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PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

Bureau of Procurement and Contract Management

GRANT AGREEMENT

HealthChoices Physical Health Grant Agreement to provide Mandatory Managed Care Services to Medicaid consumers in the following counties: Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Butler, Cambria, Cumberland, Dauphin, Fayette, Franklin, Fulton, Greene, Huntingdon, Indiana, Lancaster, Lawrence, Lebanon, Lehigh, Northampton, Perry, Somerset, Washington, Westmoreland, York

RFA # 07-19

Gateway Health Plan, Inc., d/b/a Highmark WholeCare

444 Liberty Avenue, Suite 2100

Pittsburgh, PA 15222

[REDACTED]  
[REDACTED]  
[REDACTED]

Office of Medical Assistance Programs

Gwendolyn Zander

gzander@pa.gov

717-787-1871

**For Program Office/Facility Use Only**

Are multiple agreements of this type expected? Yes  No

*If yes, avoid multiple rejections by submitting one agreement and using BPCM's feedback to improve the remaining agreements.*

# HEALTHCHOICES AGREEMENT

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 DDD-----Patient Centered Medical Home Program  
 EEE-----Business Associate Addendum *EMD*

## **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 Pennsylvania HealthChoices Extranet to provide clarifications to requirements pertaining to HealthChoices. PH-MCOs must routinely check the Pennsylvania HealthChoices Extranet. MC OPS Memos and notices are vehicles to clarify operational policies and procedures and are not intended to amend the terms of the Agreement.

### **2. Pennsylvania HealthChoices Extranet**

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

In addition to the MCO-OPS Memos, the Pennsylvania HealthChoices Extranet 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.

**Actuarially 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 C.F.R. §438.4(b).

**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 Primary Contractor** - A county, Multi-County Entity or a BH-MCO which has an Agreement with the Department to manage the purchase and provision of Behavioral Health Services.

**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.

**Caregiver** – A person employed for compensation by a provider or participant who provides personal assistance services or respite services for the purpose of providing a covered service by a healthcare worker on the staff/under contract.

**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 Based Organization (CBO)** - Nonprofit organizations that work at a local level to improve life for residents and normally focus on building equality across society in many areas, including but not limited to access to social services. These organizations must also be registered as a 501(c)(3) nonprofit corporation in Pennsylvania. A health care provider is not considered a CBO.

**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** —

1. A dispute or objection regarding a particular Provider or the coverage, operations, or management of a PH-MCO, which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with PID's Bureau of Managed Care (BMC), including, but not limited to:

- a denial because the requested service or item is not a covered service; which does not include BLE
- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- the 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 MA Program;
- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Member; or
- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

This 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 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.

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 834 Eligibility File** — An electronic file in a HIPAA compliant 834 format using data from eCIS that is transmitted to the PH-MCO on state business days.

**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's 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) is primarily and customarily used to serve a medical purpose (c) generally is not useful to an individual in the absence of a disability, illness or injury (d) can be reusable or removable and (e) is appropriate for use in any setting in which normal life activities take place.

**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 eCIS. 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 C.F.R. §438.242 and 42 C.F.R. §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.

**Extranet** — An Intranet site that can be accessed by authorized internal and external users to enable information exchange securely over the Internet.

**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 covered 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, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting, committed by any entity, including the PH-MCO, a subcontractor, a Provider, or a Member, among others.

**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 concerning the Medical Necessity and appropriateness of a covered 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 and 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(13), §1603 (28), §1679(a), or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. §136.12.

**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.

**Institution for Mental Diseases (IMD)** - a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

**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.

**Internal Control Number** — The unique number assigned by the Department's MMIS to identify an individual Claim or Encounter.

**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 C.F.R. §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 C.F.R. § 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 the Department's MMIS 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 eCIS 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 on the Daily 834 Eligibility File or the Monthly 834 Eligibility 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.

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

**Monthly 834 Eligibility File** — An electronic file in a HIPAA compliant 834 format using data from eCIS that is transmitted to the PH-MCO on a monthly basis.

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

**Network Provider** — An MA-enrolled Provider that has a written Network Provider Agreement and participates in the PH-MCO's Network to serve the PH-MCO's members.

**Non-participating Provider** — A Health Care Provider not enrolled in the Pennsylvania Medicaid Program.

**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 C.F.R. §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 Provider that does not have a signed Network Provider Agreement with the PH-MCO and does not participate in the PH-MCO's network but provides services to a PH-MCO member.

**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 C.F.R. §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 eCIS.

**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, or PAHP, but is not yet an enrollee of a specific MCO, PIHP, or PAHP.

**Preferred Drug List** — A list of Department-approved covered 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.

**Prepayment Review** – Prepayment review is performed after the service or item is provided, but prior to payment being issued. Prepayment review may include the examination of an invoice and related documentation to determine eligibility, benefit packages, or medical necessity of a service or item before payment is made to the provider. Pre-payment review is not synonymous with prior authorization.

**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.

**Prevalent** – A non-English language determined to be spoken by a significant number or percentage of potential enrollees that are limited English proficient. (42C.F.R. 438.10(a))

**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 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.

**Provider** — An individual or entity that is engaged in the delivery of medical or professional services, or ordering or referring for those services, and is legally authorized to do so by the Commonwealth or State in which it delivers the services, including a licensed hospital or healthcare facility, medical equipment supplier, or person who is licensed, certified, or otherwise regulated to provide healthcare services under the laws of the Commonwealth or states in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, CRNP, RN, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist, and an individual accredited or certified to provide behavioral health 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 C.F.R. §447.26(b).

**Provider Reimbursement and Operations Management Information System electronic (PROMISe™)** — The Department's current MMIS 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 C.F.R. §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, DHS, or DHS vendor or designee to determine whether services were delivered as prescribed and consistent with the PH-MCO's payment policies and procedures in accordance with MA regulations and section V.0.4.p of the Agreement.

**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.

**Rural Health Clinics (RHCs)** - a facility that is engaged primarily in providing services that are typically furnished in outpatient clinics in underserved rural areas.

**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.

**Social Determinants of Health (SDOH)**— Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes, which can lead to inequities and risks.

**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 Payments (VBP) Arrangements:** Agreements between the MCO and providers, which specify how providers are paid for services rendered. VBP arrangements link provider payments to the value of services provided and to relevant quality measures that are indicative of health outcomes.

**Value Based Purchasing Models:** VBP Models define a way to organize and deliver care, and may incorporate one or more VBP Payment Strategies as ways to pay providers.

**Value Based Purchasing Strategies** — Refers to the mechanism that MCOs use to pay providers (such as performance-based contracting, shared savings, shared risk, population-based payment).

**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.

All Definitions - These definitions are case-insensitive. A defined term used in the Agreement is intended to have the meaning ascribed to such term in the Definition section of the Agreement regardless of capitalization if in the context of the provision the definition is applicable.

## **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  
CBO – Community Based Organization  
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  
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  
DBM – Dental Benefits Manager  
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  
eCIS – Client Information System  
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  
ICN — Internal Control Number  
ICP — Integrated Care Program  
IGC — Initial Grievance Committee  
IHS — Indian Health Service  
IMD — Institution for Mental Diseases  
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  
MMIS — Medicaid 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  
NPES — 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  
PPR — Prepayment Review  
PPS — Prospective Payment System  
PROMISe™ — Provider Reimbursement (and) Operations Management Information System electronic (format)  
PSMI — Persistent Serious Mental Illness  
PT — Provider Type  
QA — Quality Assurance  
QARI — Quality Assurance Reform Initiative  
QM — Quality Management  
QMC — Quality Management Committee  
QM/UM — Quality Management and Utilization Management  
RBUC — Reported But Unpaid Claim  
RFP — Request for Proposal  
RHC — Rural Health Centers/Clinics  
RPAA — Risk Pool Allocation Amount  
RTF — Residential Treatment Facility  
SAM — System for Award Management  
SAP — Statutory Accounting Principles  
SDOH – Social Determinants of Health  
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  
VBM – Vision Benefit Manager  
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 the **Lehigh/Capital and Southwest Zones** in accordance with 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.

In compliance with ARRA 5006(a), the PH-MCO is prohibited from imposing enrollment fees, premiums, cost sharing, 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).

Any cost sharing imposed by the PH-MCO on enrollees is in accordance with Medicaid fee for service requirements at 42 C.F.R. §§447.50-447.82 and the Social Security Act §§1916(a)(2)(D) and (b)(2)(D).

## **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 Labor Anti-Injunction Act, 42 P.S. §§206a-206r; the Pennsylvania Labor Relations Act, 43 P.S. §§211.1-211.13; Section 1557 of the Patient Protection and Affordable Care Act (ACA), [42 C.F.R. 438.3(f)(1); 42 C.F.R. 438.100(d)]; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Health Information Technology for Economic and Clinical Health

(HITECH) Act; the HIPAA Privacy Rule and the HIPAA Security Rule, 45 C.F.R.. 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.

The PH-MCO must comply with Commonwealth 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 requirements and regulations pertaining to copyrights and rights in data.

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 7606), section 508 of the Clean Water Act (33 USC 1368) and Executive Order 1178.

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. 94-163).

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

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

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.

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

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 C.F.R. §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 C.F.R. §§455.414 and 455.432.

9. The PH-MCO is required under 42 C.F.R. §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 System for Award Management (SAM), 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 SAM 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 SAM on a monthly basis.
10. The PH-MCO must comply with the requirements of 42 CFR 438.62, the Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicaid Managed Care Plans.

**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.

## **G. Unauthorized Programs and Activities**

Should any part of the scope of work under this agreement relate to a program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the PH-MCO must do no work on that part after the effective date of the loss of program authority. The Department must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If PH-MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, PH-MCO will not be paid for that work. If the PH-MCO was paid in advance to work on a no-longer-authorized program or activity and under the terms of this agreement the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the Department. However, if PH-MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to the PH-MCO, The PH-MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

## **SECTION V: PROGRAM REQUIREMENTS**

### **A. In-Plan Services**

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

The MCO may but is not required to impose copayments, but only for those services, items, and pharmacy services that have a copayment in the MA FFS delivery system and subject to the exemptions in the MA FFS delivery system. If the MCO imposes copayments, the amount of the copayments may not exceed the amounts imposed in the MA FFS delivery system. Network Providers and other Providers that may render services under the Agreement may not deny a covered service because a Member is unable to pay the copayment amount, but the Provider may continue to attempt to collect the copayment amount.

## **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. This includes quantitative and non-quantitative treatment limits (QTL) (NQTL) as indicated in state statutes and regulations, the Medicaid state plan and other state policies and procedures. 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.

Pursuant to 42 C.F.R. §438.3(e)(2)(i) – (iii), the PH-MCO may cover services or settings for enrollees that are in lieu of those covered under the Medicaid State Plan if:

- The State determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the Medicaid State Plan.
- The State determines that the alternative service or setting is a cost effective substitute for the covered service or setting under the Medicaid State Plan.
- The enrollee is not required by the PH-MCO to use the alternative service or setting.

- The approved in lieu of services are authorized and identified in the PH-MCO contract.
- The approved in lieu of services are offered to enrollees at the option of the PH-MCO.

## **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.

The PH-MCO must include in its Provider Network any Home Health Agency that offers in-home nursing services, home health aide services, or personal care services for Members under the age of 21 that is enrolled in Pennsylvania Medical Assistance and is willing to comply with all of the PH-MCO's quality and non-quality contract standards, utilization management standards and accept PH-MCO rates that are consistent with reimbursement rates paid to similar Network Providers.

The PH-MCO must submit to the Department for prior review and written approval any Home Health Agency requests for entrance to the Network that it intends to deny based upon quality of care, program integrity or other relevant concerns.

The PH-MCO must implement a Public Health Dental Hygiene Practitioner (PHDHP) program or a dental hygienist program under the direct supervision of a dentist. The hygienists must spend the majority of their time face-to-face performing direct patient preventive care in the community.



### **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 99-10-12, 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 covered drug services standards and requirements described in Exhibit BBB, 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 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 must develop a process for paying for emergency services (including their plans, if any, to pay for triage). The PH-MCO shall pay for Emergency Services in or outside of the HealthChoices Zone (including outside of Pennsylvania). Payment for Emergency Services shall be made in accordance with applicable law.

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.

For emergency services rendered by a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103, that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical services agency that has that ability, the managed care plan may not deny a claim for payment solely because the enrollee did not require transport or refused to be transported.

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.

The PH-MCO may not deny payment for treatment obtained under either of the following circumstances:

- A Member has an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- A representative of the PH-MCO instructs the Member to seek emergency services.

The PH-MCO may not:

- Limit what constitutes an Emergency Medical Condition with reference to the definition of “Emergency Medical Condition, Emergency Services, and Post Stabilization Services” on the basis of lists of diagnoses or symptoms.
- Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member’s Primary Care Practitioner, PH-MCO, or applicable state entity of the Member’s screening and treatment within ten (10) calendar days of presentation for emergency services.
- Hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- Deny a claim for payment for emergency services rendered by a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103, that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical services agency that has that ability, solely because the enrollee did not require transport or refused to be transported.

The PH-MCO must also develop a process to ensure that PCPs promptly see Members who did not require or receive hospital Emergency Services for the symptoms prompting the attempted emergency room visit.

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 C.F.R. §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 consistent with their obligations mandated in 18 Pa.C.S.A. §5106 and all other applicable statutes. This includes reporting to Adult Protective Services any suspected abuse or neglect of Members over the age of 18. These requirements 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 the provisions outlined at 42 C.F.R. 418.1 et seq.

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

being enrolled in the PH-MCO, the Member will remain the responsibility of the PH-MCO and will not be disenrolled from HealthChoices.

**14. Organ Transplants**

The PH-MCO 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 ambulance 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.

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.

The PH-MCO maternity program must provide a maternal continuum of care by instituting a community-based maternal home visiting program. An in-person maternal home visiting program must be an extension of the PH-MCO's traditional case management program that transitions maternal family care to an evidence-informed or evidence-based home visiting program. The PH-MCO's must provide a full description of its community-based maternal home visiting program that fulfills the Department's HBP Program Description objectives for review and approval by the Department as per Exhibit B(5).A. Home Visiting Program.

## **17. Nursing Facility Services**

The PH-MCO is responsible for payment for nursing home care (including hospital reserve or bed hold days).

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.

The PH-MCO must abide by the decision of the Functional Eligibility Determination 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 Physical Health Program or individuals who enter a Nursing Facility and are then determined eligible for MA in the HealthChoices Physical Health Program. If an individual leaves the Nursing Facility to reside in the HealthChoices Physical Health Zone covered by this Agreement and is then determined eligible for Enrollment into the HealthChoices Physical Health Program, the individual will be enrolled in the HealthChoices Physical Health 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 available in DocuShare.

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, another PH-MCO, or a CHC-MCO. The FFS delivery system and CHC-MCOs 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. The PH-MCO will ensure that results of environmental lead investigations are shared with the referring provider and the Member (or Member's guardian).

#### **20. Opioid Use Disorder/Substance Abuse Disorder Management**

The PH-MCO must implement and maintain an opioid use disorder/substance abuse disorder (OUD/SUD) strategy for its members with OUD/SUD. The OUD/SUD strategy must address how the PH-MCO will manage their members with OUD/SUD and include initiatives similar to those described in the following links:

- Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016; 65(No. RR-1):1–49. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>

The Pennsylvania Guidelines on the Use of Opioids to Treat Chronic Noncancer Pain. Accessed January 31, 2017,

<https://www.health.pa.gov/topics/Documents/Opioids/Non-cancer%20Pain%20Guidelines%20Final.pdf>

At a minimum, the OUD/SUD strategy must include care management initiatives, alternative treatment modalities such as pain management, strategies to address opioid related harm reduction, tapering strategies and medication assisted treatment (MAT). In addition, the PH-MCO must coordinate and collaborate with the Opioid Use Disorder Centers of Excellence for its member with OUD/SUD.

## **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) which are available in

DocuShare. 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 available in DocuShare.

- b. If the requested information is provided within fourteen (14) days, the PH-MCO must must contact the prescribing provider at least once to confirm all available documentation pertaining to the requested service has been submitted and document the contact in the members case record before making a 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 contact the prescribing provider at least once to confirm all available documentation pertaining to the requested service has been submitted and document the contact in the members case record before making a 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<sup>th</sup>) day from the date the request is received. If the notice is not mailed by the eighteenth (18<sup>th</sup>) 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 Covered Drug Services**

The PH-MCO must comply with the requirements of Exhibit BBB specific to Prior Authorization of Covered 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.

The PH-MCO must implement a transition of care policy consistent with the above requirements and compliant with 42 C.F.R. 438.62 (b) (1) (2) (3).

The PH-MCO Special Needs Unit must have a resource account email box in place for receipt of transition of care documentation to ensure timely access to all medically necessary services. The Special Needs Unit Coordinator and multiple staff must have access to this resource account.

#### **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
- Opioid Use Disorder Centers of Excellence
- Aging Well PA/Level of Care Assessment and Pre-admission Screening Requirements
- 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 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.)
- The OBRA waiver, a home-and-community-based waiver program for individuals who have a severe developmental physical disability requiring an Intermediate Care Facility/Other Related Conditions (ICF/ORC) level of care
- Intellectual Disabilities Services (note the PH-MCO is responsible to ensure a family with a child who has or is at risk of a developmental delay is referred to the County Intellectual Disabilities office for a determination of eligibility for home and community-based services, including children living in residential facilities as described above.) Home-and Community-Based Waiver for Persons with Intellectual Disabilities
- 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 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, email, texting, 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 eCIS 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.

- I. 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 Complaint and grievance notices, adverse benefit determinations and termination notices, and 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.

The notice of nondiscrimination and the taglines must be posted on physical locations where PH-MCO, contractors, and entities interact with the public.

#### **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 (minimum 18 point font), 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.

- These materials must be in a format that is readily accessible
- The information must be placed in a location on the PH-MCOs website that is prominent and readily accessible
- The information must be provided in an electronic form which can be electronically retained and printed
- The information is consistent with content and language requirements
- The PH-MCO must notify the enrollee that the information is available in paper form without charge upon request
- The PH-MCO must provide, upon request, the information in paper form within 5 business days

## **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 Pennsylvania HealthChoices Extranet site and in Exhibit Z, Automatic Assignment, 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 Pennsylvania HealthChoices Extranet.

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 the following to the Department on a Weekly Enrollment/Disenrollment/Alert file: pregnancy (not on

eCIS), death (not on eCIS), newborn (not on eCIS) and return mail alerts in accordance with Section VIII.B.5, Alerts.

The PH-MCO must report Member status changes to the appropriate CAO using the CAO Notification Form within ten (10) Business Days of their becoming known. These changes include phone number, address, pregnancy, death and family addition/deletion. The PH-MCO must also provide a detailed explanation of how the information was verified.

## **10. Membership Files**

### **a. Monthly File**

The Department will provide a Monthly 834 Eligibility File to each PH-MCO on the next to the last Saturday of each month. The file will contain the MA Eligibility Period, PH-MCO coverage, BH-MCO coverage and other Recipient demographic information. It will contain only the most current record for each HealthChoices Recipient 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 data and notify the Department of any discrepancies within thirty (30) Business Days.

The PH-MCO is not responsible for Members not included on this file with an indication of prospective coverage unless a subsequent Daily 834 Eligibility File indicates otherwise. The PH-MCO is not responsible for Members with an indication of future month coverage if a Daily 834 Eligibility File received by the PH-MCO prior to the beginning of the future month indicates otherwise.

### **b. Daily File**

The Department will provide a Daily 834 Eligibility File to the PH-MCO that contains one record for each action taken in eCIS for each HealthChoices Recipient where data for that Recipient has changed that day. The file will contain add, termination and change records, but will not contain BH-related information. The file will also contain demographic changes, eligibility changes, Enrollment changes, Members enrolled through the automatic assignment process, and TPL information. The PH-MCO must process this file within twenty-four (24) hours of receipt.

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

## **11. Enrollment and Disenrollment Updates**

### **a. Weekly Enrollment/Disenrollment/Alert Reconciliation File**

The Department will provide a weekly file with information on Members enrolled or disenrolled in PH and the dispositions of Alerts previously submitted by the PH-MCO. The PH-MCO must use this file to reconcile Alerts submitted to the Department.

### **b. Disenrollment Effective Dates**

Member disenrollment 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 make a best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. The PH-MCO must share with DHS or any other MCO serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. The PH-MCO will collaborate with the Department to develop, adopt and disseminate a resource and referral tool.

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, as applicable, Provider Network Composition/Service Access and follow the appointment standards described in Exhibit AAA, 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,
- Education of members on how they can report suspected fraud, waste and abuse,
- 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. The PH-MCO is required to provide adult enrollees with written information on advance directives policies and include description of applicable state law. The PH-MCO is required to reflect changes in state law in its written advance directives information as soon as possible, but no later than 90 days after the effective date of the change.

### **a. Member Handbook Requirements**

- i. 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 the PH-MCO Member Handbook Template as issued by DHS.
- ii. The PH-MCO must notify members at least thirty (30) days in advance of the effective date of a significant change in the member handbook.
- iii. The PH-MCOs must have written policies guaranteeing each enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy.
- iv. The PH-MCOs must have written policies guaranteeing each enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

- v. The PH-MCOs must have written policies guaranteeing each enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- vi. The PH-MCOs must have written policies guaranteeing each enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- vii. The PH-MCOs must have written policies guaranteeing each enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected.
- viii. The PH-MCOs must ensure that each enrollee is free to exercise his or her rights without the PH-MCO or its network providers treating the enrollee adversely.

**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.
- Must be in machine readable format

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 Pennsylvania HealthChoices Extranet 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.

A paper provider directory must be updated at least:

- Monthly, if the MCO, PIHP, PAHP, or PCCM entity does not have a mobile-enabled, electronic directory; or

- Quarterly, if the MCO, PIHP, PAHP, or PCCM entity has a mobile-enabled, electronic provider directory
- An electronic provider directory must be updated no later than 30 calendar days after the MCO, PIHP, PAHP, or PCCM entity receives updated provider information.

## **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 Member newsletters in formats other than hard copy but must provide a hard copy to a Member who asks for one. 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.

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.

The PH-MCO must provide, all written materials for potential enrollees and enrollees using a font size no smaller than 12 point.

If the PH-MCO uses any of the terms included in Exhibit AA in a written communication with a potential Member or a Member, the PH-MCO's use of the term must be consistent with the definition included in Exhibit AA.

#### **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(20) are available in Docushare.

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.

PH-MCO must adhere to the mechanisms and time-frames for reporting member complaints and grievances to the Department in the manner The Department has determined.

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 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 instances involving Complaints related to adverse benefit determinations, 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 (1/4<sup>th</sup>) 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 covered drug management and serves on the PH-MCO P&T Committee.
- A Dental Director who is a current Pennsylvania-licensed Doctor of Dental Medicine or Doctor of Dental Surgery. The Dental Director must be actively involved in all program components related to dental services including, but not limited to, dental provider recruitment strategy, assessment of dental network adequacy, providing oversight and strategic direction in the quality of dental services provided, actively engaged in the development and implementation of quality initiatives, and monitor the performance of the dental benefit manager if dental benefits are subcontracted.
- A full-time Director of Quality Management who is a Pennsylvania-licensed RN, physician or physician's assistant or is a Certified Professional in Healthcare Quality by the National Association for Healthcare Quality Certified in Healthcare Quality and Management by the American Board of Quality Assurance and Utilization Review

Providers. The Director of Quality Management must be located in Pennsylvania and have experience in quality management and quality improvement. Sufficient local staffing under this position must be in place to meet QM Requirements. The primary functions of the Director of Quality Management position are:

- Evaluate individual and systemic quality of care
  - Integrate quality throughout the organization
  - Implement process improvement
  - Resolve, track, and trend quality of care complaints
  - Develop and maintain a credentialed Provider network
- 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 Coordinator, who is responsible for the oversight of all information systems issues with the Department. The Information Systems 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 BH Coordinator who is a behavioral health professional and is located in Pennsylvania. The Behavioral Health Coordinator shall monitor the PH-MCO for adherence to BH requirements in this Agreement. The primary functions of the BH Coordinator are:
  - Coordinate Member care needs with BH Providers.
  - Develop processes to coordinate behavioral healthcare between PCPs and BH Providers.

- Participate in the identification of best practices for BH in a primary care setting.
  - Coordinate behavioral care with medically necessary services.
  - Be knowledgeable of the BH Managed Care Agreement requirements and coordinate with the BH-MCO to effectuate the requirements.
- 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 SNU Coordinator must have access to the PH-MCOs Dental Director for issues related to dental services. 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/EPSTD 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 EPSTD 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. Staff must also be adequately trained to understand Cultural, Linguistic, and Disability competencies

- 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 Provider Claims Educator who is located in Pennsylvania and facilitates the exchange of information between the Grievances, Claims processing, and Provider relations systems. The primary functions of the Provider Claims Educator are to:
  - Educate contracted and non-contracted Providers regarding appropriate Claims submission requirements, coding updates, electronic Claims transactions and electronic fund transfer, and available PH-MCO resources such as Provider manuals, website, fee schedules, etc.
  - Interface with the PH-MCO's call center to compile, analyze, and disseminate information from Provider calls.
  - Identify trends and guide the development and implementation of strategies to improve Provider satisfaction.
  - Communicate frequently (i.e., telephonic and on-site) with Providers to provide for the effective exchange of information and to gain feedback regarding the extent to which Providers are informed about appropriate claims submission practices.
- 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.
- A Special Investigations Unit (SIU) Director who serves as the Department's primary contact for program integrity functions. The SIU Director oversees staff responsible for fraud, waste and abuse activities.

The PH-MCO must ensure all staff have appropriate training, education, experience and orientation to fulfill the requirements of the position and maintain documentation of completion. 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 XII, 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 Recipients. In accordance with 42 C.F.R. §431.54(e), the restrictions do not apply to emergency services furnished to the Recipient. 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, receiving unnecessary services or may be defrauding the MA program.
- Evaluating the degree of abuse including review of pharmacy and medical claims/encounter history, diagnoses and other documentation, as applicable.
- Offering a voluntary restriction to a member to protect his/her medical card from alleged misuse. For example, a voluntary restriction can be imposed when a member loses their card or believes their benefits are being used by someone other than themselves. A voluntary restriction may be ended at any time.
- 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 or via secure electronic method, for review to determine appropriateness of restriction and to approve the action.
- Forwarding case information to BPI for allegations of member fraud.
- 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 notification within five business days to BPI through the Intranet Provider change process.
- Continuing a Member restriction from the previous delivery system effective date 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.
- Submitting member's claim data to BPI, upon request, within ten (10) business days.
- 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. These functions and responsibilities shall include the requirements provided in 42 C.F.R. §438.230(3)(i).
- e. The PH-MCO shall require Subcontractors to comply with all Medicaid rules, regulations, and guidance including the requirement that the subcontractor and Network Providers agree to the audit and inspection authority of the Pennsylvania Office of Attorney General Medicaid Fraud Control Section pursuant to 42 C.F.R. §438.230(3) for services provided pursuant to the Agreement.

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 latter 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 including the Pennsylvania Office of Attorney General's Medicaid Fraud Control Unit, 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 records requested by Federal or State government agencies pursuant to audits or investigations within the timeframe designated by the requesting agency. The retention requirements in this section do not apply to DHS-generated Remittance Advices.

### **4. Fraud, Waste, and Abuse**

The PH-MCO must develop a written compliance plan that contains the following elements described in 42 C.F.R. §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 website and that includes the following:

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable Federal and State requirements.
- The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement and who reports directly to the Chief Executive Officer and the board of directors.
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.
- A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees on the applicable Federal and State requirements and applicable standards and requirements under the Agreement.
- Effective lines of communication between the compliance officer and PH-MCO employees.
- Enforcement of standards through well publicized disciplinary guidelines.
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ensure ongoing compliance with the requirements under the Agreement.
- Procedures for systematic confirmation of services actually provided.
- Policies and procedures for reporting all Fraud, Waste, and Abuse to the Department and applicable law enforcement agency .

- Policies and procedures for Fraud, Waste, and Abuse prevention, detection and investigation.
- A policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.
- A policy and procedure for monitoring provider preclusion through databases identified by the Department.

**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 C.F.R. §438.608(a)(1)(vii). This Unit must have the primary purpose of preventing, detecting, reducing, 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 a dedicated full time HC MA 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 in accordance with 42 C.F.R. § 438.608(a)(7)).

**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 C.F.R. §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, the Pennsylvania Office of Attorney General

Medicaid Fraud Control Section and their third party designees, including CMS Contractors have timely access to records of Network Providers, subcontractors, and the PH-MCOs, as outlined in this Agreement.

**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 <https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/default.aspx>

**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.
- ii. A method for verifying with Members whether services billed by providers were received, as required by 42 C.F.R. 438.608(a)(5) and 438.608(d)(1)(i-iv)....
- iii. Process to recover overpayments or otherwise sanction Providers as required by 42 C.F.R. §§438.608(a)(5) and 438.608(d)(1)(i-iv).
- iv. 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 C.F.R. §§455.23 and 438.608(a)(8).
- v. Policies and procedures to initiate a prepayment review of a network provider's services where a review indicates billings are inconsistent with MA regulations or PH-MCO policies, are unnecessary, are

inappropriate to the members' health needs or contrary to customary standards of practice.

vi 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, overlapping billings, Claims edits, post processing review of Claims, and record reviews.

**f. Fraud, Waste, and Abuse Referral**

The PH-MCO must establish a policy for prompt referral of suspected Fraud, Waste and Abuse to the Department and also referral of suspected fraud to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section as required in 42 C.F.R. §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 and to the Pennsylvania Office of Attorney General Medicaid Fraud Control Section.

If a PH-MCO fails to promptly report a case of suspected fraud or abuse before the suspected fraud or abuse is identified by the Commonwealth of Pennsylvania, its designees, the United States or private parties acting on behalf of the United States, any portion of the fraud or abuse recovered by the Commonwealth of Pennsylvania or designee shall be retained by the Commonwealth of Pennsylvania or its designees.

**g. Education Plan**

The PH-MCO must create and disseminate written materials for the purpose of educating its employees, Providers, subcontractors and subcontractors' employees about healthcare Fraud laws, the PH-MCO's policies and procedures for preventing and detecting Fraud, Waste, and Abuse and the rights of individuals to act as whistleblowers. PH-MCO must provide written policies to all employees and to any contractor or agent that provide detailed information about the False Claims Act and other Federal and State laws described in 42 U.S.C. § 1396a(a)(68), including information about rights of employees to be protected as whistleblowers.

**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, Pennsylvania 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 as well as the results of associated internal investigations and audits. 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: Including, but not limited to, someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (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/MCO card, forging or altering prescriptions, selling prescriptions/medications, trafficking SNAP benefits or taking advantage of the system in any way.
- ii. Provider Fraud: Including, but not limited to, 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, billing incorrect provider or service location); 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.

## **I. Duty to Notify**

### **i. Department's Responsibility**

The Department will provide the PH-MCO with prompt notice via electronic transmission or access to Medichex 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 SSADMF, 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 Medicare list on a monthly basis as required in 42 C.F.R. §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 C.F.R. 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 notify the Department within 24 business hours, 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, Waste or Abuse. The PH-MCO must inform the Department, in writing, of the specific

underlying conduct that led to the suspension, termination including for cause and/or best interest, 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, Waste or Abuse 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. Subcontractor and Provider Agreements**

- i. The PH-MCO will require via written agreements 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 C.F.R. §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 the applicable provisions 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.
- iv. The PH-MCO must suspend payment to a Network Provider when the Department determines there is a credible allegation of fraud against that Network Provider, unless the Department determines there is good cause for not suspending such payments pending the investigation.
- v. The PH-MCO shall require its Subcontractors to comply with the requirements set forth at 42 C.F.R. 438.230(c)(3).
- vi. The PH-MCO subcontractor agreement must specifically state that the subcontractor will grant the Department, CMS, the Pennsylvania Office of Attorney General Medicaid Fraud Control Section, HHS OIG, the Comptroller General, or their designees access to audit, evaluate, and inspect books, records, etc., which pertain to the delivery of or payment for Medicaid services under this Agreement. Subcontractor must make such books, records, premises, equipment, staff etc. all available for an audit at any time. Right to inspect extends for ten (10) years after termination of the Agreement, or conclusion of an audit, whichever is later.

**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, its vendor or other designee, the Pennsylvania 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 and any subcontractor must report to the state within 60 calendar days when it has identified any capitation

payments or other payments in excess of amounts specified in the agreement per 42 CFR 438.608(c)(3).

- The PH-MCO shall audit, review and investigate Providers within its network through prepayment and retrospective payment reviews. The PH-MCO shall cost avoid or recover any overpayments directly from its Network Providers for audits, reviews or investigations conducted solely by the PH-MCO or through Network Provider self-audits.
  - The PH-MCO will void encounters for those claims involving full recovery of the payment and adjust encounters for partial recoveries.
  - The PH-MCO must notify BPI in writing when it plans to recover and when it has recovered overpayments or improper payments related to Fraud, Abuse or Waste of Medical Assistance services.
  
- 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 as requested including, but not limited to the PH-MCO's claims history, policies/procedures, provider contracts, provider/member review history and current status, complaints, barriers to reviewing the subject provider/member and payment methodology/arrangement.
  - The PH-MCO must provide this information within fifteen (15) business days of the Department's request. The PH-MCO must respond to Urgent requests within two business days.
  - The PH-MCO cannot initiate a review of a Network Provider after the Department advises the PH-MCO of its intention to open a review or investigation by the Department, its designee, or another state or federal agency, without written Departmental authorization to proceed.
  - The PH-MCO will not notify providers/members of the Department's intention to initiate a review.
  - The Department will inform the PH-MCO and the Provider(s) of its request for records, 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 or on behalf of the Department, that are not part of mutually agreed upon joint investigation, will be recouped from the PH-MCO.
  - The Department may utilize statistically valid random sampling in the selection of claims/encounters for review and apply extrapolation methodology in determining the overpayment recovery.
- The PH-MCO should 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 findings.
    - 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 C.F.R. §§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. DHS's, its contractor's or other designee's request for vetting of a provider and/or the MCO's provision of information related to a provider review, audit or investigation does not constitute a mutually agreed upon joint review.

The Department may periodically monitor and evaluate the PH-MCO's audits, reviews and investigations of MA Providers/Members within the PH-MCO's network.

## **5. Management Information Systems**

The PH-MCO must have a secure, comprehensive, automated and integrated MIS that includes a test environment, and is capable of meeting the requirements listed below and throughout this Agreement. Information on Business and Technical Standards is available on the DHS website.

- a. The PH-MCO must have a minimum of the following MIS components or the capability to interface with other data systems containing: Membership, Provider, Claims Processing, Prior Authorization, and Reference data.
- b. The PH-MCO must have an MIS sufficient to support data reporting requirements specified in this Agreement.
- c. The PH-MCO's membership management system must have the capability to receive, update and maintain membership files consistent with specifications provided by the Department. The PH-MCO must have the capability to provide daily updates of membership information to Subcontractors and Providers who have responsibility for processing Claims and authorizing services based on membership information.
- d. The PH-MCO's Provider database must be maintained with detailed information on each Provider sufficient to support Provider payment and meet the Department's reporting and Encounter Data requirements.

The PH-MCO must be able to cross-reference its internal Provider identification number to the correct MMIS Provider ID and Provider NPI number in the Department's MMIS for each location at which the Provider renders services for the PH-MCO.

The PH-MCO must ensure that each Network Provider service location is enrolled and active with MA and that information for all service locations is maintained in its own system.

The PH-MCO must verify that each Network Provider's license information is valid in the Department's MMIS and must outreach to Network Providers to stress the importance of maintaining up to date information in the Department's MMIS.

The PH-MCO must require Network Providers with specific Provider types and specialties have the same Provider types and specialties in the Department's MMIS 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 its 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 Data requirements.
- h. The PH-MCO's credentialing system must have the capability to store and report on Provider-specific data sufficient to meet the Department's credentialing requirements and those listed in Exhibit M(1), Quality Management and Utilization Management Program Requirements.
- i. The PH-MCO must have sufficient telecommunication capabilities, including email, to meet the requirements of this Agreement.
- j. The PH-MCO must have the capability to electronically exchange 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 all operational systems listed in this Agreement, so that data captured in Encounter records matches data in Member,

Provider, Claims and Prior Authorization files. Encounter Data will be utilized for:

- Member and Provider profiling
- Claims validation
- Fraud and Abuse monitoring activities
- Rate setting
- Any other research and reporting purposes defined by the Department.

- I. The PH-MCOs must comply with the Department's Business and Technical Standards including connectivity to the Commonwealth's network for Extranet access. The PH-MCO must also comply with any changes made to these standards.

PH-MCOs must comply with the Department's Se-Government Data Exchange 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, the Department will make every reasonable effort to provide additional notice.

- m. The PH-MCO must be prepared to document its ability to expand claims processing or MIS capacity should either 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 (e.g., Monthly 834 Eligibility File. Provider files).
- 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 MIS, including upgrades and new purchases, the PH-MCO must inform the Department in writing of the potential changes at least six (6) months prior to the change. The PH-MCO must



provide a work plan detailing recovery efforts and the use of parallel systems 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 Drug, Procedure Code, and Diagnosis Code reference files available to the PH-MCO on a routine basis to allow it to effectively meet its obligation to provide services and record information consistent with requirements in this Agreement. Information about these files is available on the Pennsylvania HealthChoices Extranet site. If the PH-MCO chooses not to use these files, it must document the use of comparable files to meet its obligation with this Agreement. .
- t. The Department will supply Provider files on a routine basis to allow the PH-MCO to meet its obligation consistent with requirements in this Agreement. These files include:
  - List of Active and Closed Providers (PRV414 and PRV415)
  - NPI Crosswalk (PRV430)
  - Special Indicators (PR435)
  - Provider Revalidation File (PRV720)
  - Quarterly Network Provider File (Managed Care Affiliates, PRV640Q)

The PH-MCO must use the PRV414 or PRV415 file with the PRV430 on a monthly basis to reconcile its Provider database with that of the Department to confirm:

- All participating providers are enrolled in MA for all service locations as defined by MA enrollment rules
- Participating provider license information is valid
- Provider Types and Specialties match
- Each Provider's NPI, Taxonomy, and Nine-digit Zip code for each service location match

Any provider that does not enroll with MA cannot be enrolled as a participating provider in the PH-MCO. Discrepancies must be addressed with the provider.

PH-MCOs must use the PRV640Q file to reconcile Provider information previously submitted on the Network Provider File (PRV640M).

Information about these files is available on the Pennsylvania HealthChoices Extranet site.

- u. The PH-MCO must have a disaster recovery plan in place with written policies and procedures containing information on system backup and recovery in the event of a disaster.
- v. The PH-MCO must reconcile the 820 Capitation Payment file with its internal membership information and report any discrepancies to the Department within thirty (30) days.
- w. To support PH-MCOs in meeting the requirements of this agreement, the Department will provide access to the following systems:
  - Client Information System (eCIS)
  - Pennsylvania HealthChoices Extranet
  - The Department's MMIS
  - DocuShare

Access to these systems is in addition to the various files that PH-MCOs will receive via secure file transfer. Information on obtaining access to these resources is on the Pennsylvania HealthChoices Extranet.

## **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 grant the Department, CMS, the Pennsylvania Office of Attorney General Medicaid Fraud Control Section, HHS OIG, the Comptroller General, or their designees access to audit, evaluate, and inspect books, records, etc., which pertain to the delivery of or payment for Medicaid services under this Agreement. Subcontractors

and providers must make such books, records, premises, equipment, staff, etc. all available for an audit at any time. Right to inspect extends for ten (10) years after termination of Agreement, or conclusion of an audit, whichever is later.

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 that will be responsible to provide support and case management services 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 and Exhibit NN(1), Special Needs Unit Case Management Standards. 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. When 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.
- 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. If the PH-MCO uses the Member Services Number with an automated prompt that includes an option to be connected to the SNU, this must allow the member direct access to the SNU and not create any barriers in reaching the SNU.
- g. The PH-MCO SNU must assess and assist members with social factors that affect health outcomes. Social determinants of health include, but are not limited to, childcare access and affordability, clothing, employment, financial strain, food insecurity, housing instability/homelessness, transportation, and utilities.
- h. The PH-MCO will partner with the Department on any program-wide efforts to address targeting Social Determinants of Health factors including the development, adoption and dissemination of a resource and referral tool. This includes supporting any members who self-select to participate in any Department designed programs.

## **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 and Exhibit NN(1), Special Needs Unit Case Management Standards.

## **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 Pennsylvania HealthChoices Extranet. 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, 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. Notice of nondiscrimination and the taglines must be posted in physical locations where providers interact with the public.
- 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/School Based Health Centers 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 allow members to access school based health centers for primary care services regardless of PCP on record.

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, gender identity or expression, 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, gender identity or expression, 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, 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.

- c. **The Commonwealth must screen, enroll and periodically revalidate all MA providers. The PH-MCO may execute network provider agreements pending the outcome of the**

revalidation process of up to 120 days. The PH-MCO must terminate a network provider immediately upon notification from the Commonwealth that the network provider cannot be revalidated, or the expiration of one 120 day period without revalidation of the provider. The PH-MCO must notify affected members in accordance with the provider termination requirements of this agreement.

## **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 MMIS Provider ID for each location at which they provide services for the PH-MCO. The PH-MCO must be able to store and utilize the MMIS Provider ID and NPI stored in the Department's MMIS 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, 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, as applicable, under Appointment Standards.

#### **10. Opioid Use Disorder Centers of Excellence**

The Department will implement 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.

#### **11. Health Information Organization**

PH-MCOs must contract with at least one Health Information Organization (HIO) that is capable of connecting to the PA Patient and Provider Network, or P3N. Information about certified regional networks of HIOs can be found at: <http://dhs.pa.gov/ehealth>. Contracting efforts must be documented to demonstrate the PH-MCOs effort in complying with this requirement. The PH-MCO will work with the department and potentially the HIOs to establish a resource and referral tool.

### **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), M(1a) 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 Pennsylvania HealthChoices Extranet 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 15<sup>th</sup> 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 Pennsylvania HealthChoices Extranet. 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 Pennsylvania HealthChoices Extranet.

**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 C.F.R. 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.

**11. Centralized Credentialing**

The PH-MCO must utilize the centralized credentialing vendor when selected by the Department to credential and recredential providers seeking to become a MA-enrolled PH-MCO Network Provider. The centralized credentialing vendor will facilitate the gathering of administrative materials needed for provider credentialing and recredentialing, perform primary source verifications, and provide the results of the primary source verification to the PH-MCO. The PH-MCO will evaluate the information provided by the centralized credentialing vendor and make the final determination of whether a provider will be credentialed or recredentialed with the PH-MCO and added to the PH-MCO's Network. The PH-MCO must establish agreements and cooperate with the Commonwealth-procured centralized credentialing vendor to support the activities of the vendor, including but not limited to data exchange, receipt of verified application materials and other information, marketing, and notification of the outcome of the PH-

MCO's credentialing and recredentialing decisions. The PH-MCO will continue to be responsible for meeting the credentialing and recredentialing requirements as per Exhibit M(1) Quality Management, Utilization Management, and Quality Improvement Program Requirements, Standard VIII in of this Agreement unless otherwise specified by the Department.

## **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 C.F.R. §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:

- \$20.00 million;

- 7.000% of Revenue earned by the licensed HMO during the most recent four (4) calendar quarters; or
- 7.000% 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.

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.

With approval from the Department, the PH-MCO may elect this alternative equity requirement. This alternative requirement has three parts:

- a. PH-MCO RBC ratio of at least three (3.0); and
- b. Substitution of five and one-half percent (5.5%) where the figure seven percent (7.0%) is included in the Three Part Test above; and
- c. Compliance with the Three Part Test with the figure of eight and three tenths percent (8.3%), where seven percent (7.0%) is stated, by individual at-risk Subcontractors who collectively receive at least seventy five percent (75%) of the revenue provided by the Department to the PH-MCO. Revenue, for the purpose of this alternative equity requirement, would be premium revenue reported on the most recently available audited statements and updated to incorporate more recent quarterly information.

The PH-MCO must provide documentation of compliance that is satisfactory to the Department, and failing that, must comply with the standard Three Part Test equity requirement.



**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 below the requirement in Section VII.A.3 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 network providers. 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 C.F.R. §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.

**10. Related Party Hospitals**

The PH-MCO may not include a related party hospital in its network unless the related party hospital, and all physician sites and clinics owned or controlled by the hospital, are included in the network of all but one other PH-MCO that has an Agreement with the Department

to operate in the applicable zone. The Department may waive this requirement if the PH-MCO satisfies the Department that a sufficient number of PH-MCOs are unwilling to contract with the hospital at reasonable terms.

## **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 check and will be sent to the PH-MCO through the U.S. Mail.
- vi. Upon notice to the PH-MCO, and for those months specified by the Department, by the fifteenth (15<sup>th</sup>) of

each month, the Department will make a Capitation payment for each Member for all dates of Enrollment indicated on the Department's eCIS 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 (15<sup>th</sup>) of each month, the Department will make a Capitation payment for each Member for all dates of Enrollment indicated on the Department's eCIS 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 will be payable by July 12 of the same year.

- b) Any Capitation payment that would otherwise be payable in the month of June will be payable by July 26 of the same year.

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

- d) An exception does not apply if a PH-MCO becomes responsible to provide Member benefits effective February 1, March 1, April 1, or May 1 and is not responsible to provide Member benefits in any zone in an earlier month of the same year per any physical health HealthChoices Agreement.

- 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 or for Members aged twenty-one through sixty-four (21 – 64) residing in a free-standing IMD at least 16 days during the calendar month and the Member's condition is not

related to Substance Use Disorder for up to twenty-one (21) months after the service month for which payment was made. The Capitation amount recovered for IMD Members is calculated in accordance with Section VII.E.13.

## **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 live 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. Similarly, if the mother is covered by FFS when admitted to the hospital and then assumes PH-MCO coverage while still in the hospital, the Department will not make a maternity care payment to the PH-MCO. 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 a claim for each eligible maternity care payment to the Department's MMIS in accordance with Section VIII.B.7.

## **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 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**

These requirements and assessments are applied separately by zone.

#### **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 (1<sup>st</sup>) 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 (5<sup>th</sup>) calendar day of the fifth (5<sup>th</sup>) 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 C.F.R. §§ 422.208 and 422.210, which apply to Medicaid managed care under 42 C.F.R. §438.3.
- 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 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 by 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 C.F.R. §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 RHCs**

- a. 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.
- b. If a FQHC/RHC has opted-out of receiving the PPS rate from the PH-MCOs, upon notification from the Department of the date that the FQHC/RHC has opt-out, the PH-MCO is no longer required to make payment at the FFS PPS rate, as noted above. Effective the date the FQHC/RHC has opted-out, the PH-MCO may negotiate and pay the opted-out FQHC/RHC at rates that are no less than what the PH-MCO pays to other providers who provide comparable services within the PH-MCO's Provider Network.
- c. 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.
- d. The PH-MCO must also include in its Provider Network every FQHC and RHC located within this HealthChoices Zone that the PH-MCO operates its Program in that is willing to accept PPS rates as payment in full.
- e. 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.
- f. Effective on or after January 1, 2022, the PH-MCOs will have 90 days from the date of the Department's notification to the PH-MCO of a retroactive PPS rate adjustment to reprocess all applicable FQHC and/or RHC claims that were subject to the requirements of Section VII.E.5.a above. The PH-MCO must send notification to the Department no later than 10 working days after the completion of the required claims reprocessing.
  1. Failure to complete the required claims reprocessing for each FQHC and RHC and to submit notification of the completion of the claims reprocessing to the Department will result in the full assessment of the 90 day claims

processing sanctions in Section VII.D.2 totaling \$15,000. In addition to the sanction amount, the Department will complete a settlement in place of the PH-MCO's claims reprocessing for the FQHC or RHC. The amount the Department pays to the FQHC or RHC for this settlement will be an obligation of the PH-MCO to the Department and recovered by the Department from the PH-MCO through a reduction to a future payment.

## **6. Payments to Ambulance Service Providers**

a. Effective with dates of services beginning January 1, 2019, the PH-MCO must pay rates for certain ambulance services that are not less than the amounts listed in PA's MA fee schedule:

- Basic Life Support
- Advanced Life Support
- Air Ambulance Transport
- Ground Mileage
- Air Mileage

b. Effective January 1, 2021, the PH-MCOs must pay rates to the ambulance service owned and operated by the City of Pittsburgh that are at least 105 percent of the Medicare Fee Schedule, Urban Base Rate for the following services:

- Basic Life Support, non-emergency transport - (A0428)
- Basic Life Support, emergency transport - (A0429)
- Advanced Life Support, Level 1 - (A0426 & A0427)
- Advanced Life Support, Level 2 - (A0433)

If the payment rate required in Section VII.E.6.a are higher than the any or all of the payment rates required by this Section, then the PH-MCO must apply Section VII.E.6.a in place of the requirements in this Section for any or all of the ground ambulance services listed above. For all other services provided by the ground ambulance service owned and operated by the City of Pittsburgh not specifically listed in this Section, the PH-MCO must apply Section VII.E.6.a requirements above.

c. The requirements in 6.a. and 6.b. apply to any Subcontractor of the PH-MCO, as required by Section V.O.2.

## 7. Shift Nursing Uniform Increase

Effective with dates of service on or after January 1, 2022, the PH-MCO shall uniformly increase their contracted payment rates to MA enrolled shift nursing providers participating in their provider network, including but not limited to home health providers, in the amount of \$5 per unit for the following procedure codes:

- S9123 – Nursing Care in the Home by Registered Nurse per one hour
- S9124 - Nursing Care in the Home by Licensed Practical Nurse per one hour

The PH-MCO must submit documentation to the Department upon request to demonstrate that the increased contracted payment rates are in place with each applicable shift nursing provider in their provider network. The increased payment for shift nursing to the applicable providers may be eligible for inclusion in Home Nursing Risk Sharing. Please refer to Appendix 3c for the risk sharing arrangement terms.

## 8. Prohibited Payments

- a. In compliance with the Social Security Act §1903(i)(2)(A-C) and (i)(16-18), the PH-MCO is prohibited from paying for: Medically necessary medical services or products provided or dispensed to Members when:
  - i. The provider is excluded from participation under this or any other Federal funded program;
  - ii. The service is provided at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under this or any other Federally funded program;
  - iii. When the provider furnishing the medical product or service knew or had reason to know of the ordering or referring physician's exclusion from participation under this or any other Federally funded program (after a reasonable time period after reasonable notice has been furnished to the provider); or
  - iv. When the Department has failed to suspend payments during any period when there is a pending investigation of credible



allegation of fraud against a provider, unless the Department determines there is good cause not to suspend such payments in accordance with regulations at 42 C.F.R. 455.23 promulgated by the Secretary of Health and Human Services for purposes of Section 1862(o) of the Social Security Act.

- v. Exception – When the medically necessary medical service or product is provided as an emergency service to the Member.
- b. 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.
- c. 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.
- d. 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 Department with a surety bond as specified in §1861(o)(7) of the Social Security Act.

## **9. Value Based Purchasing**

Value-based purchasing (VBP) is the Department’s initiative to transition providers to being paid for the value of the services provided, rather than simply the volume of services. VBP Payment Strategies and VBP Models are critical for improving quality of care, efficiency of services, reducing cost, and addressing Social Determinants of Health.

The Department has developed an aligned VBP framework that consists of both VBP Payment Strategies and VBP Models. VBP Payment Strategies define the mechanism by which the providers are paid by the MCO. VBP Payment Strategies are tiered by three levels of risk: low, medium, and high.

VBP Models define a way to organize and deliver care and may incorporate one or more VBP Payment Strategies as ways to pay providers. The Department is categorizing VBP Models into recommended models and required models.

PH-MCOs, BH-MCOs, CHC-MCOs, and CHIP-MCOs can form integrated VBP models. MCOs should work towards integrating VBP

models, because addressing physical health needs can improve behavioral health outcomes, and vice versa.

a. VBP Payment Strategies

The MCO must enter into VBP Payment Arrangements with Providers that incorporate approved VBP Payment Strategies. The Department retains the ability to accept or reject any proposals to count toward the required VBP medical spend percentage. The approved VBP Payment Strategies are tiered as low-risk (performance based contracting), medium risk (shared savings, shared risk, bundled payments), and high risk (global payments).

Each arrangement must include quality benchmarks, financial incentives, penalties or both, without which the Department will reject the arrangement as counting towards the required VBP medical spend percentage. MCOs can also layer additional non-financial incentives as long as financial incentives are also in the arrangement.

Approved payment strategies:

- i. Performance based contracting (low-risk strategy): FFS contracts in which incentives payments and/or penalties are linked to Network Provider performance. The MCO must measure Network Providers against quality benchmarks or incremental improvement benchmarks, and must include in the contract incentives or penalties or both based upon meeting these benchmarks.
- ii. Shared Savings (medium-risk strategy): Supplemental payments to Network Providers if they can reduce health care spending relative to an annual cost benchmark, either for a defined Member sub-population or the total Member population served by a Network Provider. The cost benchmark should be developed prospectively, based at least in part on historical claims, and be risk adjusted if needed. The supplemental payment is a percentage of the net savings generated by the Network Provider.
- iii. Shared Risk (medium-risk strategy): Supplemental payments to Network Providers if they are able to reduce health care spending relative to a cost benchmark, either for a defined Member sub-population or the total Member population served by a Network Provider. The cost

benchmark should be developed prospectively, based at least in part on historical claims, and risk adjusted if needed. The payment is a percentage of the net savings generated by the Network Provider. These arrangements also include shared losses with Network Providers if costs are higher relative to a benchmark.

- iv. Bundled payments (medium-risk strategy): Bundled payments include all payments for services rendered to treat a Member for an identified condition during a specific time period. The payments may either be made in bulk, or be paid over regular predetermined intervals. DHS may specify certain services that must be paid through bundled payments.
- v. Global payment (high-risk strategy): Population-based payments that cover all services rendered by a Network Provider, hospital, or health system by the participating MCO.
  - An annual global budget is developed prospectively. These payments can either be made in bulk, delivered over regular predetermined intervals, or based on fee-for-service payments with retrospective reconciliation to the global budget. If these payments are subject to retrospective reconciliation, at least a portion of the payment must be prospective to allow Network Providers to make upfront investments in population health infrastructure.
  - Global payments should link payments to both improved physical health and behavioral health quality measures, and provide incentive to reduce potentially avoidable utilization and address social determinants of health. Global payments must also take into consideration market shift on an annual basis, to ensure that Network Providers are not simply decreasing the amount of care provided.
  - Network Providers who are paid via global payments are excluded from participating in separate bundled payment, shared savings, and shared risk arrangements with the same MCO, because this would be a duplication of payment for services rendered.

b. VBP Models:

VBP Models are divided into Recommended Models, which the Department encourages MCOs to adopt, and Required Models, which are models that MCOs must adopt if they decide to contract with participating Network Providers. MCOs may also implement VBP payment arrangements outside of the recommended models and required models.

Recommended Model:

- Accountable Care Organization (ACO): An ACO Model integrates the financing arm with the delivery arm within the same organization, such that both are collectively responsible for the Member. ACO models may include shared savings, shared risk, or global payments.

Required Models: MCOs must participate in required VBP payment models as specified by the Department and work with the Department on the development of new models. Required models include, but are not limited to:

- Maternity Care Bundled Payment: The MCO must pay Network Providers who elect to partake in the Maternity Care Bundled Payment as specified by the Department.
- Patient Centered Medical Home (PCMH): The MCO must include all requirements for PCMHs as defined in Exhibit DDD to have the arrangement qualify as a PCMH. Note that payments to PCMHs must be categorized as one of the VBP payment arrangements listed in Section A, and still include quality benchmarks, with incentives or penalties or both based upon meeting these benchmarks, without which the payments will not count towards the required VBP medical spend percentage.
- Rural Health Model: MCOs that pay greater than \$500,000 to a hospital participating in the PA Rural Health Model, must offer to pay the participating hospital in the form of a global budget as established by the current Technical Specifications for Rural Hospital Global Budget as published by the Rural Health Redesign Center. Hospitals participating in the Rural Health Model are excluded from bundled payment arrangements, because this would make the hospital doubly liable for a member (in both the global

budget and the bundled payment). Payments that are linked to the Rural Health Model count as a Global Payment.

c. Financial Goals

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. These goals apply collectively to all HealthChoices Agreements between the PH-MCO and the Department in all HealthChoices Zones. 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 2022 – 50% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP. At least 50% of the 50% must be from a combination of strategies 9.a.ii. through 9.a. v.

In addition, the MCOs must incorporate CBOs into VBP arrangements with Network Providers to address SDOH as follows:

- 75% of the medical portion of the capitation and maternity care revenue expended in strategies 9.a.ii. through 9.a.v., must incorporate at least one CBO that addresses at least one SDOH domain. 25% of the medical portion of the capitation and maternity care revenue expended in strategies 9.a.ii. through 9.a.v., must incorporate one or more CBOs that together address 2 or more SDOH domains. For example, if an MCO's total medical spend is \$20 million, and \$10 million is expended in strategies 9.a.ii. through 9.a.v., \$5 million of the \$10 million could incorporate a CBO that addresses food insecurity, and \$2.5 million of the \$10 million could incorporate CBOs that address both food and housing insecurity. The Department may waive this requirement upon receipt from the PH-MCO of alternate proposals to address SDOH needs through VBP.

The MCO must incorporate CBOs into VBP arrangements by either:

- Contracting with a CBO directly. The contract structures between the MCOs and CBOs may include, but are not limited to, payment for services rendered, capitation payments, or value-based payments as long as there is no downside risk to the CBO; or
- Contracting with a Network Provider that subcontracts with a CBO.

The MCO must require the CBO to address at least one of the following SDOH domains, which are included in the statewide resource and referral tool:

- Childcare access and affordability
- Clothing
- Employment
- Financial Strain
- Food insecurity
- Housing instability/ homelessness
- Transportation
- Utilities

Additionally, in determining which CBOs to incorporate into VBP agreements, the MCO should also consider the following characteristics of CBOs:

- Types of services provided
- Accessibility to community members, including hours of operation, location, staffing capacity, accommodations for individuals with special needs including physical disabilities and language barriers
- Number of MA participants served
- Quality of social services provided and experience addressing SDOH
- Soundness of fiscal, operational and administrative practices and capacity
- Service area and populations served
- Capacity for increased referrals from providers or the MCO
- Ability to capture and report SDOH data

d. 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. Performance based contracting – 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. Shared savings– 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.
- iii. Shared risk – dollar value of any performance (bonus) payments and penalty payments, direct payments made to the provider total medical costs incurred by the PH-MCO for Members of the provder’s panel during the time period of the calendar year the Member was attributed to the provder’s panel.
- iv. Bundled payments– dollar value of bundled payments made to providers. The Department may add additional reporting requirements depending on the services being bundled.

- v. Global payments – 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.
- vi. 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.

e. 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.

f. 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 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.

If the determination results in a finding of non-compliance, the Department may 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.



g. 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:

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

**10. 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

**11. 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.

**12. 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.

The Commonwealth enters into a Coordination of Benefits Agreement with Medicare for the MA populations. Consistent with 42 C.F.R. §438.3 (t), the PH-MCO must enter into individual Coordination of Benefits Agreements with Medicare for members dually eligible for Medicaid and Medicare, and participate in the automated claims crossover process.

### **13. Financial Responsibility for transitioning CHC Members**

- A. Section 13.A applies to the PH-MCO's responsibility to provide benefits to a Member who is transitioning to CHC due to approval of LTSS and does not have a spend down period.
  - i. Residence in a nursing facility is not cause for disenrollment from the PH-MCO.
  - ii. The PH-MCO is responsible for nursing facility services so long as the Member is enrolled in the PH-MCO. Once the PH-MCO is notified that a Member has been determined Nursing Facility Clinically Eligible (NFCE), despite not being enrolled in CHC at the time, the PH-MCO would continue to

be responsible to provide nursing facility benefits and all other covered health benefits from the thirty-first (31st) day forward.

- iii. If eCIS 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 same month, the last day of the PH-MCO's responsibility to provide nursing facility benefits and all other covered health benefits is the date prior to the Member's CHC start date.

B. Section 13.B applies to the PH-MCO's responsibility to provide benefits to a Member who is transitioning to CHC due to approval for LTSS and is subject to a spend down period.

- i. Residence in a nursing facility is not cause for disenrollment from the PH-MCO.
- ii. The PH-MCO will not be responsible to pay the nursing facility benefits for the Member having a spend down period for any day after the thirtieth (30<sup>th</sup>) consecutive day the Member resides in the nursing facility and is a Member of this PH-MCO.
- iii. The PH-MCO is responsible for all other services covered by this Agreement on the 31<sup>st</sup> consecutive day and all subsequent days that the Member is enrolled in the PH-MCO. This exemption from responsibility to pay the nursing facility will continue unabated if the Member 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 (30<sup>th</sup>) consecutive day the Member is in the nursing facility until notice is received that the Member's spend down requirement has been met.
- iv. The PH-MCO's responsibility for nursing facility benefits begins the date after the spend down period is complete.
- v. If eCIS 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 same month, the last day of the PH-MCO's responsibility to provide nursing facility benefits and

all other covered health benefits is the date prior to the Member's CHC start date. The CHC start date may be retroactive to the date the Member both received NFCE status and the spend down period commenced.

- C. Section 13.C applies to the PH-MCO's responsibility to provide benefits to a Member who was determined not to be NFCE due to a penalty period.
- i. Residence in a nursing facility is not cause for disenrollment from the PH-MCO.
  - ii. The PH-MCO will not be responsible to pay the nursing facility during the Member's penalty period, as determined by the Department.
  - iii. The PH-MCO is responsible for all other services covered by this Agreement during the Member's penalty period as long as the Member remains enrolled in the PH-MCO.
  - iv. This exemption from responsibility to pay the nursing facility will continue unabated if the Member is admitted to a hospital and returns to the nursing facility within the Member's penalty period. It is acceptable for the PH-MCO to decline to accept or approve nursing facility claims during the Member's established penalty period.
  - v. If the Member's penalty period has ended and the Member remained enrolled in the PH-MCO, then the PH-MCO is responsible for nursing facility benefits the day after the penalty period is complete and all subsequent days the Member remains enrolled in the PH-MCO.
  - vi. If eCIS 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 same month, the last day of the PH-MCO's responsibility to provide nursing facility benefits and all other covered health benefits is the date prior to the Member's CHC start date, which is a date subsequent to completion of the Member's penalty period.
- D. Section 13.D applies to the PH-MCO's responsibility to provide benefits to a Member who was determined not to be NFCE.

- i. Residence in a nursing facility is not cause for disenrollment from the PH-MCO.
- ii. The PH-MCO is responsible to pay the nursing facility after the thirtieth (30<sup>th</sup>) day of residence until the participant leaves the facility, including situations when the member passes away or is discharged prior to being determined eligible for CHC.

#### **14. Coverage for Members in an IMD**

Effective January 1, 2020, the Department will make Capitation payments for a Member aged twenty-one through sixty-four (21 – 64) residing in a freestanding IMD and the Member's condition is not related to Substance Use Disorder (SUD) based on the following criteria:

- If the stay is no more than fifteen (15) cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in a freestanding IMD meets the requirements for *in lieu of services* in 42 C.F.R. 438.3 (e) (2)(i) through (iv), payment will be full capitation in which a Member is enrolled in the PH-MCO.
- If the stay is at least sixteen (16) cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in a freestanding IMD meets the requirements for *in lieu of services* in 42 C.F.R. 438.3 (e) (2)(i) through (iv), the payment will be based as follows: per diem rate identified in Section VII.B.1 multiplied by the number of days the Member is both enrolled in the PH-MCO and not residing in a freestanding IMD.

#### **15. Telephonic Psychiatric Consultation Team Services**

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

#### **16. 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/ 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.

#### **17. Audits**

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

#### **18. Restitution 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 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 PH-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 penalties 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.

With respect to any third party payment received by the PH-MCO from a Provider, the PH-MCO shall ensure that the funds are within their right of recovery following the prescribed order outlined above. If the funds are outside the allowable recovery window, the funds shall be returned to the

Department. These third party payments shall not be held by the MCO for more than 30 calendar days. If the provider 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 provider funds to the Department using the established format.

**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. Confidentiality of the information must be maintained as required by Federal and State regulations. 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. 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 instance: the PH-MCO is no longer the recipient's MCO or the Contract/Policy ID

number is longer than 12 digits, or HIPP Referrals. 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 data as specified by the Department. Whenever possible, the Department will provide reasonable advance notice of modifications or additions to required electronic data submissions.

Information on the submission of the Department's data files is available on the Pennsylvania HealthChoices Extranet site.

## **1. Encounter Data Reporting**

The PH-MCO must record Encounter Data for internal use and submit complete, timely, and accurate Encounter Data to the Department. The PH-MCO shall only submit Encounter Data for Members enrolled in its plan on the date of service and must not submit duplicate records.

The PH-MCO must maintain appropriate systems and mechanisms to obtain all data from its Providers needed to comply with Encounter Data reporting requirements. Failure of a Provider or Subcontractor to provide the PH-MCO with necessary Encounter Data shall not excuse the PH-MCO's noncompliance with this requirement.

The Department will provide a minimum of sixty (60) days advance written notice to the PH-MCO regarding changes to Encounter Data requirements.

### **a. Data Format**

The PH-MCO must submit Encounter Data to the Department using established protocols. Prior to submission of production data, the PH-MCO must pass Encounter Data certification for all transaction types.

The PH-MCO must provide Encounter Data files in the following ASC X12 transactions:

- 837P
  - Professional
  - Professional Crossover
  - Professional Drug
- 837I
  - Inpatient
  - Inpatient Crossover
  - Outpatient
  - Outpatient Crossover
  - Covered Drug

- LTC
- 837D
  - Dental
- NCPDP D.0
  - NCPDP Pharmacy
  - Compound Pharmacy

**b. Timing of Data Submittal**

**i. Provider Claims**

The PH-MCO must require Providers to submit claims to the PH-MCO within one hundred eighty (180) days of 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 NCPDP transactions must be submitted by the PH-MCO and approved in the Department's MMIS on or before the last calendar day of the third month after the adjudication calendar month in which the PH-MCO adjudicated the Claim. NCPDP transactions must be submitted to and approved in the Department's MMIS within thirty (30) days following the adjudication date.

Encounter Data sent to the Department is considered approved when all Department edits are passed.

A file with Encounter Data records that deny due to Department edits will be returned to the PH-MCO. These records must be corrected and resubmitted as "new" Encounter records within the timeframes referenced above.

Corrections and resubmissions must pass all edits before they are approved 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 file submission schedule.

iv. Response Files

The PH-MCO Encounter Data system must have a mechanism in place to receive, process, and reconcile the U277, NCPDP, and ESC Supplemental response files. The PH-MCO must also store the Department's MMIS ICN associated with each processed Encounter Data record returned on the files.

**c. Data Completeness**

The PH-MCO must submit Encounter Data each time a Member has an Encounter with a 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 its Providers and Subcontractors are submitted accurately and timely as Encounters and that denied Encounters are resolved and resubmitted;
- ii. Evaluates 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.

Upon request from the Department, the PH-MCO must submit a Data Completeness Plan for review and approval. This 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 must assist the Department in its validation of Encounter Data by making medical records and Claims data available as requested. The validation may be completed by Department staff, 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, 837P Professional Drug, and 837I Covered Drug transactions used for the purpose of drug rebate dispute resolution. The file must be submitted by the fifteenth (15<sup>th</sup>) day of the month following the month in which the drug transaction was processed in the Department's MMIS as specified on the Pennsylvania HealthChoices Extranet.

The MCO Supplemental Data Status Report will be provided to the PH-MCO on or after the 20<sup>th</sup> of each month following receipt of the Drug Rebate Supplemental File. PH-MCOs must use this report to reconcile and correct any errors on Drug Rebate data that was submitted.

## **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 weekly file (EVS/PCP) to the Department's MMIS containing PCP assignments for all its Members. This file is used to update the Department's Eligibility Verification System.

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 comply with the file submission requirements found on the Pennsylvania HealthChoices Extranet.



#### **4. Provider Network**

The PH-MCO must provide a monthly Network Provider File (PRV640M) to the Department. The initial file must contain records for its entire Provider Network, including Subcontractors. Subsequent monthly files should contain only updates.

The PH-MCO must confirm the information is consistent with all requirements by utilizing the response report (PRM640M) 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 on the Pennsylvania HealthChoices Extranet.

#### **5. Alerts**

The PH-MCO must report to the Department on a Weekly Enrollment/Disenrollment/Alert file: pregnancy (not on eCIS), death (not on eCIS), newborn (not on eCIS) and returned mail.

The PH-MCO must confirm the information is consistent with all requirements specified on the Pennsylvania HealthChoices Extranet.

#### **6. Insure Kids Now File**

PH-MCOs must submit a complete, accurate, and timely Insure Kids Now file quarterly on the 15th of January, April, July, and October. The file must contain information on all active MCO network MA-enrolled dental providers. DHS collects this data and submits a master file to CMS who publishes an online list of dental providers available to eligible MA recipients.

The file must contain a unique record for each dental provider, and all PH-MCO lines of business must be submitted in the same file. Data that contains errors or are incomplete will be returned to the PH-MCO and must be corrected and resubmitted within three days of receiving notification of the errors.

All data must meet Department file specification requirements. Details are available on the PA HealthChoices Extranet.

#### **7. Maternity Care**

The PH-MCO must submit maternity care claims to the Department using established protocols. Prior to submission of production data,

the PH-MCO must pass Maternity Care certification for all transaction types.

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 Pennsylvania HealthChoices Extranet.

### **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 and annual statistical reports which relate to its Fraud and Abuse detection and sanctioning activities regarding Providers. The PH-MCO must include the following information on all quarterly reports:

- Information for all situations where a Provider action caused an overpayment to occur
- Cases under review including approximate dollar amounts
- Providers terminated due to Medicare/Medicaid preclusion
- Overpayments recovered
- Cost avoidance issues related to identifying and/or identified fraud, waste, and abuse (42 C.F.R. 438.608(a)(2))

#### **3. Electronic Visit Verification**

The PH-MCO must have a fully operational EVV system for in-home personal care and home health services that complies with the requirements of 42 U.S.C. § 1396b(l). The EVV system must verify and record electronically (for example, through a telephone or computer-based system) at least the following: the type of service performed, the individual receiving the service, the individual

providing the service, the date of the service, the location of the service, and the time the service begins and ends. In addition to capturing the elements outlined above, the EVV system must meet the technical specifications outlined in the DHS EVV Addendum and be able to interface with the DHS EVV Aggregator.

Providers may choose to use their own EVV vendor/system so long as the system meets all of the necessary requirements. Providers using an alternate EVV system in the HealthChoices Physical Health program will be required to establish an interface with the PH-MCO.

The PH-MCOs must follow all EVV requirements outlined by the Department. The PH-MCOs are responsible for monitoring provider compliance requirements outlined in the corresponding bulletins and must implement corrective action plans when providers do not meet the compliance requirements.

The PH-MCOs must validate that visit data supports claims submissions as part of the adjudication process. All encounter claims submitted for services subjected to EVV requirements must include corresponding visit data.

The implementation of EVV must not negatively impact the provision of services. The Department's policies and procedures regarding the provision of services remain the same and service delivery should continue as it did before the implementation of these EVV requirements. EVV does not change the method and location for service delivery.

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 Pennsylvania HealthChoices Extranet at Managed Care Program/*Fraud and Abuse*.

#### **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 Pennsylvania HealthChoices Extranet 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 (2<sup>nd</sup>) 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 (5<sup>th</sup>) calendar day of the second (2<sup>nd</sup>) 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 C.F.R. §§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.
  - Fails to comply with Agreement requirements and any applicable federal and state law, regulation or guidance.

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 C.F.R. 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. To offset potentially unnecessary expenditures within the MA Program, the Department will recoup any funds inappropriately expended by the PH-MCO that were the result of a violation of Agreement requirements or federal or state law, regulation or formal guidance.
  - c. Requiring the submission of a corrective action plan;
  - d. Limiting Enrollment of new Recipients;
  - e. Suspension of payments;
  - f. Temporary management subject to applicable federal or state law;
  - g. 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 (1<sup>st</sup>) 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 (15<sup>th</sup>) 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 (16<sup>th</sup>) 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, 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. Drug Encounters: Sanctions for non-compliance with drug encounter data timeliness is set forth in Exhibit BBB, 9. Drug Encounters.
- h. Pursuant to 42 C.F.R. 438.704(c), if the State imposes a civil monetary penalty on the PH-MCO for charging premiums or charges in excess of the amounts permitted under Medicaid, the State will deduct the amount of the overcharge from the penalty and return it to the affected enrollee.

#### **I. Non-Duplication of Financial Penalties**

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

#### **J. Provider-Preventable Conditions**

1. In compliance with 42 C.F.R. 434.6(a)(12)(i) and 447.26 (d) the PH-MCO will report all identified provider-preventable conditions in the form and frequency detailed in the MCO Operations Reporting Requirements on DocuShare.

2. The PH-MCO is prohibited from making payment to a provider for provider-preventable conditions that meet the following criteria:

- a. Is identified in the State Plan;
- b. 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;
- c. Has a negative consequence for the beneficiary;
- d. Is auditable;
- e. 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.

3. The PH-MCO will develop and disseminate policies and procedures that prohibit payments for inpatient services related to treating provider-preventable conditions.

4. The Department will recoup any funds expended by the PH-MCO for payments related to inpatient services for provider-preventable conditions.

## **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**

1. The PH-MCO must:

- a. 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;
- b. Inform the Department, in writing, of any change in or addition to the ownership or control of the PH-MCO;



- c. Submit to the Department the date of birth and Social Security Number (SSN) of and individual with an ownership or control interest in the PH-MCO and its subcontractors;
  - d. Submit to the Department other tax identification number of any corporation with an ownership or control interest in the PH-MCO and any subcontractor in which the PH-MCO has a five percent (5%) or more interest;
  - e. Submit information on whether an individual or corporation with an ownership or control interest in the PH-MCO is related to another person with ownership or control interest in the PH-MCO as a spouse, parent, child, or sibling;
  - f. Submit information on whether a person or corporation with an ownership or control interest in any subcontractor in which the PH-MCO has a five percent (5%) or more interest is related to another person with ownership or control interest in the PH-MCO as a spouse, parent, child, or sibling; and
  - g. Submit the name, address, date of birth, and SSN of any managing employee of the PH-MCO.
2. In accordance with 42 C.F.R. 455.104, 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:
- a. Name and address (the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address);
  - b. Date of birth and Social Security Number (in the case of an individual);
  - c. Other tax identification number (in the case of a corporation);
  - d. 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;
  - e. The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest; and

- f. The name, address, date of birth and Social Security Number of any managing employee 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.

Pursuant to Section 1903(m)(4)(B) of the Social Security Act the PH-MCO will make reports of any transactions between the PH-MCO and parties in interest that are provided to the State or other agencies available to PH-MCO enrollees upon reasonable request.

### **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. If the PH-MCO notifies the Department of its intent to terminate or terminates an agreement with the Department to provide services for any Physical Health HealthChoices zone, any HealthChoices Program, including the Behavioral Health HealthChoices Program or Community HealthChoices Program or the Children's Health Insurance Program, the Department, in its sole discretion, may terminate this Agreement for its 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<sup>th</sup>) day falls. The Department is not required to provide one hundred twenty (120) days advance notice if the Department and the PH-MCO are entering into a new agreement the Physical Health 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 (120<sup>th</sup>) 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**

Within one hundred eighty (180) days of expiration or termination of the Agreement, 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 (1<sup>st</sup>) day of the fifth (5<sup>th</sup>) 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 (1<sup>st</sup>) 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, the Pennsylvania Office of Attorney General Medicaid Fraud Control Unit, and 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.

On request, and consistent with state and federal confidentiality obligations, the PH-MCO must furnish to DHS, the Pennsylvania Office of Attorney General Medicaid Fraud Control Unit and federal agencies or their designees any information regarding payments claimed by the provider for furnishing services under the plan.

Consistent with state and federal confidentiality obligations, the Department, the Pennsylvania Office of Attorney General Medicaid Fraud Control Unit, and federal agencies or their designees are entitled to the inspection and audit of records or documents and to have access to facilities of the MCO, PIHP, PAHP, or its Subcontractors, at any time, to inspect and audit any records or documents and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.

2. In the event that the Department, the Pennsylvania Office of Attorney General Medicaid Fraud Control Unit 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 in DocuShare. In addition, the PH-MCO must include 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 C.F.R. 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 C.F.R. 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-MCO, the PH-MCO may receive all information relating to the health status of its Members, including treatment information, by the exchange of data and 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, 6<sup>th</sup> 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, 6<sup>th</sup> 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, 6<sup>th</sup> 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.

Document No.: 100735366A

SAP Vendor No.: 149939

Document Type: Grant Agreement

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

**GRANTEE**

**Ellen Duffield** 5/26/2022

Signature / Title Date

PRINT OR TYPE NAME AND TITLE

Ellen Duffield, President & CEO

**Frances A. Woodward**

Digitally signed by Frances A. Woodward  
DN: cn=Frances A. Woodward, o=Gateway Health, LLC, ou=SVP, Chief Legal Officer, email=fwoodward@gatewayhealthplan.com, c=US  
Date: 2022.05.26 11:50:24 -04'00'

Signature / Title Date

PRINT OR TYPE NAME AND TITLE

**COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES**

**DEPUTY SIGNATURE**

*Sally G. Kozal* 5/26/2022

Signature Date

**SECRETARY OR DESIGNEE**

**Ally Wullbrandt**  
Digitally signed by Ally Wullbrandt  
Date: 2022.07.19 15:43:17 -04'00'

Signature Date

**COMPTROLLER OPERATIONS**

**Ann Lefevre**

Digitally signed by Ann Lefevre  
Date: 2022.09.08 08:10:07 -04'00'

Signature Date

**Approved as to Legality and Form:**

*Lara Antonuk*  
Digitally signed by Lara Antonuk  
Date: 2022.07.22 13:42:20 -04'00'

*David E. Stover*  
Digitally signed by David E. Stover, Senior Deputy Attorney General  
Date: 2022.09.01 10:17:28 -04'00'

*Pamela J. Cross* 2022.08.03 12:19:28 -04'00'

OFFICE OF GENERAL COUNSEL  
DEPARTMENT OF  
HUMAN SERVICES

DEPUTY ATTORNEY GENERAL  
OFFICE OF ATTORNEY GENERAL

DEPUTY GENERAL COUNSEL  
OFFICE OF GENRAL COUNSEL