination date or the last date the PH-MCO is responsible to provide Medical Assistance benefits to HealthChoices recipients shall be submitted to the Commonwealth within 180 days after the Agreement termination date or the last date the PH-MCO is responsible to provide Medical Assistance benefits.

The PH-MCO shall ensure that audit working papers and audit reports are retained by the PH-MCO's auditor for a minimum of ten (10) years from the date of final payment under the Agreement, unless the PH-MCO's auditor is notified in writing by the Commonwealth to extend the retention period. Audit working papers shall be made available, upon request, to authorized representatives of the Commonwealth or Federal agencies. Copies of working papers deemed necessary shall be provided by the PH-MCO's auditor.

Annual Entity-Wide Financial Audits

The PH-MCO shall provide to the Commonwealth a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in accordance with generally accepted auditing standards. Such audit shall be submitted to the OMAP, BFM, Division of Financial Analysis and Reporting via E-FRM within 30 days after the Auditors signature date.

Other Financial and Performance Audits

The Commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional financial or performance audits of the PH-MCO, its subcontractors or Providers. Any such additional audit work will rely on work already performed by the PH-MCO's auditor to the extent possible. The costs incurred by the federal or state agencies for such additional work will be borne by those agencies.

Audits of the PH-MCO, its subcontractors or Providers may be performed by the Commonwealth or its designated representatives and include, but are not limited to:

1. Financial and compliance audits of operations and activities for the purpose of determining the compliance with financial and programmatic record keeping and reporting requirements of this Agreement;

2. Audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Commonwealth is properly safeguarded, accurate, timely, complete, reliable, and in accordance with Agreement terms and conditions; and

3. Program audits and reviews to measure the economy, efficiency and effectiveness of program operations under this Agreement.

Audits performed by the Commonwealth shall be in addition to any federally-required audits or any monitoring or review efforts. Commonwealth audits of the PH-MCO or its subcontractor's operations will generally be performed on an annual basis. However, the Commonwealth reserves the right to audit more frequently, to vary the audit period, and to determine the type and duration of these audits. Audits of subcontractors or Providers will be performed at the Commonwealth's discretion.

The following provisions apply to the PH-MCO, its subcontractors and Providers:

1. Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the entity at least three (3) weeks advance written notice of the start date, expected staffing, and estimated duration of the audit. In the event of a claims processing audit, the Commonwealth will strive to provide advance written notice of a minimum of thirty (30) calendar days. While the audit team is on-site, the entity shall provide the team with adequate workspace; access to a telephone, photocopier and facsimile machine; electrical outlets; and privacy for conferences. The PH-MCO shall also provide, at its own expense, necessary systems and staff support to timely extract and/or download information stored in electronic format, gather requested documents or information, complete forms or questionnaires, and respond to auditor inquiries. The entity shall cooperate fully with the audit team in furnishing, either in advance or during the course of the audit, any policies, procedures, job descriptions, Agreements or other documents or information requested by the audit team.

2. Upon issuance of the final report to the entity, the entity shall prepare and submit, within thirty (30) calendar days after issuance of the report, a Corrective Action Plan for each observation or finding contained therein. The Corrective Action Plan shall include a brief description of the finding, the specific steps to be taken to correct the situation or specific reasons

why corrective action is not necessary, a timetable for performance of the corrective action steps, and a description of the monitoring to be performed to ensure that the steps are taken.

Record Availability, Retention and Access

The PH-MCO shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site, during normal business hours, or through the mail. During the Agreement and record retention period, these records shall be available at the PH-MCO's chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The PH-MCO shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this Agreement as well as to all required programmatic activity and data pursuant to this Agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the Agreement period and ten years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed.

Audits of Subcontractors

The PH-MCO shall include in all risk sharing PH-MCO subcontract agreements clauses, which reflect the above provisions relative to "Annual Agreement Audits", "Annual Entity-Wide Financial Audits", "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

The PH-MCO shall include in all contract agreements with other subcontractors or Providers, clauses which reflect the above provisions relative to "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

EXHIBIT BBB

OUTPATIENT DRUG SERVICES

1. General Requirements

a. The amount, duration, and scope of Covered Outpatient Drugs must be consistent with coverage under the Fee-for-Service program. 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 policies, 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 written approval prior to implementation, prior to implementation of any changes, and annually thereafter.

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 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 submitted for Department review and written 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.

l. The PH-MCO must make available on the website, information about its drug formulary or PDL, listing which medications are covered, including both brand and generic names.

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. Requests for prior authorization will not be denied for lack of medical necessity unless a physician reviews the request for a medical necessity determination. Such a request for prior authorization must be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the Member.

h. In addition, 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:

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

    ii. 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.

i. 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.

j. 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.

k. The PH-MCO guidelines to determine medical necessity of Covered Outpatient Drugs cannot be more stringent than the FFS guidelines.

l. 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 and annually thereafter.

m. The PH-MCO must submit additions, changes and deletions to Prior Authorization (including Step Therapy) policies, procedures and all associated medical necessity guidelines for Department review and written approval prior to implementation.

n. Prior Authorization (including Step Therapy) policies, procedures and all associated medical necessity guidelines must be submitted for Department review and written approval annually.

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 by 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 PH-MCO shall also include the HCPCS units 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.

iii. Actual paid amount by the PH-MCO, or the PH-MCO's PBM, 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 PH-MCO, or the PH-MCO's PBM, 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, or the PH-MCO's PBM, 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, or the PH-MCO's PBM, 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 prescriber 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.

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.

10. 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.

11. 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 XII: 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.

12. 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 DDD

Patient Centered Medical Home (PCMH) Program

The PCMH model of care includes key components such as: whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care.

The MCO will contract with high volume providers in their network who meet the requirements of a PCMH, make payments to their contracted PCMHs, collect quality related data from the PCMHs, reward PCMHs with quality-based enhanced payments, develop a learning network that includes PCMHs and other MCOs, and report annually on the clinical and financial outcomes of their PCMH program.

A. The MCO will ensure the PCMH provider meets the following requirements:

1. Will be a high volume Medicaid practice already participating in the MCO provider pay for performance program or a defined set of practices willing to share care management resources,

2. Will accept all new patients or be open for face-to-face visits at least 45 hours per week,

3. Will have already received a payment in the Medicaid or Medicare electronic health record meaningful use program,

4. Will join a health information exchange organization in order to share health related data by January 1, 2018,

5. Will deploy a community-based care management team as described below,

   The PCMH must deploy a community based care management (CBCM) team that consists of licensed professionals such as nurses, pharmacists or social workers and unlicensed professionals such as peer recovery specialists, peer specialists, community health workers or medical assistants. The CBCM team's activities can replicate but not duplicate already existing and CBCM reimbursed care management services. The care management team will work within their local community to accept individuals with complex care needs from local emergency departments, physical and behavioral health hospitals, specialty providers, and MCO. Through acitively engaging patients and taking into account their preferences and personal health goals, the CBCM team will develop care plans that help individuals with complex chronic conditions to stay engaged in comprehensive treatment regimens that include, but are not limited to physical health, substance use disorder and mental health treatments. The CBCM team

will also connect individuals as needed to community resources and social support services through “warm hand off” referrals for assistance with problems such as food insecurity and housing instability.

6. Will collect and report annual quality data and outcomes pertinent to their patient population as defined by the current MCO provider pay for performance program, the Integrated Care Program, and additional population specific measures defined by the Department,

7. Will conduct internal clinical quality data reviews on a quarterly basis, report results and discuss improvement strategies with the MCO,

8. Will measure patient satisfaction using a validated low literacy appropriate tool to assess individual and family/caregiver experience,

9. Will include as part of the health care team patient advocates or family members to support the patients’ health goals and advise practices,

10. Will see 75% of patients within seven days of discharge from the hospital with an ambulatory sensitive condition, and

11. Will participate in a PCMH learning network.

B. The MCO will make monthly payments to each PCMH based on factors such as: clinical complexity, age, medical costs, and composition of the care management team.

C. The MCO’s PCMH network will include high volume adult and pediatric providers that serve the percentage of total membership and percentage of members that fall within the top 5th percentile of medical costs as defined for Calendar year 2017 and 2018.

1. Calendar year 2017 – PCMHs’ must serve at least 10% of their total membership and at least 20% of members that fall within the top 5th percentile of medical costs.

2. Calendar year 2018 – PCMHs’ must serve at least 20% of their total membership and at least 33% of members that fall within the top 5th percentile of medical costs.

D. The MCO will collect key quality metrics from the PCMHs and report those results annually to the Department.

E. The MCO will reward PCMHs with quality-based enhanced payments focusing on key performance measures defined by the Department. Current provider pay for performance dollars may be used for these quality based payments.

F. The MCO will develop a quarterly regional learning network that includes all PCMHs, patient advocates or family team members, and MCOs in a HealthChoices region.

G. The MCO will report annually on the clinical and financial outcomes of their PCMH program. This report will be completed during the same timeframe as the provider pay for performance reporting requirements. The report will address key quality, utilization, and financial outcomes as well as a return on investment calculation. The report will also describe the number of PCMHs that have gain share arrangements, risk arrangements, payments made for quality, and payments made for gain share or risk arrangements. The report will also list the total medical costs of the patients attributed to the PCMHs.

H. Data Sharing

The MCO must provide timely and actionable data to its PCMHs. This data should include, but is not limited to, the following:

1. Identification of high risk patients;

2. Comprehensive care gaps inclusive of gaps related to quality metrics used in the value based payment arrangement; and

3. Service utilization and claims data across clinical areas such as inpatient admissions, outpatient facility (SPU/ASC), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.