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PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

Bureau of Procurement and Contract Management

GRANT AMENDMENT #1

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

eduffield@HighmarkWholecare.com

[redacted]

149939

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.

AMENDMENT No. 1 to

HEALTHCHOICES
PHYSICAL HEALTH AGREEMENT No. 100735366A

THIS Amendment to Grant Agreement No. 100735366A ("Amendment") is made by and between the Commonwealth of Pennsylvania, Department of Human Services ("Department") and Gateway Health Plan, Inc., d/b/a Highmark WholeCare ("PH-MCO"), collectively, the "Parties."

W I T N E S S E T H:

WHEREAS, the Department and the PH-MCO are parties to Grant Agreement No. 100735366A effective September 1, 2022 ("Grant Agreement");

WHEREAS, the purpose of the Grant Agreement is to provide for a mandatory managed care program, under the name HealthChoices Physical Health Program (the "HC-Physical Health Program"), for Medical Assistance consumers in the Southwest and Lehigh/Capital HC-Physical Health Zones in Pennsylvania;

WHEREAS, the Department desires to amend the Grant Agreement and certain Appendices and Exhibits; and

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

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

1. Effective January 1, 2023, the Grant Agreement effective September 1, 2022, excluding its Appendices and Exhibits ("Prior Agreement") is deleted and replaced with the attached Grant Agreement effective January 1, 2023.

2. The following Appendices to the Prior Agreement are deleted and replaced with the attached Appendices:

    a. Effective January 1, 2023, Appendix 3b Explanation of Capitation Payments (dated May 4, 2022) is replaced with the attached Appendix 3b Explanation of Capitation Payments (dated September 21, 2022).
    b. Effective January 1, 2023, Appendix 3c Home Nursing Risk Sharing Arrangement (dated May 4, 2022) is replaced with the attached Appendix 3c Home Nursing Risk Sharing Arrangement (dated September 21, 2022).
    c. Effective January 1, 2023, Appendix 3e Family Planning Services (dated May 4, 2022) is replaced with the attached Appendix 3e Family Planning Services (dated September 21, 2022)
    d. For services provided on or after January 1, 2023, Appendix 3f Capitation Rates Lehigh Capital (prepared on May 4, 2022) is replaced with the attached Appendix 3f Capitation Rates Lehigh Capital (prepared on October 14, 2022).
    e. For services provided on or after January 1, 2023, Appendix 3f Capitation Rates Southwest (prepared on May 4, 2022) is replaced with the attached Appendix 3f Capitation Rates Southwest (prepared on October 14, 2022).

f. Effective January 1, 2023, Appendix 3g Overview of Methodologies for Rate Setting and Determination of Risk Sharing Premium Allowance Amounts (dated May 4, 2022) is replaced with the attached Appendix 3g Overview of Methodologies for Rate Setting and Determination of Risk Sharing Premium Allowance Amounts (dated September 21, 2022).
g. Effective January 1, 2023, Appendix 3h, Medical Loss Ratio Reporting and Remittance Requirements (dated May 4, 2022) is replaced with the attached Appendix 3h, Medical Loss Ratio Reporting and Remittance Requirements (dated September 21, 2022).
h. Effective January 1, 2023, Appendix 3k High Cost Risk Pool (dated May 4, 2022) is replaced with the attached Appendix 3k High Cost Risk Pool (dated September 21, 2022).
i. Effective January 1, 2023, Appendix 3m MCO Assessment (dated May 4, 2022) is replaced with the attached Appendix 3m MCO Assessment (dated October 6, 2022).
j. Effective January 1, 2023, Appendix 3p Risk Sharing Arrangement for Members Under Age One (dated May 4, 2022) is replaced with the attached Appendix 3p Risk Sharing Arrangement for Members Under Age One (dated September 21, 2022).
k. Effective January 1, 2023, Appendix 6 Home Accessibility Risk Sharing Arrangement (dated May 4, 2022) is replaced with the attached Appendix 6 Home Accessibility Risk Sharing Arrangement (dated September 21, 2022).
l. Effective January 1, 2023, Appendix 14 APR/DRG Adjustment Inpatient Acute Care Services (dated May 9, 2022) is replaced with the attached Appendix 14 Inpatient Acute Care Services Directed Payments (dated September 21, 2022).
m. Effective January 1, 2023, Appendix 17 Adjustment Outpatient Hospital Services (dated May 9, 2022) is replaced with the attached Appendix 17 Outpatient Hospital Services Directed Payments (dated September 21, 2022).
n. Effective January 1, 2023, Appendix 18 COVID-19 Vaccine Non-Risk Arrangement (dated May 4, 2022) is replaced with the attached Appendix 18 COVID-19 Non-Risk Arrangement (dated September 21, 2022).
o. Effective January 1, 2023, Appendix 18A Shift Nursing Shadow Nurse Non-Risk Arrangement (dated September 21, 2022) is added to this Grant Agreement.
p. Effective January 1, 2023, Appendix 18B High-Cost Gene Therapy Non-Risk Arrangement (dated September 30, 2022) is added to this Grant Agreement.
q. Effective January 1, 2023, Appendix 19 Physical Health HealthChoices Revenue Sharing (dated December 14, 2022) has been added to this agreement.
r. Effective January 1, 2023, Appendix 19a Physical Health HealthChoices Revenue Sharing (dated December 14, 2022) has been added to this agreement.
s. Effective January 1, 2023, Appendix 19b Physical Health HealthChoices Revenue Sharing (dated December 14, 2022) has been added to this agreement.

3. Effective January 1, 2023, the following Exhibits to the Grant Agreement are modified as follows:

a. The following Exhibits are deleted and replaced with the attached Exhibits: Exhibit A, Exhibit B(1), Exhibit B(2), Exhibit B(3), Exhibit B(4), Exhibit B(5), Exhibit B(5a), Exhibit B(6), Exhibit B(7), Exhibit F, Exhibit G, Exhibit H, Exhibit J, Exhibit L, Exhibit M(1), Exhibit M(1a), Exhibit M(4), Exhibit P, Exhibit BB, Exhibit DD, Exhibit GG, Exhibit KK, Exhibit NN, Exhibit WW, Exhibit AAA, Exhibit BBB, and Exhibit DDD.

b. The following Exhibits are added as new Exhibits: Exhibit B(1a) and Exhibit D(1).

4. The attached Grant Agreement, Appendix 3b, Appendix 3c, Appendix 3e, Appendix 3f, Appendix 3g, Appendix 3h, Appendix 3k, Appendix 3m, Appendix 3p, Appendix 6, Appendix 14, Appendix 17, Appendix 18, Appendix 18A, Appendix 18B, Appendix 19, Appendix 19a, Appendix 19b, Exhibit A, Exhibit B(1), Exhibit B(1a), Exhibit B(2), Exhibit B(3), Exhibit B(4), Exhibit B(5), Exhibit B(5a), Exhibit B(6), Exhibit B(7), Exhibit D(1), Exhibit F, Exhibit G, Exhibit H, Exhibit J, Exhibit L, Exhibit M(1), Exhibit M(1a), Exhibit M(4), Exhibit P, Exhibit BB, Exhibit DD, Exhibit GG, Exhibit KK, Exhibit NN, Exhibit WW, Exhibit AAA, Exhibit BBB, and Exhibit DDD are incorporated and made part of the Grant Agreement.

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

[SIGNATURE PAGE FOLLOWS.]

Document No.: 100735366A SAP Vendor No.: 149939

Document Type: Grant Amendment #1

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

GRANTEE

Ellen M. Duffield
Ellen M. Duffield (Dec 15, 2022 12:59 EST) Dec 15, 2022

Signature / Title Date

Ellen Duffield, President and Chief Executive Officer

Signature / Title Date

PRINT OR TYPE NAME AND TITLE

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES

DEPUTY SIGNATURE

Sally C. Kozel 12/15/2022

Signature Date

SECRETARY OR DESIGNEE

Ally Wullbrandt Digitally signed by Ally Wullbrandt DN: cn=Ally Wullbrandt, ou=BPCM, email=awullbrand@pa.gov, c=US Date: 2023.01.13 14:41:14 -05'00'

Signature Date

COMPTROLLER OPERATIONS

Donna Kohr Digitally signed by Donna Kohr Date: 2023.03.01 14:33:50 -05'00'

Signature Date

Approved as to Legality and Form:

Digitally signed by Lara Antonuk Date: 2023.02.01 11:59:21 -05'00'

OFFICE OF GENERAL COUNSEL
DEPARTMENT OF
HUMAN SERVICES

Digitally signed by David E. Stover, Senior Deputy Attorney General Date: 2023.02.22 13:08:07 -05'00'

DEPUTY ATTRONEY GENERAL
OFFICE OF ATTORNEY GENERAL

DEPUTY GENERAL COUNSEL
OFFICE OF GENRAL COUNSEL

Rev. 10.12.2020

HEALTHCHOICES AGREEMENT

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SECTION I: INCORPORATION OF DOCUMENTS

A. Operative Documents

The RFA, 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 RFA, 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 RFA conflict with, or are inconsistent with the terms of the Proposal, the terms of the RFA 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 RFA, 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 (bis primarily and customarily used to serve a medical purpose (c) generally is not useful to an individual in the absence of an 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 — Diagnosis, treatment, drugs, supplies, and related counseling which are provided to individuals of child-bearing age to enable the individuals to determine freely the number and spacing of their children.

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 individual health center site location that is receiving, or meets all of the requirements to receive (FQHC "look alike"), grant funds under Sections 329, 330, 340, or 340A of the Public Health Services (PHS) Act; or that does not currently meet all of the FQHC requirements under the PHS Act, but does meet all applicable requirements for Medical Assistance (MA) providers as set forth in Chapter 1101 of the MA regulations (including licensure and certification standards under Pennsylvania Law), and receives a temporary waiver from the Secretary of the U.S. Department of Health and Human Services allowing the health center to act as a FQHC.

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, item, procedure, or level of care compensable under the MA program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

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

- 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) - An individual health clinic site engaged primarily in providing typical outpatient clinic services in underserved areas that has been determined by the Secretary of the U.S. Department of Health and Human Services to meet the requirements of § 1861(aa)(1) of the Social Security Act and 42 Code of Federal Regulations (CFR) Part 491, has filed an agreement with the Secretary in order to provide rural health clinic services under Medicare; and meets all applicable requirements for MA providers as set forth in Chapter 1101 of the

MA regulations (including licensure and certification standards under Pennsylvania Law).

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 RFA ACRONYMS

For the purpose of this Agreement and RFA, 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
NPPES — National Plan and the Provider Enumeration System
OBRA — Omnibus Budget Reconciliation Act
OCDEL — Office of Child Development and Early Learning
OCYF — Office of Children, Youth and Families
ODP — Office of Developmental Programs
OIP — Other Insurance Paid
OLTL — Office of Long Term Living
OMAP — Office of Medical Assistance Programs
OMHSAS — Office of Mental Health and Substance Abuse Services
OPPC — Other Provider-Preventable Condition
ORC — Other Related Conditions.
OTC — Over-the-Counter
OUD-COE — Opioid Use Disorder Centers of Excellence
P&T — Pharmacy & Therapeutics
PAHP — Prepaid Ambulatory Health Plan
PARP — Prior Authorization Review Panel.
PBM — Pharmacy Benefit Manager
PCP — Primary Care Practitioner
PCCM — Primary Care Case Manager
PCMH — Patient Centered Medical Home
PDA — Pennsylvania Department of Aging
PDL — Preferred Drug List
PERT — Program Evaluation and Review Technique
PH — Physical Health
PHDHP — Public Health Dental Hygiene Practitioners
PH-MCO — Physical Health Managed Care Organization
PHS — Public Health Service
PID — Pennsylvania Insurance Department
PIHP — Prepaid Inpatient Health Plan
PIP — Physician Incentive Plan
PIPs — Performance Improvement Projects
PMPM — Per Member, Per Month

POSNet — Pennsylvania Open Systems Network
PPC — Provider Preventable Condition
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
RFA — Request for Applications
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 RFA
   - 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, 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. 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, heart, heart/lung, lung, liver, pancreas, pancreas/kidney, intestinal, corneal, stem cell, bone marrow, or peripheral stem cell.

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 as defined in 55 Pa. Code Chapter 1140 (relating to Healthy Beginnings Plus Program) and current or future guidance provided in MA Bulletins that govern the HBP Program. The PH-MCO must also continue the coordinated services relating to pregnancy included in the HBP

Program by utilizing enrolled HBP Providers or developing comparable resources. The PH- MCO must provide a full description of its plan to provide services relating to pregnancy for pregnant women and infants in fulfillment of the HBP Program objectives if requested by the Department. This plan must include comprehensive postpartum care.

The HBP Program requires that pregnant women must be adequately screened for substance use disorders and referred to treatment for positive screenings.

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 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 permissible use by the Department as per Exhibit B(5)a Home Visiting Program.

c. Opioid Use Disorder Centers of Excellence Care Management

The PH-MCO must provider care management services for members with Opioid Use Disorder according to the provisions of the State Plan and of Exhibit G to this Agreement.

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.

21. School-Based Health Centers

The PH-MCO must include in its Provider Network any School-Based Health Center 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 School-Based Health Center requests for entrance to the Network that it intends to deny based upon quality of care, program integrity or other relevant concerns.

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, Utilization Management and Quality Improvement 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^{th}) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, the PH-MCO must hand deliver the notice to the Member, or the request is automatically approved.

e. If the Member is currently receiving a requested service and the PH-MCO decides to deny the Prior Authorization request, the PH-MCO must mail the written notice of denial at least (10) days prior to the effective date of the denial of authorization for continued

services. If probable Member fraud has been verified, the period of advance notice is shortened to five (5) days. The PH-MCO is not required to provide advance notice when it has factual information on the following:

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

3. Prior Authorization of 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
- Additional Examples given in Exhibit OO

- 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 $10.00 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.

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

4. Limited English Proficiency (LEP) Requirements

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

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

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

If discrepancies are found, the PH-MCO must first check eCIS and the Daily 834 file to see if the discrepancy has been resolved prior to reaching out to the Department. If the discrepancy persists the MCO must notify the Department within thirty (30) business days.

Recipients not included on the Monthly 834 file with an indication of prospective coverage will not be the responsibility of the PH-MCO unless a subsequent Daily 834 Membership File 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), 28 Pa. Code Chapter 9, 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 PID's Bureau of Managed Care (BMC) 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 PID's BMC 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 (1/4th) of the membership of the Committee must be composed of Health Care Providers/peers;
  - Committee members who have the authority, training, and expertise to address and resolve Provider Dispute/Provider Appeal issues;
  - Access to data necessary to assist committee members in making decisions; and
  - Documentation of meetings and decisions of the Committee.

L. Certification of Authority and County Operational Authority

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

The PH-MCO must also maintain operating authority in each county covered by this Agreement. The PH-MCO must provide to the Department a copy of the PID 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 full-time 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 manger 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 Dental 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/EPSDT Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant; or has a Master's degree in Health Services, Public Health, or Health Care Administration to coordinate maternity and prenatal care and EPSDT services.

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

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

problems or inquiries. 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 Medicheck listings or upon request if a Provider with whom the PH-MCO has entered into a Provider Agreement is subsequently suspended or terminated from participation in the MA or Medicare Programs. Upon notification from the Department that a Network Provider is suspended or terminated from participation in the MA or Medicare Programs, the PH-MCO must immediately act to terminate the Provider from its Network. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

The PH-MCO is required to check the 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 Medicheck 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 vender 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.

l. 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. 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.

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

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 in lieu of a separate SNU Hotline, 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/UM/QI Program Requirements

1. Overview

The PH-MCO must comply with the Department's QM/UM/QI Program standards and requirements described in Exhibit M(1) Quality Management, Utilization Management and Quality Improvement Program Requirements, Exhibit M(1a) Quality Management Requirement for Regional Accountable Health Councils, 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/Quality Improvement 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/UM/QI programs, including subsequent changes. The PH-MCO must comply with all QM/UM/QI 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/UM/QI activities and initiatives based on areas of importance to the Department and CMS.

2. Healthcare Effectiveness Data and Information Set (HEDIS®)

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

3. External Quality Review (EQR)

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

4. Pay for Performance Programs

The Department conducts a Pay for Performance (P4P) Program that provides financial incentives for PH-MCOs that meet quality goals. Information regarding MCO Pay for Performance Programs may be found in Exhibit B(1), HealthChoices MCO Pay for Performance Program. Information regarding the Provider Pay for Performance Program may be found in Exhibit B(3), HealthChoices Provider Pay for Performance Program.

5. QM/UM/QI Program Reporting Requirements

The PH-MCO must comply with all QM/UM/QI program reporting requirements and time frames outlined in Exhibit M(1) Quality Management, Utilization Management and Quality Improvement 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/QI reporting requirements. Information regarding QM/UM/QI 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.

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^{th}) 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^{th}) 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.

viii. Upon written notification to the PH-MCO, the Department may delay the capitation payments made in May and/or June of each calendar year that would have otherwise been made under either Section VII.B.1.a.vi or VII.B.1.a.vii, above, to payment dates in July of the same calendar year. The Department will include in the written notification the applicable payment dates for the delayed capitation payments.

ix. 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 bill 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 MA 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

The Department will apply these requirements and assessments to each PH-MCO in total for all HealthChoices zones combined.

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 PH-MCO bank notification date for electronic payment. The check date is the date printed on the check. The amount of time required to adjudicate a Denied Claim is computed by comparing the date the Claim is received with the date the denial notice was

created or the transmission date of an electronic denial notice. The PH-MCO must mail checks not later than three (3) Business Days from the check date and make electronic payments within three (3) Business Days of the bank notification date.

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

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

2. Assessments

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

All Claims received during the month, for which an assessment is being computed, that have not been adjudicated at the time the assessment is being determined, shall be considered a Clean Claim.

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

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

a. Inpatient Claims

b. Claims other than inpatient and drug

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

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

The total assessment for the current month will increase to $25,000 if the following conditions exist:

- If PH-MCO fails to comply with any adjudication timeliness requirement for Claims received in any six (6) 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 $25,000.

3. Sanctions

When the PH-MCO fails to meet the claims processing timeliness standards included in Section VII.D.1 for three consecutive monthly claims processing report reviews, the Department will impose a sanction under Section VIII.H.1.a for each day the PH-MCO has not complied with the claims processing timeliness requirements. The sanction will begin with the first day of the first monthly claims processing report demonstrating non-compliance and continuing until the day prior to the date the PH-MCO submits the required claims processing report demonstrating they are in compliance with requirements in Section VII.D.1.

Per Section VIII.I, this sanction will be imposed in place of the monthly assessment amount for each applicable month of consecutive non-compliance and for each subsequent month up to and including the day prior to the date the PH-MCO submits the required claims processing report demonstrating compliance with Section VII.D.1. The Department will offset the applicable sanction amount by any monthly assessment amount paid for the initial non-compliance month and the second consecutive month of non-compliance.

The Department may at its discretion decide to waive all or only a portion of this sanction. If this sanction is waived in full, then the monthly assessment amount for each applicable non-compliant

month included as part of the sanction will apply per Section VII.D.2.

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	$2,000
80.0 – 87.9	$6,000
70.0 – 79.9	$10,000
60.0 – 69.9	$16,000
50.0 – 59.9	$20,000
Less than 50.0	$30,000
Percentage of Clean Claims Adjudicated in 45 Days	Assessment
98.0 – 99.5	$2,000
90.0 – 97.9	$6,000
80.0 – 89.9	$10,000
70.0 – 79.9	$16,000
60.0 – 69.9	$20,000
Less than 60.0	$30,000
Percentage of All Claims Adjudicated in 90 Days	Assessment
98.0 – 99.5	$2,000
90.0 – 97.9	$6,000
80.0 – 89.9	$10,000
70.0 – 79.9	$16,000
60.0 – 69.9	$20,000
Less than 60.0	$30,000

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 Methodologies in the State Plan.

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. The PH-MCO must consider the FQHC and/or RHC as both the billing and rendering provider of clinic services provided to Members.

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.

g. The PH-MCO shall participate in a conceptual modeling pilot for Value-Based Purchasing as described in Section VII.E.9 below.

6. Payments to Ambulance Service Providers

a. 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. 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 list of services. Effective January 1, 2023, the PH-MCOs must pay rates to the ambulance service owned and operated by the City of Philadelphia that are at least 105 percent of the Medicare Fee Schedule, Urban Base Rate for the following list of 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 and the City of Philadelphia 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

a. The PH-MCO must maintain the uniform increase of $5 per unit to the contracted payment rates to MA enrolled shift nursing providers participating in their provider network, including but not limited home health providers, 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

b. If the PH-MCO enters into a new network agreement with an eligible shift nursing provider that has an effective date during the current calendar year, then the contracted payment rate must be at least equal to the MA Fee Schedule Rate for the S9123 and S9124.

c. 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 per this Section. 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 in Exhibit B(7).

- 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.

- Pediatric Shift Nursing Improvement Payment: The PH-MCO must enter into performance-based contracts as described in Section VII.E.9.a that provide incentives for Network Providers that attain incremental improvement against selected measures. Network Providers eligible for inclusion in this model are Primary Care Practitioners and home health agencies that serve children who are reported as having authorized hours not covered in the monthly MCO Shift Care Operations Report. Permissible measures are described in Exhibit B(3) to this Exhibit.

- FQHC/RHC Conceptual Modeling Pilot: The PH-MCO shall develop and prepare to implement a VBP model instead of the PPS rate for any FQHC or RHC that opts in to the pilot. The VBP model may be derived from any of the strategies described in Section 9.a.ii. through 9.a.v. above, with a preference for strategies 9.a.iv and 9.a.v. The PH-MCO shall meet with each participating FQHC or RHC at least quarterly to discuss data sharing needs, potential models, and budget forecasting and projections. The PH-MCO shall participate in these meetings through Calendar Year 2023 to prepare for implementation of the selected model(s) in Calendar Year 2024. The PH-MCO shall share data in real-time regarding the FQHC/RHC's panel of members that will aid in the development of the VBP model(s). In the event that an FQHC/RHC's panel has insufficient members to support a VBP model with an individual PH-MCO, the PH-MCO shall collaborate with other PH-MCOs to develop a joint VBP proposal.

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 2023 – 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:

- 18% of the total medical portion of the capitation and maternity care revenue (or 75% of that expended in strategies 9.a.ii. through 9.a.v.), must incorporate at least one CBO that addresses at least one SDOH domain. 6.25% of the total medical portion of the capitation and maternity care revenue (or 25% of that 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 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 provider's panel during the time period of the calendar year the Member was attributed to the provider'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^{th}) 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^{st} 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^{th}) 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^{th}) 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

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 and TMSIS reporting requirements.

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

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
  - Long Term Care (LTC)
- 837D
  - Dental
- NCPDP D.0
  - NCPDP Pharmacy
  - Compound Pharmacy

Failure of Subcontractors to submit Encounter Data timely shall not excuse the PH-MCO's noncompliance with this requirement.

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.

When Error Status Code (ESC) denials occur due to MCO, Subcontractor, or Provider system faults or limitations, it is the responsibility of the MCO to make every attempt to remediate the systems concerns within a reasonable amount of time. Based on the impact of the errors and the length of time to implement a solution, the MCO may be subject to Corrective Action.

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^{th}) 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^{th} 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.

The file must contain all In-Network Medicaid Participating Active Dental Providers Only. This file should only include those providers who provide (1) Endodontics, (2) General Dentistry, (3) Oral & Maxillofacial Surgery, (4) Orthodontics & Dentofacial Orthopedic and (5) Pediatric Dentistry Specialties.

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^{nd}) previous month.

- A statement that its Equity is in compliance with the Equity requirements or is not in compliance with the Equity requirements.

- If Equity is not in compliance with the Equity requirements, 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^{th}) calendar day of the second (2^{nd}) subsequent month. Claims returned by a web-based clearinghouse (example- WebMD Envoy) are not considered as claims received and would be excluded from claims reports.

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, either directly or through a Subcontractor, 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 espended 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 (1st) month of the Agreement year. If the PH-MCO provides a report or file on or before the due date, and if the Department notifies the PH-MCO after the fifteenth (15th) calendar day after the due date that the report or file does not meet established criteria, no reduction in payment shall apply to the sixteenth (16th) day after the due date through the date that the Department notifies the PH-MCO.

c. Encounter Data Reporting: The Sanctions related to the submission of Encounter Data are set forth in Section VIII.B, Systems Reports, and Exhibit XX, Encounter Data Submission Requirements and Sanctions.

d. Marketing: The sanctions for engaging in unapproved marketing practices are described in Section V.F.3, PH-MCO Outreach Activities.

e. Access Standard: The sanction for noncompliance with the access standard is set forth in Exhibit AAA, 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^{th}) 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 (120th) day falls.

C. Responsibilities of the PH-MCO Upon Termination

1. Continuing Obligations

Termination or expiration of this Agreement shall not discharge the PH-MCO of obligations with respect to services or items furnished prior to termination, including retention of records and verification of overpayments or underpayments. Termination or expiration shall not discharge the Department's payment obligations to the PH-MCO or the PH-MCO's payment obligations to its Subcontractors and Providers.

Upon any termination or expiration of this Agreement, in accordance with the provisions in this section, the PH-MCO must:

a. Provide the Department with all information deemed necessary by the Department within thirty (30) days of the request;

b. Be financially responsible for MA Claims with dates of service through the day of termination, except as provided in c. below, including those submitted within established time limits after the day of termination;

c. Be financially responsible for hospitalized patients through the date of discharge or thirty-one (31) days after termination or expiration of this Agreement, whichever is earlier;

d. Be financially responsible for services rendered through 11:59 p.m. on the day of termination, except as provided in c. above or f. below, for which payment is denied by the PH-MCO and subsequently approved upon appeal by the Provider;

e. Be financially responsible for Member appeals of adverse decisions rendered by the PH-MCO concerning treatment of services requested prior to termination that would have been provided but for the denial prior to termination, which are subsequently overturned at a DHS Fair Hearing or Grievance proceeding; and

f. Arrange for the orderly transfer of patient care and patient records to those Providers who will be assuming care for the Member.

2. Notice to Members

In the event that this Agreement is terminated, or expires without a new Agreement in place, the PH-MCO must notify all Members of such termination or such expiration at least forty-five (45) days in advance of the effective date of termination or expiration, if practical. Notice must be made available in an accessible format for individuals with visual impairments and in the relevant language for Members with limited English proficiency. The PH-MCO must coordinate the continuation of care prior to termination or expiration for Members who are undergoing treatment for an acute condition.

3. Submission of Invoices

Upon termination or expiration, the PH-MCO must submit to the Department all outstanding invoices for allowable services rendered prior to the date of termination in the form stipulated by the Department no later than forty-five (45) days from the effective date of termination or expiration. Invoices submitted later than forty-five (45) days from the effective date of termination shall not be payable. This does not apply to submissions and payments in Appendices 3a – 3g.

4. Termination Requirements

Within one year (365 days) of expiration or termination of the Agreement, the PH-MCO must also provide the Department with all outstanding Encounter Data and Maternity Care Claims. If either the Department or the Contractor provides written notice of termination, the Department will withhold ten percent (10%) of one (1) month's Capitation payment. Once the Department determines that the Contractor has substantially complied with the requirements in this section, the Department will pay the withheld portion of the Capitation payment to the PH-MCO. The Department will not unreasonably delay or deny a determination that the PH-MCO has substantially complied. The Department will share with the PH-MCO the determination on substantial compliance by the first (1st) day of the fifth (5th) month after the Agreement ends. If the Department determines that the PH-MCO has not substantially complied, the Department will share a subsequent determination by the first (1st) day of each subsequent month.

D. Transition at Expiration or Termination of Agreement

If the PH-MCO and the Department have not entered into a new Agreement for any of the HealthChoices Zones covered by this Agreement, the Department will develop a transition plan. During the transition period, the PH-MCO must cooperate with any subsequent PH-MCO and the

Department. As part of the transition plan, the Department will define the program information and the working relationship between the PH-MCOs. The Department will consult with the PH-MCO regarding such information and relationship. The length of the transition period shall be no less than three (3) months and no more than six (6) months in duration.

The PH-MCO is responsible for the costs relating to the transfer of materials and responsibilities as a normal part of doing business with the Department.

The PH-MCO must provide necessary information to a PH-MCO and the Department during the transition period to ensure a smooth transition of responsibility. The Department will define the information required during this period and time frames for submission and may solicit input from the PH-MCOs involved.

SECTION XI: RECORDS

A. Financial Records Retention

1. The PH-MCO must maintain and must cause its Subcontractors to maintain all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity pursuant to this Agreement in accordance with the standards and procedures specified in Section V.O.3, Records Retention.

2. The PH-MCO will submit to the Department or to the Secretary of Health and Human Services or their designees, within thirty-five (35) calendar days of a request, information related to the PH-MCO's business transactions which are related to the provision of services for the HealthChoices Program which shall include full and complete information regarding:

    a. The PH-MCO's ownership of any Subcontractor with whom the PH-MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and

    b. Any significant business transactions between the PH-MCO and any wholly-owned supplier or between the PH-MCO and any Subcontractor during the five (5) year period ending on the date of the request.

3. The PH-MCO will include the requirements set forth in Section XII, Subcontractual Relationships, in all contracts it enters with Subcontractors under the HealthChoices Program.

B. Operational Data Reports

The PH-MCO must maintain and must cause its Subcontractors to maintain all source records for data reports in accordance with the procedures specified in Section V.O.3, Records Retention.

C. Medical Records Retention

The PH-MCO must maintain and must cause its Subcontractors to maintain all medical records in accordance with the procedures outlined in Section V.O.3, Records Retention.

The PH-MCO must provide Members' medical records, subject to this Agreement, to the Department or designee within twenty (20) Business Days of the Department's request. The PH-MCO must mail copies of such records to the Department if requested.

D. Review of Records

1. The PH-MCO must make all records relating to the HealthChoices Program, including but not limited to the records referenced in this Section, available for audit, review, or evaluation by the Department, 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-M CO, the PH-MCO may receive all information relating to the health status of its Members, including treatment information, by the exchange of data and other such mechanisms as the Department approves, in accordance with applicable federal and state confidentiality laws.

SECTION XIV: INDEMNIFICATION AND INSURANCE

A. Indemnification

In addition to Section 14 of Exhibit D, Standard Grant Terms and Conditions for Services, the PH-MCO must indemnify and hold harmless the Department and the Commonwealth of Pennsylvania from any audit disallowance imposed by the federal government resulting from the PH-MCO's failure to follow state or federal rules, regulations, or procedures unless prior authorization was given by the Department. The Department shall provide timely notice of any disallowance to the PH-MCO and allow the PH-MCO an opportunity to participate in the disallowance appeal process and any subsequent judicial review to the extent permitted by law. Any payment required under this provision shall be due from the PH-MCO upon notice from the Department. The indemnification provision hereunder shall not extend to disallowances which result from a determination by the federal government that the terms of this Agreement are not in accordance with federal law. The obligations under this paragraph shall survive any

termination or cancellation of this Agreement.

B. Insurance

The PH-MCO must maintain for itself, each of its employees, agents, and representatives, general liability and all other types of insurance in such amounts as reasonably required by the Department and all applicable laws. In addition, the PH-MCO must require that each of the Health Care Providers with which the PH-MCO contracts maintains professional malpractice and all other types of insurance in such amounts as required by all applicable laws. The PH-MCO must provide to the Department, upon the Department's request, certificates evidencing such insurance coverage.

SECTION XV: DISPUTES

A. In the event that a dispute arises between the parties relating to any matter regarding this Agreement, the PH-MCO must send written notice of an initial level dispute to the Contracting Officer, who will make a determination in writing of his or her interpretation and will send the same to the PH-MCO within thirty (30) calendar days of the PH-MCO's written request. That interpretation shall be final, conclusive, and binding on the PH-MCO, and unreviewable in all respects unless the PH-MCO within twenty (20) calendar days of its receipt of said interpretation, delivers a written appeal to the Secretary of the Department. Unless the PH-MCO consents to extend the time for disposition by the Secretary, the decision of the Secretary shall be released within thirty (30) calendar days of the PH-MCO's written appeal and shall be final, conclusive, and binding, and the PH-MCO must thereafter with good faith and diligence, render such performance in compliance with the Secretary's determination; subject to the provisions of Section XVI.B below. Notice of initial level dispute must be sent to:

Department of Human Services
Office of Medical Assistance Programs
Director, Bureau of Managed Care Operations
Commonwealth Tower, 6th Floor
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

B. Any appealable action regarding this Agreement must be filed by the PH-MCO in the Department’s BHA in accordance with 67 Pa.C.S. §§101 – 106 and 55 Pa. Code Chapter 41.

SECTION XVI: GENERAL

A. Suspension From Other Programs

In the event that the PH-MCO learns that a Health Care Provider with whom the PH-MCO contracts is suspended or terminated from participation in any

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

The PH-MCO shall not make any payment any services rendered by a Health Care Provider during the period the PH-MCO knew, or should have known, such Provider was suspended or terminated from a federally funded health care program.

B. Rights of the Department and the PH-MCO

The rights and remedies of the Department provided herein shall not be exclusive and are in addition to any rights and remedies provided by law.

Except as otherwise stated in Section XV of this Agreement, Disputes, the rights and remedies of the PH-MCO provided herein shall not be exclusive and are in addition to any rights and remedies provided by law.

C. Waiver

No waiver by either party of a breach or default of this Agreement shall be considered as a waiver of any other or subsequent breach or default.

D. Invalid Provisions

Any provision of this Agreement which is in violation of any state or federal law or regulation shall be deemed amended to conform with such law or regulation, pursuant to the terms of this Agreement, except that if such change would materially and substantially alter the obligations of the parties under this Agreement, any such provision shall be renegotiated by the parties. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions hereof.

E. Notice

Any written notice to any party under this Agreement shall be deemed sufficient if delivered personally, or by facsimile, telecopy, electronic or digital transmission (provided such delivery is confirmed), or by recognized overnight courier service (e.g., DHL, Federal Express, etc.), with confirmed receipt, or by certified or registered United States mail, postage prepaid, return receipt requested, sent to the address set forth below or to such other address as such party may designate by notice given pursuant to this section:

To the Department via U.S. Mail:

Department of Human Services
Director, Bureau of Managed Care Operations
Commonwealth Tower, 6th Floor
P.O. Box 2675
Harrisburg, Pennsylvania 17105

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

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

With a Copy to:

Department of Human Services
Office of Legal Counsel
3rd Floor West, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
Attention: Chief Counsel

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

F. Counterparts

This Agreement may be executed in counterparts, each of which shall be deemed an original for all purposes, and all of which, when taken together shall constitute but one and the same instrument.

G. Headings

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

H. No Third Party Beneficiaries

This Agreement does not, nor is it intended to, create any rights, benefits, or interest to any third party, person, or organization.

APPENDIX 3b

APPENDIX 3b

EXPLANATION OF CAPITATION PAYMENTS

I. Base Capitation Rates

The final schedule of Base Capitation Rates and Maternity Care Rates is found in Appendix 3f, Capitation Rates.

II. Base Capitation Rates for Subsequent Years

A. Initial Schedule of Base Capitation Rates

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

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

B. Final Schedule of Base Capitation Rates

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

III. Capitation Payment Rates with Risk Adjusted Rates

A. Applicability of Risk Adjusted Rates

The Department will risk adjust the Base Capitation Rates for Rate Cells included in this Agreement using an actuarially sound method to adjust

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

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

Base Capitation Rates contained in Appendix 3f for Under Age 1 and Maternity Care payments are not subject to risk adjustment.

B. RAR MCO Plan Factors

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

The Department and its actuaries will recalculate the RAR MCO Plan Factors in accordance with a periodicity schedule determined by the Department.

C. MCO Assessment Amount

The Base Capitation Rates include an MCO Assessment Amount. The MCO Assessment Amount is the amount included in the Base Capitation Rates for the MCO Assessment fee inclusive of a multiplier that accounts for the PH-MCO's responsibility to pay the MCO Assessment fee for partial member months. The MCO Assessment Amount for January 2023 is $25.19 ($24.95 MCO Assessment x 1.0097 multiplier).

D. Contracted Rate Less Applicable Exclusions

For each PH-MCO in a zone, the following calculation will be made for each Rate Cell and Rate Region with the exception of Under Age 1 and Maternity Care payments. Allowance Amounts are the applicable amount as shown on Appendix 3f.:

	Base Capitation Rate
MINUS	Home Nursing Risk Sharing Allowance Amount
MINUS	High Cost Risk Pool Allowance Amount
MINUS	DME Home Accessibility Risk Sharing Allowance

MINUS	Provider Pay-for-Performance Allowance
MINUS	MCO Assessment Amount
EQUALS	Contracted Rate Less Applicable Exclusions

E. Risk Adjusted Rate

The Risk Adjusted Rate paid to the PH-MCO, per Appendix 3f, for each program month for a given Rate Cell and Rate Region is calculated by the Department as follows:

The lowest Contracted Rate Less Applicable Exclusions for all the PH-MCOs for that given Rate Cell and Rate Region within each zone multiplied by the PH-MCO's RAR MCO Plan Factor.

This paragraph provides for an exception to all of the above. For the Under Age One Rate Cell, the Risk Adjusted Rate will be the Base Capitation Rate. The PH-MCO must pay Under Age 1 Allowance Amounts at the rate shown on Appendix 3f.

F. Capitation Payment Rate

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

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

This is calculated as follows:

	Risk Adjusted Rate
PLUS	Amount A (if applicable)
PLUS	Home Nursing Risk Sharing Allowance Amount
PLUS	High Cost Risk Pool Allowance Amount
PLUS	DME Home Accessibility Risk Sharing Allowance
PLUS	MCO Assessment Amount
PLUS	Provider Pay for Performance
EQUALS	Capitation Payment Rate.

In accordance with Section VII.B.1.a.ii, the Department will make capitation payments at per diem equivalents of the Capitation Payment Rates that are calculated and issued by the Department.

This paragraph provides for an exception to all of the above. For the Under Age One Rate Cell, the Capitation Payment Rate will be equal to the Base Capitation Rate reduced by the MLR Reduction described in Paragraph D. above.

G. Quality Incentives

Appendix 3f specifies per-member-per-month (PMPM) amounts for Provider Pay for Performance. The Department will pay the Provider Pay for Performance amounts to the PH-MCO in accordance with Exhibit B(3). The amounts are not subject to risk adjustment.

H. Maternity Care Payment

A Maternity Care Payment as identified in Section VII.B.2 will be made to the PH-MCO. The Maternity Care Payment made to the PH-MCO will be the amount as shown in the “Base Capitation Rate / Maternity Care Payment” column on Appendix 3f, net of the MLR Reduction as outlined in paragraph D. above. Maternity Care Payments are not subject to risk adjustment.

I. Newly Eligible

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

APPENDIX 3c

APPENDIX 3c

HOME NURSING RISK SHARING ARRANGEMENT

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

I. Arrangement Years

A. Arrangement Years are equivalent to calendar years. Exception: If the PH-MCO does not operate a HealthChoices program in a zone under this or any other HealthChoices Agreement throughout the complete calendar year, then the Arrangement Year consists of the portion of the year in which the PH-MCO operates the program. Each Arrangement Year serves as an accumulation period for incurring costs for Covered Services.

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

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

II. Covered Members

This Arrangement covers Members who have attained their first birthday and are under age twenty-one (21), and who do not reside in any of the following types of facility:

- State Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- South Mountain Restoration Center
- County Nursing Facility
- General Nursing Facility
- Hospice
- Intermediate Care Facility for Persons with Other Related Conditions

III. Covered Services

A. This Arrangement covers services provided by a Licensed Practical Nurse, Registered Nurse, Home Health Aide, or Personal Care Provider in a home, home-like, or school-based setting paid by the PH-MCO.

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

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

D. Nursing services covered under Appendix 18A are excluded from this Arrangement unless CMS does not approve Appendix 18A. Then those nursing services will be included in this Arrangement.

IV. Risk Sharing

In each Arrangement Year, the PH-MCO is responsible for the first $5,000 (Threshold Amount) in paid amounts of Covered Services provided to each Member. An additional Threshold Amount does not apply if the Member changes zones and is enrolled in the same PH-MCO. The Department will reimburse the PH-MCO eighty percent (80.0%) of Covered Services (net of third party liability/other insurance) submitted by the PH-MCO that are greater than $5,000.

V. Home Nursing Risk Sharing Allowance Amounts

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

B. The Department will determine the total Home Nursing Risk Sharing Allowance Amount obligation by multiplying the Home Nursing Risk Sharing Allowance Amounts by the applicable Member Months for all Members covered by the Arrangement.

C. Each Home Nursing Risk Sharing distribution, included in Section VII, made by the Department will be net of the PH-MCO's uncollected Home Nursing Risk Sharing Allowance Amount obligation.

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

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

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

VI. Data Source

A. The Department will use the Department's MMIS approved encounter data to identify those claims eligible for risk sharing, unless the Department notifies the PH-MCO that it will use different data. The Department will extract approved encounter data based on a schedule as determined by the Department.

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

VII. Settlements

The Department will perform at least two settlements for each Arrangement Year. The Department will use encounter data or other data that is timely available for processing prior to each settlement date. The Department will notify the PH-MCO of the settlement amount and provide documentation by the settlement date as provided below. The PH-MCO's uncollected Home Nursing Risk Sharing Allowance Amounts, as specified in Appendix 3f, will be subtracted from the settlement amount. If the result is a positive number, the Department will pay that amount to the PH-MCO. If the result is a negative number, the Department will reduce a subsequent payment to the PH-MCO by this amount. Settlement distributions will take place within thirty days of each of the settlement notifications.

A. The initial settlement will be completed by the Department at least seven (7) months after the end of the Arrangement Year. This settlement will include encounter data experience for the entire Arrangement Year with data cutoff dates determined by the Department and prior to the initial settlement date.

B. The final settlement will be completed at least fifteen (15) months after the Arrangement Year. The final settlement notification will be sent to the PH-MCO within 90 days from the data extraction date. This settlement will include experience for the entire Arrangement Year and will be net of the initial settlement for the same Arrangement Year.

APPENDIX 3e

APPENDIX 3e

FAMILY PLANNING SERVICES

A. Provision of Services

Brabender Reed, LLC ("Brabender") agrees to provide administrative services related to the provision of Family Planning Services for Gateway Health Plan, Inc. (Gateway) members as required under this Agreement. Family Planning Services will be provided in accordance with requirements of this Agreement, and relevant Provider Agreements.

The Department approves these arrangements subject to the conditions and terms of this Agreement. Gateway agrees that it continues to be responsible for the provision of all services, with the exception of Family Planning Services, under this Agreement. Gateway further acknowledges that it is responsible for all reporting, auditing, and member complaint, grievance and appeal functions under this Agreement, including those relating to Family Planning Services.

Gateway is responsible for entering into agreements with sufficient numbers of qualified Providers to ensure the timely and effective provision of Family Planning Services (hereinafter "FPS Provider Agreements") for Gateway's eligible Members. The form FPS Provider Agreement is subject to advance written approval by both Gateway and the Department. Brabender is not a licensed insurer, therefore, Brabender will not establish a network of participating providers. Brabender will provide administrative services for any Family Planning claim received by any Pennsylvania Medicaid provider for Gateway members using no less than the Department's fee schedule for medical services and using Gateway's established rates for pharmacy services.

B. Compensation

The Department has agreed to pay Gateway rates in accordance with the final Appendix 3f, Capitation Rates, of this Agreement. The Department, Gateway and Brabender agree that 0.9% of any payment made to Gateway related to this Agreement will be paid directly to Brabender. The portion of these payments made by the Department to Brabender will be considered as payment in full for the administrative services of Family Planning Services, and Brabender agrees that they will have no recourse against the Department for any compensation or reimbursement above the portion of the payments made.

Brabender must maintain documentation in support of the compensation received in accordance with this Agreement for a period of seven (7) years commencing on the effective date of this Agreement. In instances, however, where an audit is incomplete or remains unresolved, such records must be maintained until the audit is complete and resolved.

Brabender agrees that it must use its portion of the payments to pay claims in accordance with the requirements of this Agreement and the FPS Provider Agreements.

C. Member Hold Harmless

Brabender hereby agrees that in no event, including but not limited to nonpayment by the Department, insolvency or breach or termination of this Agreement, will Brabender bill, charge, collect a deposit from or seek compensation, remuneration or reimbursement from, or have any recourse against any Member or person acting on the behalf of a Member for any services, including Family Planning Services, provided under this Agreement.

D. General Provisions

The terms and conditions otherwise specified in this Agreement remain in full force and effect, including but not limited to, all terms and conditions relating to Gateway's responsibilities and obligations with respect to sub-contractual arrangements and required provisions for Subcontracts and Provider Agreements.

APPENDIX 3f

Highmark Wholecare Capitation Rates - Effective January 1, 2023

Lehigh Capital	Capitation/Maternity Payment Rate Calculation				Applicable Allowance Amounts				
Rate Region 1 - Adams, Berks, Cumberland, Lancaster, Lehigh, Northampton and York counties	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**High Cost Risk Pool Allowance**	**Home Nursing Risk Sharing Allowance**	**Under Age 1 Risk Sharing Allowance**	**DME Home Accessibility Risk Sharing Allowance**	**Provider Pay for Performance Allowance**
Under Age 1	$947.25	$947.25	$947.25	TBD	N/A	N/A	$278.19	N/A	$1.20
TANF-MAGI Ages 1-20	$198.75	TBD	TBD	TBD	$9.04	$6.27	N/A	$0.01	$1.20
TANF-MAGI Ages 21+	$403.32	TBD	TBD	TBD	$9.04	N/A	N/A	$0.01	$1.20
Disabled-BCC Ages 1+	$997.10	TBD	TBD	TBD	$128.60	$87.77	N/A	$0.05	$1.20
Newly Eligible Ages 19 to 44	$368.97	TBD	TBD	TBD	$34.10	$0.11	N/A	$0.01	$1.20
Newly Eligible Ages 45 to 64	$783.01	TBD	TBD	TBD	$34.10	N/A	N/A	$0.01	$1.20
Maternity Care	$7,576.41	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rate Region 2 - Dauphin, Franklin, Fulton, Huntingdon, Lebanon and Perry counties	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**High Cost Risk Pool Allowance**	**Home Nursing Risk Sharing Allowance**	**Under Age 1 Risk Sharing Allowance**	**DME Home Accessibility Risk Sharing Allowance**	**Provider Pay for Performance Allowance**
Under Age 1	$949.48	$949.48	$949.48	TBD	N/A	N/A	$278.19	N/A	$1.20
TANF-MAGI Ages 1-20	$199.45	TBD	TBD	TBD	$9.04	$6.27	N/A	$0.01	$1.20
TANF-MAGI Ages 21+	$391.90	TBD	TBD	TBD	$9.04	N/A	N/A	$0.01	$1.20
Disabled-BCC Ages 1+	$1,183.79	TBD	TBD	TBD	$128.60	$87.77	N/A	$0.05	$1.20
Newly Eligible Ages 19 to 44	$366.96	TBD	TBD	TBD	$34.10	$0.11	N/A	$0.01	$1.20
Newly Eligible Ages 45 to 64	$790.85	TBD	TBD	TBD	$34.10	N/A	N/A	$0.01	$1.20
Maternity Care	$7,717.37	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

TBD - To Be Determined

These rates do not apply after December 31, 2023, which is the expiration date of the actuary's certification. Exception: If this Agreement continues to be effective after December 31, 2023, the Department's Capitation obligation will continue to be defined by this Appendix 3f as applicable until the rates are supplanted by an amendment to the Agreement.

The Department's obligation is determined by the amounts included in the column titled "Base Capitation Rate / Maternity Care Payment". The capitation amounts will be converted to per diems as provided by the Agreement.

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

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

The High Cost Risk Pool Allowance (HCRPA) is used to determine the MCO's HCRPA obligation as per Appendix 3k of the HealthChoices Agreement.

The Home Nursing Risk Sharing Allowance is used to determine the MCO's Home Nursing Risk Sharing obligation as per Appendix 3c of the HealthChoices Agreement.

The Risk Sharing Allowance Amounts Obligation for the "Under Age 1" Rate Cell are used to determine the MCO's Risk Sharing obligation as per Appendix 3p of the HealthChoices Agreement.

The DME Home Accessibility Risk Sharing Allowance is used to determine the MCO's DME Home Accessibility Risk Sharing obligation as per Appendix 6 of the HealthChoices Agreement.

The Provider Pay for Performance allowance amount is included in the Base Capitation Rate. More information about the Provider Pay for Performance allowance amount is in Exhibit B(3) of the HealthChoices Agreement.

Highmark Wholecare Capitation Rates - Effective January 1, 2023

Southwest Zone	Capitation/Maternity Payment Rate Calculation				Applicable Allowance Amounts				
Rate Region 1 - Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Lawrence, Washington and Westmoreland Counties	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**High Cost Risk Pool Allowance**	**Home Nursing Risk Sharing Allowance**	**Under Age 1 Risk Sharing Allowance**	**DME Home Accessibility Risk Sharing Allowance**	**Provider Pay for Performance Allowance**
Under Age 1	$993.26	$993.26	$993.26	TBD	N/A	N/A	$299.15	N/A	$1.20
TANF-MAGI Ages 1-20	$204.55	TBD	TBD	TBD	$10.98	$5.86	N/A	$0.01	$1.20
TANF-MAGI Ages 21+	$416.37	TBD	TBD	TBD	$10.98	N/A	N/A	$0.01	$1.20
Disabled-BCC Ages 1+	$1,070.68	TBD	TBD	TBD	$118.62	$72.05	N/A	$0.06	$1.20
Newly Eligible Ages 19 to 44	$419.51	TBD	TBD	TBD	$31.17	$0.29	N/A	$0.01	$1.20
Newly Eligible Ages 45 to 64	$747.10	TBD	TBD	TBD	$31.17	N/A	N/A	$0.01	$1.20
Maternity Care	$7,665.44	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rate Region 2 - Bedford, Blair, Cambria, Indiana and Somerset Counties	**Base Capitation Rate / Maternity Care Payment**	**Risk Adjusted Rate**	**Capitation Payment Rate**	**DHS Payment Rate Obligation, Per Member Per Day**	**High Cost Risk Pool Allowance**	**Home Nursing Risk Sharing Allowance**	**Under Age 1 Risk Sharing Allowance**	**DME Home Accessibility Risk Sharing Allowance**	**Provider Pay for Performance Allowance**
Under Age 1	$791.18	$791.18	$791.18	TBD	N/A	N/A	$299.15	N/A	$1.20
TANF-MAGI Ages 1-20	$208.44	TBD	TBD	TBD	$10.98	$5.86	N/A	$0.01	$1.20
TANF-MAGI Ages 21+	$412.58	TBD	TBD	TBD	$10.98	N/A	N/A	$0.01	$1.20
Disabled-BCC Ages 1+	$1,099.93	TBD	TBD	TBD	$118.62	$72.05	N/A	$0.06	$1.20
Newly Eligible Ages 19 to 44	$402.77	TBD	TBD	TBD	$31.17	$0.29	N/A	$0.01	$1.20
Newly Eligible Ages 45 to 64	$728.56	TBD	TBD	TBD	$31.17	N/A	N/A	$0.01	$1.20
Maternity Care	$7,827.35	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

TBD - To Be Determined

These rates do not apply after December 31, 2023, which is the expiration date of the actuary's certification. Exception: If this Agreement continues to be effective after December 31, 2023, the Department's Capitation obligation will continue to be defined by this Appendix 3f as applicable until the rates are supplanted by an amendment to the Agreement.

The Department's obligation is determined by the amounts included in the column titled "Base Capitation Rate / Maternity Care Payment". The capitation amounts will be converted to per diems as provided by the Agreement.

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

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

The High Cost Risk Pool Allowance (HCRPA) is used to determine the MCO's HCRPA obligation as per Appendix 3k of the HealthChoices Agreement.

The Home Nursing Risk Sharing Allowance is used to determine the MCO's Home Nursing Risk Sharing obligation as per Appendix 3c of the HealthChoices Agreement.

The Risk Sharing Allowance Amounts Obligation for the "Under Age 1" Rate Cell are used to determine the MCO's Risk Sharing obligation as per Appendix 3p of the HealthChoices Agreement.

The DME Home Accessibility Risk Sharing Allowance is used to determine the MCO's DME Home Accessibility Risk Sharing obligation as per Appendix 6 of the HealthChoices Agreement.

The Provider Pay for Performance allowance amount is included in the Base Capitation Rate. More information about the Provider Pay for Performance allowance amount is in Exhibit B(3) of the HealthChoices Agreement.

APPENDIX 3g

APPENDIX 3g

OVERVIEW OF METHODOLOGIES FOR RATE SETTING AND DETERMINATION OF RISK SHARING PREMIUM ALLOWANCE AMOUNTS

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

To develop Actuarially Sound Capitation Rates (Actuarially Sound Capitation Rates are projected to provide reasonable, appropriate and attainable costs that are required under the terms of the contract and for the operation of the Primary Contractor for the time period and the population covered under the terms of the contracts, and such Capitation rates are developed in accordance with the requirement in 42 CFR §438.4(b)) for the HealthChoices program using historical fee-for-service (FFS) data, the following general steps are performed:

- Summarize the FFS Claims and Eligibility Data
- Assess Data Credibility
- Include the Effect of Program/Policy Changes
- Project the FFS Base Data Forward
- Adjust the FFS Data to Reflect Managed Care Principles
- Add an Appropriate Non-Medical Load
- Add an Amount for State/Federal Taxes/Assessments

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

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

Include the Effect of Program/Policy Changes — The Commonwealth

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

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

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

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

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

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

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

- Summarize, Analyze, and Adjust the Managed Care Data,
- Include the Effect of Program/Policy Changes,
- Project the Managed Care Base Data Forward,
- Add Appropriate Non-Medical Load,and
- Add an Amount for State/Federal Taxes/Assessments.

Summarize, Analyze, and Adjust the Managed Care Data — The Commonwealth collects data from each of the managed care organizations (MCOs) participating in the HealthChoices program. This data is summarized, analyzed, and adjustments (positive and/or negative) are applied as needed to account for underlying differences between each MCO's management of the HealthChoices program. These adjustments can account for items such as, but not limited to, reinsurance, over- or under-reserving of unpaid claims, under/over reporting between sources of data, utilization and unit cost efficiency, risk class structure, and provider contracting relations. After adjusting each MCO's data, each plan's specific medical claim costs is aggregated together to arrive at a set of base data for each rate cell.

Include the Effect of Program/Policy Changes — The Commonwealth occasionally changes the services or populations covered under the HealthChoices program (e.g., an expansion of a new benefit or a restructuring of a currently covered benefit).
Any new, material program/policy changes that were not already reflected in the managed care data are included in the capitation rates by either increasing or decreasing the managed care data by an appropriate adjustment.

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

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

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

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

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

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

- Project the prior year's rates forward (Track 1),
- Summarize and adjust the managed care data (Track 2),
- Include the effect of new program/policy changes and trend (Track 1 and Track 2),
- Apply credibility factors to each track and blend together,
- Add Appropriate Non-medical Load, and
- Add an Amount for State/Federal Taxes/Assessments.

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

Include the Effect of New Program/Policy Changes (Track 1) — In Track 1, any new, material program/policy changes implemented by the Commonwealth or required by the federal government that were not already accounted for in the previous year's rates, are included in the new capitation rates by either increasing or decreasing the rates by an appropriate adjustment.

Summarize and Adjust the Managed Care Data (Track 2) — The more recent managed care data is collected from the MCOs, summarized, and analyzed to support rate setting. Adjustments (positive and/or negative) are applied to the managed care data as needed to account for underlying differences between each MCO's management of the HealthChoices program. These adjustments can account for items such as, but not limited to, the collection of TPL/COB, over- or under-reserving of unpaid claims, reinsurance, rebates, management efficiency, and provider contracting relations.

Include the Effect of Trend and New Program/Policy Changes (Track 2) — In Track 2, the managed care data is projected forward to the time period the capitation rates are contracted. Trend factors may vary by major category of service, geographic area, or rate cell, and are used to estimate the future costs of the services that the covered population would generate under managed care. Any new program/policy changes that were not already reflected in the managed care data are included in the rates by either increasing or decreasing the data by an

appropriate adjustment.

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

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

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

IV. Additional Information on Rate Development

The reimbursement provided under this contract is intended for Medically Necessary services covered under the Commonwealth's State Plan. The MCO has the option to utilize this reimbursement to provide alternatives to the Medically Necessary services covered under the State Plan in order to meet the needs of the individual enrollee in the most efficient manner. However, an adjustment may be required in the rate development process to ensure that only alternative services approved by the Commonwealth are included.

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

V. Information Sharing with MCOs

The Commonwealth will annually provide the MCO with certain information on the development of capitation rates, maternity care rates, and risk mitigation premium allowances. This information will include the pieces of information listed below, exclusive of the underlying data used to develop the information. The majority of the numerical data provided will take the form of rating exhibits, variously detailed by geographic rating area, by rate cell, and/or by category of service group. The Commonwealth’s commitment to provide data does not extend to data to which it is not legally entitled. The accuracy of data furnished

by the Commonwealth is in some cases dependent on the integrity of data supplied by MCOs. The following items pertain where applicable to all three types of rates indicated above:

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

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

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

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

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

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

- Average PMPM trend rates by rate cell and by service group used by the actuaries in each HealthChoices zone to project future costs.

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

- The lower end, "best estimate," and upper end of the range of actuarially sound rates determined by the Commonwealth's actuaries for each rate cell.

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

The Commonwealth will provide this information in advance of discussions with the MCOs. DHS may provide the MCO, upon request, documentation that addresses the actuarial soundness of the rates.

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

VI. Methodology to Determine High Cost Risk Pool (HCRP) Amount(s) (Where Applicable)

The amount that is attributable to a risk pool is the portion of the capitation rates used to fund a risk pool based on an analysis of data (FFS or managed care) from the population and services covered, as well as the design of the HCRP (e.g., threshold levels). This data is considered the primary source of information for developing the risk pool amounts which may vary by rate cell. Since any one (1) year may reflect unusual occurrences, when available, multiple years of information may be reviewed and combined together. Since the data is generally historical in nature and risk pool(s) are applicable to the future capitation rates, the data must be trended and adjusted as necessary to coincide with the period in which the rates are contracted. These trends are estimates of the future costs and utilization of services provided. Given the programs' narrow specificity of risk and high per recipient cost, total risk pool costs may fluctuate substantially from year to year.

VII. Methodology to Determine Risk Sharing Amount(s)

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

APPENDIX 3h

APPENDIX 3h

MEDICAL LOSS RATIO REPORTING AND REMITTANCE REQUIREMENTS

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

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

I. Timing

The PH-MCO must submit the annual MLR report to the Department by November 30 of the following CY.

II. MLR Reporting Year

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

III. Contents of Annual MLR Report

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

1. Total incurred claims (including fraud reduction efforts)
2. Expenditures on quality improving activates
3. Expenditures on fraud prevention activities (not applicable)
4. Non-claim costs
5. Premium revenue
6. Premium related taxes, licensing, and regulatory fees
7. Methodologies for allocation of expenditures
8. Any credibility adjustment applied

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

IV. New HealthChoices PH-MCOs

The Department, at its discretion, may exclude a PH-MCO that did not previously have a HC Agreement from these requirements for the first year of the PH-MCO's HC operations. However, the new PH-MCO will be required to comply with these requirements during the next MLR reporting year even if the first year of operations was not a full 12 months. For example, if a PH-MCO is new on July 1, 2022, the Department may exclude the new PH-MCO from completing and submitting the CY 2022 MLR report. The new PH-MCO will be required to complete the subsequent CY 2023 MLR report. If a PH-MCO exits HC, a report will still be required, even if it is less than twelve months of experience.

V. MLR Numerator and Denominator

Detail of what is included and how the MLR numerator and denominator are computed can be found in 42 CFR §438.8(e) and (f) respectively. If an expenditure related to Social Determinants of Health is an "activity that improves health care quality" as specified in 42 CFR § 438.8(e)(3), the PH-MCO may include the costs in the numerator of the MLR. The PH-MCO is expected to comply with any additional requirements, guidance or instructions released by CMS that relate to the computation of the MLR as required in 42 CFR §438.8.

VI. Aggregate Medicaid Eligibility Groups

The Department requires the PH-MCO's MLRs and MLR report to be calculated for two aggregated groups: Newly Eligibles and all other populations. These two aggregated groups must represent all HC Medicaid/Title XIX rate cells/populations and rating regions/zones combined that are covered under the HC Agreements.

VII. Credibility Adjustment

Per 42 CFR §438.8(h), the PH-MCO may add a credibility adjustment to the reported MLRs per Aggregate Medicaid Eligibility Group in section VI of this appendix if the PH-MCO has sufficient member months to be partially credible, but not enough member months to be fully credible. The credibility adjustment is required for any remittance calculations. CMS will publish the table of credibility adjustments to be used. Fully credible plans may not use a credibility adjustment.

VIII. Remittance

Per 42 CFR §438.8(c) the Department has chosen a minimum MLR of 85.00 percent (85.00%). The Department will require a remittance in accordance with

42 CFR §438.8(j) for each Aggregate Medicaid Eligibility Group listed in section VI above. Settlement of any remittance obligation will be due 75 calendar days after the Department has issued a remittance notification to the PH-MCO.

IX. Newly Eligibles

For purposes of this Appendix, Newly Eligibles are defined as Members who have a category of assistance/program status code combination of MG91 and Members age 19 and 20 who have a category of assistance/program status code combination of MG90.

X. Attestation

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

XI. Sub-Regulatory Guidance and Capitation Adjustments

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

XII. Continuation

If CMS issues regulation that revises or replaces the citations in this appendix, the revised or replacement citations will apply.

APPENDIX 3k

APPENDIX 3k
HIGH COST RISK POOL

Overview

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

Each zone's quarterly risk pool will be funded through High Cost Risk Pool Allowance Amounts (HCRPAA). HCRPAAs are contained in Appendix 3f and provide for different amounts by zone and Medicaid Eligible Group (MEG). The Department will utilize encounter data or files submitted by the PH-MCO with information on high cost Members in each zone during the Experience Period (defined below). After repricing inpatient encounters, to the amount the Department would have paid, the Department will sum the amount spent by each PH-MCO in each zone in excess of the HCRP Threshold on each Member in each of three MEGs, defined below, for the Experience Period. The Department will distribute the funds in each zone's HCRP in proportion to each PH-MCO's adjusted expenditures for that zone in excess of the HCRP Threshold for all Members included in each zone's risk pool for the Experience Period. The Department's payment to each PH-MCO will be net of the PH-MCO's HCRPAA obligation for each zone for the Quarter. If the PH-MCO's HCRPAA obligation exceeds its share of the HCRP, the Department will reduce a subsequent payment to the PH-MCO by the amount of the difference.

High Cost Risk Pool Quarters

A High Cost Risk Pool Quarter (Quarter) is defined as a calendar quarter unless the HealthChoices program period covered by this Agreement ends mid-quarter. In this event, the last High Cost Risk Pool Quarter will begin on the first day of the next-to-last calendar quarter and end on the last day of the program period covered by this Agreement. Example: The program period covered by this Agreement ends May 31, 2022. The last High Cost Risk Pool Quarter begins January 1, 2022, and ends May 31, 2022.

Medicaid Eligible Group (MEG)

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

- TANF – which is inclusive of Members with TANF and MAGI Medical Assistance (MA) eligibility. Newly Eligible Members with eligibility as identified in the Newly Eligible MEG below are excluded from the TANF MEG.
- Disabled – which is inclusive of Members with SSI, Healthy Horizons, Breast and Cervical Cancer, Other Disabled MA eligibility, and Members aged twenty-one (21) or older having MAGI MA eligibility under program status code 90. Newly Eligible Members with eligibility as identified in the Newly Eligible MEG below are excluded from the Disabled MEG.
- Newly Eligible - which is inclusive of Members having eligibility under MAGI MA eligibility with program status code 91 aged between nineteen through sixty four (19-64) and Members aged nineteen through twenty (19-20) with program status code 90.

Members under age one (1) are excluded from all MEGs of this risk pool.

Members in an IMD

Provisions 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 (SUD) are outlined below:

- The Department will apply the HCRPAA on a per-diem basis and include any claim with a date of service within a calendar month for those days in which the Member is both enrolled in the PH-MCO and not residing in the IMD and the provision of inpatient psychiatric treatment in an IMD meets the requirements for *in lieu of* services in 42 CFR 438.3 (e) (2)(i) through (iii).

HCRP Threshold

The HCRP Threshold is $80,000.

PH-MCO Inclusion/exclusion

A PH-MCO will participate in a zone's quarterly HCRP if both of the criteria below are met:

- The Department has made or will make Capitation payments to the PH-MCO for this HealthChoices zone under this HealthChoices Agreement for all months during the High Cost Risk Pool Quarter; and

- The Department has made or will make Capitation payments to the PH-MCO under this HealthChoices Agreement or any other HealthChoices Agreement for this HealthChoices zone for all of the twelve months prior to the High Cost Risk Pool Quarter. These twelve months constitute the Experience Period.

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

- The current PH-MCO purchased the assets or liabilities of the Previous PH-MCO; or

- The Department transferred all of the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO.

If the PH-MCO does not meet the criteria for inclusion in a zone's quarterly HCRP, then:

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

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

- The PH-MCO will not be required to contribute to that quarterly zone's HCRP through a reduction to a subsequent payment.

The Department will determine each Quarter which PH-MCOs meet the criteria for inclusion in that Quarter's HCRPs.

Calculation of Quarterly Funds in each Zone's Risk Pool

Appendix 3f provides HCRPAAs. After each Quarter has ended, the Department will determine the sum of the PH-MCO's HCRPAA obligation for the Quarter for each MEG, by multiplying the HCRPAA by the number of Member Months included in the PH-MCO during the High Cost Risk Pool Quarter (not the Experience Period). The Department will use membership data compiled as of one date, for the purpose of determining each PH-MCO's HCRPAA obligation, for the Quarter. The Department will provide documentation to the PH-MCO related to their Quarterly HCRP distribution amounts.
The sum of the HCRPAA obligation of every PH-MCO will be the total amount allocated to each HCRP for that Quarter.

Covered Services

All medical claims paid by the PH-MCO for a medical product or service received by an enrolled Member during the Experience Period, with the following exceptions:

- Any product or service provided to Members under age one (1).

- Any product or service covered under the Department's other risk mitigation arrangements including, but not limited to:
    - Home Nursing Risk Sharing (Appendix 3c)
    - Under Age One Risk Sharing (Appendix 3p)
    - Home Accessibility Risk Sharing (Appendix 6)
    - COVID non-risk share (Appendix 18)
    - Shadow Nurses (Appendix 18A)
    - High Cost Gene Therapy (Appendix 18B)

The Department will apply the same criteria if it elects to use the PH-MCO's submitted files at its request in lieu of encounter data.

Experience Period

The Experience Period is defined as the twelve months that ended the day before the Quarter for which HCRPAAs are allocated to the quarterly risk pools.

The Experience Period defines the dates that Covered Services are provided to Members, not the dates claims are paid.

The discharge date on an inpatient claim determines PH-MCO eligibility for inclusion in an Experience Period.

Data Source

Unless the Department has informed the PH-MCO that it has determined a need to use a different data source, the Department will utilize the Department's MMIS approved encounter data to administer the steps outlined in this Appendix, and to determine the adjusted amount each PH-MCO paid in excess of the HCRP threshold for each Member for Covered Services provided during the Experience Period. The Department will extract encounter data at least 7 months after the last day in the Experience Period.

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

For purposes of risk pool allocation, the Department will utilize information on Members whose costs exceed the HCRP Threshold during the Experience Period, after repricing

and other adjustments. Interim encounters for acute care inpatient services (Provider Type and Specialty of 01/010) are excluded.

Covered Service cost for the Experience Period will be included in total for each Member exceeding the threshold in only one MEG's risk pool. The MEG for the Member will be determined based on the category and program status code in the last monthly capitation payment made to the PH-MCO within the Experience Period.

Inpatient Hospital Repricing

The Department will reprice each acute care inpatient hospital encounter to the amount the Department would have paid for the discharge, except where a repriced amount is not able to be determined. The Department may request supplemental information from the PH-MCO to be able to complete this repricing. The Department will send the PH-MCO a file that shows the repriced amount for each inpatient hospital claim.

When the inpatient hospital encounter is not able to be repriced by the Department, the PH-MCO paid amount will be used in place of the repriced amount.

If the PH-MCO is required to submit a data file in lieu of use of encounter data, the PH-MCO must submit all necessary data fields so that inpatient claims can be repriced. Failure to submit the necessary fields may result in exclusion of inpatient claims from the HCRPs.

Quarterly Distributions

The Department will utilize the Department's MMIS approved encounter data to administer the steps outlined in this Appendix, and to determine the adjusted amount each PH-MCO paid in excess of the HCRP Threshold, for each Member, for Covered Services provided, during the Experience Period. These steps will be separately applied for the risk pool for each MEG. The PH-MCO-specific sum will be the numerator in the calculation, for the risk pool distribution. The denominator will be the applicable sum for all PH-MCOs in the HealthChoices zone. The resulting percentage figure will be multiplied by the amount in the risk pool. The PH-MCO's uncollected HCRPAA obligation for the Quarter will be subtracted from this amount. If the result is a positive number, the Department will pay the amount to the PH-MCO. If the result is a negative number, the Department will reduce a subsequent payment to the PH-MCO by this amount.

The Department will notify PH-MCOs of information related to the quarterly distribution amounts resulting from this HCRP Arrangement at least 90 days after the Department's extraction of encounter data.

Early Payment of a PH-MCO's HCRPAA Obligation

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

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

- The Department may reduce each subsequent monthly capitation payment by the PH-MCO's HCRPAA obligation for the same month.

APPENDIX 3m

APPENDIX 3m

MCO ASSESSMENT

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

The Department will make an Annual MCO Assessment Payment to the PH-MCO no later than June 5 of each year. The Department will not make the payment if the PH-MCO has no obligation to make an MCO Assessment payment on its HealthChoices membership for the April to June calendar quarter of the same year. If the Department notifies the PH-MCO that it will pay the capitation for the June program month under Section VII.B.1.a.vi, then the Department will not make a payment to the PH-MCO under this Appendix.

The Department will calculate the payment amount as follows for this Agreement:

	The MCO Assessment fee amount per person provided by statute or as adjusted by the Secretary in accordance with 62 P.S. § 803-I, if applicable, as of March 1 of the same year
MULTIPLIED BY	The number of Members enrolled in the PH-MCO on any one or more days in February of the current year per the Department's records in March
EQUALS	The Monthly MCO Assessment Fee Amount

The Department's payment obligation under this Appendix will equal the Monthly MCO Assessment Fee Amount unless the Department notifies the PH-MCO under Section VII.B.1.a.viii of this HealthChoices Agreement of the delay in capitation payment(s). If the Department provides the PH-MCO with the required written notification of the delay capitation payment(s) by March 1 of the same year, then the Department will multiply the Monthly MCO Assessment Fee Amount by two (2) if only one capitation payment is delayed or by three (3) if two capitation payments are delayed.

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

APPENDIX 3p

APPENDIX 3p

RISK SHARING ARRANGEMENT FOR MEMBERS UNDER AGE ONE

This Agreement establishes a risk sharing arrangement (Arrangement) between the Department and the PH-MCO for each HealthChoices Member who has not attained their first birthday.

I. Arrangement Years

A. Arrangement Years are equivalent to calendar years. Exception: If the PH-MCO does not operate a HealthChoices program in a zone under this or any other HealthChoices Agreement throughout the complete calendar year, then the Arrangement Year consists of the portion of the year in which the PH-MCO operates the program. Each Arrangement Year serves as an accumulation period for incurring costs for Covered Services.

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

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

II. Covered Members

This Arrangement covers each Member who has not attained their first birthday. The Member is covered from birth through the day prior to their first birthday unless otherwise specified under IV. E. in this Arrangement.

III. Covered Services

All medical claims paid by the PH-MCO for a medical product or service received by an enrolled Under Age 1 Member during the Arrangement Year unless otherwise specified under IV. E. in this Arrangement.

Any product or service covered under the non-risk share arrangements in this HealthChoices Agreement Appendix 18, 18A, and/or 18B are excluded from Covered Services under this Arrangement.

IV. Risk Sharing

A. In each Arrangement Year, the PH-MCO is responsible for the first $25,000 (Threshold Amount) in paid amounts of Covered Services provided to each Member.

B. The Department will reimburse the PH-MCO seventy five percent (75.0%) of Covered Services (net of third party liability/other insurance) submitted by the PH-MCO that are greater than $25,000.

C. A new Threshold Amount applies at the beginning of each Arrangement Year.

D. If the Member moves to a different HealthChoices zone and is covered by the same PH-MCO, a new Threshold Amount does not apply.

E. All amounts paid by the PH-MCO to an acute care hospital for an admission are counted as of the admission date, which might be the date of birth, and are limited to admissions where the admission is before the first birthday and discharge occurs on or before the date of the Member's second (2^{nd}) birthday. Admissions, where admission is after the first birthday, or discharge occurs after the Member's 2nd birthday, will be counted in the appropriate HealthChoices zone High Cost Risk Pool per Appendix 3k. The Department will not cover interim hospital claims as part of this Arrangement.

F. Only the PH-MCO's payment to the acute care hospital and any medications dispensed and billed separately to the PH-MCO by that same hospital's pharmacy during the dates of that Member's admission will be included in this Arrangement as part of the Member's Covered Services per IV.E above.

G. Nursing services covered under Appendix 18A are excluded from this Arrangement unless CMS does not approve Appendix 18A. Then those nursing services will be included in this Arrangement.

V. Under Age One Risk Sharing Allowance Amounts

A. The Under Age One Risk Sharing Allowance Amounts are an obligation of the PH-MCO to the Department. These amounts are specified in Appendix 3f.

B. The Department will determine the Under Age One Risk Sharing Allowance Amounts obligation by multiplying the Under Age One Risk Sharing Allowance Amount by the applicable Member months for all Members covered by the Arrangement.

VI. Data Source

A. The Department will use the Department's MMIS approved encounter data to identify those claims eligible for risk sharing, unless the Department notifies the PH-MCO that it will use different data. The Department will extract approved encounter data based on a schedule as determined by the Department.

B. Interim encounters for acute care inpatient services (Provider Type and Specialty of 01/010) are excluded.

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

VII. Distributions

The Department will perform at least two settlements for each Arrangement Year. The Department will use encounter data or other data that is timely available for processing prior to each settlement date. The Department will notify the PH-MCO of the settlement amount and provide documentation by the settlement date as provided below. The PH-MCO's uncollected Under Age 1 Risk Sharing Allowance Amounts as specified in Appendix 3f will be subtracted from the settlement amount. If the result is a positive number, the Department will pay the amount to the PH-MCO. If the result is a negative number, the Department will reduce a subsequent payment to the PH-MCO by this amount. Settlement distributions will take place within thirty days of each of the settlement notifications.

A. The initial settlement will be completed by the Department at least twelve (12) months after the end of the Arrangement Year. This settlement will include encounter data experience for the entire Arrangement Year with data cutoff dates determined by the Department and prior to the initial

settlement date.

B. The final settlement will be completed at least eighteen (18) months after the end of the Arrangement Year. This settlement will include experience for the entire Arrangement Year and will be net of the initial settlement for the same Arrangement Year.

C. The Department will provide the PH-MCOs notification of the dates of the data extractions related to the settlements above.

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

- The Department may elect to reduce a subsequent monthly capitation payment by the total amount of the outstanding Under Age One Risk Sharing Allowance Amounts obligation for current and previous program months; AND

- The Department may reduce each subsequent monthly capitation payment by the PH-MCO's Under Age One Risk Sharing Allowance Amounts obligation for the same month.

APPENDIX 6

APPENDIX 6

HOME ACCESSIBILITY RISK SHARING ARRANGEMENT

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

This Appendix does not apply to Members under age one (1).

I. Arrangement Years

A. Arrangement Years are equivalent to calendar years. Exception: If the PH-MCO does not operate a HealthChoices program in a zone under this or any other HealthChoices Agreement throughout the complete calendar year, then the Arrangement Year consists of the portion of the year in which the PH-MCO operates the program. Each Arrangement Year serves as an accumulation period for incurring costs for Covered Services.

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

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

II. Covered Members

This Arrangement covers Members who have attained their first birthday and who do not reside in any of the following types of facility:

- State Intermediate Care Facilities for Individuals with Intellectual Disabilities (State ICFs/IID)
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFs/IID)
- South Mountain Restoration Center
- County Nursing Facility
- General Nursing Facility
- Hospice
- Intermediate Care Facility for Persons with Other Related Conditions
- Prescribed Pediatric Extended Care Centers
- Residential Skilled Pediatric Facilities

III. Covered Services

A. This Arrangement covers medically necessary services prescribed by a licensed physician for a Covered Member to support mobility activities of daily living in the Member's home and to enter/exit their home and that meet the environmental and clinical guidelines as authorized by the Department.

B. Covered Services for medically necessary services include, but are not limited to:
   a. Stair Lifts/Chair Glides
   b. Wheelchair Lifts
   c. Ceiling Lifts
   d. Metal Accessibility Ramps
   e. Other mobility products that are medically necessary to enter/exit their home or to support activities of daily living and are removeable or reusable without damage to the item.

C. Installation costs include, but are not limited to:
   a. Parts or supplies provided or recommended by the manufacturer for attaching or mounting the item to the surface at the home or residence,
   b. Labor to attach or mount the item to a surface per the manufacturer's installation guide,
   c. Required permits,
   d. Installing an electrical outlet or connection to an existing electrical source,
   e. Pouring a concrete foundation (slab) according to the manufacturer's instructions (which may include leveling the ground under the concrete foundation),
   f. External supports, such as bracing a wall, and
   g. Removing a portion of an existing railing or bannister only as needed to accommodate the equipment.

D. Home modifications are not considered to be Covered Services and are not eligible for this Arrangement.

IV. Risk Sharing

In each Arrangement Year, the PH-MCO is responsible for payment amounts of Covered Services provided to each Member. The Department will reimburse the PH-MCO eighty percent (80.0%) of Covered Services (net of third party liability/other insurance) submitted by the PH-MCO. There is no deductible.

V. Home Accessibility Risk Sharing Allowance Amounts

A. The Home Accessibility Risk Sharing Allowance Amounts are an obligation of the PH-MCO to the Department. Home Accessibility Risk Sharing Allowance Amounts are specified in Appendix 3f.

B. The Department will determine the total Home Accessibility Risk Sharing Allowance Amount obligation by multiplying the Home Accessibility Risk Sharing Allowance Amounts by the applicable Member months for all Members covered by this Arrangement.

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

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

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

VI. Data Source

A. The Department will use the Department's MMIS approved encounter data to identify those claims eligible for risk sharing, unless the Department notifies the PH-MCO that it will use different data. The Department will extract the Department's MMIS approved encounter data based on a schedule as determined by the Department.

B. The PH-MCO will submit a supplemental file containing a detailed cost breakdown indicating device and installation amounts.

C. The Department will audit claims as necessary.

VII. Distributions

The Department will perform at least two settlements for each Arrangement Year. The Department will use encounter data or other data that is timely available for processing prior to each settlement date. The Department will notify the PH-MCO of the settlement amount and provide documentation by the settlement date as provided below. The PH-MCO's uncollected Home Accessibility Risk Sharing Allowance Amount obligation, as specified in Appendix 3f, will be subtracted from the settlement amount. If the result is a positive number, the Department will pay that amount to the PH-MCO. If the result is a negative number, the Department will reduce a subsequent payment to the PH-MCO by this amount. Settlement distributions will take place within thirty days of each of the settlement notification. The PH-MCO will be notified in writing if the Department elects to suspend or postpone the settlement.

A. The initial settlement will be completed by the Department at least seven (7) months after the end of the Arrangement Year. This settlement will include encounter data experience for the entire Arrangement Year with data cutoff dates determined by the Department and prior to the initial settlement date.

B. The final settlement will be completed at least fifteen (15) months after the Arrangement Year. This settlement will include experience for the entire Arrangement Year and will be net of the initial settlement for the same Arrangement Year.

APPENDIX 14

APPENDIX 14

INPATIENT ACUTE CARE SERVICES DIRECTED PAYMENTS

I. Definitions

For the purposes of this Appendix 14, the term hospital means either of the following:

A. An acute care hospital, including critical access hospital, that receives APR/DRG payments from the Department under the MA Fee for Service Program;
B. An Out of State acute care hospital that provides inpatient acute care services to a PH-MCO's Members.

II. Payments to the PH-MCO

A. The Department's obligation under this Appendix is across all PH-MCOs that are responsible to operate a HealthChoices program in any or all zones during the applicable program year.

B. The Department's obligation under this Appendix will not exceed $646 million for each applicable program year.

C. The Department will calculate quarterly payments based on twenty-five percent (25.0%) of the amount in Section II.B.

D. Payments will be calculated by the Department based on a directed payment methodology approved by CMS for each applicable program year, and the amount paid to the PH-MCO will be the total of all hospital directed payment amounts calculated under Section III.A.

III. Payments by the PH-MCO to Hospitals

A. The Department will calculate the directed payment amount for each hospital based on a directed payment methodology approved by CMS for each applicable program year and will provide a schedule of hospital directed payment amounts (Schedule) to each PH-MCO.

B. If the Department makes a payment to the PH-MCO provided by Section II.D., then the PH-MCO must pay the directed payment amount to each hospital, as included on the Schedule, within 30 days of the receipt of the payment or the Schedule, whichever is later.

C. The PH-MCO must provide documentation to the Department that all hospital directed payments have been completed per the Schedule within 30 days of the payment date per Section III.B.

IV. Payment Adjustments

A. If based on the CMS-approved directed payment methodology, the Department is required to recalculate the directed payment amounts to hospitals in Section III.A, then the Department will notify the PH-MCO in writing of the recalculated directed payments to hospitals and the process for making the recalculated payment(s).

B. The recalculated payment will be paid to the PH-MCO per Section II.D, and the Department will recover the initial payment at the time the recalculated payment is processed.

C. The Department will provide an updated Schedule to the PH-MCO that includes the recalculated payments for each hospital.

D. The PH-MCOs must pay the hospitals within 30 days of the receipt of the recalculated payment or the Schedule, whichever is later.

V. Hospital overpayments

If the Department identifies that any or all hospital(s) received an overpayment, per Section III.A or IV.A, the Department will notify the PH-MCO in writing of their obligation, if any, to collect the overpayment from each applicable hospital and of the process to remit the recovered hospital overpayments to the Department.

APPENDIX 17

APPENDIX 17

OUTPATIENT HOSPITAL SERVICES DIRECTED PAYMENTS

I. Definitions

For the purposes of this Appendix 17, the term hospital means either of the following:

A. An acute care hospital, including critical access hospital, that receives reimbursement for outpatient hospital services from the Department under the MA Fee for Service Program;
B. An Out of State acute care hospital that provides outpatient hospital services to a PH-MCO's Members.

II. Payments to the PH-MCO

A. The Department's obligation under this Appendix is across all PH-MCOs that are responsible to operate a HealthChoices program in any or all zones during the applicable program year.

B. The Department's obligation under this Appendix will not exceed $510 million for each applicable program year.

C. The Department will calculate quarterly payments based on twenty-five percent (25.0%) of the amount in Section II.B.

D. Payments will be calculated by the Department based on a directed payment methodology approved by CMS for each applicable program year, and the amount paid to the PH-MCO will be the total of all hospital directed payment amounts calculated under Section III.A.

III. Payments by the PH-MCO to Hospitals

A. The Department will calculate the directed payment amount for each hospital based on a directed payment methodology approved by CMS for each applicable program year and will provide a schedule of hospital directed payment amounts ("Schedule") to each PH-MCO.

B. If the Department makes a payment to the PH-MCO provided by Section II.D., then the PH-MCO must pay the directed payment amount to each hospital, as included

on the Schedule, within 30 days of the receipt of the payment or the Schedule, whichever is later.

C. The PH-MCO must provide documentation to the Department that all hospital directed payments have been completed per the Schedule within 30 days of the payment date per Section III.B.

IV. Payment Adjustments

A. If based on the CMS-approved directed payment methodology, the Department is required to recalculate the directed payment amounts to hospitals in Section III.A, then the Department will notify the PH-MCO in writing of the recalculated directed payments to hospitals and the process for making the recalculated payment(s).

B. The recalculated payment will be paid to the PH-MCO per Section II.D, and the Department will recover the initial payment at the time the recalculated payment is processed.

C. The Department will provide an updated Schedule to the PH-MCO that includes the recalculated payments for each hospital.

D. The PH-MCOs must pay the hospitals within 30 days of the receipt of the recalculated payment or the Schedule, whichever is later.

V. Hospital overpayments

If the Department identifies that any or all hospital(s) received an overpayment, per Section III.A or IV.A, the Department will notify the PH-MCO in writing of their obligation, if any, to collect the overpayment from each applicable hospital and of the process to remit the recovered hospital overpayments to the Department.

APPENDIX 18

APPENDIX 18
COVID-19 NON-RISK ARRANGEMENT

This Appendix establishes a Non-Risk Arrangement for the coverage and administration of COVID-19 vaccines and COVID-19 Over-the-Counter (OTC) tests, in accordance with 42 CFR 447.362. This Appendix will only become effective in the event that at least one COVID-19 vaccine or one COVID-19 OTC Test is the financial responsibility of the PH-MCO during the January 1, 2023 to December 31, 2023 program period. This program period will be considered the Arrangement Year.

For the Arrangement Year, the following terms shall apply:

I. Covered Population

Any Member that is eligible to receive a COVID-19 vaccine and is enrolled with the PH-MCO during the Arrangement Year is potentially eligible for this Arrangement. To be included in this Arrangement, a Member must have received a covered COVID-19 vaccine and/or COVID-19 OTC test during the Arrangement Year.

Members in an IMD

Provisions 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 (SUD) are outlined below:

- Effective January 1, 2020, the Department will include any claim with a date of service within a calendar month for those days in which the Member is both enrolled in the MCO and not residing in the IMD and the provision of inpatient psychiatric treatment in an IMD meets the requirements for *in lieu of* services in 42 CFR 438.3 (e) (2)(i) through (iii).

II. Covered Services

Covered Services for this Arrangement will include any COVID-19 OTC test or COVID-19 vaccine, as well as the associated cost to administer the vaccine, that become the financial responsibility of the PH-MCO during the Arrangement Year. Only OTC tests and vaccines to specifically address COVID-19 will be included. To be eligible for this Arrangement, COVID-19 services which include the OTC tests or vaccines and the administration must be eligible for reimbursement under the MA Fee-for-Service program. The Non-Risk Arrangement only applies to Covered Services with dates of service during the Arrangement Year.

III. Quarterly Payment Process

There will be quarterly payments. Each payment will include covered services paid by the PH-MCO for dates of service beginning with the start date of the Non-Risk Arrangement and limited to not more than 18 months prior to the end of the payment quarter. The payment for each covered service will be the lesser of the amount paid by the PH-MCO or the MA Allowed Amount. Each payment will exclude any claim that was included in a prior quarter's payment. The Department will provide the PH-MCO with the payment amount, and documentation not later than the last workday of the fourth month after the end of the quarter. The Department will utilize the Department's MMIS approved encounter data for the purpose of calculating payments for this Non-Risk Arrangement at least 75 days after the last day in the quarter.

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

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

IV. Transportation Expenses Paid by the PH-MCO

The Department will reimburse the PH-MCO for the paid expenses the PH-MCO made for transportation to and from Covered Services for the Covered Population. This reimbursement is limited to the Member's case county's transportation trip rate. The Department will provide to the PH-MCO a transportation trip rate schedule including the maximum per trip transportation reimbursement amount for each county for each quarter covered by this Arrangement.

Where a Member in the Covered Population currently receives transportation to and from medical services under the Medical Assistance Transportation Program (MATP), the PH-MCO shall refer the Member to the MATP prior to the PH-MCO paying for the transportation to and from the Covered Services. The PH-MCO can reimburse the transportation expenses to and from the Covered Services when the MATP covered Member receives notice from the MATP provider that they are not eligible to receive MATP transportation to and from the Covered Services.

The PH-MCO must submit to the Department one invoice that includes the

amount the PH-MCO paid for transportation expenses to and from Covered Services for the Covered Population during the Arrangement Year. The Department will limit transportation expenses included on the invoice to the maximum per trip transportation reimbursement amount shown on the transportation trip rate schedule. When necessary, the Department will apply an adjustment to the invoice to limit the reimbursement to the maximum per trip transportation reimbursement amount based on each Member's case county for transportation to and from each Covered Service for the Covered Population.

The invoice must be in the format approved by the Department and must be submitted by no later than 180 days from the end of the Arrangement Year.

The Department will verify the invoice by confirming that the transportation expense paid by the PH-MCO was for transportation to and from Covered Services for the Covered Population. If the Department requests supporting documentation, the PH-MCO must submit the requested documentation within 15 business days.

The Department will notify the PH-MCO in writing of transportation expenses that cannot be confirmed. The PH-MCO shall submit within 45 calendar days from the date of the written notification additional documentation to the Department which would allow the Department to confirm the transportation expense paid by the PH-MCO was for transportation to and from Covered Services for the Covered Population. The Department will issue a final written notification on transportation expenses that cannot be confirmed, and the Department will apply an adjustment to reduce the invoice by that same amount.

The Department will make a separate payment to the PH-MCO in the amount of the invoice less any applicable adjustments through the gross adjustment process.

Administrative expenses incurred by the PH-MCO for transportation to and from Covered Services for the Covered Population will not be reimbursed under this Appendix.

Member's having a case county of Philadelphia are excluded from reimbursement under this Section IV. PH-MCO must refer the Members needing transportation to Covered Services to Philadelphia County's MATP broker.

V. CMS Requirements

This Arrangement shall comply with all applicable CMS requirements and regulations pertaining to non-risk arrangements and is subject to the CMS regulations for payments under non-risk managed care contracts at 42 CFR 447.362. Payments to the PH-MCO are contingent upon CMS approval and participation of federal matching funds. The PH-MCO agrees to provide DHS any supporting information or data that may be required to respond to CMS questions

about this Arrangement. The PH-MCO agrees to perform under the terms of this Appendix beginning on the effective date of this Appendix pending CMS approval. In the event that CMS rejects this Appendix, the parties shall work in good faith to propose an alternate arrangement to CMS within twenty (20) business days of notification of rejection by CMS. In the event that the parties fail to negotiate an acceptable proposed alternative within the twenty-day period specified herein, or in the event that CMS does not accept the alternative jointly submitted by the Parties pursuant to this paragraph, all obligations under this Appendix are immediately terminated without further recourse from either party. No payment obligation under this Arrangement shall arise prior to CMS approval of this Appendix.

APPENDIX 18a

APPENDIX 18A

SHIFT NURSING
SHADOW NURSE NON-RISK ARRANGEMENT

This Appendix establishes a Non-Risk Arrangement for reimbursement from the Department to the PH-MCO of the cost of shift nursing services provided to medically complex Members under age 21 by a shadow nurse for the purpose of training the shadow nurse and/or to transition a specific Member's authorized shift nursing services from the previous nurse to the shadow nurse. This Appendix is effective for shift nursing services provided by a shadow nurse only and having dates of service during the January 1, 2023 to December 31, 2023 program period, which is considered to be the Arrangement Year.

For the Arrangement Year, the following terms shall apply:

I. Covered Members

This Arrangement covers Members who have attained their first birthday and are under age twenty-one (21), and who do not reside in any of the following types of facility:

- State Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- South Mountain Restoration Center
- County Nursing Facility
- General Nursing Facility
- Hospice
- Intermediate Care Facility for Persons with Other Related Conditions
- Residential Skilled Pediatric Facility
- Prescribed Pediatric Extended Care Centers (PPECCs)

I. Covered Services

A. This Arrangement covers shift nursing services provided by a shadow nurse. A shadow nurse is defined as a Licensed Practical Nurse or Registered Nurse in a home, home-like, or school-based setting at the same time as the first or primary nurse.

B. Covered Services include only the Shadow Nurse's hours of training on the Medically Necessary nursing services required by the Covered Member and reimbursement is limited to the maximum number of hours that can be authorized in the Fee-for-Service program for a Shadow Nurse.

C. Training includes both observation by or instruction to the Shadow Nurse from the primary nurse and/or nursing services provided by the Shadow Nursing to the Covered Member in addition to the primary nurse.

D. Administrative services, as defined in the HealthChoices Financial Reporting Requirements, are not covered by this Arrangement.

II. Non-risk Reimbursement

The Department will limit the reimbursement for Covered Services under this Arrangement to the lesser of the MA Fee Schedule rate based on the applicable date of service or the amount paid by the PH-MCO for Covered Services provided to Covered Members.

III. Settlements

The Department will perform one settlement for the Arrangement Year. The Department will use encounter data or other data that is timely available for processing the settlement. The Department will notify the PH-MCO of the settlement amount and provide documentation by the settlement date as provided below.

A. The settlement will be completed 45 days after the end of the Arrangement Year. This settlement will include experience for the entire Arrangement Year

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously contracted with the Department to operate a HealthChoices program in at least one zone ("Previous PH-MCO"); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will allow the PH-MCO to include claims paid by the Previous PH-MCO with dates of service in the current Arrangement Year, provided the Previous PH-MCO relinquishes any claims to revenue under the non-risk Arrangement for dates of service during the Arrangement Year.

II. Data Source

A. The Department will use the Department's MMIS approved encounter data to identify those claims eligible for this Arrangement.

B. Upon notification by the Department, the PH-MCO must submit supplemental data files, in a format determined by the Department, for use in the administration of this Arrangement.

IV. CMS Requirements

This Arrangement shall comply with all applicable CMS requirements and regulations pertaining to non-risk arrangements and is subject to the CMS regulations for payments under non-risk managed care contracts at 42 CFR 447.362.

A. Payments to the PH-MCO are contingent upon CMS approval and participation of federal matching funds. No payment obligation under this Arrangement shall arise prior to CMS approval of this Appendix.

B. The PH-MCO agrees to perform under the terms of this Appendix beginning on the effective date of this Appendix pending CMS approval.

C. In the event that CMS rejects this Appendix, the Covered Services will be included in the risk sharing arrangement under Appendix 3c or Appendix 3p for the applicable Arrangement Year.

APPENDIX 18b

APPENDIX 18B

HIGH-COST GENE THERAPY NON-RISK ARRANGEMENT

This Appendix establishes a Non-Risk Arrangement (Arrangement) for the coverage of high-cost gene therapy products for Members in accordance with 42 CFR § 447.362. The program period of January 1, 2023 to December 31, 2023 will be considered the Arrangement Year.

For the Arrangement Year, the following terms shall apply:

I. Covered Population

Any Member who has a diagnosis of Hemophilia or Beta Thalassemia and receives treatment for that diagnosis with a Food and Drug Administration (FDA) approved gene therapy product.

II. Covered Services

A. Covered Services for this Arrangement will include any potentially curative gene therapy that is considered a Covered Outpatient Drug by Centers for Medicare & Medicaid Services (CMS) and is FDA approved for the treatment of either hemophilia A, hemophilia B, or beta thalassemia.

B. The Department will provide a list of gene therapy products that are covered under this Arrangement to the PH-MCO. No other FDA approved gene therapy product is covered by this Appendix.

C. This Arrangement includes only the cost of the gene therapy product and does not include the cost of dispensing, administration of the treatment, or any other associated treatment costs.

D. Administrative costs incurred by the PH-MCO are not covered by this Appendix.

III. Non-risk Reimbursement

A. The Department will provide written notification to the PH-MCO of Covered Services per this Arrangement at the end of each calendar year quarter.

B. Reimbursement is limited to the lesser of the amount paid by the PH-MCO for

the gene therapy product or the amount that would be paid by the MA Fee-for-Service (FFS) program.

a. The PH-MCO paid amount will be net of any third-party liability amount.

b. The Department will include the FFS price on the list of Covered Services. This amount will be considered the maximum MA Allowed Amount for each gene therapy product.

c. Any provider identified by the Department as a 340B covered entity, must dispense or administer non-340B purchased product. The Department will invoice for drug rebates on claims paid by PH-MCOs.

d. The Department will provide instructions on how the PH-MCOs can identify the applicable 340B covered providers per this Arrangement.

IV. Authorization of Services

PH-MCOs must prior authorize the Covered Services included in this Arrangement using the Department's approved prior authorization policy in accordance with the requirements in Exhibit BBB.

V. Quarterly Payment Process

A. The PH-MCO must submit to the Department quarterly invoices that include the amount the PH-MCO paid for Covered Services for the Covered Population having dates of service during each applicable calendar year quarter in the Arrangement Year.

B. Each quarterly invoice submitted must be in a format approved by the Department and must be submitted by no later than 120 days after the end of each calendar year quarter.

C. The Department will review and verify all information submitted on each quarterly invoice. The Department may request supplemental documentation to complete this verification. The PH-MCO must submit the requested supplemental documentation within 15 business days of the Department's request.

D. The Department will make one payment for each calendar year quarter to the PH-MCO for Covered Services for the Covered Population per this Arrangement.

VI. CMS Requirements

This Arrangement shall comply with all applicable CMS requirements and regulations pertaining to Non-Risk Arrangements and is subject to the CMS regulations for payments under non-risk managed care contracts at 42 CFR § 447.362.

A. Payments to the PH-MCO are contingent upon CMS approval and participation of federal matching funds. No payment obligation under this Arrangement shall arise prior to CMS approval of this Appendix.

B. The PH-MCO agrees to perform under the terms of this Appendix beginning on the effective date of this Appendix, pending CMS approval.

C. In the event that CMS rejects this Appendix, the Covered Services will be included in the risk sharing arrangement under Appendix 3k or 3p for the applicable Arrangement Year.

APPENDIX 19

Appendix 19

Physical Health HealthChoices Revenue Sharing

This Appendix establishes a requirement for remittance to the Department of any Realized Revenue, as defined in this Appendix, earned by a PH-MCO in excess of 3 percent.

The reporting requirements apply collectively to all HealthChoices zone(s) in which the PH-MCO operates under this Agreement or a previous Agreement with the Department during the applicable time period. This requirement is specific to the Physical Health HealthChoices (PH HC) program only and does not include revenue from any other MA managed care program in which the PH-MCO may operate.

I. Time Period

The time period for purposes of reporting PH HC program revenue aligns with the Department's PH HC program year and the PH HC program rating period. The applicable Time Period included in this Appendix will be PH HC program year CY2023.

II. Extent of Calculation

Revenue sharing calculations will be based on PH HC revenue and corresponding costs for all Rate Cells for each rating region and zone, including maternity care, as identified in Appendix 3f. The PH-MCO may not include revenue or costs that are not specific to the PH HC program.

III. Calculation Process

The revenue sharing calculation will utilize information reported in each applicable annual Medical Loss Ratio Report (Annual Financial Report #42) for the Time Period. The Department will utilize the Department reviewed and approved Annual Financial Report #42 for each applicable program year within the Time Period and will combine the reported amounts in each referenced section on the Annual Financial Report #42 for each Aggregated Medicaid Eligibility Group for the applicable Time Period.

The following items reference Sections within the Annual Financial Report #42:

a. **Capitation Revenue** will be based on "Total Premium Revenue" as reported in Section 4 as follows:

   i. Capitation revenue will not include PH-MCO quality incentive payments, such as any received PH-MCO Pay-for-Performance (P4P) and/or Integrated Care Plan (ICP) incentive funds pursuant to Agreement Exhibits B(1) and B(1)a: *MCO Pay for Performance Program* and B(2): *PH-MCO and BH-MCO Integrated Care Plan Program P4P*.

ii. The MCO Assessment in Section 5 will be deducted from Capitation Revenue.
iii. Applicable Federal and Pennsylvania State taxes will be deducted from Capitation Revenue.
iv. If the PH-MCO paid a MLR Remittance amount to the Department as calculated on the Annual Financial Report #42, the MLR Remittance amount paid by the PH-MCO will be deducted from the Capitation Revenue.

b. **Medical Expenses** will include paid claims and alternative method payments made by the PH-MCO for allowable Medically Necessary services rendered to Members during the Time Period. Medical Expenses will be based on "Total Incurred Claims" as reported in Section 1. The Department may review a portion of or all of the reported Medical Expenses and may exclude Medical Expenses that do not constitute payment for State Plan services and/or allowed in lieu of services, including but not limited to:

i. Any allowance for Unpaid Claim Liability (UCL). The Department has full discretion to modify UCL allowances that, in the professional judgment of the Department's Actuary, overstate projected liabilities; and
ii. Payments to Related Parties.

c. **Activities that improve health care quality** are reported in Section 2 and will be considered in the revenue sharing calculation in a manner consistent with the Medical Loss Ratio calculation in Appendix 3h, as long as they meet one or more of the following criteria:

i. Community Based Care Management (CBCM) expenditures. The Department will review CBCM expenditures included in Financial Report #5i or other supplemental financial reporting) and may exclude expenses that do not meet the program expenditures under Exhibit B(5).
ii. PH-MCO activity that meets requirements of 45 CFR § 158.150(b) and is not excluded under 45 CFR § 158.150(c).
iii. PH-MCO activity related to any External Quality Review related activity as described in 42 CFR § 438.358(b) and (c).
iv. PH-MCO expenditure that is related to Health Information Technology and meaningful use, under 45 CFR § 158.151.

d. **Administrative Expenses** will include those administrative expenses as reported in Section 6 and determined by the Department to be an allowable program expense.

e. **Taxes and assessments** imposed on the PH-MCO pursuant to law are to be included in Section 5.

f. **Prohibited Expenses** – the following expenses will not be included as expenses under this Appendix:
i. Outreach activities as described in Section V.F.3 of this Agreement

ii. Payments described in Section VII.E.8: Prohibited Payments of this Agreement
iii. Claims payments covered under a non-risk arrangement(s) included in this HealthChoices Agreement
iv. Premium Deficiency Reserves
v. Cost of advertisements in mass media
vi. Start-up, development or RFA expenses incurred before the Start Date on which the PH-MCO is responsible for the provision of services to Members
vii. Any expense related to exiting or terminating operations in a given zone/region under this Agreement
viii. Donations
ix. Excessive allocation of corporate overhead, as determined by the Department (see also item IV.d.i).

g. **Percent Limit** will be the maximum retained percentage of certain PH HC revenue, which is 3 percent.

h. **Maximum Retained Revenue**, or the amount of revenue that may be retained by the PH-MCO, will be calculated by multiplying Capitation Revenue by the Percent Limit.

i. **Realized Revenue -** the Department will calculate the Realized Revenue for the Time Period as follows:

	Capitation Revenue
LESS:	Medical Expenses
LESS:	Expenses for Activities that improve health care quality
LESS:	Administrative Expenses
EQUALS:	Realized Revenue

j. **Revenue Recovery Amount -** If the Realized Revenue is greater than the Maximum Retained Revenue, the Revenue Recovery Amount will be the difference between the Realized Revenue and Maximum Retained Revenue. If this amount is greater than zero (0), then the Revenue Recovery Amount is an obligation due from the PH-MCO to the Department. The Department will recover this obligation due from the PH-MCO by offsetting a future payment due to the PH-MCO under this Agreement. The Department will notify the PH-MCO of the future payment that will be offset in advance of that scheduled payment.

k. **Retention of Excess Revenue –** The PH-MCO may retain fifty percent (50%) of the Realized Revenue in excess of the Maximum Retained Revenue with express written approval from the Department if the PH-MCO agrees to expend the remaining fifty percent (50%) of funds in excess of the Maximum Retained Revenue on initiatives that align with the Department's goals of improving access and provider retention; investments in social determinants of health such as

housing, employment and food insecurity; achieving health equity; and programs that focus on community development.

i. A PH-MCO shall submit to the Department a written expenditure proposal for any funds in excess of the Maximum Retained Revenue.

ii. This proposal shall be submitted within thirty (30) days of receiving the preliminary calculation per Section V, below.

iii. After the Department accepts the PH-MCO's proposal, the Department will decrease the Revenue Recovery Amount to zero (0).

IV. Risk of Insolvency

If the PH-MCO decides not to invest excess revenue as described in Section III.k of this Appendix, and the Department determines that payment of a Revenue Recovery Amount by the PH-MCO would result in the PH-MCO being put at significant risk of insolvency, the Department may at the Department's discretion, waive all or a portion of the Revenue Recovery Amount owed by the PH-MCO.

V. Communication and Timing of Revenue Sharing Administration

The Department will notify each PH-MCO of the preliminary revenue sharing calculation and associated Revenue Recovery Amount within ninety (90) days following the date the Department completes the review and approves the Annual Financial Report #42 for CY2023. The PH-MCO will have thirty (30) days from the notification date to provide additional documentation or supplemental information to the Department regarding the calculation, including the reported amounts in the Annual Financial Report #42. The Department will have up to sixty (60) days to review the additional documentation and supplemental information submitted by the PH-MCO and to finalize the Revenue Recovery Amount calculation. If the Revenue Recovery Amount is greater than zero (0), the Department will recover this amount per Section IV of this Appendix.

VI. Final Revenue Sharing Notification and Remittance

The Department will provide the PH-MCO with written notification of the final Revenue Recovery Amount and the date when the amount due to the Department will be recovered, if applicable.

VII. Documentation of PH-MCO Expenses

At the request of the Department, the PH-MCO shall make available all books, accounts, documents, files and information that relate to the PH-MCO's PH HC transactions within ten (10) business days after the request was made. The PH-MCO shall cooperate with the Department and any representatives of the Department.

VIII. Continuation

If CMS issues regulation(s) that revises or replaces the requirements in this appendix, the revised or replacement requirements will apply. The Department at its discretion may choose to waive any or all requirements of this Appendix. If the requirements of this Appendix are waived in full or in part, the Department will notify the PH-MCO in writing of the waived Sections.

APPENDIX 19a

HC Agreements
CY 2023 Amendment
December 14, 2022

Appendix 19A

Physical Health HealthChoices Revenue Sharing

This Appendix establishes a requirement for remittance to the Department of any Realized Revenue, as defined in this Appendix, earned by a PH-MCO in excess of 3 percent.

The reporting requirements apply collectively to all HealthChoices zone(s) in which the PH-MCO operates under this Agreement or a previous Agreement with the Department during the applicable time period. This requirement is specific to the Physical Health HealthChoices (PH HC) program only and does not include revenue from any other MA managed care program in which the PH-MCO may operate.

I. Time Period

The time period for purposes of reporting PH HC program revenue aligns with the Department's PH HC program year and the PH HC program rating period. The applicable Time Period included in this Appendix will be PH HC program year CY2024.

II. Extent of Calculation

Revenue sharing calculations will be based on PH HC revenue and corresponding costs for all Rate Cells for each rating region and zone, including maternity care, as identified in Appendix 3f. The PH-MCO may not include revenue or costs that are not specific to the PH HC program.

III. Calculation Process

The revenue sharing calculation will utilize information reported in each applicable annual Medical Loss Ratio Report (Annual Financial Report #42) for the Time Period. The Department will utilize the Department reviewed and approved Annual Financial Report #42 for each applicable program year within the Time Period and will combine the reported amounts in each referenced section on the Annual Financial Report #42 for each Aggregated Medicaid Eligibility Group for the applicable Time Period.

The following items reference Sections within the Annual Financial Report #42:

a. **Capitation Revenue** will be based on "Total Premium Revenue" as reported in Section 4 as follows:

   i. Capitation revenue will not include PH-MCO quality incentive payments, such as any received PH-MCO Pay-for-Performance (P4P) and/or Integrated Care Plan (ICP) incentive funds pursuant to Agreement Exhibits B(1) and B(1)a: *MCO Pay for Performance Program* and B(2): *PH-MCO and BH-MCO Integrated Care Plan Program P4P*.

ii. The MCO Assessment in Section 5 will be deducted from Capitation Revenue.
iii. Applicable Federal and Pennsylvania State taxes will be deducted from Capitation Revenue.
iv. If the PH-MCO paid a MLR Remittance amount to the Department as calculated on the Annual Financial Report #42, the MLR Remittance amount paid by the PH-MCO will be deducted from the Capitation Revenue.

b. **Medical Expenses** will include paid claims and alternative method payments made by the PH-MCO for allowable Medically Necessary services rendered to Members during the Time Period. Medical Expenses will be based on "Total Incurred Claims" as reported in Section 1. The Department may review a portion of or all of the reported Medical Expenses and may exclude Medical Expenses that do not constitute payment for State Plan services and/or allowed in lieu of services, including but not limited to:

i. Any allowance for Unpaid Claim Liability (UCL). The Department has full discretion to modify UCL allowances that, in the professional judgment of the Department's Actuary, overstate projected liabilities; and
ii. Payments to Related Parties.

c. **Activities that improve health care quality** are reported in Section 2 and will be considered in the revenue sharing calculation in a manner consistent with the Medical Loss Ratio calculation in Appendix 3h, as long as they meet one or more of the following criteria:

i. Community Based Care Management (CBCM) expenditures. The Department will review CBCM expenditures included in Financial Report #5i or other supplemental financial reporting) and may exclude expenses that do not meet the program expenditures under Exhibit B(5).
ii. PH-MCO activity that meets requirements of 45 CFR § 158.150(b) and is not excluded under 45 CFR § 158.150(c).
iii. PH-MCO activity related to any External Quality Review related activity as described in 45 CFR § 438.358(b) and (c).
iv. PH-MCO expenditure that is related to Health Information Technology and meaningful use, under 45 CFR § 158.151.

d. **Administrative Expenses** will include those administrative expenses as reported in Section 6 and determined by the Department to be an allowable program expense.

e. **Taxes and assessments** imposed on the PH-MCO pursuant to law are to be included in Section 5.

f. **Prohibited Expenses** – the following expenses will not be included as expenses under this Appendix:
i. Outreach activities as described in Section V.F.3 of this Agreement

ii. Payments described in Section VII.E.8: Prohibited Payments of this Agreement
iii. Claims payments covered under a non-risk arrangement(s) include in this HealthChoices Agreement
iv. Premium Deficiency Reserves
v. Cost of advertisements in mass media
vi. Start-up, development or RFA expenses incurred before the Start Date on which the PH-MCO is responsible for the provision of services to Members
vii. Any expense related to exiting or terminating operations in a given zone/region under this Agreement
viii. Donations
ix. Excessive allocation of corporate overhead, as determined by the Department (see also item IV.d.i).

g. **Percent Limit** will be the maximum retained percentage of certain PH HC revenue, which is 3 percent.

h. **Maximum Retained Revenue**, or the amount of revenue that may be retained by the PH-MCO, will be calculated by multiplying Capitation Revenue by the Percent Limit.

i. **Realized Revenue -** the Department will calculate the Realized Revenue for the Time Period as follows:

	Capitation Revenue
LESS:	Medical Expenses
LESS:	Expenses for Activities that improve health care quality
LESS:	Administrative Expenses
EQUALS:	Realized Revenue

j. **Revenue Recovery Amount -** If the Realized Revenue is greater than the Maximum Retained Revenue, the Revenue Recovery Amount will be the difference between the Realized Revenue and Maximum Retained Revenue. If this amount is greater than zero (0), then the Revenue Recovery Amount is an obligation due from the PH-MCO to the Department. The Department will recover this obligation due from the PH-MCO by offsetting a future payment due to the PH-MCO under this Agreement. The Department will notify the PH-MCO of the future payment that will be offset in advance of that scheduled payment.

k. **Retention of Excess Revenue –** The PH-MCO may retain fifty percent (50%) of the Realized Revenue in excess of the Maximum Retained Revenue with express written approval from the Department if the PH-MCO agrees to expend the remaining fifty percent (50%) of funds in excess of the Maximum Retained Revenue on initiatives that align with the Department's goals of improving access and provider retention; investments in social determinants of health such as

housing, employment and food insecurity; achieving health equity; and programs that focus on community development.

i. A PH-MCO shall submit to the Department a written expenditure proposal for any funds in excess of the Maximum Retained Revenue.

ii. This proposal shall be submitted within thirty (30) days of receiving the preliminary calculation per Section V, below.

iii. After the Department accepts the PH-MCO's proposal, the Department will decrease the Revenue Recovery Amount to zero (0).

IV. Risk of Insolvency

If the PH-MCO decides not to invest excess revenue as described in Section III.k of this Appendix and the Department determines that payment of a Revenue Recovery Amount by the PH-MCO would result in the PH-MCO being put at significant risk of insolvency, the Department may at the Department's discretion, waive all or a portion of the Revenue Recovery Amount owed by the PH-MCO.

V. Communication and Timing of Revenue Sharing Administration

The Department will notify each PH-MCO of the preliminary revenue sharing calculation and associated Revenue Recovery Amount within ninety (90) days following the date the Department completes the review and approves the Annual Financial Report #42 for CY2024. The PH-MCO will have thirty (30) days from the notification date to provide additional documentation or supplemental information to the Department regarding the calculation, including the reported amounts in the Annual Financial Report #42. The Department will have up to sixty (60) days to review the additional documentation and supplemental information submitted by the PH-MCO and to finalize the Revenue Recovery Amount calculation. If the Revenue Recovery Amount is greater than zero (0), the Department will recover this amount per Section IV of this Appendix.

VI. Final Revenue Sharing Notification and Remittance

The Department will provide the PH-MCO with written notification of the final Revenue Recovery Amount and the date when the amount due to the Department will be recovered, if applicable.

VII. Documentation of PH-MCO Expenses

At the request of the Department, the PH-MCO shall make available all books, accounts, documents, files and information that relate to the PH-MCO's PH HC transactions within ten (10) business days after the request was made. The PH-MCO shall cooperate with the Department and any representatives of the Department.

VIII. Continuation

If CMS issues regulation(s) that revises or replaces the requirements in this appendix, the revised or replacement requirements will apply. The Department at its discretion may choose to waive any or all requirements of this Appendix. If the requirements of this Appendix are waived in full or in part, the Department will notify the PH-MCO in writing of the waived Sections.

APPENDIX 19b

HC Agreements
CY 2023 Amendment
December 14, 2022

Appendix 19B

Physical Health HealthChoices Revenue Sharing

This Appendix establishes a requirement for remittance to the Department of any Realized Revenue, as defined in this Appendix, earned by a PH-MCO in excess of 3 percent.

The reporting requirements apply collectively to all HealthChoices zone(s) in which the PH-MCO operates under this Agreement or a previous Agreement with the Department during the applicable time period. This requirement is specific to the Physical Health HealthChoices (PH HC) program only and does not include revenue from any other MA managed care program in which the PH-MCO may operate.

I. Time Period

The time period for purposes of reporting PH HC program revenue aligns with the Department's PH HC program year and the PH HC program rating period. The applicable Time Period included in this Appendix will be PH HC program year CY2025 and the two calendar years immediately preceding CY2025.

II. Extent of Calculation

Revenue sharing calculations will be based on PH HC revenue and corresponding costs for all Rate Cells for each rating region and zone, including maternity care, as identified in Appendix 3f. The PH-MCO may not include revenue or costs that are not specific to the PH HC program.

III. Calculation Process

The revenue sharing calculation will utilize information reported in each applicable annual Medical Loss Ratio Report (Annual Financial Report #42) for the Time Period. The Department will utilize the Department reviewed and approved Annual Financial Report #42 for each applicable program year within the Time Period and will combine the reported amounts in each referenced section on the Annual Financial Report #42 for each Aggregated Medicaid Eligibility Group for the applicable Time Period.

The following items reference Sections within the Annual Financial Report #42:

a. **Capitation Revenue** will be based on "Total Premium Revenue" as reported in Section 4 as follows:

   i. Capitation revenue will not include PH-MCO quality incentive payments, such as any received PH-MCO Pay-for-Performance (P4P) and/or Integrated Care Plan (ICP) incentive funds pursuant to Agreement Exhibits B(1) and B(1)a: *MCO Pay for Performance Program* and B(2): *PH-MCO and BH-MCO Integrated Care Plan Program P4P*.

ii. The MCO Assessment in Section 5 will be deducted from Capitation Revenue.
iii. Applicable Federal and Pennsylvania State taxes will be deducted from Capitation Revenue.
iv. If the PH-MCO paid a MLR Remittance amount to the Department as calculated on the Annual Financial Report #42, the MLR Remittance amount paid by the PH-MCO will be deducted from the Capitation Revenue.

b. **Medical Expenses** will include paid claims and alternative method payments made by the PH-MCO for allowable Medically Necessary services rendered to Members during the Time Period. Medical Expenses will be based on "Total Incurred Claims" as reported in Section 1. The Department may review a portion of or all of the reported Medical Expenses and may exclude Medical Expenses that do not constitute payment for State Plan services and/or allowed in lieu of services, including but not limited to:

i. Any allowance for Unpaid Claim Liability (UCL). The Department has full discretion to modify UCL allowances that, in the professional judgment of the Department's Actuary, overstate projected liabilities; and
ii. Payments to Related Parties.

c. **Activities that improve health care quality** are reported in Section 2 and will be considered in the revenue sharing calculation in a manner consistent with the Medical Loss Ratio calculation in Appendix 3h, as long as they meet one or more of the following criteria:

i. Community Based Care Management (CBCM) expenditures. The Department will review CBCM expenditures included in Financial Report #5i or other supplemental financial reporting) and may exclude expenses that do not meet the program expenditures under Exhibit B(5).
ii. PH-MCO activity that meets requirements of 45 CFR § 158.150(b) and is not excluded under 45 CFR § 158.150(c).
iii. PH-MCO activity related to any External Quality Review related activity as described in 45 CFR § 438.358(b) and (c).
iv. PH-MCO expenditure that is related to Health Information Technology and meaningful use, under 45 CFR § 158.151.

d. **Administrative Expenses** will include those administrative expenses as reported in Section 6 and determined by the Department to be an allowable program expense.

e. **Taxes and assessments** imposed on the PH-MCO pursuant to law are to be included in Section 5.

f. **Prohibited Expenses** – the following expenses will not be included as expenses under this Appendix:
i. Outreach activities as described in Section V.F.3 of this Agreement

ii. Payments described in Section VII.E.8: Prohibited Payments of this Agreement
iii. Claims payments covered under a non-risk arrangement(s) include in this HealthChoices Agreement
iv. Premium Deficiency Reserves
v. Cost of advertisements in mass media
vi. Start-up, development or RFA expenses incurred before the Start Date on which the PH-MCO is responsible for the provision of services to Members
vii. Any expense related to exiting or terminating operations in a given zone/region under this Agreement
viii. Donations
ix. Excessive allocation of corporate overhead, as determined by the Department (see also item IV.d.i).

g. **Percent Limit** will be the maximum retained percentage of certain PH HC revenue, which is 3 percent.

h. **Maximum Retained Revenue**, or the amount of revenue that may be retained by the PH-MCO, will be calculated by multiplying Capitation Revenue for CY2025 by the Percent Limit.

i. **Realized Revenue -** the Department will calculate the Realized Revenue for the Time Period as follows:

	Capitation Revenue
LESS:	Medical Expenses
LESS:	Expenses for Activities that improve health care quality
LESS:	Administrative Expenses
LESS:	Retention of Excess Revenue from Prior Program Years
LESS:	Revenue Recovery Amount from Prior Program Years
EQUALS:	Realized Revenue

NOTE – Prior Program Years included in this Realized Revenue calculation is defined as the two calendar years immediately preceding CY2025.

The Department will determine the Realized Revenue Percentage by dividing the Realized Revenue by the Capitation Revenue. The Department will apply this Realized Revenue Percentage to the CY2025 Capitation Revenue to determine the CY2025 Realized Revenue.

j. **Revenue Recovery Amount -** If the CY 2025 Realized Revenue is greater than the Maximum Retained Revenue, the Revenue Recovery Amount will be the difference between the Realized Revenue and Maximum Retained Revenue. If this amount is greater than zero (0), then the Revenue Recovery Amount is an obligation due from the PH-MCO to the Department. The Department will recover this obligation due from the PH-MCO by offsetting a future payment due to the PH-MCO under this Agreement. The Department will notify the PH-MCO of the future payment that will be offset in advance of that scheduled payment.

k. **Retention of Excess Revenue –** The PH-MCO may retain fifty percent (50%) of the Realized Revenue in excess of the Maximum Retained Revenue with express written approval from the Department if the PH-MCO agrees to expend the remaining fifty percent (50%) of funds in excess of the Maximum Retained Revenue on initiatives that align with the Department's goals of improving access and provider retention; investments in social determinants of health such as housing, employment and food insecurity; achieving health equity; and programs that focus on community development.

   i. A PH-MCO shall submit to the Department a written expenditure proposal for any funds in excess of the Maximum Retained Revenue.

   ii. This proposal shall be submitted within thirty (30) days of receiving the preliminary calculation per Section V, below.

   iii. When the Department accepts the PH-MCO's proposal, the Department will decrease the Revenue Recovery Amount to zero (0).

IV. Risk of Insolvency

If the PH-MCO decides not to invest excess revenue as described in Section III.k of this Appendix, and the Department determines that payment of a Revenue Recovery Amount by the PH-MCO would result in the PH-MCO being put at significant risk of insolvency, the Department may at the Department's discretion, waive all or a portion of the Revenue Recovery Amount owed by the PH-MCO.

V. Communication and Timing of Revenue Sharing Administration

The Department will notify each PH-MCO of the preliminary revenue sharing calculation and associated Revenue Recovery Amount within ninety (90) days following the date the Department completes the review and approves the Annual Financial Report #42 for CY2025. The PH-MCO will have thirty (30) days from the notification date to provide additional documentation or supplemental information to the Department regarding the calculation, including the reported amounts in the Annual Financial Report #42. The Department will have up to sixty (60) days to review the additional documentation and supplemental information submitted by the PH-MCO and to finalize the Revenue Recovery Amount calculation. If the Revenue Recovery Amount is greater than zero (0), the Department will recover this amount per Section IV of this Appendix.

VI. Final Revenue Sharing Notification and Remittance

The Department will provide the PH-MCO with written notification of the final Revenue Recovery Amount and the date when the amount due to the Department will be recovered, if applicable.

VII. Documentation of PH-MCO Expenses

At the request of the Department, the PH-MCO shall make available all books, accounts, documents, files and information that relate to the PH-MCO's PH HC transactions within ten (10) business days after the request was made. The PH-MCO shall cooperate with the Department and any representatives of the Department.

VIII. Continuation

If CMS issues regulation(s) that revises or replaces the requirements in this appendix, the revised or replacement requirements will apply. The Department at its discretion may choose to waive any or all requirements of this Appendix. If the requirements of this Appendix are waived in full or in part, the Department will notify the PH-MCO in writing of the waived Sections.

EXHIBIT A

EXHIBIT A

MANAGED CARE REGULATORY COMPLIANCE GUIDELINES

The following apply to all managed care organizations under contract with the Office of Medical Assistance Programs:

- All federal and state laws, including but not limited to 55 Pa. Code Chapters 1101-1249
- Non-compensable or non-covered services (managed care organizations may provide additional services beyond MA Fee for Service (FFS), but must cover, at a minimum, those services on the fee schedule in the same amount, duration and scope as the Fee for Service Program.)
- Scope of Benefits based on Recipient's eligibility (as determined by the County Assistance Office)
- Staff/Provider Licensing/Scope of Practice Requirements
- Frequency of service
- Program standards/quality of care standards
- Provider participation (enrolled as an MA Participating Provider)
- Utilization review
- Administrative sanctions
- Definitions

The following, which may appear in any of the above sections or Medical Assistance Bulletins, will not apply to managed care organizations:

- Maximum frequency of service limits (managed care organizations may provide more than the maximum).
- Maximum service reimbursement rates.
- Payment methodology.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1101, General Provisions, with the following exceptions:	
1101.21 Definition of "Prior Authorization"	Definitions
1101.21 Definition of "Shared Health Facility", (iv) and (v)	(iv) At least one practitioner receives payment on a fee for service basis. (v) A provider receiving more than $30,000 in payment from the MA Program during the 12-month period prior to the date of the initial or renewal application of the shared health facility for registration in the MA Program.
1101.21 Definition of "Medically Necessary"	A service, item, procedure or level of care that is: (i) Compensable under the MA Program. (ii) Necessary to the proper treatment or management of an illness, injury or disability. (iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.
1101.31(b) (13) "…Dental Services as specified in Chapter 1149 (relating to Dentists' Services)."	Benefits, Scope for categorically needy

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1101.31(f) Note: The managed care organizations are not required to impose limits that apply in the Fee-for-Service delivery system, although they are permitted to do so. The managed care organizations may not impose limits that are more restrictive than the limits established in the Fee-for-Service system. If the managed care organizations impose limits, their exception process cannot be more restrictive than the process established in §1101.31(f).	Benefits, Exceptions (for limits specified in subsections (b) and (e) - FFS Program Exception Process
1101.32(a) (1) "…Medically needy children referred from EPSDT are not eligible for pharmaceuticals, medical supplies, equipment or prostheses and orthoses." 1101.32(a)(2)	Coverage Variations, Expanded coverage EPSDT Coverage Variations, Expanded Coverage School Medical Program for Medically Needy school children
1101.33(a) "…If the applicant is determined to be eligible, the Department issues Medical Services Eligibility (MSE) cards that are effective from the first of the month through the last day of the month..."	Recipient Eligibility, Verification of Eligibility (issuance of card)
1101.33(b)	Recipient Eligibility, Services restricted to a single provider
1101.51(a)	Responsibilities, Ongoing responsibilities of providers, Recipient freedom of choice of providers
1101.61	Fees and Payments, Reimbursement policies.
1101.62	Maximum fees
1101.63(b)(1) through (9)	Payment in full, Copayments for MA services
1101.63(c)	Payment in full, MA deductible
1101.64(b) "…Payment will be made in accordance with established MA rates and fees."	Third-party medical resources, Persons covered by Medicare and MA
1101.65	Method of payment
1101.67	Prior Authorization (including timeframes for notice)
1101.68	Invoicing for services
1101.69	Overpayment – underpayment (related to providers)
1101.69(a)	Establishment of a uniform period for the recoupment of overpayments from providers (COBRA)
1101.72	Invoice adjustment
1101.83	Restitution and repayment (related to providers for payments that should not have been made)
Managed care organizations are not required to adhere to the provisions of 55 Pa. Code Chapter 1102, Shared Health Facilities. Managed care organizations are responsible for establishing their own provider networks.	
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1121, Pharmaceutical Services, with the following exceptions:	
1121.2	Definitions of AWP, Compounded Prescription, Pricing Service, Federal Upper Limit, CMS Multi-source Drug, State MAC, and Usual and Customary Charge
1121.52(a)(6)	Payment conditions for various services (indication for "brand medically necessary")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1121.52(b)	Payment conditions for various services (prenatal vitamins)
1121.53(a)	Limitations on payment (not exceeding UCC to general public)
1121.53(b)(1)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(b)(2)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(c)	Limitations on payment (34 day supply or 100 units, total authorization not exceeding 6 months' or five refill supply)
1121.53(f)	Limitations on payment (Payment to pharmacy for prescriptions dispensed to a recipient in either a skilled nursing facility, an intermediate care facility or an intermediate care facility for the mentally retarded and specific scripts not included in the limitation)
1121.54(10)	Drugs prescribed in conjunction with sex reassignment procedures or other noncompensable procedures. As directed in MAB 99-16-11, this is inconsistent with the Federal Final Rule, "Nondiscrimination in Health Programs and Activities", and will no longer be applied.
1121.55	Method of payment. (relating to the Department's payment to pharmacies)
1121.56	Drug cost determination.
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1123, Medical Supplies, with the following exceptions:	
1123.1 "and the MA Program fee schedule"	Policy. (Payment for medical supplies is subject to this chapter, Chapter 1101 (relating to general provisions) and the limitations established in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule.
1123.13(a) and (b).	Inpatient services.
1123.22(1).	Scope of benefits for the medically needy. ("Medical supplies which have been prescribed through the School Medical Program...")
1123.22(2) "who are enrolled in EPSDT, or which have been prior authorized by the Department as specified in 1123.56 (a) (2) (relating to vision aids)"	Scope of benefits for the medically needy. ("Eyeglasses which have been prescribed as treatment for individuals under 21 years of age who are enrolled in EPSDT...")
1123.51 "and the MA Program fee schedule"	Payment for Medical Supplies. General payment policy.
1123.53	Hemophilia products.
1123.54 "in accordance with the limitations described in this section and the maximum fees listed in Chapter 1150 (relating to Medical Assistance program payment policies) and the Medical Assistance Program fee schedule"	Orthopedic shoes, molded shoes and shoe inserts (Relating to payment when prescribed for eligible persons to approved MA providers)
1123.54(1) through (5).	Orthopedic shoes, molded shoes and shoe inserts (Relating to prior approval, conditions for payment, payment for modifications necessary for the application of a brace or splint, payment for repairs w/o a prescription or prior authorization, and payment for orthopedic shoes only if the recipient is 20 years of age or younger."
1123.55(a) "The prescription shall contain the cardiopulmonary diagnosis"	Oxygen and related equipment. (Relating to payment conditions)
1123.55(b) and (c).	Oxygen and related equipment. (Relating to prior authorization and prescription inclusion requirements)
1123.55(d) "and recertification shall be kept by the provider"	Oxygen and related equipment. ("A physician shall recertify orders for oxygen at least every 6 months and recertification shall be kept by the provider.")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1123.56(a)(1) through (3)	Vision aids. (“Payment for eyeglasses is made only if the recipient is 20 years of age or younger and the eyeglasses have been one of the following...”)
1123.56(b)(1) through(3)	Vision aids. (“Payment for low vision aids is made only if the recipient is categorically needy or if the recipient is medically needy and the low vision aid has been one of the following...”)
1123.56(c)	Vision aids. (“Payment for eye prostheses will be made only if the recipient is categorically needy.”)
1123.57(a) and (b)	Hearing aids. (Relating to payment for hearing aids only if recipient is 20 years of age or younger and have been prescribed through the EPSDT program, and for repairs to hearing aids owned by the recipient when the invoice is accompanied by an itemized statement.)
1123.58(1) and (2)	Prostheses and orthoses.
1123.60(a) through (i)	Limitations on payments.
1123.61 (1) through (8) and (10)	Noncompensable services and items. (Relating to when payment will not be made. (9) is not excluded, as it relates to items prescribed or ordered by a practitioner who has been barred or suspended during an administrative action from participation in the MA Program.)
1123.62	Method of payment.
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-86-02, Durable Medical Equipment Warranties.	
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 05-87-02, Coverage of Motorized Wheelchairs, with the following exceptions: **- requiring Prior Authorization at the State level.** **- Page 2, number 7.**	
Managed care organizations are to adhere to the provisions of Medical Assistance Bulletin 1123-91-01, EPSDT – OBRA ’89 with the following exceptions: **- Page 3 – Vision Services – the “age of 21” and the MA fee schedule do not apply.** **- Page 3 – Dental Services – the “age of 21” and the MA fee schedule do not apply.** **- Page 3 – Hearing Services – the “age of 21” and the MA fee schedule do not apply.** **- Page 3 – “and use of existing Medical Assistance Program Fee Schedule”**	
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-85-02, Policy Clarification for Services Provided to Hospitalized Recipients Under the DRG Payment System.	
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1126, Ambulatory Surgical Center and Hospital Short Procedure Unit Services, with the following exceptions:	
1126.51(f) through (h) and (k) through (m)	Payment for Same Day Surgical Services. General payment policy. ((f-h)Relating to submission of invoices to the Department, consideration if ASC or SPU has fee schedule based on patient's ability to pay that the Department will consider it as the usual and customary charge, and the Department's payment being the lesser of the facility's charge to general public to be the most frequent charge to the self-paying public for the same service.) and (k-m relating to payment when patient in conjunction with same day service are transferred to a hospital due to complications and when patients due to complications must be transferred to inpatient hospital care)
1126.52(a) and (b)	Payment criteria. (Relating to the Department's maximum reimbursement and developed fees.)
1126.53(b)	Limitations on covered procedures. (Relating to limits for appropriate same day surgical procedures for same day surgery but are not yet included in the established list of covered ASC/SPU services.)
1126.54(a)(7)	Procedures and medical care performed in connection with sex reassignment. As directed in MAB 99-16-11, this is inconsistent with the Federal Final Rule, “Nondiscrimination in Health Programs and Activities”, and will no longer be applied.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1126.54(a)(11) through (13) and (b)	Noncompensable services and items. ("...The Department does not pay ASCs and SPUs for services directly or indirectly related to, or in conjunction with...diagnostic tests and procedures that can be performed in a clinic or practitioner's office and diagnostic tests and procedures not related to the diagnosis"; "Services and items for which full payment equal to or in excess of the MA fee is available through Medicare or other financial resources or other health insurance programs"; "Services and items not ordinarily provided to the general public"; and "...if the admission to the ASC or SPU is not certified under the Department's utilization review process applicable to the type of provider furnishing the service".)
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1127, Birth Center Services, with the following exceptions:	
1127.51(d)	Payment for Birth Center Services. General payment policy. ("Claims shall be submitted to the Department under the provider handbook.")
1127.52(a) through (c)	Payment criteria. (Relating to the Department's establishment of maximum reimbursement fees and payment methodology)
1127.52(d) "The birth center visit fee shall be the amount equal to that of the midwives' or physicians' visit fee under the MA Program fee schedule."	Payment criteria. (Relating to termination of birth center services during prenatal care)
1127.52(e) "The amount of the payment is 50% of the third trimester rate of payment."	Payment criteria (to payment if complications develop during labor and patient is transferred to a hospital)
1127.53(c)	Limitations on payment.
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1128, Renal Dialysis Facilities, with the following exceptions:	
1128.51(a) "and the MA Program fee schedule"	Payment for Renal Dialysis Services. General payment policy.
1128.51(b)	General payment policy. ("A fee determined by the Department is paid for support services provided to an eligible recipient during the course of a dialysis procedure."
1128.51(c) "and for billings"	General payment policy. ("The dialysis facility is considered the provider regardless of whether the facility is operated directly by the enrolled provider or through contract between the provider and other organizations or individuals. The enrolled provider is responsible for the delivery of the service and for billings.")
1128.51(d) "up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee"	General payment policy. ("The Department will pay for the unsatisfied portion of the Medicare deductible and remaining 20% coinsurance up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee.")
1128.51(f) through (i), (k) and (l)	General payment policy. (Relating to what is included in the fee paid to the facility, procedures fees are applicable to, Department's consideration of provider's usual and customary charge if facility has a fee schedule based on patient's ability to pay, and the Department's payment for dialysis services shall be considered payment in full.)
1128.51(m) "Payment shall be made in accordance with §1128.52 (relating to payment criteria)."	General payment policy. ("If a dialysis facility voluntarily terminates the provider agreement, payment is made for services provided prior to the effective date of the termination of the provider agreement. Payment shall be made in accordance with §1128.52 (relating to payment criteria).")
1128.51(n)	General payment policy. (Relating to payment to out-of-State dialysis facility.)
1128.52	Payment criteria.
1128.53(a) through (e)	Limitations on payment.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1128.53(f) "Payment for backup visits to the facility is limited to no more than 15 in one calendar year"	Limitations on payment.
1128.53(g)	Limitations on payment. (Relating to payment for nonexpendable equipment or installation of equipment necessary for home dialysis)
1128.54(1)	Noncompensable services and items. ("The Department does not pay dialysis facilities for: (1) Services that do not conform to this chapter.")
1128.54(4) through (7)	Noncompensable services and items. (Relating to Diagnostic or therapeutic procedures solely for experimental, research or educational purposes; procedures not listed in the MA Program fee schedule; services that are not medically necessary; and services provided to recipients who are hospital inpatients.)
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1129, Rural Health Clinic Services, with the following exceptions:	
1129.51(b) and (c)	Payment for Rural Health Clinic Services. General payment policy. (Relating to payment for rural health clinic services made on the basis of an all-inclusive visit fee established by the Medicare carrier. When the cost for a service provided by the clinic is included in the established visit fee, the practitioner rendering the service shall not bill the MA Program for it separately; and adjustment to the all-inclusive visit fee when Medicare determines the difference between the total payment due and the total payment made. The Department will make a lump sum payment for the amount due.)
1129.52	Payment policy for provider rural health clinics.
1129.53	Payment policy for independent rural health clinics.
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1130, Hospice Services, with the following exceptions:	
1130.22(4) "…Department's…specified in Appendix A." ***Note: The provider must have a Certification of Terminal Illness form containing the information found in Appendix A. The provider is not required to use the Department's Certification of Terminal Illness form.***	Duration of coverage. Certification form. (Relating to certification of terminal illness carried out using the Department's certification of terminal illness form.)
1130.41(a) "…specified in Appendix B." ***NOTE: The provider must have an Election statement containing the information found in Appendix B. The provider is not required to use the Department's Election statement.***	Election of hospice care. Election statement. (Relating to filing of the Election statement by the recipient or recipient's representative.)
1130.41(c) "specified in Appendix C." ***Note: The provider must have a Change of Hospice statement containing the information found in Appendix C. The provider is not required to use the Department's Change of Hospice statement.***	Election of hospice care. Change of designated hospice. (Relating to the ability to the ability to change hospices once in each certification period.)
1130.42(a) "specified in Appendix D." ***Note: The provider must have a Revocation statement containing the information found in Appendix D. The provider is not required to use the Department's Revocation statement.***	Revocation of hospice care. Right to revoke. (Relating to the ability of the recipient or recipient's representative to revoke the election of hospice care at any time utilizing the revocation statement.)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1130.63(b)	Limitations on coverage. (Relating to Respite care not exceeding a total of 5 days in a 60 day certification period.)
1130.63(c) "…but it is not reimbursable."	Limitations on coverage. (Relating to Bereavement counseling being a required hospice service but it is not reimbursable.)
1130.63(d) "…participating in the MA Program."	Limitations on coverage. (Relating to general inpatient care being provided in a general hospital, skilled nursing facility or a freestanding hospice participating in the MA Program.)
1130.63(e)	Limitations on coverage. (Relating to intermediate care facilities may only provide respite services to the hospice. Eligible MA recipients residing in an intermediate care facility may elect to receive care from a participating hospice.)
1130.71(c) through (h)	Payment for Hospice Care. General payment policy. (Relating to days not covered by valid certification, limitations on inpatient respite care to 5 days in a 60 day certification period; payment limitation for general inpatient care, if lesser care was provided; no MA payments will be made directly to nursing facility for services provided to a recipient under the care of a hospice; ambulance transportation inclusion in daily rates; and the Department's reduction in payment for hospice care by the amount of income available from the recipient towards the hospice care rate established by the Department.)
1130.72.	Payment for physicians' services. (Relating to the services performed by hospice physicians that are included in the level of care rates paid for a day of hospice care."
1130.73.	Additional payment for nursing facility residents. (Relating to additional payments made to a hospice for hospice care furnished to an MA recipient who is a resident of a skilled or intermediate care facility – taking into account the cost of room and board and how room and board rates will be calculated.)
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1140, Healthy Beginnings Plus Program, with the following exceptions:	
1140.52(2) "…billed to the Department…"	Payment for HBP Services. Payment Conditions.
1140.53	Limitations on Payment. (Relating to payment for the trimester component including all prenatal visits during the trimester; qualified providers may bill for either high risk maternity care package OR the basic maternity care package for each trimester; and the fee for the applicable trimester maternity care package includes payment to the practitioner performing the delivery and postpartum care.)
1140.54(1)	Noncompensable services and items.
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1141, Physicians' Services, with the following exceptions:	
1141.53(a) through (c)	Payment conditions for outpatient services. (Relating to payment made in an approved SPU only if the service could not appropriately and safely be performed in the physician's office, clinic or ER of a hospital; prior authorization requirements for specialists' examinations and consultations; and services provided to recipients in skilled and intermediate care facilities by the physician administrator or medical director.)
1141.53(f) and (g)	Payment conditions for outpatient services. (Relating to all covered outpatient physicians' services billed to the Department shall be performed by such physician personally or by a registered nurse, physician's assistant, or a midwife under the physician's direct supervision; and payment by the Department of a $10 per month fee to physicians who are approved by the Department to participate in the restricted recipient program.)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.54(a)(1) through (3)	Payment conditions for inpatient services. (Relating to when a physician is eligible to bill the Department for services provided to a hospitalized recipient.)
1141.54(f)	Payment conditions for inpatient services. (Relating to inpatient physicians' services billed to the Department shall be performed by the physician, an RN, PA or midwife under the physician's direct supervision.)
1141.55(b)(1) "MA 31"; "in accordance with all instructions in the Provider Handbook"; and "See Appendix A for a facsimile of the Consent Form and the Provider Handbook for detailed instructions on its completion." ***NOTE: A consent form is required and must contain all the information found in Appendix A.***	Payment conditions for sterilizations. (Relating to consent requirements and use of the MA31 Consent Form.)
1141.55(c) "MA 31" 1141.55(c)(2) "in accordance with instructions in the Provider Handbook" 1141.55(c)(3) "in accordance with instructions in the Provider Handbook"	Payment conditions for sterilizations. ("A Consent Form, MA 31, is considered to be completed correctly only if all of the following requirements are met:") Payment conditions for sterilizations. ("The person obtaining informed consent has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given." Payment conditions for sterilizations. ("Any other witness or interpreter has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given.")
1141.56(a)(3) "See the Provider Handbook for a facsimile of the Patient Acknowledgement Form for Hysterectomy, MA 30, and for instructions on its completion."	Payment conditions for hysterectomies. (Relating to Patient Acknowledgement Form for Hysterectomy MA 30)
1141.57(a)(1) "Where a physician has certified in writing and documented in the patient's record that the life of the woman would be endangered if the pregnancy were allowed to progress to term. The decision as to whether the woman's life is endangered is a medical judgment to be made by the woman's physician.	Payment conditions for a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.57(a)(2) "and the incident was reported to a law enforcement agency or to a public health service within 72 hours of its occurrence in the case of rape and within 72 hours of the time the physician notified the patient that she was pregnant in the case of incest. A law enforcement agency means an agency or part of an agency that is responsible for the enforcement of the criminal laws, such as a local police department or sheriff's office. A public health service means an agency of the Federal, State, or local government or a facility certified by the Federal government as a Rural Health Clinic that provides health or medical services except for those agencies whose principal function is the performance of abortions."	Payment conditions for necessary abortions (Where the recipient was the victim of rape or incest)
1141.57(a)(2)(i) "with the Medical Services Invoice along with documentation signed by an official of the law enforcement agency or public health service to which the rape or incest was reported. The documentation shall include the following": 1141.57(a)(2)(i)(A) and (B)	Payment conditions for necessary abortions (Payment will be made only if a licensed physician submits a signed ''Physician Certification for an Abortion'' form, as set forth in Appendix B,) (A) All of the information specified in subparagraph (ii). (B) A statement that the report was signed by the person making the report.
1141.57(a)(2)(ii)(A) through (D)	Payment conditions for necessary abortions (report of rape or incest)
1141.57(c)	Abortions after the first 12 weeks
1141.59(1) through (5)	Payment for Physician Services, Noncompensable services, Procedures not listed in the Medical Assistance program fee schedule. Medical services or surgical procedures performed on an inpatient basis that could have been performed in the physician's office, the clinic, the emergency room, or a short procedure unit without endangering the life or health of the patient, Medical or surgical procedures designated in the Medical Assistance program fee schedule as outpatient procedures, Dental rehabilitation and restorative services, Diagnostic tests, for which a patient was admitted, that may be performed on an outpatient basis; tests not related to the diagnosis and treatment of the illness for which the patient was admitted; tests for which there is no medical justification.
1141.59(7) and (8)	Payment for Physician Services, Noncompensable services, Hysterectomy performed solely for the purpose of rendering an individual incapable of reproducing, Acupuncture, medically unnecessary surgery, insertion of penile prosthesis, gastroplasty for morbid obesity, gastric stapling or ileo-jejunal shunt—except when all other types of treatment of morbid obesity have failed—
1141.59(10) and (11)	Services to inpatients who no longer require acute inpatient care and surgical procedures and medical care provided in connection with sex reassignment.
1141.59 (14) through (16)	Diagnostic pathological examinations of body fluids or tissues, Services and procedures related to the delivery within the antepartum period and postpartum period, Medical services or surgical procedures performed in a short procedure unit that could have been appropriately and safely performed in the physician's office, the clinic, or the emergency room without endangering the life or health of the patient.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.60	Payment for medications dispensed or ordered in the course of an office visit.
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1142, Midwives' Services, with the following exceptions:	
1142.51 "and the MA payment fee schedule"	General payment policy for Midwife services
1142.52(2) "billed to the Department"	General payment policy for Midwife services
1142.55(1) through (4)	Noncompensable Midwife services. Procedures not listed in the fee schedule in the MA Program fee schedule, More than 12 midwife visits per recipient per 365 days. Services and procedures furnished by the midwife for which payment is made to an enrolled physician, rural health clinic, hospital or independent medical clinic. Services and procedures for which payment is available through other public agencies or private insurance plans as described in § 1101.64 (relating to third party medical resources (TPR)).
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1143, Podiatrists' Services, with the following exceptions:	
1143.2 Definition of "Medically-necessary"	A term used to describe those medical conditions for which treatment is necessary, as determined by the Department, and which are compensable under the MA Program.
1143.2 Definition of "Non-emergency medical services."	A compensable podiatrists' service provided for conditions not requiring immediate medical intervention in order to sustain the life of the person or to prevent damage to health.
1143.51 "and the MA Program fee schedule" and "as specified in §1101.62(relating to maximum fees)."	General Payment Policy
1143.53	Payment conditions for outpatient services.
1143.54	Payment conditions for inpatient hospital services.
1143.55(1),(2) and (4)	Payment conditions for diagnostic X-ray services performed in the podiatrist's office.
1143.56	Payment conditions for orthopedic shoes, molded shoes and shoe inserts (enrolled medical suppliers). Refers to 1123.54
1143.57	Limitations on payment for podiatrist visits and x-rays.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1143.58(a)(1) through (12)	Noncompensable services and items for podiatry services. (1) Services and items not listed in the MA Program fee schedule. (2) Fabricating or dispensing orthopedic shoes, shoe inserts and other supportive devices for the feet. (3) Casting for shoe inserts. (4) Medical services or surgical procedures performed on an inpatient basis that could have been performed in the podiatrist's office, the emergency room, or a short procedure unit without endangering the life or health of the patient. (5) Medical or surgical procedures designated in the fee schedule in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule as outpatient procedures. (6) Medical services or surgical procedures performed on an inpatient basis if the Department denies payment to the hospital for the days during which the podiatrist's care is rendered. (7) Services rendered in the emergency room of a hospital if the recipient is admitted to the hospital as an inpatient on the same day or the service is a nonemergency medical service. (8) Treatment of flat foot. (9) Treatment of subluxations of the foot. (10) Routine foot care, including the cutting or removal of corns, callouses, the trimming of nails and other routine hygienic care. (11) Physical therapy. (12) Diagnostic or therapeutic procedures for experimental, research or educational purposes.
1143.58(a)(13) "as specified in § 1101.62 (relating to maximum fees)"	Compensable podiatrist services if full payment is available from another agency, insurance or health program.
1143.58(b)	Noncompensable services and items. Payment is not made for sneakers, sandals etc., even if prescribed by a podiatrist.
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1144, Certified Registered Nurse Practitioner Services, with the following exceptions:	
1144.42(b) "to the Department"	Ongoing responsibilities of providers
1144.52(1)	Payment conditions for CRNP services. CRNP employee
1144.52(2) "billed to the Department"	Payment conditions for CRNP services. CRNP employee
1144.52(3)	Payment conditions for CRNP services. CRNP employee
1144.53(1), (2), and (4)	Noncompensable services. Procedures not listed in the MA Program fee schedule. Services and procedures furnished by the CRNP for which payment is made to an enrolled medical service provider or practitioner. The same service and procedure furnished to the same recipient by a CRNP and physician.
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1145, Chiropractor's Services, with the following exceptions:	
1145.11	Types of services covered. Evaluation by means of examination. Treatment by means of manual manipulation of the spine.
1145.12	Services are covered when rendered in the chiropractors' office, the home of the patient or in a skilled nursing or intermediate care facility.
1145.13	Chiropractors' services are not covered when rendered in a location in a hospital.
1145.14	Payment will not be made for treatment other than manipulation of the spine, physical therapy, traction, physical examinations, and consultations.
1145.51 "and the MA Program fee schedule" and "Chiropractors' services shall be billed in the name of the chiropractor providing the services."	Payment policy for chiropractor services.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1145.54	Noncompensable services. Payment will not be made to a chiropractor for 1) Orthotics, 2) Prosthetics, 3) Medical supplies, 4) X-rays, 5) Services not included in Chapter 1150
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1147, Optometrists' Services, with the following exceptions:	
1147.2 Delete the following portion included in the definition of eyeglasses: "untinted."	Definitions - *Eyeglasses*—A pair of untinted prescription lenses and a frame.
1147.12 "Outpatient optometric services are compensable when provided in the optometrist's office, the office of another optometrist during the other optometrist's temporary absence from practice, a hospital, a nursing home or in the patient's home when the patient is physically incapable of coming to the optometrist's office." "and the MA Program Fee Schedule"	Outpatient services
1147.13 "and the MA Program Fee Schedule"	Inpatient services
1147.14(1)	Non-covered services: Orthoptic training.
1147.21 "They are not eligible for eyeglasses unless they are 20 years of age or younger and the eyeglasses have been: " 1147.21(1) through (3)	Scope of benefits for the categorically needy: eyeglasses. Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program.
1147.22 "They are not eligible for eyeglasses, low vision aids or prostheses unless they are 20 years of age or younger and the eyeglasses, low vision aids or prostheses have been:" 1147.22 (1) through (3)	Scope of benefits for the medically needy: eyeglasses. Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program.
1147.23 "only" and "They are not eligible for eyeglasses, low vision aids or eye prostheses. However, State Blind Pension recipients are eligible for eye prostheses if they are also categorically needy."	Scope of benefits for State Blind pension recipients.
1147.51 "and §§ 1147.53 and 1147.54 (relating to limitations on payment; and noncompensable services and items)" and "and the MA Program fee schedule" and "Optometric services shall be billed in the name of the optometrist providing the service."	General payment policy for optometric services
1147.53	Limitations on payments for optometric services
1147.54	Noncompensable optometric services and items
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1149, Dentists' Services, with the following exceptions:	
1149.1 "and the MA Program Fee Schedule"	Dental services general policy
1149.43(6)	Radiographs are requested by the Department for prior authorization purposes

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1149.43(9) through (11)	Pathology reports are required for surgical excision services. Pre-operative X-rays are required for surgical services. Postoperative X-rays are required for endodontic procedures.
1149.51 "and the MA Program Fee Schedule" and “The following payment policies are applicable for dental services:”	General payment policy for dental services
1149.51(1) and (2)	General payment policy for dental services
1149.52	Payment conditions for various dental services
1149.54 "and the MA Program Fee Schedule" 1149.54 (1) through (7) 1149.54(10)	Payment policies for orthodontic services
1149.55(1) 1149.55(5) through (8)	Payment conditions for orthodontic services
1149.56	Payment limitations for orthodontic services
1149.57	Noncompensable dental services and items
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1150, MA Program Payment Policies, with the following exceptions:	
1150.2 Definitions of PSR and Second Opinion program	Definitions
1150.51(a) "Payment will be made to providers. Payment may be made to practitioners' professional corporations or partnerships if the professional corporation or partnership is composed of like practitioners. Payment will be made directly to practitioners if they are members of professional corporations or partnerships composed of unlike practitioners. Practitioners who render services at eligible provider hospitals, either through direct employment or through contract, may direct that payment be made to the eligible provider hospital." **and** "Payment will not be made for services that are not medically necessary." 1150.51(b) 1150.51(c) “facilities and practitioners rendering services which require a PSR or second opinion, or both” and “funeral directors” 1150.51(d) “which is contained in the Provider’s Handbook” and the following” 1150.51(d)(1) “all-inclusive” 1150.51(d) (2) through (8) 1150.51(e) through (h)	General MA Program Payment policies
1150.52	Payment for Anesthesia services
1150.54	Payment for Surgical Services

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1150.55	Payment for Obstetrical Services
1150.56	Payment for Medical Services
1150.56a	Payment Policy for Consultations
1150.56b	Payment Policy for Observation Services
1150.57	Payment for Diagnostic Services and Radiation Therapy
1150.58	Prior authorization for services in the MA Program Fee Schedule
1150.59	PSR Program
1150.60	Second Opinion Program
1150.61	Guidelines for Fee Schedule changes
1150.62	Payment levels and notice of rate setting changes
1150.63 1150.63(a) Delete the word “Department” 1150.63(b) Delete the word “Department”. Also delete in second sentence “the practitioner may either …by mail.” 1150.63(c) Delete the first two sentences: The CAO shall …consultants. The office of MA…decision.” 1150.63(d)Delete the word “Department”	Waiver of General Payment Policies. The plan must adhere to the following section, except:
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1151, Inpatient Psychiatric Services, with the following exceptions:	
1151.34	Inpatient Psychiatric Services, Provider Participation, Changes of ownership or control
1151.41(b)	Payment for inpatient psychiatric services, Readmission within 24 hours after discharge
1151.41(c) (1) and (2)	Payment for Inpatient Psychiatric Services, Admitted and discharged the same calendar day
1151.41(d), (i) and (j)	Payment for Preadmission diagnostics, transfer to another facility due to strike, payment for studies related to the patient’s condition not preprinted regimen.
1151.42 (a), (c) and (d)	Payment methods and rates
1151.43(a) and (b)	Limitations on payments
1151.45(2) and (3)	Nonallowable costs, costs related to a noncompensable item, costs related to preadmission diagnostics
1151.46	Payment rate calculations for FY 1993-94 and 1994 - 95
1151.48(a)(2)through (6), (9) through (16) and (18) through (20)	Noncompensable services and items, experimental procedures and services, inpatient treatment for diagnostic testing that could be done as outpatient, inpatient care if payment is available from another source, services not normally provided to the public, methadone maintenance, days of inpatient care that the patient was absent due to training, meetings or conferences, unnecessary inpatient care, and days of care that are not certified or failure to apply for a court-ordered commitment.
1151.52	Payment for capital costs not included in the base year
1151.53	Billing requirements for inpatient psychiatric services
1151.54	Disproportionate share payments
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1153, Outpatient Psychiatric Services, with the following exceptions:	
1153.1 “and the MA Program fee schedule”	Outpatient psychiatric services, general policy

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1153.2 Psychiatric outpatient clinic services -- "listed in the MA Program Fee Schedule"	Definitions
1153.2 Psychiatric partial hospitalization -- "listed in the MA Program Fee Schedule" and "and a maximum of six hours in a 24 hour period"	Definitions
1153.11 "as specified in the MA Program Fee Schedule"	Types of Outpatient Psychiatric Services
1153.12 "specified in the MA Program Fee Schedule"	Coverage of outpatient Psychiatric services
1153.14(2), (3), (9) and(13)	Noncovered services: cancelled appointments, covered services not rendered, Psychiatric outpatient clinic services and psychiatric partial hospitalization provided on the same day to the same patient, and Services not specifically included in the MA Program Fee Schedule
1153.21 "in the MA Program Fee Schedule"	Scope of benefits for the categorically needy
1153.22 "in the MA Program Fee Schedule"	Scope of benefits for the medically needy
1153.23 "in the MA Program Fee Schedule"	Scope of benefits for State Blind Pension recipients
1153.51 "and the MA Program Fee Schedule"	Payment for Outpatient Psychiatric clinic and partial hospitalization
1153.52(a)(2) "Separate billings for these additional services are not compensable."	Additional interviews with other staff may be included as part of the examination but shall be included in the psychiatric evaluation fee.
1153.52(d) "listed in the MA Program Fee Schedule"	Psychiatric clinic services provided in the home.
1153.53	Limitations on payments
1153.53a	Request for waiver of hourly limits
1153.54	Noncompensable services and items

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 1157-95-01 Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children Under 21 Years of Age with the following exceptions: • Page 2, A. 2. c. • Page 3, A. 4. • Page 3, Section B. • Page 3, C. "To receive MA reimbursement," • Page 3, D. 1. • Page 3, D. 2. "Payment will be made only for services prior approved by OMAP." • Pages 5-7 Sections A and B. • Attachment 2, 3.e.; 4.b.; and 4.e. • Attachment 5 • Attachment 6 • Attachment 7 • Attachment 8 • Attachment 9 • Attachment 11	
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1163, Inpatient Hospital Services, Subchapter A, Acute Care General Hospitals Under the Prospective Payment System, with the following exceptions:	
1163.32	Hospital Units excluded from the DRG prospective payment system
1163.41	General participation requirements for general hospitals and out of state hospitals for Commonwealth recipients
1163.51 (a) through (s)	General payment policy for hospital services
1163.52 through 1163.59	Prospective payment methodology, assignment of DRG, prospective capital reimbursement system, payments for direct medical education, outliers, payment policy for readmissions and transfers, and noncompensable services and items and outlier days.
1163.60(b)(1) “in accordance with the instructions in the Provider Handbook”.	Informed consent for voluntary sterilization
1163.60(c)(2) “in accordance with the instructions in the Provider Handbook”.	The person obtaining informed consent signs and dates the form on same day informed consent was obtained.
1163.60(c)(3) “in accordance with the instructions in the Provider Handbook”.	Another witness or interpreter must sign the consent form.
1163.62 (a) (2) through 1163.65	Payment conditions for abortions if the recipient was a victim of rape or incest, billing, cost reports and payment for out of state services.
1163.67	Disproportionate share payments

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1163.70 through 1163.71	Changes of ownership or control and scope of utilization review process
1163.72 (a), (c) through (g)	General utilization review, admissions, day and cost outliers.
1163.73 through 1163.75 (6) and (8) through (12)	Hospital utilization review plan, requirements for hospital utilization review committees, and responsibilities for hospital utilization review committees.
1163.76 through 1163.77	Written plan of care within 2 days of admission and Admission review requirements within 24 hours of admission
1163.78a and 1163.78b	Review requirements for day outliers and cost outliers
1163.92 (a) through (f)	Administrative sanctions
1163.122	Determination of DRG relative values
1163.126	Computation of hospital specific computation rates
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1163, Inpatient Hospital Services, Subchapter B, Hospitals and Hospital Units Under Cost Reimbursement Principles, with the following exceptions:	
1163.402 Definition of “certified day”	Definitions
1163.451 (a) through (g), (i), (k) through (o)	General payment policy
1163.452	Payment methods and rates
1163.453 (a) and (c)	Allowable and nonallowable costs, allowable costs for inpatient services, payment not higher than hospital’s customary charge
1163.453 (d) (2) through (9)	Costs not allowable under the MA Program
1163.453 (e) and (f)	Allowable costs
1163.454	Limitations on payment
1163.455 (a)(1) through (5) and (7) through (16)	Noncompensable inpatient services
1163.455 (b) and (c)	Noncompensable inpatient services
1163.457	Payment policies relating to out of state hospitals
1163.458	Payment policies relating to same calendar day admissions and discharges
1163.459	Disproportionate share payments
1163.481(b) and (c)	Utilization review sanctions
1163.511	Change of ownership or control
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 1165-93-07 Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age with the following exceptions: • Page 1 - Beginning with the second sentence "The procedures described in this Bulletin apply to every child." up to “A separate bulletin will describe the procedures necessary to seek reimbursement for other mental health services not on the Medical Assistance Fee Schedule.” • Page 2, Section A.4. • Pages 3 - 4, Sections C through E • Attachment 6 • Attachment 7 • Attachment 8 • Attachment 9	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 1165-95-01 Update JCAHO-Accredited RTF Services with the following exceptions: • Page 2 - The two paragraphs following item c. "If a child is admitted . . . alternative to RTF." • Page 2 - The third complete paragraph, "All admissions are subject," through the end of 3. • Page 3, number 4.	
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions:	
1221.43 through 1221.45	Participation requirements for hospital clinics and emergency rooms for higher reimbursement rate, additional participation requirements for independent clinics, and additional participation requirements for medical school clinics.
1221.51 and 1221.52	General payment policy for clinic and emergency room services and payment conditions for various services.
1221.55 (b) (1). NOTE: A consent form is required and must contain all of the information found in Appendix A to 55 PA Code Chapter 1141	Voluntary informed consent for sterilizations
1221.57(a) (2) and 1221.57(c). NOTE: PH-MCO must comply with MA Bulletin 99-95-09	Payment conditions for necessary abortions for victims of rape or incest
1221.58 and 1221.59	Limitations on payments and noncompensable services and items
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletins related to 55 PA Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions: • 11-95-04 • 11-95-10 • 11-95-12	
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1223, Outpatient Drug and Alcohol Clinic Services, with the following exceptions:	
1223.1 “and the MA fee schedule”	Payment for specific medically necessary outpatient drug and alcohol clinic services rendered to eligible recipients by drug/alcohol outpatient clinics.
1223.11 “as specified in the fee schedule in the Medical Assistance program fee schedule”	Medical Assistance Program coverage for outpatient drug/alcohol clinics is limited to professional medical and psychiatric services.
1223.12 "specified in the Medical Assistance program fee schedule"; "and the Medical Assistance program fee schedule"; and "fee for service"	Outpatient drug and alcohol clinic services
1223.14 (3) and (4)	Noncovered services: Cancelled appointments and Covered services that have not been rendered.
1223.14(6) “and the Medical Assistance program fee schedule”	Noncovered services: Vocational rehabilitation; day care; drug/alcohol or mental health partial hospitalization; reentry programs, occupational or recreational therapy; Driving While Intoxicated (DWI) or Driving Under the Influence Programs or Schools; referral, information or education services; experimental services; training; administration; follow-up or aftercare; program evaluation; case management; central intake or records; shelter services; research; drop-in, hot-line or social services; inpatient nonhospital or occupational program services, or any other service or program not specifically identified as a covered service in Chapter 1150.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1223.14 (8) and (9)	Drug/alcohol outpatient clinic services provided to residents of treatment institutions. outpatient clinic services provided to residents of inpatient nonhospital and shelter facilities. outpatient clinic services provided to patients receiving psychiatric partial hospitalization services or drug/alcohol partial hospitalization services
1223.14(14)	Methadone maintenance clinic services provided before the date of the physician's comprehensive medical examination, diagnosis and treatment plan.
1223.21 "in the MA Program fee schedule"	Scope of services for the categorically needy
1223.22 "in the MA Program fee schedule"	Scope of services for the medically needy
1223.23 "in the MA Program fee schedule"	Scope of services for State Blind Pension recipients
1223.51 "and the Medical Assistance program fee schedule"	General payment policy for outpatient drug/alcohol clinic services
1223.52(a)(2) and (a)(3) "Separate billings for these interviews are not compensable."	Additional interviews with other staff
1223.52(a)(5) "listed in the Medical Assistance Program Fee Schedule"	Diagnostic psychological services
1223.52(c) "Separate billings for these interviews are not compensable."	Interviews or consultations with family members alone, without the presence of the family member with a drug/alcohol abuse or dependence problem, are considered to be part of the family psychotherapy fee.
1223.53	Limitations on Payment for outpatient drug and alcohol clinic services
1223.54(2) "and the Medical Assistance program fee schedule"	Items and services not listed as compensable in Chapter 1150
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1225, Family Planning Clinic Services, with the following exceptions:	
1225.1 "and the MA Program fee schedule"	General provisions
1225.51"and the MA Program fee schedule"	General payment policy
1225.54(2)	Noncompensable family planning services
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1229, Health Maintenance Organizations Services, with the following exceptions:	
NONE	
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1230, Portable X-Ray Services, with the following exceptions:	
1230.1 "and the MA Program fee schedule"	General provisions
1230.51 "and the MA fee schedule"	General payment policy for portable x-ray services
1230.52(b) "and the MA Program fee schedule"	Payment for transporting portable X-ray equipment from the provider's office to the place of service
1230.53 (a) through (c)	Portable x-ray services, provider maximum payment, payment for transportation of portable x-ray equipment and electrocardiogram services
1230.54 (1)	Noncompensable services, procedures not listed in the MA Program fee schedule
Managed care organizations are to adhere to the requirements of Medical Assistance Bulletin 99-94-08 (relating to 55 Pa. Code Chapter 1239, Medical Case Management), Medical Assistance Case Management Services for Recipients Under the Age of 21, with the following exceptions: • Discussion • Page 2, paragraph 3 "The OMAP reserves the right to limit the number of recipients in a case manager's caseload." • Page 3, Payment for case management services covered by this bulletin, 1 through 3 and 4 c through f.	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1241, Early and Periodic Screening, Diagnosis and Treatment Program, with the following exceptions:	
1241.2 Definition of "Administrative contractors"	Definitions
1241.42(1) "or to the CAO for supportive help in locating an appropriate provider"	If not licensed or equipped to render the necessary treatment or further diagnosis, the screening provider shall refer the individual to an appropriate enrolled practitioner or facility.
1241.51	Payment to the provider
1241.53	Limitations on payments
1241.54 (a) (1) through (5)	Noncompensable services and items
1241.54 (b) (1) through (5)	Noncompensable services and items
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1243, Outpatient Laboratory Services, with the following exceptions:	
1243.51 "and the MA Program fee schedule"	General payment policy for outpatient laboratory services
1243.52(b) "billed to the Department"	Laboratory services billed to the Department will be based on the written request of the practitioner
1243.53 (a)	The fees listed in the MA Program fee schedule are the maximum allowed
1243.54 (1) and (2)	Noncompensable services
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1245, Ambulance Transportation, with the following exceptions:	
1245.1 "and the MA Program fee schedule"	General provisions for payment of ambulance transportation to eligible beneficiaries
1245.21 "and the MA Program fee schedule"	Scope of services for the categorically needy
1245.22 "and the MA Program fee schedule"	Scope of services for the medically needy
1245.23 "and the MA Program fee schedule"	Scope of services for State Blind Pension recipients
1245.51 (b)	Ambulance services which obtain Voluntary Ambulance Service Certification (VASC) from the Department of Health will be reimbursed at a higher rate than non-VASC certified services
1245.52(1)	Payment conditions for ambulance transportation, medically necessary
1245.52(3) through (5)	Transportation to the nearest appropriate medical facility and medical services/supplies invoice.
1245.53	Limitations on payment for ambulance service when more than one patient is transported. Payment is made for transportation of the patient whose destination is the greatest distance. No additional payment is allowed for the additional person.
1245.54(1) through (7)	Noncompensable services and items relating to ambulance transportation.
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1249, Home Health Agency Services, with the following exceptions:	
1249.51 "and the MA Program fee schedule"	General payment policy for Home Health Services
1249.55(b)	Payment conditions for medical supplies. Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care services. Payment for these supplies is included in the comprehensive fee.
1249.57	Payment conditions for maternal/child services
1249.58	Payment conditions for travel costs
1249.59	Limitations on payments for home health agency services

EXHIBIT B(1)

EXHIBIT B(1)

MCO PAY FOR PERFORMANCE

This Exhibit B(1) defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® as defined below. This Exhibit is effective only if the PH-MCO operates a HealthChoices program in at least one HealthChoices zone under this Agreement in the month of December 2022. If the PH-MCO does not operate a HealthChoices program in at least one HealthChoices zone under this Agreement in the month of December 2022 the Department has no payment obligation under this Exhibit.

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

I. Quality Performance Measures

For 2022, the Department selected ten (10) HEDIS® and two (2) Pennsylvania Performance Measure (PAPM) as quality indicators (representing MY 2021 data) for the MCO P4P program. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices Program as well as the potential to improve health care for a broad base of the HealthChoices population. The twelve (12) quality indicators are:

HEDIS®

1. Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
2. Controlling High Blood Pressure
3. Prenatal Care in the First Trimester
4. Postpartum Care
5. Well-Child Visits in the First 15 Months
6. Child and Adolescent Well-Care Visits (Total)
7. Annual Dental Visit (Ages 2 – 20 years)
8. Asthma Medication Ratio
9. Lead Screening in Children
10. Plan All Cause Readmissions – Count of Observed 30-Day Readmissions

PAPM

1. Developmental Screening First Three Years of Life
2. Maternal Home Visiting

The MCO P4P Program measures Benchmark Performance and Improvement Performance. The PAPM measure, Developmental Screening First Three Years of Life, will be eligible for a performance goal and an Improvement Performance component. While this measure does not have a national benchmark, the measure value will be calculated the same as HEDIS measures in the benchmark performance, Section I. A., below.

NOTE: The MCO P4P measures are subject to change due to NCQA specifications.

A. Benchmark Performance*:* The Department will award a Benchmark Performance payout amount for each measure in Section I. that will range from 0% up to and including 125% of the measure's value. The PH-MCO's Maximum Program Payout amount is equivalent to 43% of the sum of the amounts defined in Section II. below divided by twelve (12) (consisting of eleven (11) quality indicators with Annual Dental Visit counted twice). The Department will make Benchmark Performance payouts for performance relative to the HEDIS® MY 2021 benchmarks, for all measures excluding Developmental Screening First Three Years of Life. A goal has been set for Developmental Screening First Three Years of Life (see Section I.A.3.) If the PH-MCO's HEDIS MY 2021 performance rate is below the 50th Percentile Benchmark, the Department will implement a 75% off-set. The Department will distribute the payouts according to the following criteria:

1. All HEDIS® Measures

   - HEDIS® MY 2021 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
   - HEDIS® MY 2021 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
   - HEDIS® MY 2021 rate at or above the 50th percentile and below the 75th percentile benchmark: No payout.
   - HEDIS® MY 2021 rate below the 50th percentile benchmark: -75 percent offset

2. Annual Dental Visit Performance Only

   - The Benchmark Performance measure value applicable to Annual Dental Visit Performance is equal to double the Benchmark Performance measure value (as identified in Section I.A.).
   - The -50% off-set will be applied to double the Benchmark Performance measure value (as identified in Section I. A.).

3. Developmental Screening First Three Years of Life

   - Performance goal at or above 57.00 percent (57.00%): 100 percent of the measure value.
   - Performance goal below 57.00 percent (57.00%): No payout

4. Benchmark Bonus Bundles: The Department will award a Benchmark Bonus Bundle payment for two groups of measures in the current MCO P4P model. If a bundle payment is earned this payment method will apply in addition to I.A.

The first bundle is the Perinatal and Infant Bundle. The measures in this bundle are:

- Prenatal Care in the First Trimester
- Postpartum Care, and
- Well-Child Visits in the First 15 Months

The second bundle is the Child and Adolescent Well Care Bundle. The measures in this bundle are:

- Child and Adolescent Well Care Visits (Total) and
- Lead Screening in Children

a. Perinatal and Infant Bundle:

- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months is ≥90th percentile benchmark: 130% of the measure value payout for each measure.

- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months is ≥75th percentile benchmark: 115% of the measure value payout for each measure.

- If a rate achieved is ≥50th percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a ≥ 75th percentile benchmark and another measure(s) achieves a ≥90th percentile benchmark, the measure(s) that achieved the ≥75th percentile benchmark will receive 115% of the measure value payout, while the measure(s) that achieved a ≥90th percentile benchmark will receive 130% of the measure value payout.

b. Child and Adolescent Well Care Bundle:

- If the rate for Child and Adolescent Well Care Visits (Total) and Lead Screening in Children are ≥90th percentile benchmark: 130% of the measure value payout will be issued for each measure.

  If the rate for Child and Adolescent Well Care Visits (Total) and Lead Screening in Children are ≥75th percentile benchmark: 115% of the measure value payout will be issued for each measure.

- If the rate achieved for any of the measures is ≥50th percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a ≥ 75th percentile benchmark and another measure(s) achieves a ≥90th percentile benchmark, the measure (s) that achieved the ≥75th percentile benchmark will receive 115% of the measure value payout, while the other measure(s) that achieved a ≥90th percentile benchmark will receive 130% of the measure value payout.

B. Improvement Performance*:* The Department will award an Improvement Performance payout amount for each measure in Section I. that will range from 0% up to and including 100% of the measure's value. The PH-MCO's Maximum Program Payout amount is equivalent to 43% of the sum of the amounts defined in Section II. below divided by twelve (12) (consisting of eleven (11) unique quality indicators with Annual Dental Visit counted twice).

The improvement performance payout scales will be applied contingent on benchmark percentile performance for each HEDIS MY 2021 measure (see Section I.C.1. and I.C.2.).

- If improvement is achieved and the benchmark performance for that measure is ≤50th percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance for that measure is >50th percentile and <75th percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance ≥75th percentile (see Section I.C.2.), Scale 2 will be applied.

Scale 2 applies to improvement performance for the PAPM Developmental Screening the First Three Years of Life. Receiving the Improvement Performance payout is not contingent on meeting the goal of 57.00 percent (57.00%) for Developmental Screening First Three Years of Life.

1. Scale 1:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® MY 2020 (RY 2021) to HEDIS® MY 2021 (RY 2022).

- ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 4 and < 5 Percentage Point Improvement: 80 percent of the measure value.
- ≥ 3 and < 4 Percentage Point Improvement: 70 percent of the measure value.
- < 3 Percentage Point Improvement: No payout

2. Scale 2:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® MY 2020 (RY 2021) to HEDIS® MY 2021 (RY 2022) and PAPM MY 2020 (RY 2021) to PAPM MY 2021 (RY 2022).

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

3. Annual Dental Visit Performance Only

The Improvement Performance measure value available for Annual Dental Visit Performance is equal to double the Improvement Performance measure value (identified in Section I.C.).

C. Health Equity: The PH-MCO is eligible for a Health Equity Improvement Performance payout for Controlling High Blood Pressure, Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months for their African American population. The PH-MCO's Maximum Program Payout amount is equivalent to 10% of the sum of the amounts defined in Section II. below divided by five (5) unique quality indicators.

Scale 2 (See Section I. B. 2.) applies to improvement performance for the Health Equity quality measures Controlling High Blood Pressure, Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months.

D. Maternal Home Visiting: The PH-MCO is eligible for a Home Visiting Performance payout for meeting a set of performance goals. The PH-MCO's Maximum Program Payout amount is equivalent to 4.0% of the sum of the amounts defined in Section II. below.

- **Tier 1** – Greater than 6 home visits and 8-10 EPSDT visits: 100 percent of the relevant incentive pool
- **Tier 2** – Between 4-5 home visits and 6-7 EPSDT visits: 20 percent of the relevant incentive pool
- **Tier 3** - Less than 4 home visits: No payout

II. Payment for MCO Pay for Performance

The Department will inform the PH-MCO of the Maximum Program Payout amount by November 30, 2022.

The Maximum Program Payout amount will be equivalent to two (2.0) percent of the sum of the amounts defined below:

Limitation on Payout Amounts

The total awarded payout amount to a PH-MCO, which includes Benchmark Performance (I.A.) and Improvement Performance (I.C.), cannot exceed the Maximum Program Payout amount, as identified in Section II. below.

Capitation Revenue - For the purpose of this Exhibit, Capitation Revenue is defined as all Capitation revenues paid or payable by the Department to the PH-MCO in accordance with this Agreement or another HealthChoices Agreement, Appendix 3b and Appendix 3f, for the program period July 2021 through June 2022 inclusive of allowance amounts for the risk sharing and risk pool arrangements. Any settlements for the risk sharing and risk pool arrangements will not be considered in the Capitation Revenue.

Maternity Care Revenue - For the purpose of this Exhibit, Maternity Care Revenue is defined as all Maternity Care payments, paid or payable by the Department to the PH-MCO in accordance with this Agreement or another HealthChoices Agreement, for the program period July 2021 through June 2022.

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously contracted with the Department to operate a HealthChoices program in the same zone (“Previous PH-MCO”); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will allow the PH-MCO to include Capitation Revenue and Maternity Care Revenue paid to the Previous PH-MCO for the program period July 2021 through June 2022, provided the Previous PH-MCO relinquishes any claims to payment under the terms of this Exhibit B(1).

Capitation Revenues or Maternity Care Revenue paid or payable by the Department can be included in only one Maximum Program Payout amount provided by the Department. Transition in HealthChoices Agreements or in PH-MCOs will not lead to double counting of any set of revenue when the Department calculates Maximum Program Payout amounts.

Per 42 C.F.R. 438.6(b)(2)(ii) –(iii), this incentive arrangement does not automatically renew and is made available to both public and private PH-MCOs under the same terms of performance.

NOTE: The Department may change the payout methodology based on reporting restrictions due to a natural disaster, pandemic or other unforeseen events. The payout methodology will be shared with the PH-MCOs prior to finalizing.

If the Department has a payment obligation to the PH-MCO pursuant to this Exhibit B(1), the Department will issue the payment by August 31, 2023. If the PH-MCO has a payment obligation to the Department pursuant to this Exhibit B(1), the Department will reduce a subsequent payment to the PH-MCO by this amount.

EXHIBIT B(1)a

EXHIBIT B(1)a

MCO PAY FOR PERFORMANCE

This Exhibit B(1)a defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® as defined below. This Exhibit is effective only if the PH-MCO operates a HealthChoices program in at least one HealthChoices zone under this Agreement in the month of December 2023. If the PH-MCO does not operate a HealthChoices program in at least one HealthChoices zone under this Agreement in the month of December 2023 the Department has no payment obligation under this Exhibit.

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

I. Quality Performance Measures

For 2023, the Department selected ten (10) HEDIS® and two (2) Pennsylvania Performance Measure (PAPM) as quality indicators (representing Measurement Year (MY) 2022 data) for the MCO P4P program. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices Program as well as the potential to improve health care for a broad base of the HealthChoices population. The twelve (12) quality indicators are:

HEDIS®

1. Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9.0%)
2. Controlling High Blood Pressure
3. Prenatal Care in the First Trimester
4. Postpartum Care
5. Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months age band
6. Child and Adolescent Well-Care Visits (Total)
7. Annual Dental Visit
8. Asthma Medication Ratio
9. Lead Screening in Children
10. Plan All Cause Readmissions – Count of Observed/Expected Ratio

PAPM

1. Developmental Screening First Three Years of Life
2. Maternal Home Visiting

The MCO P4P Program measures Benchmark Performance and Improvement Performance. The PAPM measure, Developmental Screening First Three Years of Life, will be eligible for a performance goal and an Improvement Performance

component. While this measure does not have a national benchmark, the measure value will be calculated the same as HEDIS measures in the benchmark performance, Section I. A., below.

NOTE: The MCO P4P measures are subject to change due to NCQA specifications.

A. Benchmark Performance*:* The Department will award a Benchmark Performance payout amount for each measure in Section I. that will range from 0% up to and including 125% of the measure's value. The PH-MCO's Maximum Program Payout amount is equivalent to 43% of the sum of the amounts defined in Section II. below divided by twelve (12) (consisting of eleven (11) quality indicators with Annual Dental Visit counted twice). The Department will make Benchmark Performance payouts for performance relative to the HEDIS® MY 2022 benchmarks, for all measures excluding Developmental Screening First Three Years of Life. A goal has been set for Developmental Screening First Three Years of Life (see Section I.A.3.) If the PH-MCO's HEDIS MY 2022 performance rate is below the 50th Percentile Benchmark, the Department will implement a 75% off-set. The Department will distribute the payouts according to the following criteria:

1. All HEDIS® Measures

   - HEDIS® MY 2022 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
   - HEDIS® MY 2022 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
   - HEDIS® MY 2022 rate at or above the 50th percentile and below the 75th percentile benchmark: No payout.
   - HEDIS® MY 2022 rate below the 50th percentile benchmark: -75 percent offset

2. Annual Dental Visit Performance Only

   - The Benchmark Performance measure value applicable to Annual Dental Visit Performance is equal to double the Benchmark Performance measure value (as identified in Section I.A.1.).
   - The off-set will be applied to double the Benchmark Performance measure value (as identified in Section I. A.1.).

3. Developmental Screening First Three Years of Life

   - Performance goal at or above 60.00 percent (60.00%): 100 percent of the measure value.
   - Performance goal below 60.00 percent (60.00%): No payout

4. Benchmark Bonus Bundles: The Department will award a Benchmark Bonus Bundle payment for two groups of measures in the current MCO

P4P model. If a bundle payment is earned this payment method will apply in addition to I.A.1.

The first bundle is the Perinatal and Infant Bundle. The measures in this bundle are:

- Prenatal Care in the First Trimester
- Postpartum Care, and
- Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months age band

The second bundle is the Child and Adolescent Well Care Bundle. The measures in this bundle are:

- Child and Adolescent Well Care Visits (Total) and
- Lead Screening in Children

a. Perinatal and Infant Bundle:

- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months age band is ≥90th percentile benchmark: 130% of the measure value payout for each measure.

- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months age band is ≥75th percentile benchmark: 115% of the measure value payout for each measure.

- If a rate achieved is ≥50th percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a ≥ 75th percentile benchmark and another measure(s) achieves a ≥90th percentile benchmark, the measure(s) that achieved the ≥75th percentile benchmark will receive 115% of the measure value payout, while the measure(s) that achieved a ≥90th percentile benchmark will receive 130% of the measure value payout.

b. Child and Adolescent Well Care Bundle:

- If the rate for Child and Adolescent Well Care Visits (Total) and Lead Screening in Children are ≥90th percentile benchmark: 130% of the measure value payout will be issued for each measure.

If the rate for Child and Adolescent Well Care Visits (Total) and Lead Screening in Children are ≥75th percentile benchmark: 115% of the measure value payout will be issued for each measure.

- If the rate achieved for any of the measures is ≥50th percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a ≥ 75th percentile benchmark and another measure(s) achieves a ≥90th percentile benchmark, the measure (s) that achieved the ≥75th percentile benchmark will receive 115% of the measure value payout, while the other measure(s) that achieved a ≥90th percentile benchmark will receive 130% of the measure value payout.

B. Improvement Performance*:* The Department will award an Improvement Performance payout amount for each measure in Section I. that will range from 0% up to and including 100% of the measure's value. The PH-MCO's Maximum Program Payout amount is equivalent to 43% of the sum of the amounts defined in Section II. below divided by twelve (12) (consisting of eleven (11) unique quality indicators with Annual Dental Visit counted twice).

The improvement performance payout scales will be applied contingent on benchmark percentile performance for each HEDIS MY 2022 measure (see Section I.B.1. and I.B.2.).

- If improvement is achieved and the benchmark performance for that measure is ≤50th percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance for that measure is >50th percentile and <75th percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance ≥75th percentile (see Section I.B.2.), Scale 2 will be applied.

Scale 2 applies to improvement performance for the PAPM Developmental Screening the First Three Years of Life. Receiving the Improvement Performance payout is not contingent on meeting the goal of 60.00 percent (60.00%) for Developmental Screening First Three Years of Life.

1. Scale 1:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® MY 2021 (Reporting Year (RY) 2022) to HEDIS® MY 2022 (RY 2023).

- ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 4 and < 5 Percentage Point Improvement: 80 percent of the measure value.
- ≥ 3 and < 4 Percentage Point Improvement: 70 percent of the measure value.
- < 3 Percentage Point Improvement: No payout

2. Scale 2:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® MY 2021 (RY 2022) to HEDIS® MY 2022 (RY 2023) and PAPM MY 2021 (RY 2022) to PAPM MY 2022 (RY 2023).

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

3. Annual Dental Visit Performance Only

The Improvement Performance measure value available for Annual Dental Visit Performance is equal to double the Improvement Performance measure value (identified in Section I.B.).

C. Health Equity: The PH-MCO is eligible for a Health Equity Improvement Performance payout for the African American population rate for the following measures:

1. Controlling High Blood Pressure,
2. Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9.0%)
3. Prenatal Care in the First Trimester
4. Postpartum Care and
5. Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months age band

If the PH-MCO's denominator for any of the above Health Equity quality measures is below 30, the PH-MCO is not eligible for an incentive payout.

The PH-MCO's Maximum Program Payout amount is equivalent to 10% of the sum of the amounts defined in Section II. below divided by five (5) unique quality indicators.

Scale 2 (See Section I.B.2.) applies to improvement performance for the Health Equity quality measures.

D. Maternal Home Visiting: The PH-MCO is eligible for a Home Visiting Performance payout for meeting a set of performance goals. The PH-MCO's Maximum Program Payout amount is equivalent to 4.0% of the sum of the amounts defined in Section II. below.

The Department will make an incentive payout based upon the number of completed home visits per member according to the below criteria:

- For members who had six (6) or more completed home visits:: 100 percent of the relevant incentive pool per member
- For members who had between 4-5 completed home visits: 20 percent of the relevant incentive pool per member
- –For members who had less than 4 completed home visits: No payout

II. Payment for MCO Pay for Performance

The Department will inform the PH-MCO of the Maximum Program Payout amount by November 30, 2023.
The Maximum Program Payout amount will be equivalent to two (2.0) percent of the Annualized Revenue defined below:

Limitation on Payout Amounts

The total awarded payout amount to a PH-MCO, which includes Benchmark Performance (I.A.) and Improvement Performance (I.C.), cannot exceed the Maximum Program Payout amount, as identified in Section II. below.

Capitation Revenue - For the purpose of this Exhibit, Capitation Revenue is defined as all Capitation revenues paid or payable by the Department to the PH-MCO in accordance with this Agreement or another HealthChoices Agreement, Appendix 3b and Appendix 3f, for the program period September 2022 through June 2023 inclusive of allowance amounts for the risk sharing and risk pool arrangements divided by ten (10) to determine the average monthly Capitation Revenue multiplied by twelve (12).

Any settlements for the risk sharing and risk pool arrangements will not be considered in the Capitation Revenue.

Maternity Care Revenue - For the purpose of this Exhibit, Maternity Care Revenue is defined as all Maternity Care payments, paid or payable by the Department to the PH-MCO in accordance with this Agreement, for the program period September 2022 through June 2023 divided by ten (10) to determine the average monthly Maternity Care Revenue multiplied by twelve (12).

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously contracted with the Department to operate a HealthChoices program in the same zone ("Previous PH-MCO"); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will allow the PH-MCO to include Capitation Revenue and Maternity Care Revenue paid to the Previous PH-MCO for the program period September 2022 through June 2023, provided the Previous PH-MCO relinquishes any claims to payment under the terms of this Exhibit B(1).

Capitation Revenues or Maternity Care Revenue paid or payable by the Department can be included in only one Maximum Program Payout amount provided by the Department. Transition in HealthChoices Agreements or in PH-MCOs will not lead to double counting of any set of revenue when the Department calculates Maximum Program Payout amounts.

Per 42 C.F.R. 438.6(b)(2)(ii) –(iii), this incentive arrangement does not automatically renew and is made available to both public and private PH-MCOs under the same terms of performance.

NOTE: The Department may change the payout methodology based on reporting restrictions at the Department's discretion.

If the Department has a payment obligation to the PH-MCO pursuant to this Exhibit B(1), the Department will issue the payment by August 31, 2024. If the PH-MCO has a payment obligation to the Department pursuant to this Exhibit B(1), the Department will reduce a subsequent payment to the PH-MCO by this amount.

EXHIBIT B(2)

Exhibit B(2)

PH-MCO and BH-MCO INTEGRATED CARE PLAN (ICP) PROGRAM PAY FOR PERFORMANCE PROGRAM

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

This Exhibit is effective only if the PH-MCO operates a HealthChoices program in at least one HealthChoices zone under this Agreement in the month of December 2023. If the PH-MCO does not operate a HealthChoices program in at least one HealthChoices zone under this Agreement in the month of December 2023, the Department has no payment obligation under this Exhibit.

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

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

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

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

2. **Integrated Care Plan/Member Profile** - At least **1200 members** must receive an ICP that has been used in care management activity by both the PH and BH MCO. For purposes of this requirement, the Department considers an ICP or member profile, to be the collection, integration and documentation of key physical and behavioral health information that is easily accessible in a timely manner to persons with designated access. The ICP must be reviewed and

updated at least annually. An ICP will not count towards the required amount if the member has disenrolled from the PH-MCO prior to the calendar year. An ICP will count towards the required amount if a member has an ICP and disenrolls from the PH-MCO during the calendar year.

3. **Hospitalization Notification and Coordination** - Each PH-MCO and BH-MCO will jointly share responsibility for notification of all inpatient hospital admissions and will coordinate discharge and follow-up. This includes at a minimum the individual's member identification, the date of inpatient admission and name of the acute care hospital. Additional information sharing is encouraged as appropriate per HIPAA and regulatory standards. Notification to the partner MCO of hospital admissions shall occur within one (1) business day of when the responsible MCO partner learns of the admission (e.g., if the PH-MCO knows of an admission, it will notify the BH-MCO within one (1) business day and vice versa). Each PH-MCO will attest on the Operations 17 report that 90% of the admission notifications occurred within one (1) business day of the PH-MCO learning of the admission. The PH-MCO must maintain documentation to support the attestation of 90% admissions notifications.

   For Measurement Year (MY) 2022/Reporting Year (RY) 2023, the PH-MCO must create a process to share and discuss the ICP with the Member and the member's Primary Care Provider (PCP). Sharing the ICP with the member is not limited to the PH-MCO and should be completed by someone who has the most direct or best relationship with the member. The PH-MCO and BH-MCO must work together to develop a process for identifying who shares and discusses the ICP with the member. As part of the PH-MCO and BH-MCO collaboration, the MCO who shares and discusses the ICP with the member needs to notify the partner MCO within one (1) business day when the responsible MCO partner shared the ICP with the member. The PH-MCO must document who shared and discussed the ICP with the member. Beginning in MY 2023/RY 2024 sharing and discussing the ICP with both the Member and member's PCP will become an eligibility requirement for an incentive payout.

   The Operations Report 17 will be reviewed to verify the accuracy of the stratification, number of integrated care plans, hospital notification information and sharing and discussing the ICP with the Member and Member's PCP.

B. <u>Performance Measures</u>

The performance measures for the MY 2022/RY 2023 ICP Program include the following:

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-ICP)*
   a. Initiation rate*
   b. Engagement rate*

2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia (SAA-ICP)*

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

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

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

6. Diabetes Screening for People with Serious Persistent Mental Illness who are using Antipsychotic Medications SSD-ICP)*

7. Diabetes Care for People with Serious Persistent Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9/0%) (HPCMI-ICP)**

8. Cardiovascular Monitoring for People with Cardiovascular Disease and Serious Persistent Mental Illness (SMC-ICP)*

9. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence for Individuals with Serious Persistent Mental Illness (FUA-ICP)*
    a. Within 7-day follow-up rate
    b. Within 30-day follow-up rate

10. Follow-Up After Emergency Department Visit for Mental Illness for Individuals with Serious Persistent Mental Illness (FUM-ICP)*
    a. Within 7-day follow-up rate
    b. Within 30-day follow-up rate

NOTE: The ICP P4P measures are subject to change due to NCQA specifications.

**NCQA HEDIS® measure ** ICP measure defined by EQRO*

C. Payment for MCO Performance

The ICP P4P Program measures Benchmark Performance and Improvement Performance. Payments will be based on meeting a Benchmark performance/Goal and/or an incremental improvement goal calculated from the previous HEDIS®/PAPM MY 2021 (RY 2022) to the current HEDIS®/PAPM MY 2022 (RY 2023).

- **Benchmark Performance***:* The Department will make a Benchmark Performance payout for performance relative to the HEDIS® MY 2022 (RY

2023) benchmarks, for all measures excluding the measures below which will have a goal assigned:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement rate,
- Emergency Room Utilization for Individuals with SPMI,
- Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SPMI,
- Combined BH-PH Inpatient Admission Utilization for Individuals with SPMI.

There is no Benchmark Performance payout for:

- Diabetes Screening for People with Serious Persistent Mental Illness who are using Antipsychotic Medications (SSD-ICP),
- Diabetes Care for People with Serious Persistent Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9/0%) (HPCMI-ICP) and
- Cardiovascular Monitoring for People with Cardiovascular Disease and Serious Persistent Mental Illness (SMC-ICP).

The Department will award a Benchmark Performance or Goal payout amount for each measure that will range from 0% up to and including 125% of the measure's value, defined as half of the PH-MCO's Maximum Program Payout amount divided by seven (7) quality indicators.

The Department will distribute the payouts according to the following criteria:

a. All HEDIS® Measures
   - HEDIS® MY 2022/RY 2023 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
   - HEDIS® MY 2022/RY 2023 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
   - HEDIS® MY 2022/RY 2023 rate at or above the 50th percentile and below the 75th percentile benchmark: 75 percent of the measure value.

b. Emergency Department Utilization for Individuals with SPMI
   - Performance goal at or below 142.00: 100 Percent of the measure value.
   - Performance goal above 142.00: No payout.

c. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SPMI
   - Performance goal at or below 15.00%: 100 Percent of the measure value.
   - Performance goal above 15.00%: No payout.

d. Combined BH-PH Inpatient Admission Rate for Individuals with SPMI

- Performance goal at or below 22.00: 100 percent of the measure value.
- Performance goal above 22.00: No payout.

e. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement rate
   - Performance goal at or above 32.00%: 100 percent of the measure value.
   - Performance goal below 32.00%: No payout.

- **Improvement Performance***:* The Department will award an Improvement Performance payout amount for each measure that will range from 0% up to and including 100% of the measure's value, defined as half of the PH-MCO's Maximum Program Payout Amount divided by ten (10) quality indicators.

  The Improvement Performance payout scales will be applied contingent on benchmark percentile performance for each HEDIS® MY 2022 measure.

  - If improvement is achieved and the benchmark performance for that measure is <50th percentile, Scale 1 will be applied.
  - If improvement is achieved and the benchmark performance for that measure is ≥50th percentile and <75th percentile, Scale 1 will be applied.
  - If improvement is achieved and the benchmark performance ≥75th percentile Scale 2 will be applied.

  a. Scale 1

     The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® MY 2021 (RY 2022) to HEDIS® MY 2022 (RY 2023).

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

  b. Scale 2:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from MY 2021 (RY 2022) to MY 2022 (RY 2023) and PAPM MY 2021 (RY 2022) to PAPM MY 2022 (RY 2023).

Scale 2 also applies to the following measures:

- Initiation and Engagement of Alcohol and Other Drug Dependence - Engagement rate, (IET-ICP)
- Emergency Department Utilization for Individuals with Serious Persistent Mental Illness (EDU-ICP)
- Combined BH-PH Inpatient Admission Utilization Rate for Individuals with Serious Persistent Mental Illness (IPU-ICP)
- Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with Serious Persistent Mental Illness (REA-ICP)
- Diabetes Screening for People with Serious Persistent Mental Illness who are using Antipsychotic Medications (SSD-ICP)
- Diabetes Care for People with Serious Persistent Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-ICP)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Serious Persistent Mental Illness (SMC-ICP)

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

NOTE: The payout structure is subject to change based on reporting restriction in the Department's discretion.

D. PH-MCO's Maximum Program Payout Amount

Ten million dollars ($10M) will be allocated for the ICP Program in RY 2023 for the PH-MCOs. The funding will be allocated to each PH-MCO according to its overall percent of HealthChoices member months from the previous calendar year.

If the Department has a payment obligation to the PH-MCO under Section C above, pursuant to this Exhibit B(2), the Department will issue the payment by August 31, 2024.

EXHIBIT B(3)

Exhibit B(3)

PROVIDER PAY FOR PERFORMANCE PROGRAM

The Provider Pay-for-Performance (Provider P4P) program described in this Exhibit B(3) is for services rendered by providers during a Calendar Year (CY) and defined in Section I below.

I. Provider P4P Program Requirements

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

A. The PH-MCO is required to develop a Provider P4P program using the following **mandatory** ten (10) HEDIS® Quality Measures (per HEDIS® Measurement Year (MY) 2022 Technical Specifications, Vol. 2), one (1) PA Performance Measure (PAPM) and three (3) Electronic Quality Measures:

HEDIS®

1. Annual Dental Visit (Age 2 – 20 Years)
   a. Part of the incentive for the Annual Dental Visit measure must include payments to dental providers that must be based on preventive dental services. The incentives must be structured to pay defined minimal amounts to dentists for performing episodes of preventive care for new and established recipients in at least two age bands (0-5 years and 6-20 years). The specific incentive model will be relatively uniform across the HealthChoices program. The incentive model will be determined by the Department in cooperation with all HealthChoices PH-MCOs.
2. Controlling High Blood Pressure
3. Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9.0%))
4. Prenatal Care in the First Trimester
5. Postpartum Care
6. Child and Adolescent Well-Care Visits (Total)
7. Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months age band
8. Asthma Medication Ratio
9. Lead Screening for Children
10. Plan All Cause Readmissions - Count of Expected/Observed Ratio

PAPM

1. Developmental Screening in the First Three (3) Years of Life

Electronic Quality Measure

Payment for electronic submission of any mandatory measure, the Obstetrical Needs Assessment Form (ONAF), or any Electronic Clinical Quality Measure

(eCQM) approved by the current CMS Promoting Interoperability electronic health record program rules. Information on these eCQMs may be found at the following link: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures and https://vsac.nlm.nih.gov/download/ecqm?rel=20210506.

In addition, the PH-MCO must work with their Providers and Health Information Exchanges to obtain actual data values, not just CPT-II codes. For 2023, the Department requires the following mandatory electronic measures:

1. Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9.0%)
2. Controlling High Blood Pressure

NOTE: The Provider P4P program measures are subject to change due to NCQA specifications.

In addition to the mandatory HEDIS® Quality Measures, PAPMs, and eCQMs, the PH-MCO must include in its Provider P4P program a component related to pediatric shift nursing services. The PH-MCO must identify measures, and set goals for those measures, to reward incremental improvements by eligible Network Providers, as described in Section VII.E.9(b) of this Agreement. These measures and associated goals must relate to improved clinical and social outcomes for children receiving pediatric shift nursing services. Examples of permissible goals include reductions in emergency department utilization and hospitalizations, decreased rates of uncovered authorized shift care hours, and increased rates of screenings and referrals for SDOH needs.

B. The PH-MCO is required to develop and submit a proposal to the Department using the Provider P4P Submission Template on DocuShare. The proposal must be reviewed and informally approved by the Department prior to implementing.

C. A PH-MCO's Provider P4P program will remain in effect until December 31 of each calendar year. The PH-MCO may submit one (1) revision per quarter only to the provider payout amounts for the Department's review and approval. The PH-MCO must complete and submit the Provider P4P Submission Change Form. Payout revisions must be submitted no later than close of business on the last day of each calendar quarter. No Provider P4P Change Forms will be accepted in the third or fourth quarter. No other revisions to the Provider P4P program will be accepted.

D. The PH-MCO must provide a quarterly update of its approved Provider P4P program at the Quarterly Quality Review Meetings (QQRM). These updates will be based on selected topics chosen by the Department and will be shared with the PH-MCO prior to the quarter they are being discussed.

E. The PH-MCO must annually evaluate and provide an analysis to the Department of the effectiveness of its Provider P4P.

F. The Department may request that PH-MCOs share Provider P4P program findings with other HealthChoices PH-MCOs to identify best practices and improve the overall HealthChoices Program.

G. The PH-MCO must implement an incentive program for the following Health Equity Measures:

- Prenatal Care in the First Trimester
- Postpartum Care
- Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months age band
- Controlling High Blood Pressure

Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9.0%)

II. Payments to the PH-MCO

A. The Department will make payments for Provider P4P based on a per member per month (PMPM) rate, noted in Appendix 3f. The Provider P4P payments are part of the monthly capitation process, as identified in Appendix 3b. Coverage for Members in a freestanding IMD is specified in Section VII. E. 13.

1. If the PH-MCO has unspent Provider P4P funds, as determined by the Department, upon receipt and review of Report #40, the Department may reduce a future payment to the PH-MCO by the unspent amount or the Department may direct unspent Provider P4P funds provided to the PH-MCO per this Exhibit for the current or a prior program year. Any directed P4P funds are to be used in support of an initiative to improve access to care or improved quality outcomes for Members.

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

B. Payments made to the PH-MCO under the Provider P4P program are intended to fund all mandatory measures

III. Payments to Providers

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

B. The PH-MCO is required to develop and maintain a separate accounting process of the receipts and disbursements of all Provider P4P funds. The PH-MCO must be able to separately identify and track each payment to a provider for each specific mandatory HEDIS® Quality Measure identified in the Provider P4P program.

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

D. Incentive Payment Attestation: The PH-MCO shall make a Provider incentive payment to Network Providers using P4P funds received from the Department contingent upon submission of an attestation by June 30th of the subsequent calendar year. No less than 80% of the incentive payment will be dispersed to the Network Provider who completed the Provider P4P requirement(s) and no more than 20% of those funds will be used for general administrative purposes.

IV. Reporting

A. Clinical Reporting
The PH-MCO is required to meet the Department's reporting requirements by providing updates at the QQRMs and an annual analysis of the effectiveness of its approved Provider P4P program.

B. Financial Reporting
Expenditures for this program are reported on annual Report #40 as required by the annual Financial Reporting Requirements. Reported disbursements should only reflect disbursements for the specified program year.

V. Clinical Review

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

EXHIBIT B(4)

Exhibit B(4)

HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)

The Department is administering a HQIP. This program is designed to incentivize acute care general hospitals, and potentially other hospitals, enrolled in HealthChoices to improve the quality of healthcare services. The Department developed this initiative as part of its commitment to promote cost-effective, quality healthcare through an outcome and value-based payment structure. The Department makes an annual determination of Hospital Quality measures.

The Department will measure performance by hospital statewide across HealthChoices. The performance measurements will not be PH-MCO specific. The Department will make one HQIP payment to the PH-MCO on or before October 31, 2023 per this Agreement if the PH-MCO is responsible to operate a HealthChoices program per this Agreement on October 1, 2023.

The Department's obligation for this program across all PH-MCOs that are responsible to operate a HealthChoices program in any or all zones on October 1, 2023, is $110 million for the 2022 performance year. The Department will divide the $110 million, across all PH-MCOs participating in HealthChoices in any or all zones based on each PH-MCO's monthly enrollment, as determined by the Department. The Department will make a HQIP payment, as determined above, to the PH-MCO for each zone of operation.

The Department will calculate the HQIP payments by hospital and will provide a schedule of HQIP payment(s) and instructions to each PH-MCO. The PH-MCO will make HQIP payments to hospitals per the instructions within ten business days of the later of the receipt of this payment or the PH-MCO's receipt of payment instructions from the Department. The PH-MCO will not be required to make HQIP payments that exceed, in total, the amount paid by the Department for this purpose.

The Department will continue this HQIP for subsequent calendar years' performance. The Department will share hospital quality data prepared per this program with all PH-MCOs.

EXHIBIT B(5)

Exhibit B(5)

COMMUNITY BASED CARE MANAGEMENT PROGRAM

The Community Based Care Management (CBCM) Program requirements described in this Exhibit B(5) are for care rendered during a CY and defined in the PH-MCO specific CBCM Program approved by the Department. The PH-MCO shall submit CBCM proposals solely utilizing partnerships with Community-Based Organizations (CBOs), Hospital/Health systems, and Providers that encourage the use of preventive services, mitigate Social Determinates of Health barriers, reduce healthcare disparities and improve maternal and child health.

I. CBCM Program Requirements

A. The PH-MCO must propose CBCM activities and funding focused on partnerships with CBOs, Hospital/Health systems, and Providers integrating a holistic approach to patient care and education to:

1. Assess, refer and mitigate Social Determinants of Health;
2. Promote maternal, infant and early childhood assessment, education and referral including expansion and capacity building of existing home visiting programs;
3. Localize efforts to promote health education and wellness and encourage the use of preventive health services;
4. Promote education on the appropriate management of chronic health conditions;
5. Enhance behavioral and physical health coordination of services; and
6. Reduce healthcare disparities.

CBCM staff must spend the majority of time in face-to-face encounters with members. Face-to-face visits are preferred but the use of telemedicine visits is allowed. Telemedicine visits must provide the same level of care and achieve the same outcomes as an in-person visit. Telehealth visits must be consistent with the requirements in Medical Assistance Bulletin 99-21-06. Telephone calls are acceptable in situations where the individual/family does not possess or have access to video technology. Text messages may be used to provide supplemental communication but are not considered a telemedicine visit. The PH-MCO or contracted CBCM entity must obtain and document informed consent for the use of telemedicine technology for the initial telemedicine visit.

The PH-MCO cannot use CBCM funds to employ PH-MCO staff.

The PH-MCO shall only use funding for CBCM services that have been informally approved by the Department in writing.

B. The PH-MCO must implement a minimum of one rapid cycle quality improvement pilot program per year. To qualify as a rapid cycle quality improvement program, the PH-MCO must make and test changes at least monthly over a period of three months or less. The PH-MCO must implement at least one rapid cycle quality

improvement pilot program by the end of the second calendar quarter. If a rapid cycle quality improvement pilot program is demonstrating success, the PH-MCO must progressively expand the program. The PH-MCO must employ at least one individual who possesses a nationally-recognized quality improvement credential to coordinate the rapid cycle quality improvement program.

C. The PH-MCO must include in it CBCM agreements the requirements that:

1. Interventions conducted are carried out by appropriately trained/qualified personnel.
2. Participation in collaborative learning sessions.
3. Systems are capable to document services and interventions provided to Members and communities. Where feasible, systems include the use of electronic health records.
4. Exchange program and outcome data with the PH-MCO.
5. CBCM funds cannot be used for commodities.

D. If the PH-MCO does business in multiple HealthChoices Zones, the PH-MCO may allocate CBCM Program funds across any Zone in which it provides Physical Health HealthChoices services.

E. The PH-MCO shall develop and submit a proposal to the Department prior to implementing its 2023 CBCM Program, which may include multiple programs for use of the CBCM funds. If multiple programs are identified, each one must follow the requirements below. Proposals are due no later than **October 1, 2022** and must be submitted to the appropriate folder in DocuShare using the CBCM Proposal template. The PH-MCO must include in each CBCM proposal:

1. A program description, and operations timeline that outlines the startup of the program from January 1, 2023 through December 31, 2023.
2. A rapid cycle quality improvement pilot program with program description and operations timeline. If the program is expanded, a revised program description must be submitted on a CBCM Proposal Change Form.
3. Clearly defined goals, objectives and outcome measures that include incremental benchmarks for success. The majority of goals need to be non-HEDIS member focused outcomes based.
4. An outline of interventions performed.
5. Outline of time frames.

F. A PH-MCO's approved CBCM program will remain in effect until December 31 of each calendar year. The PH-MCO may only submit one revision in the first and second quarter no later than the last business day of each calendar quarter for the Department's review and approval. The PH-MCO must complete and submit the

CBCM Proposal Change Form, that is available on DocuShare. The Department will not accept changes for the third and fourth calendar quarter.

G. The PH-MCO must implement an evidenced informed, outcomes-based home visit program as per Exhibit B(5)A.

II. Payments to the PH-MCO

A. The Department will make payments for the CBCM program as part of each per member per month (PMPM) Base Capitation Rate in Appendix 3f. The PH-MCO must spend at least $0.75 PMPM from each Base Capitation Rate after risk adjustment for their approved CBCM program.

If the PH-MCO has not spent at least $0.75 PMPM from each Base Capitation Rate after risk adjustment on their approved CBCM program as determined by the Department as reported on the 4th quarter Report 5i for the applicable program period, the Department will apply a sanction to the PH-MCO in an amount equivalent to the difference between the $0.75 PMPM multiplied by the PH-MCO's Member Months for the applicable CBCM program year minus the actual amount spent by the PH-MCO on their approved CBCM program. If applicable, the Department will recover this sanction amount by reducing a future payment to the PH-MCO. The Department may agree to waive this sanction based on additional information provided by the PH-MCO to the Department detailing the reasons why the expenditures for the CBCM program were less than the required $0.75 PMPM.

If the Department determines the PH-MCO made CBCM expenditures that were not in accordance with the PH-MCO's approved CBCM plan, upon advanced written notice to the PH-MCO, the Department may require that the PH-MCO resubmit any required CBCM reporting to remove these expenditures. Please refer to the paragraph above if the resubmitted report(s) result in expenditures that are less than the required $0.75 PMPM.

Maternity Care, as shown on Appendix 3f, is excluded from this requirement.

III. Payments to Providers

The PH-MCO must make payment within the approved time period for the approved CBCM program, as identified above.

IV. Reporting

A. **Clinical Reporting**

1. The PH-MCO must submit an annual analysis of their Comprehensive Care Management in addition to submitting a sub-analysis of the CBCM program.
2. The PH-MCO shall report on the clinical outcomes of the program,

B. **Financial Reporting**

The PH-MCO must submit the required Report 5i as required by Section VIII.D. If requested by the Department, the PH-MCO must submit additional financial reports in the format and by the date requested.

EXHIBIT B(5)a

Exhibit B(5a)

HOME VISITING PROGRAM

The Home Visiting Program requirements described in this Exhibit B(5a) are for Parent/Caregiver and infant care coordination activities rendered during a CY and defined in the PH-MCO specific Home Visiting Program approved by the Department per Section II below. Proposals submitted for the Home Visiting Program must encourage the use of preventive services, identify and resolve barriers to care, and mitigate social determinants of health barriers.

I. Home Visiting Program Requirements and Goals

A. The PH-MCO must implement a Home Visiting Program that is available to all first-time parents and parents/caregivers of children who have been identified as having additional risk factors which may include social, clinical, racial, economic or environmental factors. The Home Visiting Program must also be available to any infant and the infant's parent/caregiver who requests Home Visiting services. Services must be available from the prenatal period and at a minimum through the child's first 18 months of life. The PH-MCO may only use Community Based Care Management funds for Home Visiting services provided during the prenatal period and the first 18 months of the child's life.

B. The Home Visiting Program must be designed to provide support to parents/caregivers, children, and families. The program must be individualized, strengths-based and family-focused to ensure that all needs are addressed, and families are active partners in their care. The Home Visiting Program must be innovative, expansive, and inclusive.

C. Home Visiting activities must primarily be focused on:

1. Parent/Caregiver and Infant Health promotion and prevention
2. Parent/caregiver education and support
3. Healthy child development
4. Child safety (Infant sleep safety, car seat safety, crib and changing table safety, environmental lead, accident prevention, environmental safety, etc.)
5. Identification and mitigation of social determinants of health (SDOH)
6. Increasing screenings and referrals to community resources for SDOH (food insecurity, health care access/affordability, housing, education transportation, childcare, employment, utilities, clothing, financial strain)
7. Prevention of intimate partner violence
8. Reducing disparities in perinatal health
9. Strengthening family economic self-sufficiency
10. Family planning, which includes access to counseling for available contraceptive options, childbirth-spacing education, and support to attain contraceptives if requested by mother
11. Increasing postpartum health care visits

12. Increasing screenings for Maternal/Caregiver depression and anxiety
13. Increasing screenings for substance use disorder (SUD)
14. Increasing follow up care on positive postpartum depression screenings and/or other behavioral healthcare needs
15. Increasing rates of well-child visits and follow up on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) appointments
16. Increasing plans of safe care for all infants born affected by substance abuse, NAS and FASD.
17. Increasing rates of dental appointments and follow up for the child's first dental appointment and routine 6-month dental appointments thereafter.

D. The objective of the Home Visiting Program is to improve Parent/Caregiver and infant health outcomes and reduce maternal and infant morbidity and mortality, especially in individuals identified to be at risk.

E. Home Visiting Programs will include licensed and/or non-licensed staff with an emphasis on expanding the use of non-licensed providers.

1. Home visitors must meet the requirements of nationally recognized Home Visiting Programs. Home visitors must be provided initial and ongoing training, supervision and professional development. High-quality supervision, including reflective supervision, must be implemented for all home visitors.
2. The home visitor must have knowledge about resources in the family's community and be able to link the family to needed services and local health care organizations.

F. The PH-MCO maternity case manager must offer to initiate a warm handoff to a contracted Home Visiting agency.

G. Families who decline Home Visiting services at initial outreach must receive follow up outreaches by the PH-MCO to the parent/caregiver every 90 days until the child has reached age 18 months to ensure the family does not need home visiting support. The PH-MCO must reach out to parents/caregivers who did not participate in the PH-MCO's Maternity Care Management program to inform and offer the Home Visiting Program.

H. If the family has risks identified that are already being met by an evidence-based Home Visiting Program, the PH-MCO case manager will follow up with the evidence-based program with the caregiver/parental consent to avoid duplication of services and to ensure that there are no unmet needs.

I. The PH-MCO should focus on expanding their Home Visiting Program to new geographic areas and new populations. PH-MCOs that are currently working with evidence-based Home Visiting Programs are encouraged to expand and build their capacity by partnering with evidence-informed Home Visiting Programs.

J. The PH-MCO must educate their network providers on their Home Visiting Program and services offered.

K. The PH-MCO maternity case manager must discuss and offer Home Visiting services to the parent/caregiver during the perinatal period and first postpartum contact. Home Visiting services must be initiated by a contracted Home Visiting agency, as soon as the parent/caregiver agrees to the first visit, but no more than fourteen (14) calendar days after first contact. If services cannot be provided during this time frame, the member must be contacted by the PH-MCO case manager to assess and address any immediate needs and refer to needed resources or services.

L. Home Visiting services must be delivered appropriate to the family's level of knowledge and must be culturally and linguistically competent. Bilingual services must be provided or arranged for when necessary and any health care records must be accessible in the beneficiary's primary language. There must be no barriers to services for families with limited English proficiency, partial/full vision and/or auditory loss. Necessary supportive aids and services, such as sign language, interpretation, translation, and alternative formats must be available to beneficiaries.

M. All first-time parents, parents/caregivers of children who have been identified as having additional risk factors, any infant and the infant's parent/caregiver who requests Home Visiting services are to be offered home visits. The time and location of the visit must be scheduled to accommodate the parent/caregiver. Visits should be at the home unless the parent/caregiver requests services at another location frequented by the parent/caregiver or if the parent/caregiver requests a telemedicine visit as per O below.

N. All postpartum visits must include the parent/caregiver and child as appropriate. Health promotion, including oral health promotion, must begin at the first visit. Services will be individualized and will focus on the parent/caregiver-child dyad and family supports. The needs and risks identified in the family's plan of care must be addressed at every visit. Subsequent home visits must be tailored to the family and must follow the objectives, interventions and goals outlined in the plan of care.

O. In-person home visits are preferred but the use of telemedicine visits are allowed. Telemedicine visits must provide the same level of care and achieve the same outcomes as an in-person home visit. Telehealth visits must be consistent with the requirements in Medical Assistance Bulletin 99-21-06. Telephone calls are acceptable in situations where the family does not possess or have access to video technology. Text messages may be used to provide supplemental communication between visits but are not considered a telemedicine visit. The PH-MCO or contracted Home Visiting agency must obtain and document informed consent for the use of telemedicine technology for the initial telemedicine visit.

P. The contracted Home Visiting agency must work to identify the family's risks and needs and provide referrals to needed resources and services. Parental/caregiver, infant and family risk levels must be assigned based on the needs and risk assessments. The duration and frequency of Home Visiting services and referrals will be managed according to risk level. The number of visits received must be based on need and cannot be limited to a certain number. Home visits must be continuous without limitations of prior authorizations or approvals.

Q. The PH-MCO or contracted Home Visiting agency must follow-up with all provided referrals to ensure risks and needs are addressed. All families must receive information on child development, well child visits/EPSDT screenings and their importance, lead exposure during pregnancy through infancy and during childhood, infant safety, safe sleep practices, family planning, positive parenting techniques, health promotion, preventative health care and decision making around accessing safe childcare, if needed. Families must also be offered a referral to Women Infants and Children (WIC) services if they are not already involved. Referrals must be made to Early Intervention Services as appropriate. Referrals to a dental provider must be made for the child's first dental visit, at the earlier of either the eruption of the first tooth, or the child's first birthday. The PH-MCO or contracted Home Visiting agency must also provide care coordination for routine 6-month follow-up dental visits for the child, as well as all other family members.

R. The home visitor must complete maternal, infant and family needs and risk assessments starting at the first visit. The home visitor must evaluate the home and environment during the first visit to ensure there are no safety concerns that need addressed. The PH-MCO maternity case manager must coordinate with the home visitor to develop a parent/caregiver, infant, and family focused plan of care based on the home visitor's assessment. The plan of care addresses the family's needs, applies the family's strengths and is outcome focused. The plan of care includes family-specific objectives, interventions and goals based on identified needs and risks. If any safety concerns are identified for the parent/caregiver or child, a safety plan must be included.

S. The PH-MCO maternity case manager must monitor the plan of care implementation throughout the Home Visiting Program duration and ensure all needs are met and referrals are followed up and completed.

T. The Maternal Needs and Risk Assessment must include at a minimum the following: demographic information, pregnancy health history, chronic disease health history, other health history (sexually transmitted infections, prescription drugs, oral health), family planning, prenatal care, nutrition, breastfeeding, tobacco, alcohol and drug use, stressors, social support, mental health (depression, anxiety), intimate partner violence and social determinants of health (food insecurity, health care access/affordability, housing, education,

transportation, childcare, employment, utilities, clothing, financial strain), and parenting.

U. Infant Needs and Risk Assessment must include at a minimum the following: infant and caregiver demographics, parental family planning, parental/caregiver tobacco, alcohol and drug use, parental/caregiver stress, parental/caregiver mental health (depression, anxiety), intimate partner violence, social determinants of health (food insecurity, health care/medical access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain), infant family support, parenting and childcare, infant birth health status, infant health care, infant safety, safe sleep practices, infant feeding and nutrition, infant development and infant needs (clothing, car seat, crib, diapers, formula, etc.).

   For families of multiples (for example: twins, triplets), an Infant Needs and Risk Assessment must be completed for each infant.

V. The following domains must be addressed in assessments for all families:

   Socio-Economic Status: Examples of factors that indicate risks under this domain include family living below the poverty level, parent/caregiver employment status, highest education level attained by parent/caregiver, age of parent/caregiver, family participation in assistance benefits (SSI, Cash assistance, SNAP, WIC, etc.) and current or past food insecurity.

   Substance Use: Examples of factors that indicate risks under this domain include parent/caregiver/household member current opioid prescription, current or past substance abuse treatment, history of impaired driving, history of opioid overdose hospitalization, substance use disorder, binge alcohol use, marijuana use, illicit drug use, pain medication use, maternal smoking during pregnancy and child born with neonatal abstinence syndrome.

   Perinatal and Child Health Outcomes: Examples of factors that indicate risks under this domain include mother’s utilization of adequate and timely prenatal care, was the mother counseled about family planning options, is the mother breastfeeding, current or past maternal postpartum depression, infant preterm birth, low birth weight, NICU admission and status of well child visit utilization.

   Child Maltreatment: Examples of factors that indicate risks under this domain include reported child abuse and neglect, substantiated child abuse and neglect, current or past child maltreatment and current or past intimate partner violence for parent/caregiver/household member.

   Environment and Community: Examples of factors that indicate risks under this domain include family access to SNAP and WIC authorized stores, adequate access to affordable health care, does the family feel safe in their neighborhood, lead, air and/or water pollution concerns in the home

environment, family access to transportation, adequate housing, family sharing the home with others, and current or recent homelessness.

Child Care: Examples of factors that indicate risks under this domain include family access to affordable and quality child care.

Note: The Office of Child Development and Early Learning (OCDEL) funded Evidence-based home vising programs use Maternal Infant Early Childhood Home Visiting (MIECHV) approved screening tools for Intimate Partner Violence, Parent-Child Interaction, Depression and Child Development. A list of the screening tools will be made available to the PH-MCOs via DocuShare.

W. The Home Visiting Program must minimally address the following:

1. Parent/Caregiver Physical Assessment
2. Infant Physical Assessment
3. Maternal Depression and Anxiety Screening
4. Childbirth Preparation including obtaining prenatal care if needed
5. Substance Use Assessment and Referral (Drug, Opioid and Alcohol)
6. Tobacco Use Assessment
7. Lactation Care
8. Parent/Caregiver-Infant Care and interaction
9. Well Child Screening and Visits Assessment
10. Family Planning
11. Home Assessment
12. Intimate Partner/Interpersonal Violence Risk Assessment
13. Parent/Caregiver Skills Education
14. Positive Parenting Practices
15. Nutrition Counseling
16. Physical recovery from birth
17. Chronic disease management
18. Health promotion
19. Postpartum health
20. Safe Sleep practices
21. Assessment and Development of Home Visiting Plan
22. Social Determinants of Health (food insecurity, health care access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain)
23. Referral to support programs (Home Visiting Programs, Health coverage, SNAP, housing, employment, transportation, WIC)
24. Child Safety Education
25. Child Development Screening
26. Age Appropriate Immunizations
27. EPSDT scheduling and education
28. Early language and literacy activities
29. Maternal and Infant Lead Screening and education
30. Oral Heath Instructions and Prevention Counseling

II. Reporting

A. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its Home Visiting Program. The Home Visiting Program may include multiple programs. If multiple programs are identified, each one must follow the requirements below. Proposals are due no later than **October 1, 2022** and must be submitted to the appropriate folder in DocuShare using the Home Visiting Program proposal template. Each Home Visiting Program proposal must include:

1. A Home Visiting Program description that lists targeted providers/organizations and operations timeline that outlines the startup of the program from January 1, 2023 through December 31, 2023.

2. The targeted providers/organizations involved with the Home Visiting Program. The PH-MCO will be responsible for reporting the targeted providers/organizations and recipients.

3. Clearly defined goals, objectives and outcome measures that include incremental benchmarks for success.

4. An outline of interventions that the Home Visiting worker will be performing for each of the targeted providers.

B. The PH-MCO must submit an analysis of their Home Visiting Program. This analysis must be submitted as part of Operations Report #15 to the Department on the scheduled reporting due date(s).

III. Clinical Review

A. The Department may choose to perform a review of the Home Visiting Program. The PH-MCO must reasonably cooperate with Department staff during the review process.

EXHIBIT B(6)

Exhibit B(6)

MEDICATION ADHERENCE PAY FOR PERFORMANCE

This Exhibit B(6) defines a potential payment obligation by the Department to the PH-MCO for managing Members with a diagnosis of Hepatitis C to cure through adherence to their medication regimen as verified through point of sale claims for Hepatitis C medication dispensed and by the Member's subsequent laboratory test post medication regimen for viral load.

The Department will make a one-time payment in the amount of $1,000 to the PH-MCO for each Member with a diagnosis of Hepatitis C that has received Hepatitis C medication(s), as identified on the Department's Specialty Drug List, within the given calendar year and received a subsequent laboratory test that confirms the Member has achieved cure. Example: A Member's last Hepatitis C medication was dispensed on October 1, 2022 and a Sustained Viral Response (SVR) was administered on February 15, 2023 with cure. The Member will be considered for the second semi-annual period.

The Department will verify eligible Members for this incentive payment through encounter data for pharmacy services that have dates of service during the given calendar year and for which the PH-MCO submits an SVR that confirms the Member achieved cure. The PH-MCO will notify the Department of SVRs it has obtained that document undetectable Hepatitis C Ribonucleic Acid (RNA) twelve to twenty-four weeks following completion of the medication therapy. The Department will not utilize an SVR if it utilized an SVR for the same Member that is dated less than 24 months prior, or if the PH-MCO has not followed procedures specified by the Department.

The Department will accept a SVR from the PH-MCO if at least one of the following criteria is met, along with other requirements:

A. The PH-MCO has paid for a Hepatitis C drug for the Member during the given calendar year; OR
B. The Member was enrolled with the PH-MCO on the date the SVR was completed and confirmed cure.

If the Member switches PH-MCOs prior to the date of the SVR confirming cure, the Department will make a proportional payment to the PH-MCO in which a Member was enrolled on the date of the SVR. If the PH-MCO did not make a payment for any days of the medication regimen received by the switching Member, the one-time payment will be multiplied by 10 percent (10.0%); If the PH-MCO paid for 1 to 28 days of the medication regimen received by the switching Member, the one-time payment will be multiplied by 50 percent (50.0%); If the PH-MCO paid for 29 days or more of medication regimen received by the switching Member, the PH-MCO will receive the one-time payment in full. The difference between the one-time payment less the proportional payment, will be paid to the PH-MCO from which the Member switched.

The Department will process one payment to the PH-MCO for each semi-annual period for the given calendar year. Each payment will total the sum of the one-time payments earned plus

any proportional payments earned by the PH-MCO during that period. The Department will determine the inclusion of Members in each semi-annual period based on the date of service for that Member's last Hepatitis C drug claim as identified through encounter data. The Department will not process each semi-annual payment until, at the earliest, nine months after the end of the semi-annual period. Members that have been determined cured will be included in only one of the two semi-annual periods during the given calendar year.

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

EXHIBIT B(7)

EXHIBIT B(7)

MATERNITY CARE BUNDLED PAYMENT

1. Maternity Care Bundle: As part of VBP, the PH-MCO must utilize a Maternity Care Bundled Payment for Network Providers that elect to take part in the model, use a maternity care team, and have at least twenty (20) births annually attributed to the maternity care team. A PH-MCO utilizing a Maternity Care Bundled Payment must require that the Network Provider use a maternity care team that:

    a. Includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to provide prenatal care to pregnant women.
    b. Includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to assist in vaginal delivery of babies.
    c. Includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to provide newborn services.
    d. Provides access to at least one (1) physician who is qualified to treat women with high-risk pregnancies, to treat complications experienced during pregnancy or childbirth, and to perform cesarean sections.
    e. Provides access to at least one (1) hospital that has the capability to perform cesarean sections and treat common complications of labor and delivery.
    f. Provides access to at least one (1) physician practice, hospital, clinical laboratory, or other entity that has the ability to perform laboratory tests or imaging studies needed as part of prenatal care, labor and delivery, and postpartum care.
    g. Includes at least one (1) individual, such as a doula, community health worker, social worker, or peer recovery specialist, to coordinate the care of the pregnant woman to address other needs, including behavioral health, substance use disorder, and Social Determinants of Health.

2. Payment to the Maternity Care Team: The target price of the bundle shall be prospectively developed with the maternity care team. The PH-MCO shall pay the maternity care team the applicable fee-for-service payments and perform a retrospective review to compare the fee-for-service payments to the target price. If the fee-for-service payments made for the services included in the bundle are less than the target price, the PH-MCO shall include the difference in a pool of shared savings. On an annual basis, the PH-MCO shall determine the amount of shared savings to be paid to a Network Provider using a maternity care team as specified in section 9.

    The PH-MCO must base the prospectively developed target price on:

    a. The trimester in which the pregnant woman engaged in care;
    b. Historical spending, with factors taken into consideration that reflect patient acuity.

In addition, the PH-MCO may base the prospectively developed target price on:

Blended regional prices of vaginal births, cesarean section rates, including prenatal, postpartum, and newborn services for up to sixty (60) days postpartum, with a proportion of cesarean sections set for 2021 at:

i. 25.50% cesarean sections in the Southeast Zone
ii. 25.75% cesarean section in the Southwest Zone
iii. 27.25% cesarean sections in the Lehigh/Capital Zone
iv. 29.00% cesarean sections in the Northeast Zone
v. 29.75% cesarean sections in the Northwest zone

3. Services included in the bundle: The PH-MCO must develop a target payment that includes all services provided during pregnancy episode: prenatal care, labor and delivery, care coordination services, and up to sixty (60) days postpartum for the mother and newborn, other than contraceptive care.

4. Services excluded from the bundle: Contraceptive care, including placement of long-acting reversible contraception.

5. Pregnancies excluded from the bundle: Non-singleton pregnancies.

6. Stop loss mechanism: If the cost of the maternity care episode (including services provided during pregnancy, labor and delivery, and postpartum) for a member exceeds 300% of the target price of the maternity care bundle, then no costs over 300% of the target price of the bundle will be attributed to the Maternity Care Team.

7. Quality Measures: The PH-MCO shall use the following quality measures to determine its incentive payments:

    a. Social Determinants of Health Screening: Complete at least one (1) Social Determinants of Health screening using a Nationally recognized tool, during the episode duration with submission of G9919 (positive screening result) or G9920 (negative screening result) Procedure Codes. Claims must include appropriate ICD-10 Z-codes when relevant those determinant areas as defined by Social Determinants of Health.
    b. Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS®)
    c. Timeliness of Prenatal Care (HEDIS®)
    d. Postpartum Care (HEDIS®)
    e. Prenatal Depression Screening (PAPM)
    f. Prenatal Depression Screening Follow Up (PAPM)
    g. Postpartum Depression Screening (PAPM)
    h. Postpartum Depression Screening Follow Up (PAPM)
    i. Prenatal Immunization Status – Combination (HEDIS® - ECDS)

j. Well-Child Visits: Children who receive two (2) or more well-child visits with a primary care physician within the first sixty (60) days after birth.

8. Scoring of Quality Measures: Point totals for each quality measures are listed below. Virtual or telehealth visits should count for calculation of quality scores.

   a. Social Determinants of Health:
      i. 0.5 points for screening 50% of Members
      ii. 1 point for screening 75% of Members
      iii. 1.5 points for screening 90% of Members

   b. Initiation of Alcohol and Other Drug Abuse or Dependence Treatment: (HEDIS®)
      i. 0.5 points for reaching NCQA 50th percentile
      ii. 1 point for reaching NCQA 75th percentile
      iii. 1.5 points for reaching NCQA 90th percentile

   c. Timeliness of Prenatal Care (HEDIS®):
      i. 0.5 points for reaching NCQA 50th percentile
      ii. 1 point for reaching NCQA 75th percentile
      iii. 1.5 points for reaching NCQA 90th percentile

   d. Postpartum Care (HEDIS®):
      i. 0.5 points for reaching NCQA 50th percentile
      ii. 1 point for reaching NCQA 75th percentile
      iii. 1.5 points for reaching NCQA 90th percentile

   e. Prenatal Depression Screening (PAPM)
      i. 0.5 points for reaching or exceeding the goal of 66.18%

   f. Prenatal Depression Screening Follow Up (PAPM):
      i. 0.5points for reaching or exceeding the goal of 77.91%

   g. Postpartum Depression Screening (PAPM)
      i. 0.5 points for reaching or exceeding the goal of 71.44%

   h. Postpartum Depression Screening Follow Up (PAPM):
      i. 0.5 points for reaching or exceeding the goal of 85.06%

   i. Prenatal Immunization Status - Combination (HEDIS® - ECDS):
      i. 0.5 points for reaching NCQA 50th percentile
      ii. 1 point for reaching NCQA 75th percentile
      iii. 1.5 points for reaching NCQA 90th percentile

j. Well-Child Visits: Benchmarks are based on the HEDIS® Well-Child Visits in the First 30 Months of Life, Well-Child in the First 15 Months age band, two (2) visits in the first fifteen (15) months of life:
    i. 0.5 points for reaching NCQA 50th percentile
    ii. 1 point for reaching NCQA 75th percentile
    iii. 1.5 points for reaching NCQA 90th percentile

k. Health Equity score: Points should be awarded for the following quality measures: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment, Timeliness of Prenatal Care, Postpartum Care, Prenatal Immunization Status and Well-Child Visits as follows:
    i. 0.5 points for reaching NCQA 75th percentile for two (2) out of the five (5) HEDIS® measures within the Black/ African American community
    ii. 1 point for reaching NCQA 75th percentile for three (3) out of the five (5) HEDIS® measures within the Black/ African American community
    iii. 1.5 points for reaching NCQA 75th percentile for four (4) out of the five (5) HEDIS® measures within the Black/ African American community

9. Shared Savings Incentive Payment: The PH-MCO will pay eligible Network Providers the following percentage of shared savings based on the Network Provider's performance:

    a. (0-2 points): 0% of shared savings
    b. (2.5-3.0 points): 25% of shared savings
    c. (3.5-5.5 points): 50% of shared savings
    d. (6-8 points): 75% of shared savings
    e. (8.5-12.5 points): 100% of savings

10. Incentive Payment Attestation: The PH-MCO shall make a shared savings incentive payment to Network Providers using a maternity care team contingent upon submission by July 31, 2024 of an attestation of the maternity care team receiving the payment. No less than 80% of the reward payment will be dispersed to the maternity care team or distributed to the maternity care staff who cared for the Member, and that no more than 20% of those funds will be used for general administrative purposes.

11. Attestation for The Joint Commission Standards: The PH-MCO must attest by July 31, 2024 that each Maternity Care Bundle practice meets The Joint Commission Standard PC.06.01.01 (Reduce the likelihood of harm related to maternal hemorrhage Requirement EP 2) and Standard PC.06.01.03 (Reduce the likelihood of harm related to maternal severe hypertension/preeclampsia Requirement EP 2). The link to The Joint Commission is: https://www.jointcommission.org/-/media/tjc/documents/standards/r3-

reports/r3_24_maternal_safety_hap_9_6_19_final1.pdf. The Department may waive this requirement upon receipt of information from the PH-MCO.

12. Quality measures that will be reported to DHS by PH-MCOs: This is the list of quality measures that PH-MCOs will report to the Department at the aggregate level for their Maternity Care Bundle population and non-Maternity Care Bundle population. The PH-MCO must track these quality measures for the Maternity Care Bundle population at the Practice level and report to the Department, as requested.

    a. Severe Maternal Morbidity (SMM) rate by race and ethnicity (+Alliance for Innovation on Maternal Health (AIM®)): The PH-MCO must provide an aggregate SMM rate by race and ethnicity for their Maternity Care Bundle population and non-Maternity Care Bundle population. The link to the AIM SMM code set is:https://safehealthcareforeverywoman.org/aim/resources/aim-data-resources/ - SMM Code List
    b. Obstetrical Needs Assessment Form (ONAF) screening: The PH-MCO is to report the total number of completed ONAF forms submitted to the PH-MCO for the Maternity Care Bundle population and non-Maternity Care Bundle population.
    c. Postpartum visit follow-up: The PH-MCO needs to provide the total number of postpartum visits completed between 7 and 84 days after delivery for their Maternity Care Bundle population and non-Maternity Care Bundle population. In addition, the PH-MCO must also include a breakout rate for the medical home visit and telehealth visits in the numerator.
    d. Prenatal Care Screening Rate (AHRQ): The PH-MCO will provide the AHRQ Prenatal Care Screening rate for their Maternity Care Bundle population and non-Maternity Care Bundle population. The link to the AHRQ Prenatal Care Screening specification is: https://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/fullreports/chipra-170-prenatal-screening-specifications.pdf
    e. C-section Rate: The PH-MCO must report the percent of nulliparous women with a term, singleton baby in vertex position delivered by C-section for their Maternity Care Bundle population and non-Maternity Care Bundle population.
    f. Birth Weight outcomes: The PH-MCO must report the percent of low birth weight and very low birth weight for their Maternity Care Bundle population and non-Maternity Care Bundle population.
    g. Average Length of Stay: The PH-MCO will report the average inpatient length of stay of all neonates for their Maternity Care Bundle population and non-Maternity Care Bundle population.

NOTE: The Quality Measures and Quality Measure Reporting may be revised based upon NCQA technical specifications, PA Perinatal Quality Collaborative feedback and data reporting from the PH-MCOs. The Department may waive this requirement upon receipt of information from the PH-MCO.

13. The PH-MCO will attest by July 31, 2024 to the completion of maternity care bundled payment arrangements described in this Exhibit with providers that account for 25% of the PH-MCO's live births in calendar year 2023.

EXHIBIT D(1)

Exhibit D(1)

Requirements for Non-Commonwealth Hosted Applications/Services

The purpose of this Attachment is to define requirements for business or technology solutions and services procured by the Commonwealth that are hosted within the Licensor's or its subcontractor's managed infrastructure.

A. Hosting Requirements

1. The Licensor or its subcontractor shall supply all hosting equipment (hardware and software) required for the cloud services and performance of the software and services set forth in the Quote and Statement of Work.

2. The Licensor shall provide secure access to applicable levels of users via the internet.

3. The Licensor shall use commercially reasonable resources and efforts to maintain adequate internet connection bandwidth and server capacity.

4. The Licensor or its subcontractors shall maintain all components of the hosted solution with commercially reasonable support and replace as necessary to maintain compliance.

5. The Licensor shall monitor, prevent and deter unauthorized system access. The Licensor shall use all commercially reasonable methods to confirm suspected breaches. In the event of any impermissible disclosure unauthorized loss or destruction of Confidential Information, the receiving Party must immediately notify the disclosing Party and take all reasonable steps to mitigate any potential harm or further disclosure of such Confidential Information. In addition, pertaining to the unauthorized access, use, release, or disclosure of data, the Licensor shall comply with state and federal data breach notification statutes and regulations, and shall report security incidents to the Commonwealth within **twenty-four (24) hours** of when the Licensor has reasonable confirmation of such unauthorized access, use, release, or disclosure of data.

6. The Licensor or the Licensor's subcontractor shall allow the Commonwealth or its delegate, at times chosen by the Commonwealth, and with at least **ten (10) business days'** notice, to review the hosted system's data center locations and security architecture.

7. The Licensor's employees or subcontractors, who are directly responsible for day-to-day monitoring and maintenance of the hosted system, shall have industry standard certifications applicable to the environment and system architecture used.

The Licensor or the Licensor's subcontractor shall locate servers in a climate- controlled environment. The Licensor or the Licensor's contractor shall house all servers and equipment in an operational environment that meets industry standards including climate control, fire and security hazard detection, electrical needs, and physical security.

8. The Licensor shall examine applicable system and error logs daily to minimize and predict system problems and initiate appropriate action.

9. The Licensor shall completely test and apply patches for all third-party software products in the server environment before release.

10. The Licensor shall provide all Commonwealth data to the Commonwealth, upon request, in a form acceptable to the Commonwealth, at no cost to the Commonwealth.

B. System and Organization Controls (SOC) Reporting Requirements

1. Subject to this section and unless otherwise agreed to in writing by the Commonwealth, the Licensor shall, and shall require its subcontractors to, engage, on an annual basis, a CPA certified third-party auditing firm to conduct the following, as applicable:

   (i) Reserved

   (ii) a SOC 2 Type II report with respect to controls used by the Licensor relevant to internal and external procedures and systems that access, process, host or contain Commonwealth Data designated as Class "C" Classified Records or Closed Records, as defined in ITP-SEC019, or in compliance with mandates by federal or state audit requirements and/or policy.

   The Licensor shall receive and review their subcontractor's relevant SOC reports, and the Licensor shall provide the Commonwealth with a Letter of Attestation that includes an analysis of their subcontractor's SOC report.

2. Unless otherwise agreed to in writing by the Commonwealth, the Licensor's SOC Report(s) shall be provided upon contract execution and annually thereafter. While it is preferable that SOC Reports coincide with Pennsylvania's fiscal year (July 1 through June 30), SOC Reports, at the very least, must cover at least **6 consecutive months** of Pennsylvania's fiscal year.

3. SOC 2 Type II reports shall address the following:

(i) Security of Information and Systems;
(ii) Availability of Information and Systems;
(iii) Processing Integrity;
(iv) Confidentiality; and
(v) Privacy.
(vi) Reserved

4. At the request of the Commonwealth, the Licensor shall, and shall require its subcontractors, as applicable, complete a SOC for Cybersecurity audit, or another risk management framework as may be approved by the Commonwealth in its sole discretion, in the event:

(i) repeated non-conformities are identified in any SOC report required by subsection 1; or

(ii) if the Licensor's business model changes (such as a merger, acquisition, or change sub-contractors, etc.).

The SOC for Cybersecurity report shall detail the controls used by the Licensor or its subcontractor setting forth the description and effectiveness of the Licensor's or subcontractor's cybersecurity risk management program and the policies, processes and controls enacted to achieve each cybersecurity objective.

The Licensor shall provide to the Commonwealth a report of the SOC for Cybersecurity audit findings within **60 days** of its completion.

5. The Commonwealth may specify other or additional standards, certifications or audits it requires under any Purchase Orders or within an ITP.

6. The Licensor shall adhere to Statement on Standards for Attestation Engagements (SSAE) 18 audit standards. The Licensor acknowledges that the SSAE guidance may be updated during the Term of this Contract, and the Licensor shall comply with such updates which shall be reflected in the next annual report.

7. In the event an audit reveals any non-conformity to SSAE standards, the Licensor shall provide the Commonwealth, within **45 days** of the issuance of the SOC report, a documented corrective action plan that addresses each non-conformity that is identified within the SOC report, including any subcontractor's SOC report. The corrective action plan shall provide, in detail:

(i) clear responsibilities of the personnel designated to resolve the non-conformity;
(ii) the remedial action to be taken by the Licensor or its subcontractor(s);
(iii) the dates when each remedial action is to be implemented; and
(iv) a summary of potential risks or impacts to the Commonwealth that are associated with the non-conformity(ies).

8. The Commonwealth may in its sole discretion agree, in writing, to accept alternative security report in lieu of a SOC report.

C. Security Requirements

1. The Licensor shall conduct a third-party independent security/vulnerability assessment at its own expense on an annual basis.

2. The Licensor shall comply with the Commonwealth's directions/resolutions to remediate the results of the security/vulnerability assessment to align with the standards of the Commonwealth.

3. The Licensor shall use industry best practices to protect access to the system with a firewall and firewall rules to prevent access by non-authorized users and block all improper and unauthorized access attempts.

4. The Licensor shall use industry best practices to provide applicable system intrusion detection and prevention in order to detect intrusions in a timely manner.

5. The Licensor shall use industry best practices to provide applicable malware and virus protection or compensating controls on all servers and network components.

6. The Licensor shall limit access to Commonwealth-specific systems, data and services and provide access only to those staff, located within CONUS (any of the Continental United States and Hawaii) that must have access to provide services proposed. If Licensor staff located outside of the United States require access to the Commonwealth's data for any purpose, such as **but not limited to** system administration and support services, investigation, or debugging, these provisions shall apply to any offshore support provided by the Licensor and any subcontractors:

   i. No offshore support shall be permitted from any countries that are identified as state sponsors of terrorism by the US Department of State, which shall be monitored by the purchasing Agency to ensure compliance through the life of the Agreement, Contract, or Purchase Order;

ii. Access by offshore vendor resources shall be limited to solely that which is required to perform the Services, including support services;
iii. Offshore vendor resources who are providing the services shall be trained in the proper handling of Commonwealth Data;
    a. Any vendor offshore resources that are dedicated to the Commonwealth shall be required to undergo Commonwealth Security Awareness Training provided by the Commonwealth and the vendor shall provide monthly compliance report.
    b. Vendor attests that offshore vendor resources shall comply with Management Directive 205.34 and Management Directive 245.18 and that the Vendor has trained the offshore resources in the proper handling of Commonwealth Data.
iv. Offshore vendor resources that are providing the services shall be obligated to handle Commonwealth Data in ways at least as restrictive as the requirements outlined in the Agreement;
v. Offshore vendor resources that are providing the services and require access must be uniquely identified (e.g., by a unique User ID);
vi. Offshore vendor resources that are providing the services shall access Commonwealth systems, data, or services in a manner that meets or exceeds the minimum requirements set forth in Commonwealth ITPs;
vii. The date, time (including time zone), resource name, source IP, and nature of the access (i.e., read-only or modify) shall be recorded in a log file which is maintained and preserved according to applicable data protection law(s) and industry best practice standards;
viii. Any offshore vendor resource access must be granted by an authorized Commonwealth resource and shall only be granted on least required privilege or need-to-know basis prior to any offshore vendor resource obtaining access and shall only be granted to offshore vendor resource that must have access to provide and/or support the services;
ix. The vendor shall agree explicitly in the agreement that with respect to any services provided by any offshore vendor resources, the vendor shall be obligated to comply with the terms and conditions of the Agreement, Contract or Purchase Order, as though the offshore vendor resources were located within the United States and that the vendor shall assume all obligations and risks associated with the use of offshore vendor resources as if those resources were located within the United States;
x. The purchasing agency shall ensure that background check requirements apply to all offshore vendor resources assigned to perform services under the Agreement, Contract or Purchase Order.
    a. The vendor shall identify each offshore vendor resource that will perform services under the Agreement, Contract or Purchase Order and shall perform the following background checks on each individual offshore vendor resource providing services:

i. Criminal Records Database check (country where the offshore vendor resource is located);
ii. Civil Litigation Database check (country where the offshore vendor resource is located);
iii. Credit and Reputational Risk Database Check (country where the offshore vendor resource is located);
iv. Compliance Authorities (global check);
v. Regulatory Authorities (global check);
vi. Serious and Organized Crimes (global check); and
vii. Web and media searches (global check).

b. On an annual basis, the vendor shall provide written confirmation that the above required background checks have been completed and that the background checks did not identify any criminal record that includes a felony or misdemeanor (or equivalent) involving terroristic behavior, violence, use of a lethal weapon, or breach of trust/fiduciary responsibility or which raises concerns about building, system or personal security or is otherwise job-related. This written confirmation must be provided prior to the subject offshore vendor resource being provided access to Commonwealth data or systems. The vendor shall not assign any offshore vendor resource that fails to pass the background checks required in this section to any Commonwealth services and shall remove any access privileges already given to the offshore vendor resource unless the Commonwealth consents to the access, in writing, prior to the access.

xi. No recording, streaming, monitoring, or photographic devices enter, are accessible, or utilized in the workspace where work under the Agreement, Contract or Purchase Order is performed while located outside of the United States.

7. The Licensor shall provide the services, using security technologies and techniques in accordance with industry best practices and the Commonwealth's ITPs set forth in Attachment 1, including those relating to the prevention and detection of intrusions, and any other inappropriate use or access of systems and networks.

D. Data Protection

1. The Licensor shall only host, store or backup Commonwealth Data in physical locations within CONUS.

2. The Licensor shall use industry best practices to update and patch all applicable systems and third-party software security configurations to reduce security risk.

3. The Licensor shall protect their operational systems with applicable anti-virus, host intrusion protection, incident response monitoring and reporting, network firewalls, application firewalls, and employ system and application patch management to protect its network and customer data from unauthorized disclosure.

4. The Licensor shall be solely responsible for applicable data storage required.

5. The Licensor shall encrypt all Commonwealth data in transit and at rest. The Licensor shall comply with ITP-SEC031, and ITP-SEC019, encryption policies and minimum standards or stronger.

6. The Licensor shall take all commercially viable and applicable measures to protect the data availability including, but not limited to, real-time replication, traditional backup, and/or georedundant storage of Commonwealth data in accordance with industry best practices and encryption techniques.

7. The Licensor shall have appropriate controls in place to protect critical or sensitive data and shall employ stringent policies, procedures, to protect that data particularly in instances where such critical or sensitive data may be stored on a Licensor-controlled or Licensor-owned electronic device.

8. The Licensor shall utilize a secured backup solution to prevent loss of data. Stored backups must be kept in an all-hazards protective storage environment at the primary location and any additional locations where the data is being maintained. All back up data and media shall be encrypted.

E. Adherence to Policy

1. The Licensor support and problem resolution solution shall provide a means to classify problems as to criticality and impact and with appropriate resolution procedures and escalation process for classification of each problem.

2. The Licensor shall abide by the applicable Commonwealth's Information Technology Policies (ITPs), a list of the most relevant being attached hereto as Attachment 1.

3. The Licensor shall comply with all pertinent federal and state privacy regulations.

F. Closeout

When the purchase order's or other procurement document's term expires or terminates, and a new purchase order or other procurement document has not been issued by a Commonwealth Agency within **60 days** of expiration or termination, or at any other time at the written request of the Commonwealth, the Licensor must promptly return to the Commonwealth all Commonwealth's data (and all copies of this information) that is in the Licensor's possession or control. The Commonwealth's data shall be returned in a format agreed to by the Commonwealth.

Upon confirmation that Commonwealth data is in possession or control of the Commonwealth, the Licensor shall ensure all residual user account(s) are promptly deleted or reset in the solution. The Licensor shall notify the Commonwealth within **10 business days** that all user account(s) have been deleted or reset.

ATTACHMENT 1

Information Technology Policies (ITPs) for Outsourced/Licensor(s)-hosted Solutions

ITP Number - Name	Policy Link
ITP_ACC001 - Accessibility Policy	https://www.oa.pa.gov/Policies/Documents/itp_acc001.pdf
ITP_APP030 - Active Directory Architecture	https://www.oa.pa.gov/Policies/Documents/itp_app030.pdf
ITP_BUS007 - Enterprise Service Catalog	https://www.oa.pa.gov/Policies/Documents/itp_bus007.pdf
ITP_BUS010 - Business Process Management Policy	https://www.oa.pa.gov/Policies/Documents/itp_bus010.pdf
ITP_BUS012 -Artificial Intelligence General Policy	httpss://www.oa.pa.gov/Policies/Documents/itp_bus012.pdf
ITP_INF000 - Enterprise Data and Information Management Policy	https://www.oa.pa.gov/Policies/Documents/itp_inf000.pdf
ITP_INF001 - Database Management Systems	https://www.oa.pa.gov/Policies/Documents/itp_inf001.pdf
ITP_INF006 - Commonwealth County Code Standard	https://www.oa.pa.gov/Policies/Documents/itp_inf006.pdf
ITP_INF009 - e-Discovery Technology Standard	https://www.oa.pa.gov/Policies/Documents/itp_inf009.pdf
ITP_INF010 - Business Intelligence Policy	https://www.oa.pa.gov/Policies/Documents/itp_inf010.pdf
ITP_INF011 - Reporting Policy	https://www.oa.pa.gov/Policies/Documents/itp_inf011.pdf
ITP_INF012 - Dashboard Policy	https://www.oa.pa.gov/Policies/Documents/itp_inf012.pdf
ITP_INFRM001 - The Life Cycle of Records: General Policy Statement	https://www.oa.pa.gov/Policies/Documents/itp_infrm001.pdf
ITP_INFRM004 - Management of Web Records	https://www.oa.pa.gov/Policies/Documents/itp_infrm004.pdf
ITP_INFRM005 - System Design Review of Electronic Systems	https://www.oa.pa.gov/Policies/Documents/itp_infrm005.pdf
ITP_INFRM006 - Electronic Document Management Systems	https://www.oa.pa.gov/Policies/Documents/itp_infrm006.pdf
ITP_INT_B_1 - Electronic Commerce Formats and Standards	https://www.oa.pa.gov/Policies/Documents/itp_int_b_1.pdf
ITP_INT_B_2 - Electronic Commerce Interface Guidelines	https://www.oa.pa.gov/Policies/Documents/itp_int_b_2.pdf
ITP_INT006 - Business Engine Rules	https://www.oa.pa.gov/Policies/Documents/itp_int006.pdf
ITP_NET004 - Internet Protocol Address Standards	https://www.oa.pa.gov/Policies/Documents/itp_net004.pdf

ITP_NET005 - Commonwealth External and Internal Domain Name Services (DNS)	https://www.oa.pa.gov/Policies/Documents/itp_net005.pdf
ITP_PRV001 - Commonwealth of Pennsylvania Electronic Information Privacy Policy	https://www.oa.pa.gov/Policies/Documents/itp_prv001.pdf
ITP_SEC000 - Information Security Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec000.pdf
ITP_SEC001 - Enterprise Host Security Software Policy	httpss://www.oa.pa.gov/Policies/Documents/itp_sec001.pdf
ITP_SEC002 - Internet Accessible Proxy Servers and Services	https://www.oa.pa.gov/Policies/Documents/itp_sec002.pdf
ITP_SEC003 - Enterprise Security Auditing and Monitoring	https://www.oa.pa.gov/Policies/Documents/itp_sec003.pdf
ITP_SEC004 - Enterprise Web Application Firewall	https://www.oa.pa.gov/Policies/Documents/itp_sec004.pdf
ITP_SEC006 - Commonwealth of Pennsylvania Electronic Signature Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec006.pdf
ITP_SEC007 - Minimum Standards for IDs, Passwords and Multi-Factor Authentication	https://www.oa.pa.gov/Policies/Documents/itp_sec007.pdf
ITP_SEC008 - Enterprise E-mail Encryption	https://www.oa.pa.gov/Policies/Documents/itp_sec008.pdf
ITP_SEC009 - Minimum Contractor Background Checks Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec009.pdf
ITP_SEC010 - Virtual Private Network Standards	https://www.oa.pa.gov/Policies/Documents/itp_sec010.pdf

ITP Number - Name	Policy Link
ITP_SEC011 - Enterprise Policy and Software Standards for Agency Firewalls	https://www.oa.pa.gov/Policies/Documents/itp_sec011.pdf
ITP_SEC012 - System Logon Banner and Screensaver Requirements	httpss://www.oa.pa.gov/Policies/Documents/itp_sec012.pdf
ITP_SEC015 - Data Cleansing	https://www.oa.pa.gov/Policies/Documents/itp_sec015.pdf
ITP_SEC016 - Information Security Officer Policy	httpss://www.oa.pa.gov/Policies/Documents/itp_sec016.pdf
ITP_SEC017 - Copa Policy for Credit Card Use for e-Government	https://www.oa.pa.gov/Policies/Documents/itp_sec017.pdf
ITP_SEC019 - Policy and Procedures for Protecting Commonwealth Electronic Data	https://www.oa.pa.gov/Policies/Documents/itp_sec019.pdf
ITP_SEC021 - Security Information and Event Management Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec021.pdf
ITP_SEC023 - Information Technology Security Assessment and Testing Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec023.pdf
ITP_SEC024 - IT Security Incident Reporting Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec024.pdf
ITP_SEC025 - Proper Use and Disclosure of Personally Identifiable Information (PII)	https://www.oa.pa.gov/Policies/Documents/itp_sec025.pdf
ITP_SEC029 - Physical Security Policy for IT Resources	https://www.oa.pa.gov/Policies/Documents/itp_sec029.pdf
ITP_SEC031 - Encryption Standards	https://www.oa.pa.gov/Policies/Documents/itp_sec031.pdf
ITP_SEC032 - Enterprise Data Loss Prevention (DLP) Compliance Standards	https://www.oa.pa.gov/Policies/Documents/itp_sec032.pdf
ITP_SEC034- Enterprise Firewall Rule Set	https://www.oa.pa.gov/Policies/Documents/itp_sec034.pdf
ITP_SEC035 - Mobile Device Security Policy	httpss://www.oa.pa.gov/Policies/Documents/itp_sec035.pdf
ITP_SEC038 - Commonwealth Data Center Privileged User IAM Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec038.pdf
ITP-SEC039 - Keystone Login and Identity Proofing	https://www.oa.pa.gov/Policies/Documents/itp-sec039.pdf
ITP_SEC040 - Commonwealth Cloud Computing Services Requirements	https://www.oa.pa.gov/Policies/Documents/itp_sec040.pdf
ITP SFT000 - Software Development Life Cycle (SDLC) Policy	https://www.oa.pa.gov/Policies/Documents/itp_sft000.pdf

ITP_SFT001 - Software Licensing	https://www.oa.pa.gov/Policies/Documents/itp_sft001.pdf
ITP_SFT002 - Commonwealth of PA Website Standards	https://www.oa.pa.gov/Policies/Documents/itp_sft002.pdf
ITP_SFT003 - Geospatial Enterprise Service Architecture	https://www.oa.pa.gov/Policies/Documents/itp_sft003.pdf
ITP_SFT004 - Geospatial Information Systems (GIS)	https://www.oa.pa.gov/Policies/Documents/itp_sft004.pdf
ITP_SFT005 - Managed File Transfer (MFT)	https://www.oa.pa.gov/Policies/Documents/itp_sft005.pdf
ITP_SFT007 - Office Productivity Policy	https://www.oa.pa.gov/Policies/Documents/itp_sft007.pdf
ITP SFT008 - Enterprise Resource Planning (ERP) Management	https://www.oa.pa.gov/Policies/Documents/itp_sft008.pdf
ITP SFT009 - Application Development	https://www.oa.pa.gov/Policies/Documents/itp_sft009.pdf
ITP_SYM003 - Off-Site Storage for Commonwealth Agencies	https://www.oa.pa.gov/Policies/Documents/itp_sym003.pdf
ITP_SYM004 - Policy for Establishing Alternate Processing Sites for Commonwealth Agencies	https://www.oa.pa.gov/Policies/Documents/itp_sym004.pdf
ITP_SYM006 - Commonwealth IT Resources Patching Policy	https://www.oa.pa.gov/Policies/Documents/itp_sym006.pdf
ITP_SYM008 - Server Virtualization Policy	https://www.oa.pa.gov/Policies/Documents/itp_sym008.pdf
ITP_SYM010 - Enterprise Services Maintenance Scheduling	https://www.oa.pa.gov/Policies/Documents/itp_sym010.pdf

EXHIBIT F

EXHIBIT F

FAMILY PLANNING SERVICES PROCEDURES

Procedures Which May Be Included with a Family Planning Clinic Comprehensive Visit, a Family Planning Clinic Problem Visit or a Family Planning Clinic Routine Revisit:

- Insertion, implantable contraceptive capsules
- Implantation of contraceptives, including device (e.g. Norplant) (once every five years)
- Removal, Implantable contraceptive capsules
- Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant) (once per five years)
- Destruction of vaginal lesion(s); simple, any method
- Biopsy of vaginal mucosa; simple (separate procedure)
- Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)
- Colposcopy (vaginoscopy); separate procedure [A]
- Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage[A]
- Colposcopy (vaginoscopy); with loop electrosurgical excision(s) of the cervix (LEEP) [B]
- Intensive colposcopic examination with biopsy and or excision of lesion(s) [B]
- Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure)
- Cauterization of cervix; electro or thermal
- Cauterization of cervix; cryocaury, initial or repeat
- Cauterization of cervix; laser ablation

- Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
- Alpha-fetoprotein; serum
- Nuclear molecular diagnostics; nucleic acid probe, each
- Nuclear molecular diagnosis; nucleic acid probe, each
- Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each
- Fluorescent antibody; screen, each antibody
- Immunoassay for infectious agent antibody; quantitative, not elsewhere specified
- Antibody; HIV-1
- Antibody; HIV-2
- Treponema Pallidum, confirmatory test (e.g., FTA-abs)
- Culture, chlamydia
- Cytopathology, any other source; preparation, screening and interpretation
- Progestasert I.U.D.
- Depo-Provera injection (once per 60 days)
- ParaGuard I.U.D.
- Hemoglobin electrophoresis (e.g., A2, S, C)
- Microbial Identification, Nucleic Acid Probes, each probe used
- Microbial Identification, Nucleic Acid probes, each probe used; with amplification (PCR)

[A] Medical record must show a Class II or higher pathology.

[B] Medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure.

Procedures Which May Be Included with a Family Planning Clinic Problem Visit:

- Gonadotropin, chorionic, (hCG); quantitative
- Gonadotropin, chorionic, (hCG); qualitative
- Syphilis test; qualitative (e.g., VDRL, RPR, ART)
- Culture, bacterial, definitive; any other source
- Culture, bacterial, any source; anaerobic (isolation)
- Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography
- Culture, bacterial, urine; quantitative, colony count
- Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection
- Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
- Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
- Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites
- Smear, primary source, with interpretation; wet and dry mount, for ova and parasites
- Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision
- Level IV - Surgical pathology, gross and microscopic examination
- Antibiotics for Sexually Transmitted Diseases (course of treatment for 10 days) (two units may be dispensed per visit)
- Medication for Vaginal Infection (course of treatment for 10 days) (two units may be dispensed per visit)
- Breast cancer screen
- Mammography, bilateral
- Genetic Risk Assessment

EXHIBIT G

Exhibit G

OPIOID USE DISORDER CENTERS OF EXCELLENCE

A. The PH-MCO must develop an adequate network of physical health Opioid Use Disorder Centers of Excellence (OUD-COE) enrolled in the MA Program as Provider Specialty Type 232 – Opioid Center of Excellence according to the terms of Exhibit AAA of this Agreement.

B. The PH-MCO must coordinate with a Member's BH-MCO and any OUD-COE providing services to the member in accordance with Section V.D.2 of this Agreement to ensure that the Member's care is coordinated and not duplicated.

C. The following services, when provided as clinically appropriate and included or reflected in the individual Member's care plan, constitute community-based care management services. COE care management services may be provided via telemedicine in accordance with Medical Assistance Bulletin 99-21-06: Guidelines for the Delivery of Physical Health Services via Telemedicine.

1. Screening and Assessment

    a. Assessments to identify a member's needs related to Social Determinants of Health, administered in home and community-based settings whenever practicable.

    b. Level of Care Assessments, which may be completed either by the OUD-COE or through a referral. If a level of care assessment results in a recommendation of MAT, the OUD-COE must provide education related to MAT.

    c. Screenings for clinical needs that require referrals or treatment, including screenings for risk of suicide.

2. Care Planning

    a. Development of integrated, individualized care plans that include, at a minimum:

        1. A member's treatment and non-treatment needs

        2. The member's preferred method of care management, such as in-person meetings, phone calls, or through a secure messaging application

3. The identities of the members of the member's community-based care management team, as well as the members of the member's individual support system

b. Care coordination with a member's primary care provider, mental health service provider, drug & alcohol treatment provider, pain management provider, obstetrician or gynecologist, and PH-MCO, as applicable

3. Referrals

a. Facilitating referrals to necessary and appropriate clinical services according to the member's care plan, including:

1. Primary Care, including screening for and treatment of positive screens for: HIV, Hepatitis A (screening only); Hepatitis B; Hepatitis C; and Tuberculosis.

2. Perinatal Care and Family Planning Services

3. Mental Health Services

4. Forms of Forms of medication approved for use in MAT not provided at the OUD-COE Provider's enrolled service location(s)

5. MAT for pregnant women, if the OUD-COE Provider does not provide MAT to pregnant women

6. Drug and Alcohol Outpatient Services

7. Pain Management

b. Facilitating referrals to any ASAM Level of Care that is clinically appropriate according to a Level of Care Assessment

c. Facilitating referrals to necessary and appropriate non-clinical services according to the results of the member's needs identified through a Social Determinants of Health screening

4. Monitoring

a. Individualized follow-up with members and monitoring of members' progress per the member's care plan, including referrals for clinical and non-clinical services

b. Continued and periodic re-assessment of a member's Social Determinants of Health needs

c. Performing Urine Drug Screenings at least monthly

5. Making and receiving warm hand-offs. In the event of a warm hand-off from an overdose event, the OUD-COE must provide education related to overdose risk and naloxone.

D. The PH-MCO will perform a claims analysis on an annual basis, due to the Department no later than July 31 of the calendar year following the year for which claims are being analyzed. The PH-MCO will identify OUD-COE clients as those members for whom a COE care management service claim was submitted during the previous year and will analyze the additional claims submitted for those members, focusing on the metrics defined in the instructions for Operations Report 10, available on DocuShare. The purpose of this analysis will be to monitor COEs for adherence with the terms of their provider contracts and to ensure quality services are being provided to the PH-MCO's members. This claims analysis must demonstrate that there has been no significant negative impact on member outcomes year over year.

EXHIBIT H

EXHIBIT H

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

A. General Requirement

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

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

Future changes in state and federal law, state and federal regulations, and court cases may require re-evaluation of any previously approved Prior Authorization proposal. Any deviation from the policies and procedures approved by the Department, including time frames for decisions, is considered to be a change and

requires a new request for approval. Failure of the PH-MCO to comply may result in sanctions and/or penalties by the Department The Department defines prior authorization as a determination made by a PH-MCO to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiation or continuation of the requested service.

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

B. Guidelines for Review

1. Basic Requirements:

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

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

2. Medically Necessary Requirements:

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

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

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

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

      - Purchased and licensed, the PH-MCO must identify the vendor;
      - Developed/recommended/endorsed by a national or state health care provider association or society, the PH-MCO must identify the association or society;

- Based on national best practice guidelines, the PH-MCO must identify the source of those guidelines;

- Based on the medical training, qualifications, and experience of the PH-MCO's Medical Director, Dental Director or other qualified and trained practitioners, the PH-MCO must identify the individuals who will determine if the service or benefit is Medically Necessary.

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

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

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

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

- That the service or item is not Medically Necessary, after making at a minimum three reasonable efforts to contact the prescriber prior to issuing a denial for the requested service. For Drug denials, refer to Exhibit BBB. The reasonable efforts to contact the prescriber must be documented in writing.

3. Administrative Requirements

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

maximum time frames:

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

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

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

- 21 days: All other services.

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

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

4. Notification, Grievance, and DHS Fair Hearing Requirements

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

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

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

EXHIBIT J

EXHIBIT J

EPSDT GUIDELINES

The PH-MCO must adhere to specific Department regulations at 55 PA Code Chapters 3700 and 3800 as they relate to EPSDT examinations for individuals under the age of twenty-one (21) and entering substitute care or a child residential facility placement. These examinations must be performed within the timeframes established by the regulations. The scope of PH-MCO EPSDT requirements that address screening, diagnosis and treatment, tracking, follow-up and outreach, and interagency teams for children are provided below.

The PH-MCO must have written policies and procedures for providing all Medically Necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included on the Medicaid State Plan. The PH-MCO must assist individuals in gaining access to necessary medical, social, education, and other services in accordance with the HealthChoices agreement.

1. Screening

The PH-MCO must ensure that periodic EPSDT screens are conducted by a process, including data collection format, approved by the Department, on all Members under age twenty-one (21) to identify health and developmental problems. These screens must be in accordance with the most current periodicity schedule developed by the Department and based on guidelines issued by the American Academy of Pediatrics (AAP), and recommended pediatric immunization schedules, which are based on guidelines issued by the Centers for Disease Control and Prevention (CDC).

2. Diagnoses and Treatment

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, s/he is required to refer the child (not over five (5) years of age) through CONNECT, 1-800-692-7288, for referral for local Early Intervention Program services. The PH-MCO is also responsible to ensure that a child is referred to the county Intellectual Disabilities (ID) office for a determination of eligibility for home and community-based services. The Intellectual Developmental Disabilities County contacts are found at http://pafamiliesinc.org/understanding-systems/intellectual-disabilities/intellectual-developmental-disabilities-county-contact-information-for-pennsylvania. The PH-MCO is responsible for developing a system that tracks treatment needs as they are identified and ensures that appropriate follow-up is pursued and reflected in the medical record (see Section 3, Tracking, for all requirements).

OBRA '89 entitles individuals under the age of twenty-one (21) to receive all Medically Necessary health care services that are contained in Section 1905(a) of the Social Security Act and to receive treatment for a condition diagnosed during any encounter with a Health Care Provider practicing within the scope of state law. Any Medically Necessary health

care, eligible under the federal Medicaid program, required to treat conditions detected during a visit must be covered by the PH-MCO, except Behavioral Health Services which will be covered through the BH-MCO. Even though the PH-MCO is not responsible for behavioral health treatment, it is still responsible for identifying Members who are in need of behavioral health treatment services, and for linking the Member with the appropriate BH-MCO.

The PH-MCO must have a system in place to address the need for and furnish expanded services. Such policies will be clearly communicated to Providers and Recipient through the Provider Manual and the Member Handbook. If a Health Care Provider prescribes services or equipment for an individual under the age of twenty-one (21), which is not normally covered by the MA Program, or for which the PH-MCO requires Prior Authorization, the PH-MCO must follow the Prior Authorization requirements outlined in Section V.B. and Exhibit H of the contract.

3. Tracking

The PH-MCO must establish a tracking system that provides information on compliance with EPSDT service provision requirements in the following areas:

- Initial visit for newborns. The initial EPSDT screen shall be the newborn physical exam in the hospital.

- EPSDT screen and reporting of all screening results.

- Diagnosis and/or treatment, or other referrals for children.

- Other tracking activities include: Number of comprehensive screens (reported by age); hearing and vision examinations; dental screens; age appropriate screens; complete age appropriate immunizations; blood lead screens; prenatal care for teen mothers; provision of eyeglasses to those in need of them; dental sealants; newborn home visits; referral of very low birth weight babies to early intervention; referral of Members under the age of five (5) with elevated blood lead levels to early intervention; routine evaluation for iron deficiencies; maternal depression screening; screenings for developmental delays and autism spectrum disorders; depression screenings; and timely identification and treatment of asthma.

4. Follow-ups and Outreach

The PH-MCO must have an established process for reminders, follow-ups and outreach to Members that includes:

- Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Members.

- Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period.

- If requested, any necessary assistance with transportation to ensure that recipients obtain necessary EPSDT screening services. This assistance must be offered prior to each due date of a child's periodic examination.

- Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate.

- A process for outreach and follow-up to Members under the age of twenty-one (21) with Special Needs, such as homeless children.

- A process for outreach and follow-up with County Children and Youth Agencies and Juvenile Probation Offices to assure that they are notified of all Members under the age of twenty-one (21) who are under their supervision and who are due to receive EPSDT screens and follow-up treatment.

- The PH-MCO may develop alternate processes for follow up and outreach subject to prior written approval from the Department.

The PH-MCO shall submit to the Department reports, as requested, that identify its performance in the above four required services (Screening, Diagnosis and Treatment, Tracking, and Follow-up and Outreach).

Arranging for Medically Necessary follow-up care for health care services is an integral part of the Provider's continuing care responsibility after a screen or any other health care contact. In cases involving a Member under the age of twenty-one (21) with complex medical needs or serious or multiple disabilities or illnesses, case management services must be offered, consistent with the HealthChoices agreement and exhibits.

To assist the PH-MCO in provision of the above four (4) required services (Screening, Diagnosis and Treatment, Tracking and Follow-up and Outreach) to children in substitute care, the PH-MCO will be required to develop master lists of all enrolled children who are coded as such on the monthly membership files. The PH-MCO must assign specific staff to monitor the services provided to these children and to ensure that they receive comprehensive EPSDT screens and follow-up services. The assigned staff must contact the relevant agencies with custody of these Members or with jurisdiction over them (e.g., County Children and Youth Agency, Juvenile Probation Office) when a particular child has yet to receive an EPSDT screen or is not current with their EPSDT screen and/or immunizations and to ensure that an appointment for such service is scheduled.

Further, in addition to the EPSDT related Pennsylvania Performance Measures, the PH-MCO must submit to the Department reports, as requested, providing all data regarding children in substitute care (e.g., the number of children enrolled in substitute care who have received comprehensive EPSDT screens, the number who have received blood level assessments, etc.).

5. Interagency Teams for EPSDT Services for Children

For the ongoing coordination of EPSDT services for Members under the age of twenty-one (21) identified with Special Needs, the PH-MCO must appoint a PH-MCO representative who will ensure coordination with other health, education and human services systems in the development of a comprehensive individual/family services plan.

The goal is to develop and implement a comprehensive service plan through a collaborative interagency team approach, which ensures that children have access to appropriate, coordinated, comprehensive health care. To achieve this goal, The PH-MCO must ensure the following:

- Children have access to adequate pediatric care.
- The service plan is developed in coordination with the interagency team, including the child (when appropriate), the adolescent and family members and a PH-MCO representative.
- Development of adequate specialty Provider Networks.
- Integration of covered services with ineligible services.
- Prevention against duplication of services.
- Adherence to state and federal laws, regulations and court requirements relating to individuals with Special Needs.
- Cooperation of PH-MCO Provider Networks.
- Applicable training for PCPs and Providers including the identification of PH-MCO contact persons.

EXHIBIT L

EXHIBIT L

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM

The Medical Assistance Transportation Program (MATP) is responsible for the following:

- Providing non-emergency medical transportation to and/or from a MA compensable service received at a medical facility, doctor's or dentist's offices, hospital or clinic, pharmacy or supplier of medical equipment.

- Providing the least costly and most appropriate transportation to meet the needs of consumers, including paid mass transit trips on buses or trains or rides in paratransit vehicles.

- Reimbursement to the consumer for mileage at a rate determined by the Department, parking fees, and tolls with valid receipts, when the consumer uses their own car or someone else's to get to their medical provider.

- Paratransit services that pick up and discharges consumers at the curb or driveway of their home or destination.

- Providing transportation services when the consumer has no other available means of transportation for urgent care. Urgent care, for the purpose of this exhibit, is defined as any illness or severe condition, which under reasonable standards of medical practice would be diagnosed and treated within a 24-hour period and if left untreated, could rapidly become a crisis or emergency. A hospital discharge shall be considered urgent care.

The county MATP agency, Program Monitor, and/or MATP Standards and Guidelines, found on the MATP website, should be contacted or referenced for detailed policies and procedures in carrying out the above services.

EXHIBIT M(1)

EXHIBIT M(1)

QUALITY MANAGEMENT, UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT PROGRAM REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

1. The PH-MCO must demonstrate evidence by submitting to the Department accreditation survey type and level, results of survey including recommendations actions and/or improvements, corrective action plans, and summaries of findings conducted by the accrediting national recognized organization.

2. The PH-MCO must submit to the Department an expiration of the accreditation and future accreditation survey date.

I. Consider attaining NCQA's Health Equity Accreditation by meeting the requirement guidelines set forth by NCQA.

J. Determine whether algorithms used for case management, disease management, quality management, or decisions about which enrollees receive additional services from the PH-MCO, contain inadvertent racial bias. If any racial bias is identified, the PH-MCO must take steps to eliminate that bias to the satisfaction of the Department. As part of the determination of whether the algorithms contain racial bias and the elimination of racial bias, the PH-MCO will work with entities designated by the Department to identify bias and the actions that can be taken to eliminate or mitigate bias.

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

A. Adhere to current Medicaid CMS guidelines.

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

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

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

E. Contain a written program description that addresses all standards, requirements and objectives established by the Department and that describes the goals,

objectives, and structure of the PH-MCO's QM, UM and QI programs. The written program description must, at a minimum:

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

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

    a. Primary, secondary, and tertiary care;

    b. Preventive care and wellness programs;

    c. Acute and/or chronic conditions;

    d. Dental care;

    e. Care coordination; and

    f. Continuity of care.

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

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

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

    a. Studies and activities undertaken; including the rationale, methodology and results;

    b. Subsequent improvement actions; and

    c. Aggregate clinical and financial analysis of Encounter, HEDIS, CAHPS, Pennsylvania Performance Measures, Community Based Care Management, Maternity Home Visiting program, Diabetic Prevention Program and other utilization of services data and quality of care rendered to Members.

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

   a. Data collection and analysis;

   b. Evaluation and reporting of findings;

   c. Implementation of improvement actions where applicable; and

   d. Individual accountability for each activity.

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

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

   a. Special Needs;

   b. Provider Relations;

   c. Member Services; and

   d. Management Information Systems

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

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

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

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

A. The Governing Body:

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

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

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

B. The Quality Management Committee (QMC):

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

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

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

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

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

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

D. The Medical Director:

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

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

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

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

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

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

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

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

9. Has knowledge of risk management standards;

10. Is directly accountable for all Quality Management, Utilization Management and Quality Improvement activities and

11. Oversees and is accountable for:

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

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

E. The Dental Director must be directly accountable to and act as a liaison to the Chief Dental Officer for DHS. The Dental Director is also responsible for the same standards listed for the Medical Director (above in section D) as it pertains to dental related activities.

F. Employ at least one individual who possesses a nationally-recognized quality improvement credential.

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

Standard III: The PH-MCO QM, UM and QI programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services provided to Members through quality of care studies and related activities with a focus on identifying and pursuing opportunities for continuous and sustained improvement.

A. The QM, UM and QI programs must adopt, in consultation with network providers, and include professionally developed practice guidelines/standards of care that are:

1. Written in measurable and accepted professional formats,

2. Based on valid and reliable clinical and scientific evidence or a consensus of providers in the particular field; and

3. Applicable to Providers for the delivery of certain types or aspects of health care.

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

C. Practice guidelines and clinical indicators must consider the needs of the PH-MCO Enrollees and must address the full range of health care needs of the populations served by the PH-MCO. (per 42 C.F.R. 438.236 (b)(2)).

D. The clinical areas addressed must include, but are not limited to:

1. Adult preventive care;

2. Pediatric and adolescent preventive care with a focus on EPSDT services;

3. Obstetrical care including a requirement that Members be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;

4. Selected diagnoses and procedures relevant to the enrolled population;

5. Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the PH-MCO's membership; and

6. Preventive dental care.

E. The PH-MCO QM, UM and QI programs must disseminate practice guidelines, clinical indicators and medical record keeping standards to all affected Providers and appropriate subcontractors. This information must also be provided to Members or potential Enrollees upon request. (per 42 C.F.R 438.236 (c)).

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

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

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

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

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

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

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

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

3. Use of progressive sanctions as indicated;

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

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

    a. Education;

    b. Follow-up monitoring and re-evaluation;

    c. Changes in processes, structures, forms;

    d. Informal counseling;

    e. Procedures for terminating the affiliation with the physician or other health professional or Provider;

f. Assessment of the effectiveness of the actions taken; and

g. Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care).

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

I. The QM, UM and QI programs must contain procedures for Member satisfaction surveys that are conducted on at least an annual basis including the collection of annual Member satisfaction data through application of the CAHPS instrument as outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).

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

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

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

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

1. Utilization information on Member Encounters with PCPs;

2. Specialty Claims;

3. Prescriptions;

4. Inpatient stays;

5. Emergency room use;

6. Clinical indicators for preventive care services (e.g., mammograms, immunizations, pap smear, etc.); and

7. Clinical indicators for EPSDT requirements.

B. PH-MCO must submit to the department on an annual basis network provider profiles.

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

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

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

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

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

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

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

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

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

F. Include and refer members who are identified as pre-diabetic to programs that addresses prevention of diabetes mellitus. The programs must be recognized by the Centers for Disease Control (CDC) or be enrolled in the Medicare program as a Medicare Diabetes Prevention Program. Requirements for program recognition by the CDC are available at: https://www.cdc.gov/diabetes/prevention/requirements-recognition.htm

G. Include participation and membership in the Perinatal Collaborative developed by the DHS and DOH.

H. Include collaboration with the Department to adopt and disseminate a resource and referral tool.

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

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

B. Other HealthChoices PH-MCOs;

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

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

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

F. The PH-MCO and other third party insurers

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

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

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

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

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

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

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

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

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

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

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

3. Verification that Providers and/or subcontractors have a current Provider Agreement and an active PROMIS*e*™ Provider ID issued by the Department;

4. Evidence of malpractice/liability insurance;

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

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

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

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

C. Appropriate PCP qualifications:

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

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

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

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

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

6. Demonstrate evidence of continuing professional medical education;

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

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

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

F. The Department will recoup from the PH-MCO any and all payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by the PH-MCO in a manner that is not consistent with the

Provider's licensure. In addition, the PH-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.

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

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

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

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

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

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

3. Provider applications submitted to the PH-MCO for credentialing must be completed within sixty (60) calendar days of the PH-MCO, Dental Benefit Manager (DBM) or Vision Benefit Manager (VBM) receipt of a complete application packet.

4. The PH-MCO, DBM or VBM must notify the provider of the status of their credentialing application as follows:

a. First Correspondence: The PH-MCO, DBM or VBM must provide an Acknowledge of Application notification to the provider within ten (10) calendar days of receipt.

b. Second Correspondence: The PH-MCO, DBM or VBM will send an Application Status to the provider within thirty (30) calendar days stating:

i. Their application is clean and is being submitted through the credentialing process or;

ii. Their application is not clean with a list of items needing to be addressed. If a provider's Medicaid ID (PROMISe) number is not in place at the time of this notification, it may be noted as an outstanding item.

c. Third Correspondence: A Credentialing Approval/Denial notice will be sent within a maximum of sixty (60) calendar days. If the provider application is denied, the correspondence should include all of the requirements that were not met.

d. The PH-MCO, DBM and VBM must also include language in the First and Second Correspondence reminding providers that credentialing cannot be completed until their Medicaid Number (PROMISe ID) is in place.

e. The PH-MCO, DBM and VBM are encouraged to provide communications electronically to the provider.

5. Failure to comply will result in sanctions as per Section VIII. H. to include retrospective payments to the provider as directed by the Department.

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

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

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

Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review or Retrospective Review basis, shall be documented in writing. The PH-MCO shall base its determination on medical information provided by the Member, the Member's family/care taker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Member. Medical necessity determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement. Satisfaction of any one of the standards listed under the definition of Medically Necessary as defined in Section II, Definitions, of this Agreement will result in authorization of the service.

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

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

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

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

4. Comply with state/federal regulations;

5. Comply with HealthChoices RFP and other contractual requirements;

6. Specify populations covered by the policy;

7. Contain an effective date; and

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

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

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

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

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

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

5. Be developed using a scientific based process;

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

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

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

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

2. That result in a denial may only be made by a licensed physician or licensed dentist;

3. Are made in accordance with established time-frames outlined in the Agreement for routine, urgent, or emergency care; and

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

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

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

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

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

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

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

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

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

4. Not allow for UM staff rendering an adverse determination of a denial to use Prior Authorization policy, Medical literature, PA codes and Federal regulations as a means of informing a member of a service or item denial.

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

1. Submission of a log of all denials issued using formats to be specified by the Department.

2. Submission of denial notices for review as requested by the Department.

3. Submission of utilization review records and documentation as requested by the Department.

4. Identifying the source of the criteria used to review the request for Prior Authorization of services.

5. Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.

6. Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department prior to implementation.

L. The PH-MCO must follow the Department’s Technology Assessment Group (TAG) process and determinations when new and existing services or items are reviewed and added to the MA Program.

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

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

B. QM/UM/QI sanctions

C. Adverse credentialing/recredentialing decisions

D. Provider Terminations

Standard XI: The PH-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM, UM and QI program activities are documented and reported to appropriate individuals within the PH-MCO for use in other management activities.

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

1. PH-MCO Provider Network changes;

2. Benefit changes;

3. Medical management systems (e.g., pre-certification); and

4. Practices feedback to Providers.

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

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

A. The PH-MCO must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for medical

records that promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

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

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

1. History and physical that is appropriate to the patient's current condition;

2. Treatment plan, progress and changes in treatment plan;

3. Diagnostic tests and results;

4. Therapies and other prescribed regimens;

5. Disposition and follow-up;

6. Referrals and results thereof;

7. Hospitalizations;

8. Reports of operative procedures and excised tissues; and

9. All other aspects of patient care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. To formulate advance directives including:

    a. Written policies and procedures that meet advance directive requirements in accordance with 42 C.F.R. 489, Subpart I

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

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

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

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

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

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

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

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

1. Rights and responsibilities of Members;

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

    a. Any special benefit provisions (for example, co-payment, higher deductibles, rejection of Claim) that may apply to services obtained outside the system; and

    b. The procedures for obtaining Out-of-Area Services;

    c. Charges to Members if applicable;

d. Benefits and services excluded.

e. Provisions for after-hours, urgent and emergency coverage;

f. The PH-MCO's policy on referrals for specialty care;

g. PH-MCO Procedures for notifying, in writing, those Members affected by denial, termination or change in any benefit or service including denials, terminations or changes in level of care or placement;

h. Procedures for appealing decisions adversely affecting the Member's coverage, benefits or relationship to the PH-MCO;

i. Information about OMAP's Hotline functions;

j. Procedures for changing practitioners;

k. Procedures for disenrolling from the PH-MCO;

l. Procedures for filing Complaints and/or Grievances; DHS Fair Hearings; and

m. Procedures for recommending changes in policies and services.

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

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

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

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

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

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

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

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

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

A. The PH-MCO must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM, UM and QI programs.

B. The PH-MCO must adhere to all systems requirements as outlined in Section V.O.5., Management Information Systems, and Section VIII.B, Systems Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the HealthChoices Extranet.

C. The PH-MCO must adhere to all Encounter Data requirements as outlined in Section VIII.B.1, Encounter Data Reporting, of the Agreement.

EXHIBIT M(1)a

EXHIBIT M(1a)

QUALITY MANAGEMENT REQUIREMENT FOR REGIONAL ACCOUNTABLE HEALTH COUNCILS

The PH-MCO must participate, with all other MA and CHIP MCOs and Behavioral Health Primary Contractors that operate within the region defined by each Physical Health HealthChoices Zone, a Regional Accountable Health Council (RAHC), subject to the following:

A. The purpose of the RAHC shall be to serve as a forum for regional strategic health planning and coordination of community-wide efforts to improve health outcomes across each region in the state. This planning shall be focused on areas of high burden of disease and on demographic groups impacted by health disparities within the HealthChoices Zone, in order to identify the root causes of those disparities and to establish strategies and interventions to address those root causes of these disparities. The RAHC will use state and community-based health assessments, regional Social Determinants of Health (SDOH) needs assessments, as well as any other specific health indicators, as the basis to advance population health planning.

    1. In serving as a forum for regional strategic health planning and coordination of community-wide efforts, with a special focus on addressing the root causes of disparities, the RAHC's goals shall be to:

        a. Promote health equity and eliminate health disparities;
        b. Address regional SDOH needs;
        c. Bend the cost curve by aligning VBP initiatives and achieving better care, better health, at lower costs;
        d. Support and steer population health improvement processes, including regional efforts to integrate physical and behavioral health care; and
        e. Center health improvement efforts in the communities where people live.

B. Each RAHC's region of operation shall be the Physical Health HealthChoices Zone in which the MCO operates under agreement with the Department. There shall be five RAHCs: Southeast, Southwest, New East, New West and Lehigh Capital.

C. The RAHC's governing document, such as Bylaws, are subject to the following:

    1. The governing document shall address, at a minimum, the following: the name of the RAHC; the purpose of the RAHC; the constituent parts of the RAHC, such as members or partners; the governing body of the RAHC as set forth below, including appointment, removal, resignation and filling vacancies of positions on the governing body; the standing and ad hoc committees; the procedures of

conduct of meetings; the procedures for exercise of the RAHC's powers; and the enunciation of the RAHC's fiscal year.

2. The governing document shall include a conflict of interest policy for organizations and individuals in the RAHC.

3. The governing document shall allow other health care payers to join the strategic direction outlined by the RAHC, such as regional business groups on health, commercial health insurance plans, special needs plans, health foundations, and other lines of business.

4. All changes to the governing document must be approved by the Department prior to implementation.

D. The governing body of the RAHC shall be a council, the chair of the council and the vice chair of the council.

1. The chair of the council shall be voted on by the Council.

2. The vice chair of the council shall be voted on by the council.

3. The council shall consist of, at the minimum:

a. One (1) representative from the executive leadership team of the MA MCO;
b. One (1) representative from each of the executive leadership teams of the MA and CHIP MCOs and Behavioral Health Primary Contractors operating under agreement with the Department in the Physical Health HealthChoices Zone;
c. One (1) representative from each of the high MA utilization health systems (as defined by the Department);
d. One (1) representative from three Community-Based Organizations (CBOs) that focus on SDOH (as identified by the Department); and
e. At least one (1) representative from each of the following sectors:

i. Mental health administrators not otherwise represented by a Behavioral Health Primary Contractor:
ii. Single County Authorities;
iii. FQHCs;
iv. Mental health treatment providers;
v. Institutional long-term care service providers;
vi. Home and community-based service providers;
vii. Substance use disorder treatment providers;

viii. Other community institutions outside of clinical settings, such as faith-based organizations, schools, or libraries.
ix. MA Consumers and CHIP consumers.

4. The membership of the council should reflect the racial and ethnic diversity of the HealthChoices Zone.

E. The RAHC shall be a part of a statewide RAHC learning network developed by the Department, so each RAHC can learn best practices from one another in improving population health, reducing costs, improving health equity, and addressing SDOH needs.

F. The RAHC shall be responsible for providing CBOs technical assistance that is available on consultation. The MA MCOs shall also support a regional or statewide learning network that is informed by frequently asked questions or topics. The goals of the technical assistance will be to help support administrative functions of CBOs that are important in their ability to improve population health, improve equity, and address the SDOH needs of the region. The technical assistance must include the ability to assist with data analytics and measurement, contract management and negotiations, sharing best practices and outcomes, measuring return on investment, and incorporation of CBOs into VBP agreements.

G. The RAHC shall maintain an annual Regional Health Transformation Plan (RHTP) for its HealthChoices Zone, subject to the following:

1. The RHTP is subject to approval of the Department.
2. Each RHTP shall originate from a template published by the Department and fulfill the requirements in the template. The template may include at a minimum the following requirements:

    a. Identify demographic groups impacted by health disparities, and geographic areas with significant health disparities (“health equity zones”) and strategies for eliminating disparities in these groups and areas;
    b. Identify SDOH needs in the area and strategies for addressing them;
    c. Identify population health priority measures across physical, behavioral, and integrated health measures of the HealthChoices Zone that should be improved and population health strategies for improvement;
    d. Identify strategies and interventions for bending the cost curve and limiting regional cost growth, including aligning VBP arrangements across payers, which must in no way be construed to indicate that payers will coordinate to set prices;
    e. Identify CBOs and other trusted community partners and how they are incorporated into the overall plan;
    f. Identify strategies and interventions to continuously monitor for improvement in health equity, SDOH, and population health priority measures established

by the regional transformation plan, including a rapid-cycle quality improvement strategy to rapidly scale interventions that are successful.

g. Identify best practices and challenges from the prior year's RHTP.

The PH-MCO shall coordinate with other MA and CHIP MCOs and Behavioral Health Primary Contractors in the PH-MCO's HealthChoices Zone to continue the strategies outlined in the RHTP.

EXHIBIT M(4)

EXHIBIT M(4)

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

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

- Effectiveness of Care,
- Access/Availability of Care,
- Experience of Care
- Utilization and Risk Adjusted Utilization,
- Health Plan Descriptive Information and
- Measures Reported Using Electronic Clinical Data Systems

The Department requires that the PH-MCOs:

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

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

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

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

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

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

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

A. Must conduct both an Adult and Child CAHPS® survey using the current version of CAHPS®.
B. Must include all Medicaid core questions in both surveys.
C. Must add the additional three adult dental, four child dental and two (2) equity questions for the child and the adult sections listed below.,

Additional Adult CAHPS® dental and equity questions:

1. C1. In the last 6 months, did you get care from a dentist's office or dental clinic?

   1☐ Yes
   2☐ No

2. C2. In the last 6 months, how many times did you go to a dentist's office or dental clinic?

   00☐ None (If None, the Adult dental questions are complete. Thank you.)
   01☐ 1
   02☐ 2
   03☐ 3
   04☐ 4
   05☐ 5 to 9

06☐ 10 or more

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

00☐ 0 Worst dental care possible
01☐ 1
02☐ 2
03☐ 3
04☐ 4
05☐ 5
06☐ 6
07☐ 7
08☐ 8
09☐ 9
10☐ 10 Best dental care possible

4. C4. In the last 6 months, how often was it hard to find a personal doctor who speaks your language?

00☐ 0 Not Applicable
01☐ 1 I did not have a problem
02☐ 2 I do not have a personal doctor
03☐ 3 Never
04☐ 4 Sometimes
05☐ 5 Usually
06☐ 6 Always

5. C5. In the last 6 months, how often was it hard to find a personal doctor who knows your culture?

00☐ 0 Not Applicable
01☐ 1 I did not have a problem
02☐ 2 I do not have a personal doctor
03☐ 3 Never
04☐ 4 Sometimes
05☐ 5 Usually
06☐ 6 Always

Additional Child CAHPS® dental and equity questions:

6. D1. In the last six months, did you get care from a dentist's office or

dental clinic?

1☐ Yes
2☐ No

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

00☐ None (If None, the Adult dental questions are complete. Thank you.)
01☐ 1
02☐ 2
03☐ 3
04☐ 4
05☐ 5 to 9
06☐ 10 or more

8. D3. We want to know your rating of your dental care from all dentists and other dental providers in the last six months. How would you rate your dental care (on a scale of 1 to 10)?

00☐ 0 Worst dental care possible
01☐ 1
02☐ 2
03☐ 3
04☐ 4
05☐ 5
06☐ 6
07☐ 7
08☐ 8
09☐ 9
10☐ 10 Best dental care possible

9. D4. Which of the following would help your child see the dentist more often?

a☐ Help with transportation to the dentist
b☐ Reminders to visit the dentist
c☐ More dentists to choose from
d☐ More convenient office hours
e☐ Dentists that speak my language
f☐ Help in finding a dentist
g☐ Better communication about benefits from my child's health plan
h☐ Education about good dental care
i☐ None of the above. My child sees the dentist as often as I like.
j☐ Other (write in)

10. D5. In the last 6 months, how often was it hard to find a personal doctor who speaks your language?

    00☐ 0 Not Applicable
    01☐ 1 I did not have a problem
    02☐ 2 I do not have a personal doctor
    03☐ 3 Never
    04☐ 4 Sometimes
    05☐ 5 Usually
    06☐ 6 Always

11. D6. In the last 6 months, how often was it hard to find a personal doctor who knows your culture?

    00☐ 0 Not Applicable
    01☐ 1 I did not have a problem
    02☐ 2 I do not have a personal doctor
    03☐ 3 Never
    04☐ 4 Sometimes
    05☐ 5 Usually
    06☐ 6 Always

D. Must forward CAHPS® data to the Department both electronically in an Excel and .csv file.

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

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

EXHIBIT P

EXHIBIT P

OUT-OF-PLAN SERVICES

Out of Plan Services include, but are not limited to:

A. Transitional Care Homes

The PH-MCO will only be responsible to provide medical services to children upon the child leaving the transitional care home to reside with family or other caretakers living within the HealthChoices Zone. The PH-MCO must ensure continuity of care, as well as coordination with necessary Providers and interagency teams once they are notified that the child has become enrolled in the PH-MCO.

B. Medical Foster Care Services

Medical foster care services are provided to children with special or chronic medical conditions or physical disabilities in the custody of the County Children and Youth Agency and placed in foster family care. Medical foster care services enable the child to be treated by a licensed practitioner on an outpatient rather than an inpatient or institutional basis. Medical foster care services include both supportive and supervisory activities as well as direct care of children. Such tasks include but are not limited to: medical management, nutritional care, hygiene and personal care and developmental education.

Medical foster care services are provided by both county and private children and youth social service agencies. The foster parents who are under contract with the agency provide direct care. The licensed foster care agency is enrolled as a Provider Type 40, Specialty 400, Medically Fragile Foster Care, and claims reimbursement is through the Medical Assistance Fee-for-Service Program according to the maximum daily fees for the four levels of medical foster care as established by the Office of Medical Assistance Programs. Even though the PH-MCO is responsible to provide Medically Necessary services to children residing in medical foster care homes, the PH-MCO is not responsible for the medical foster care services identified in the four levels of care. These four levels of medical foster care are described as Level(s) I - IV with each level progressively requiring increased care.

1. Level I
    a. The Child has one or more medical conditions or physical disabilities that can be relieved, alleviated, or controlled by a regimen of medical supervision and consistent non-specialized care. No life-threatening situations are anticipated.
    b. Some specialized training may be required for the foster parent to care for the child, such as the preparation and control of special diets and the administration of non-oral medications.
    c. Wheelchairs, ramps, and/or prostheses may be required but sophisticated technological equipment usually will not be necessary. Few special medical supplies are necessary.

2. Level II
    a. The child has one or more acute medical conditions or physical disabilities that can be relieved, alleviated, or controlled by specialized intervention and a regimen of medical supervision and consistent care. No immediate life-threatening situations are anticipated.
    b. Some special medical procedures training may be required for the foster parent for the management of tracheostomies, ileostomies, NG feeding tubes, catheters, etc.
    c. Use of sophisticated technological equipment will be minimal. Some special medical supplies will be necessary.
    d. The child will usually require special therapeutic interventions and special social, educational, and vocational planning.
3. Level III
    a. The child has a combination of acute temporary, chronic, or permanent medical conditions or physical disabilities which require intensive, home-based medical intervention on a constant basis to sustain life. Life threatening situations are anticipated.
    b. Considerable special medical procedures training will be required for the foster parent.
    c. Use of sophisticated technological equipment will be necessary. Special medical supplies will be necessary.
    d. Because the child will usually be home-bound, all developmental areas will require special planning.
4. Level IV
    a. The child has a combination of acute, chronic, or permanent medical conditions or physical disabilities whose life can be sustained only by intensive, home-based medical intervention on a 24-hour basis. Life threatening situations are constantly present.
    b. Extensive special medical procedures training will be required for the foster parent.
    c. Use of a variety of sophisticated technological equipment will be necessary. Special medical supplies will be necessary.
    d. Because the child will be home-bound, all developmental areas will require special planning.

When children in the custody of the County Children and Youth Agency are placed in medical foster care homes, the PH-MCO's Special Needs Unit must work with the medical foster care agency to ensure that necessary medical and ancillary services are provided in the amount and level that enable the child to be maintained in the foster care home and minimize hospitalization/institutionalization of the child.

C. Early Intervention Services

An infant or toddler may receive services under both the HealthChoices Program and the Early Intervention Program, but the services are separate and distinct. The HealthChoices Program consists of Medically Necessary services prescribed by the Primary Care Practitioner. Early intervention services consist of a range of family-centered habilitation services and supports as defined by each family's individualized family service plan.

D. OLTL/OBRA Waiver: The Home and Community Based Waiver Program

This program provides services to people with developmental physical disabilities to allow them to live in the community and remain as independent as possible.

The Department's Office of Long-Term Living, (OLTL) currently operates a Home and Community-Based Waiver that provides services to Pennsylvania residents age 18 and older with a severe developmental physical disability requiring an Intermediate Care Facility / Other Related Conditions (ICF/ORC) level of care. The disability must result in substantial functional limitations in three or more of the following major life activities: mobility, communication, self-care, self-direction, capacity for independent living, and learning.

The OBRA waiver provides home and community-based services to persons with development disabilities aged 18 and over who require an Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC) level of care, and is designed to support individuals to live more independently in their homes and communities and to provide a variety of services that promote community living, including participant directed service models and traditional agency-based service models. The Department's Office of Long Term Living (OLTL) currently operates the OBRA Waiver. Individuals are able to enroll in the waiver through age 59. Individuals that turn 60 while in the waiver are able to continue to receive services through the OBRA waiver.

Waiver services are limited to individuals with developmental disabilities, and who meet all of the following conditions:

a. Individuals who have a developmental disability (but do not have a primary diagnosis of either mental retardation or a major mental illness),
b. Have been assessed to require services at the level of an ICF/ORC;
c. The disability manifested prior to the age of 22;
d. The disability is likely to continue indefinitely;
e. The disability results in three or more substantial functional limitations in major life activity: self-care, understanding and use of language, learning, mobility, self-direction and/or capacity for independent living.

Other related conditions (ORCs) include physical, sensory, or neurological disabilities which manifested before age 22, are likely to continue indefinitely, and result in substantial functional limitations in three or more of the following areas of major life activity: capacity for independent living, mobility, self-direction, learning, understanding and use of language, and self-care.

Recipients receiving home and community based services through the OLTL/ OBRA Waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the OLTL/ OBRA Waiver. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is not responsible to

provide any medical services that are determined to fall under the scope of Behavioral Health Services or is the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook.

E. Community HealthChoices Waiver

The Community HealthChoices Waiver targets individuals 21 and over who require a Nursing Home Level of Care and are in need of long term services and supports (LTSS), and meet the other requirements of the waiver as determined by the Office of Long Term Living. HealthChoices members who qualify for the Community HealthChoices Waiver will be disenrolled from HealthChoices and enrolled into the Community HealthChoices program. The PH-MCO shall be required to provide assistance to these members in transitioning their care between the HealthChoices and the Community HealthChoices program as stated in section V.D of the agreement.

F. Office of Developmental Programs (ODP) Waivers: Person/Family Directed Support Waiver (P/FDS), Community Living Waiver and Consolidated Waiver and

: ODP currently operates the P/FDS, Community Living , and Consolidated Waivers which provide services to individuals with intellectual disabilities and autism of any age and children with developmental disabilities from birth through age eight, and children with complex medical conditions from birth through age 21. The waivers are designed to help individuals with an intellectual disability, autism or developmental disability to live more independently in their homes and communities and to provide a variety of services that promote community living and family support. Eligibility determinations require a recommendation for an Intermediate Care Facilities (Intellectual Disabilities (ICF/ID) or Other Related Conditions (ICF/ORC)) level of care based on a medical evaluation.

Recipients receiving community based services through these waivers will be enrolled in the HealthChoices Program. 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. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the ODP Waivers. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is also not responsible to provide any medical services that fall under the scope of Behavioral Health Services, or are the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook .

G. ODP Adult Autism Waiver (AAW): The Home and Community Based Waiver program for Adults with Autism Spectrum Disorder.

The Adult Autism Waiver (AAW) is a Home and Community Based Waiver program. The Office of Developmental Programs administrates this waiver which provides home and community based services specifically designed to help adults, 21 and older, who have an autism diagnosis . The waiver is designed to help individuals with autism live more independently in their homes and communities and to provide a variety of services that promote community living and family support. Eligibility determinations require a recommendation for an Intermediate Care Facilities for Other Related Conditions (ICF/ORC) level of care based on a medical evaluation.

Recipients receiving community-based services through this waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the Autism waiver. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is also not responsible to provide any medical services that fall under the scope of Behavioral Health Services, or are the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook.

EXHIBIT BB

EXHIBIT BB

PH-MCO RECIPIENT COVERAGE DOCUMENT

This Recipient Coverage Document (RCD) includes descriptions of policies supported by the Department's data systems and processes. In cases where policies in this document conflict with another provision of the Managed Care Organization's (PH-MCO) Agreement, the Agreement will take precedence.

PH-MCO coverage as detailed in this document does not imply coverage under a BH-MCO, or CHC-MCO. Refer to the BH-MCO RCD for behavioral health coverage guidelines and CHC-MCO PCD for Community Health Choices coverage guidelines.

The Department will provide sufficient information to the PH-MCO to reconcile PH-MCO membership data and amounts paid to and recovered from the PH-MCO. The Department will pay capitation to only one PH-MCO per recipient per month.

Coverage Rules

A PH-MCO is responsible for a Member if coverage is determined by applying the general rules found in any of paragraphs A, B, or C below, subject to exceptions and clarifications found in paragraphs D, E, F, and G.

Refer to the HealthChoices Intranet site for additional information on Recipient coverage, clarifications, examples, and Membership Enrollment/Disenrollment procedures.

A. Responsibility to Provide MA Benefits - Unless otherwise specified, the PH-MCO is responsible for providing MA benefits to its Members in accordance with eligibility information included on the Daily or Monthly 834 Eligibility File, which is provided by the Department to each PH-MCO.

B. Membership Files/Coverage Dates/Eligibility - Daily and Monthly 834 Eligibility Files are provided to each PH-MCO containing information and changes that apply to its Members. The PH-MCO is responsible for providing services for each PH-MCO Member identified on the Daily or Monthly 834 Eligibility File from the first day of the calendar month or the PH-MCO Start Date, whichever is later, through the last day of the calendar month or the PH-MCO coverage end date, if different. The Department will pay Capitation to the PH-MCO from the first day of coverage in a month through the last day of the calendar month, except when transferring to a CHC-MCO. Since the Capitation is paid for the full month, the PH-MCO is responsible for covered services for that entire month. If a PH-MCO member transfers to a CHC-MCO the Department will pay capitation to the PH-MCO only through the day prior to the CHC begin date. PH-MCO coverage dates beyond the last day of the month are preliminary information that is subject to change.

   eCIS will retain a Member's PH-MCO selection for six (6) months after a Member becomes ineligible for MA. These Members will become the responsibility of the

same PH-MCO if they regain MA eligibility during that six-month period and their category of assistance and geographic location are valid for that PH-MCO. Upon regaining MA eligibility, the PH-MCO Start Date will be the MA eligibility Start Date on Client Information System (eCIS) or the date MA eligibility was reopened in eCIS, whichever is later.

C. Benefit Packages - The Department has established two benefit packages based on age: Adult and Children's. The Adult package includes individuals age 21 years old or older. The Children's package includes individuals under age 21 years.

D. Exceptions and Clarifications - The Department will recover Capitation payments made for Members who the Department has determined the PH-MCO was not responsible for providing services.

The PH-MCO will not be responsible for and will not be paid when the Department notifies the PH-MCO of Members for whom they are not responsible.

1. Errors in PH-MCO coverage identified from any source must be reported to the Department within forty-five (45) days of receipt of the Daily 834 Eligibility File for changes to be considered.

   If a Recipient is enrolled in a PH-MCO in error, that PH-MCO is responsible for covering the Recipient until the Department is notified and the correction is applied to the eCIS eligibility record.

   If at the time of notification to the Department, the Member was disenrolled in error from a PH-MCO and then enrolled in a different PH-MCO, the Member will be reenrolled in the previous PH-MCO effective the first of the next month. However, if at the time of notification, the Recipient is covered by FFS, the Recipient will be reenrolled into the same PH-MCO effective the day following notification to the Department.

2. If eCIS shows an exemption code or a facility/placement code that precludes PH-MCO coverage, the Recipient will not be enrolled in a PH-MCO.

3. If eCIS shows Fee-For-Service (FFS) coverage that coincides with PH-MCO coverage, the Member may use either coverage and there will be no monetary adjustment between the Department and the PH-MCO. (This is subordinate to #7 below.)

4. If a PH-MCO has actual knowledge that a Member is deceased, and if such Member shows on either the Daily or Monthly 834 Eligibility File as active, the PH-MCO is required to notify the County Assistance Office (CAO) and the Department. The Department will recover Capitation payments made for up to twenty-one (21) months after the service month in which the date of death occurred.

5. The Department will recover Capitation payments for Members who were later determined to be ineligible for PH-MCO coverage or who were placed in a setting that results in the termination of PH-MCO coverage by the Department. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (e.g., today's date is 9/18/2020 and central office staff end date managed care coverage 9/30/2020 – payments are recouped for 10/2019 through 9/2020. See Section F for examples of placements that result in termination of coverage).

6. The Department is not responsible for making a Capitation payment for a month in which a Member aged twenty-one through sixty-four (21 – 64) resides in a free-standing IMD at least sixteen (16) days in that calendar month and the Member's condition is not related to a Substance Use Disorder (SUD). This applies without regard to the number of days in the month in which the Member is enrolled in the PH-MCO. Recovery of capitation payments that meet these criteria is limited to 18 (eighteen) months. Additionally, the Department will make a separate payment to the PH-MCO for the days the Member does not reside in the freestanding IMD during a calendar month as noted in Section VII.E.13 of the Agreement.

7. A newborn is the responsibility of the PH-MCO that covered the mother on the newborn's date of birth. Where eCIS does not reflect this, the PH-MCO must notify the Department to correct coverage. The Department will generate Capitation payments as appropriate. Limitations in Sections E-2 and E-3 applicable to the mother will apply to the newborn.

   Exception #1: If mother is in a PH-MCO, and C&Y assumes custody of the newborn at birth and places the child in a county within the same HC zone as the mother, the child's coverage will mirror the mother's PH-MCO coverage.

   Exception #2: If mother is in a PH-MCO, and C&Y assumes custody of the newborn at birth and places the child in a county outside of the same HC zone where the mother resides, the child will be FFS until auto-assignment or the selected PH-MCO is effective in the new HC County.

8. A Member's change of residence out of a PH-MCO's service area does not necessarily exempt the PH-MCO from the responsibility to provide MA benefits. It is the PH-MCO's responsibility to inform the CAO of the address change upon receipt of information that a Member is residing outside the PH-MCO service area.

9. Pursuant to the rules outlined in the RCD, the absence of MA eligibility indicated on eCIS for a certain date does not necessarily exempt the PH-MCO from its responsibility to provide MA benefits for that date. Refer to Section E, Coverage During Inpatient Hospital Stays, for applicable rules.

10. Dual Eligibles who are enrolled in Medicare Part D and who turn 21 years of age will be identified by the Department on the first Friday of each month, and will be disenrolled from the PH-MCO effective the end of the month in which the Department identifies that the Member turned 21 years of age. In addition, newly identified Dual Eligibles age 21 and over will be disenrolled the end of the month following the month in which Medicare Part D is posted to their eligibility record. The PH-MCO remains responsible for these Members through the end of the month of the disenrollment date.

11. The Department reserves the right to intercede in requests for expedited enrollments when Medically Necessary. The Department's determination for the expedited enrollment will be final. The Capitation rate will be retroactively adjusted for each PH-MCO based on the effective date of the expedited enrollment.

12. The PH-MCO must provide Out-Of-Area Covered Services for a Member as long as they remain a resident of the Commonwealth and the zone. The PH-MCO remains responsible for a Member who is:

    - attending a college or university in a state other than Pennsylvania,
    - attending a college or university in a zone other than their zone of residence, or
    - traveling outside of the zone.

    At the sole discretion of the Department, the Member may be disenrolled from the PH-MCO and enrolled in FFS. The Department will take into consideration such factors as distance from Pennsylvania, the intensity and duration of medically required services, and whether the PH-MCO has a business presence nearby.

E. Change in PH-MCO Coverage During Inpatient Hospital Stays - Payment responsibility when an MA Recipient has managed care coverage during part of a hospital stay is detailed in the Rules below. Note that one or more of these rules may apply during a particular hospital stay.

RULE: E-1.	
Condition	**A Recipient who is covered by FFS when admitted to a hospital becomes eligible for PH-MCO coverage while still in the hospital.**
PH-MCO Coverage Responsibility	As of the PH-MCO start date, the PH-MCO is responsible for physician, DME, and all other covered services not included in the hospital bill.
MA FFS Coverage Responsibility	The FFS program is responsible for the hospital bill through the date of discharge. Note: If the Recipient is discharged from the initial hospital and admitted to another hospital (acute or rehabilitation) after the PH-MCO Start Date, FFS is only responsible for the stay in the initial hospital through the date of discharge. The PH-MCO is responsible for the stay in the subsequent hospital upon admission.

RULE: E-2.

Condition	**A Recipient who is covered by a PH-MCO when admitted to a hospital loses PH-MCO coverage and assumes FFS coverage while still in the hospital.**
PH-MCO Coverage Responsibility	The PH-MCO is responsible for the hospital stay with the following exceptions: EXCEPTION #1: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is the first day of the month, the PH-MCO is financially responsible for the stay through the last day of that month. Example: If a Recipient covered by the PH-MCO is admitted to a hospital on June 21 and the FFS coverage begin date is July 1, the FFS program assumes payment responsibility for the stay on August 1. The PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is any day other than the first day of the month, the PH-MCO is financially responsible for the stay through the last day of the following month. Example: If a Recipient covered by a PH-MCO is admitted to a hospital on June 21 and the FFS program coverage begin date is July 15, the FFS program assumes payment responsibility for the stay on September 1. The PH-MCO program remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	Starting with the FFS coverage begin date, FFS is responsible for physician, DME, and other bills not included in the hospital bill. EXCEPTION #1: The FFS program is financially responsible for the stay beginning on the first day of the next month. EXCEPTION #2: The FFS program is financially responsible for the stay beginning on the first day of the month following the next month.

RULE: E-3.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital transfers to another PH-MCO while still in the hospital.**
PH-MCO Coverage Responsibility	The surrendering PH-MCO is responsible for the hospital stay with the exceptions below. As of the gaining PH-MCO's Start Date, it is responsible for the physician, DME, and all other covered services not included in the hospital bill. EXCEPTION #1: If the Recipient is still in the hospital on the gaining PH-MCO Start Date, and the Recipient's gaining PH-MCO Start Date is the first day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO start date is July 1, the gaining PH-MCO assumes payment responsibility for the stay on August 1. The surrendering PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the gaining PH-MCO coverage begin date, and the gaining PH-MCO Start Date is any day other than the first day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the following month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO start date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The surrendering PH-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

RULE: E-4.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Recipient is not discharged), resulting in a break in PH-MCO coverage. The Department's Division of Medicaid Management Information Systems (MMIS) Operations becomes aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.**
PH-MCO Coverage Responsibility	MMIS Operations will reopen the Recipient's PH-MCO coverage retroactive to the day it was end-dated on eCIS and adjust the Capitation payment accordingly. The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services. Example: A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22 and regains it on April 9 retroactive to March 22. The PH-MCO coverage on eCIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new PH-MCO begin date of April 9. On April 25, MMIS Operations becomes aware of the situation. Because MMIS Operations is aware of the loss of MA eligibility within the month following the month in which it was lost, MMIS Operations reopens the PH-MCO coverage retroactive to April 1, the day after the PH-MCO end-date is posted on eCIS (March 31). The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services.
MA FFS Coverage Responsibility	There would be no FFS coverage in this example.

RULE: E-5.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Recipient is not discharged), resulting in a break in PH-MCO coverage. MMIS Operations does not become aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.**
PH-MCO Coverage Responsibility	Example: A recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22 and regains it on April 9 retroactive to March 22. The PH-MCO coverage on eCIS shows the Recipient as end-dated March 31 and reopened in the PH-MCO with a new begin date of April 9. Because MMIS Operations was not aware of the break in PH-MCO coverage by the end of the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on eCIS (March 31). The PH-MCO is only responsible for covering the Recipient through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-6.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility while in the hospital (Recipient is not discharged). The Recipient regains MA eligibility retroactively after the month following the month in which the MA eligibility was ended, regardless of when MMIS Operations became aware of the action.**
PH-MCO Coverage Responsibility	Example: A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient regains MA eligibility on May 15 retroactive to March 22. The PH-MCO coverage on eCIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new start date of May 15. Because the MA eligibility was not reopened within the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on eCIS (March 31). The PH-MCO is only responsible for covering the Recipient through the end of March.

MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-7.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility while in the hospital. The Recipient is discharged from the hospital after the month in which the MA eligibility was lost but before the MA eligibility is regained by the Recipient and reopened retroactively, regardless of when MMIS Operations became aware of the situation.**
PH-MCO Coverage Responsibility	Example: A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient is discharged from the hospital April 3. The Recipient regains MA eligibility on April 22 retroactive to March 22. The PH-MCO coverage on eCIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new begin date of April 22. Because the Recipient was discharged from the hospital before the MA eligibility was reopened, which resulted in a 3-day period of FFS coverage on eCIS, MMIS Operations does not reopen the PH-MCO coverage retroactive to April 1. The PH-MCO is only responsible for the stay through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-8.	
Condition	**A hospitalized Recipient never regains MA eligibility.**
PH-MCO Coverage Responsibility	If the Recipient is never determined retroactively eligible for MA, the PH-MCO is only responsible for covering the Recipient through the end of the month in which MA eligibility ended.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Recipient has not regained MA eligibility.

RULE: E-9.	
Condition	**A Recipient who is covered by PH-MCO when admitted to a hospital loses PH-MCO and assumes CHC-MCO while still in the hospital.**
PH-MCO Coverage Responsibility	The surrendering PH-MCO is responsible for the hospital stay with the exceptions below. As of the gaining CHC-MCO's Start Date, the gaining CHC-MCO is responsible for the physician, DME, and all other Covered Services not included in the hospital bill. EXCEPTION #1: If the Recipient is still in the hospital on the gaining CHC-MCO Start Date, and the Recipient's gaining CHC-MCO Start Date is the first (1st) day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining CHC-MCO Start Date is July 1, the gaining CHC-MCO assumes payment responsibility for the stay on August 1. The surrendering PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the gaining CHC-MCO Start Date, and the Recipient's gaining CHC-MCO start date is any day other than the first day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the following month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the month following the next month.

	Example: If a Recipient is admitted to a hospital on June 21 and the gaining CHC-MCO start date is July 15, the gaining CHC-MCO assumes payment responsibility for the stay on September 1. The surrendering PH-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

RULE: E-10.	
Condition	**Recipient who is covered by CHC-MCO when admitted to a hospital loses CHC-MCO and assumes PH-MCO while still in the hospital.**
PH-MCO Coverage Responsibility	The surrendering CHC-MCO is responsible for the hospital stay with the exceptions below. Starting with the gaining PH-MCO's Start Date, the gaining PH-MCO is responsible for the physician, DME, and all other Covered Services not included in the hospital bill. EXCEPTION #1: If the Recipient is still in the hospital on the gaining PH-MCO Start Date, and the Recipient's gaining PH-MCO Start Date is the first (1st) day of the month, the surrendering CHC-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO Start Date is July 1, the gaining PHC-MCO assumes payment responsibility for the stay on August 1. The surrendering CHC-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the gaining PH-MCO Start Date, and the Recipient's gaining PH-MCO Start Date is any day other than the first day of the month, the surrendering CHC-MCO is financially responsible for the stay through the last day of the following month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO Start Date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The surrendering CHC-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

F. Other Causes for Coverage Termination and Involuntary Disenrollment**.** If a condition described in the following sections occurs, the PH-MCO must notify the Department. In accordance with the Department's disenrollment guidelines, MMIS Operations will take action to disenroll the Member. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards. For example, today's date is 9/18/2020 and central office staff end date managed care coverage 9/30/2019 – payments are recouped for 10/2019 through 9/2020).

If a Recipient is placed in a setting listed in these sections and is under FFS prior to the PH-MCO's Start Date, PH-MCO coverage will be voided and adjustments will be processed for any Capitation payments made.

The PH-MCO must notify the Department within sixty (60) days following the satisfaction of the Department's disenrollment guidelines in order for MMIS Operations to end-date the member's enrollment. Failure on the part of the PH-

MCO to notify MMIS Operations within the sixty (60) days will result in the end date being delayed, thereby extending the PH-MCO's responsibility for covering the Recipient. The PH-MCO should not hold and then later submit the notifications.

RULE: F-1.	
Condition	**A Member who is covered by a PH-MCO when admitted to a Nursing Facility transfers to a CHC-MCO.**
PH-MCO Coverage Responsibility	Residence in a nursing facility is not cause for disenrollment from a PH-MCO. 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 month of the CHC start date, or a later date, the last day of the PH-MCO's responsibility to provide benefits is the date prior to the CHC start date. Refer to the Agreement, Section VII., E.12.
MA FFS Coverage Responsibility	FFS is not responsible for coverage.

RULE: F-2.	
Condition	**A Member who is covered by a PH-MCO when admitted to a Nursing Facility transfers to another PH-MCO.**
PH-MCO Coverage Responsibility	The surrendering PH-MCO is responsible for the Nursing Facility stay with the following exceptions. Starting with the gaining PH-MCO's begin date, the gaining PH-MCO is responsible for the physician, DME and all other covered services not included in the Nursing Facility bill. Recipients who have facility codes 35 or 36 assigned prior to a plan transfer request being processed will have the plan transfer denied with code 53, Enrollment Conflicts with Facility/Waiver Code. EXCEPTION #1: If the Recipient is still in the Nursing Facility on the gaining PH-MCO coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is the first day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a Nursing Facility on June 21 and the gaining PH-MCO coverage begin date is July 1, the gaining PH-MCO assumes payment responsibility for the stay on August 1. The surrendering PH-MCO remains financially responsible for the stay through July 31.
MA FFS Coverage Responsibility	FFS is not responsible for coverage.

RULE: F-3.	
Condition	**A Member is admitted to an out of state Nursing Facility (regardless of who places the Member in the facility).**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for Members who are placed in a Nursing Facility outside of Pennsylvania. A Member who is placed in an out-of-state Nursing Facility is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS is not responsible for coverage in an out of state Nursing Facility.

RULE: F-4.	
Condition	**A member is admitted to a Veteran's Home (MA provider type/specialty 03/042).**

PH-MCO Coverage Responsibility	The PH-MCO is not responsible for Members who are admitted to a Veteran's Home. A Member who is admitted to a Veteran's Home is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: F-5.	
Condition	**A member is placed into Hospice care while in a Nursing Facility.**
PH-MCO Coverage Responsibility	If Hospice care begins during the Nursing Facility placement, the member remains the responsibility of the PH-MCO.
MA FFS Coverage Responsibility	FFS is not responsible for coverage.

RULE: F-6.	
Condition	**A Member is enrolled in the CHC Waiver.**
PH-MCO Coverage Responsibility	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 month of the CHC start date, or a later date, the last day of the PH-MCO's responsibility to provide benefits is the date prior to the CHC start date.
MA FFS Coverage Responsibility	FFS is not responsible for coverage.

RULE: F-7.	
Condition	**A Member is admitted to a State Facility (MA Provider Type/Specialty Codes 01/23 - Public Psychiatric Hospital and 03/37 - State LTC Unit located at State Mental Hospitals).**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for Members in a state facility. A Member admitted to a state facility is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: F-8.	
Condition	**A Member is incarcerated in a Penal Facility, Correctional Institution (including work release), or Youth Development Center.**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility. The Member is disenrolled from the PH-MCO effective the day before incarceration in the facility or institution.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility, except for inpatient hospital services.
NOTE:	This rule is based upon section 392.2 of the MA Eligibility Handbook which states, "For purposes of MA eligibility, other than eligibility for inpatient hospital services, the needs of an inmate in a correctional institution are the responsibility of the governmental authority exercising administrative control over the facility.".

RULE: F-9.

Condition	**A Member is placed in a Juvenile Detention Center (JDC).**
PH-MCO Coverage Responsibility	During the first thirty-five (35) days of a Member's placement in a JDC, the PH-MCO is responsible for all covered services that are provided to the Member *outside* of the JDC site. A Member who is placed in a JDC is disenrolled from the PH-MCO after thirty-five (35) days.
MA FFS Coverage Responsibility	Services provided to the Member *onsite* at the JDC during the first thirty-five (35) days will be covered under the MA FFS Program. FFS coverage is effective on the 36th day.

RULE: F-10.	
Condition	**A Member becomes eligible for the Health Insurance Premium Payment Program (HIPP).**
PH-MCO Coverage Responsibility	A Member determined to be HIPP eligible (Employer Group Health Plan) is disenrolled from the PH-MCO. HIPP-eligible MA Recipients are prevented from enrolling in PH-MCOs.
MA FFS Coverage Responsibility	FFS benefits with HIPP insurance coverage begin the day after the disenrollment date.

RULE: F-11.	
Condition	**A Member is enrolled in the Living Independence for the Elderly Program (LIFE) (MA Provider Type/Specialty Code 07/70 – LIFE)** LIFE is Pennsylvania's managed care option for individuals who are Nursing Home Clinically Eligible (NFCE) and age 55 and older. It provides fully integrated acute care, long-term care, behavioral health, and pharmacy services to individuals who wish to remain in the community.
PH-MCO Coverage Responsibility	A Member enrolled in LIFE is disenrolled from the PH-MCO effective the day before the start date in the LIFE program.
MA FFS Coverage Responsibility	LIFE coverage begins the day after the disenrollment date.

G. Other Facility Placement Coverage - The following rules provide information relating to PH-MCO coverage of Recipients placed in other types of facilities.

RULE: G-1.	
Condition	**A Member is admitted to a state ICF-ID (MA Provider Type/Specialty Code 03/38 – State Intellectual Disability Center).**
PH-MCO Coverage Responsibility	A Member admitted to a state ICF-ID is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: G-2.	
Condition	**A Member is admitted to a private ICF-ID/ICF-ORC (MA Provider Type/Specialty Code 03/32 – ICF/ID 8 Beds or Less, 03/33 – ICF/ID 9 Beds or More, and 03/39 – ICF/ORC).**
PH-MCO Coverage Responsibility	A Member admitted to a private ICF-ID or ICF-ORC facility will continue to be covered by their selected PH-MCO for all covered physical health services with the exception of those services the ICF-ID or ICF-ORC has historically and customarily provided to residents of the facility or those services covered under the facility's per diem payment.

	The residential and treatment costs that are the responsibility of the ICF-ID or ICF-ORC under its agreement with DHS are not the responsibility of the BH-MCO. All other Behavioral Health Services are the responsibility of the BH-MCO.
MA FFS Coverage Responsibility	FFS is responsible for the residential and treatment costs. DHS will make direct payments to the ICF-ID or ICF-ORC facility to cover room, board, ID-specific non-MA services, and physical and behavioral health services to the extent these services have been customarily and historically provided to residents of the facility.

RULE: G-3.	
Condition	**A. A Member is admitted to a JCAHO-approved Residential Treatment Facility (RTF) (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital).** **B. A Member is admitted to a non-JCAHO approved Residential Treatment Facility (RTF) (MA Provider Type/Specialty Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified).**
PH-MCO Coverage Responsibility	A. With the exception of Children in Substitute Care who are placed in residential facilities by another government agency that has responsibility for these children, a Member placed in a JCAHO-approved RTF (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital) remains covered by their selected PH-MCO for all covered physical health services. The BH-MCO is responsible for the residential and treatment costs. B. A Member placed in a non-JCAHO approved RTF (MA Provider Type/Specialty Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified) remains covered by their selected PH-MCO for all covered physical health services. The BH-MCO is responsible for the MA per diem. The Room & Board per diem can be the responsibility of the BH-MCO, Children and Youth, or another agency, depending on medical necessity and who places the Recipient.
MA FFS Coverage Responsibility	A. FFS is responsible for the residential and treatment costs. B. FFS is responsible for the facility's per diem payment.

RULE: G-4.	
Condition	**A Member is admitted to an Extended Acute Psychiatric Care Hospital (MA Provider Type/Specialty Code 01/18 – Extended Acute Psych Inpatient Unit).**
PH-MCO Coverage Responsibility	A Member admitted to an extended acute psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. If the Recipient is placed in the facility by the BH-MCO, that BH-MCO is responsible for the residential and treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

RULE: G-5.	
Condition	**A Member is admitted to an Inpatient Private Psychiatric Facility (MA Provider Type/Specialty Code 01/11 – Private Psychiatric Hospital and 01/22 – Private Psychiatric Unit).**
PH-MCO Coverage Responsibility	A Member admitted to a private psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. The BH-MCO is responsible for the residential/treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

EXHIBIT DD

EXHIBIT DD

PH-MCO MEMBER HANDBOOK

A. The PH-MCO must ensure that the Member handbook contains written information regarding Member rights and protections and is written at no higher than a sixth grade reading level. The PH-MCO must provide a Member handbook in the appropriate prevalent language, or alternate format, to all members within five (5) business days of being notified of a Member's enrollment, but no sooner than five (5) business days before the member's effective date of enrollment. The PH-MCO may provide the Member handbook in formats other than hard copy. If this option is exercised, the PH-MCO must inform Members what formats are available and how to access each. Upon request, the PH-MCO must provide a hard copy version of the Member handbook to the Member.

B. In compliance with 42 C.F.R. §438.10(g), the content of the member handbook must include information that enables the member to understand how to effectively use the managed care program. At a minimum, the Member handbook shall include:

1. Benefits provided by the PH-MCO.

2. How and where to access benefits provided by the Department, including any cost sharing, and how transportation is provided.

    a. In the case of a counseling or referral service that the PH-MCO does not cover because of moral or religious objections, the PH-MCO must inform Members that the service is not covered by the PH-MCO and provide information to Members about how to access the services

3. The amount, duration, and scope of benefits available in sufficient detail to ensure that Members understand the benefits to which they are entitled.

4. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Member's PCP.

5. The extent to which, and how, after-hours and emergency coverage are provided, including:

    a. What constitutes an emergency medical condition and emergency services.

    b. The fact that prior authorization is not required for emergency services.

    c. The fact that the Member has a right to use any hospital or other setting for emergency care.

6. Any restrictions on the Member's freedom of choice among network providers.

7. The extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the PH-MCO cannot require a Member to obtain a referral before choosing a family planning provider.

8. Any imposed cost sharing.

9. Member rights and responsibilities, including the elements specified in 42 C.F.R. §438.100.

10. The process of selecting and changing the Member's PCP.

11. Grievance, appeal, and fair hearing procedures and timeframes, consistent with 42 C.F.R. Subpart F §§ 438.400 – 438.424, in a DHS-developed or DHS-approved description. Such information must include:

    a. The right to file grievances and appeals.

    b. The requirements and timeframes for filing a grievance or appeal.

    c. The availability of assistance in the filing process.

    d. The right to request a DHS fair hearing after the PH-MCO has made a determination on a Member's appeal which is adverse to the Member.

    e. The fact that, when requested by the member, benefits that the PH-MCO seeks to reduce or terminate will continue if the Member files an appeal or a request for a DHS fair hearing within the timeframes specified for filing, and that the Member may, consistent with DHS policy, be required to pay the cost of services furnished while the appeal of DHS fair hearing is pending if the final decision is adverse to the Member.

12. How to exercise an advance directive, as set forth in 42 C.F.R. § 438.3(j).

13. How to access auxiliary aids and services, including additional information in alternative formats or languages.

14. The toll-free telephone number for member services, medical management, and any other unit providing services directly to Members.

15. Information on how to report suspected fraud or abuse.

16. Any other content required by DHS.

C. Information required by this exhibit to be provided by the PH-MCO will be considered to be provided if the PH-MCO:

1. Mails a printed copy of the information to the Member's mailing address;

2. Provides the information by email after obtaining the member's agreement to receive the information by email;

3. Posts the information on the Web site of the PH-MCO and advises the Member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that Members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

4. Provides the information by any other method that can reasonably be expected to result in the Member receiving that information.

D. In compliance with 42 C.F.R. §438.10(c)(4)(ii), the PH-MCO is required to use the Member handbook template provided within this exhibit or as most recently updated by the Department and made available on DocuShare. 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. of this Agreement.

[MCO – add cover sheet and taglines page]

Table of Contents

Topic **Page**
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Section – 1

Welcome

Introduction

What is HealthChoices?

HealthChoices is Pennsylvania's Medical Assistance managed care program. The Office of Medical Assistance Programs (OMAP) in Pennsylvania's Department of Human Services (DHS) oversees the physical health portion of HealthChoices. Physical health services are provided through the physical health managed care organizations (PH-MCOs). Behavioral health services are provided through behavioral health managed care organizations (BH-MCOs). For more information on behavioral health services, see page **[MCO insert page number]**.

Welcome to [MCO Name]

[MCO Name] welcomes you as a member in HealthChoices and **[MCO Name]**! **[MCO to provide a brief description of plan including a map of counties where the plan operates.] [MCO Name]** has a network of contracted providers, facilities, and suppliers to provide covered physical health services to members. **[MCO to provide explanation of the need/importance to get services from network providers]**

Member Services

Staff at Member Services can help you with:

[MCO to provide list and description of things that Member Services can help with and services offered]

[MCO Name]'s Member Services are available:

[MCO to provide hours of operation]

And can be reached at **[MCO Member Services Phone Number and TTY]**

Member Services can also be contacted in writing at:

[MCO address]

And

[MCO to provide any additional means of contact (email, website, etc.)]

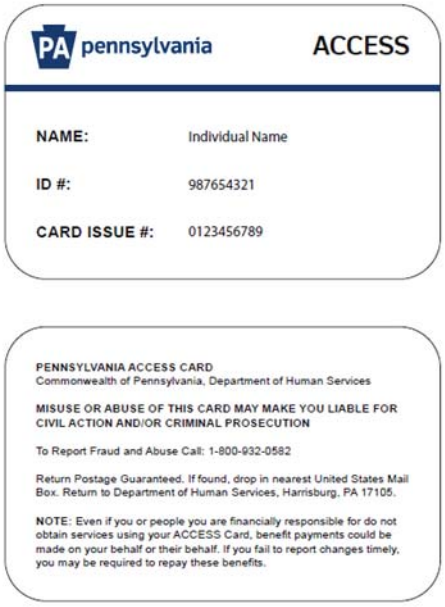
Member Identification Cards

[MCO to provide description of member ID card and pharmacy card, if it has one, and image(s). The MCO should explain what information is on the card(s) and how they are used. It should also explain what to do if a card is lost or stolen, with a statement that explains services the member is receiving will continue and all services will continue to be available while the member waits for a new card to be delivered.]

You will also get an ACCESS or EBT card. You will need to present this card along with your **[MCO Name] ID** card at all appointments. If you lose your ACCESS or EBT card, call your County Assistance Office (CAO). The phone number for the CAO is listed later in the **Important Contact Information** section. You will receive the following card.

The MA cards with the Capitol and cherry blossoms may be used for cash assistance, the Supplemental Nutritional Assistance Program (SNAP) and MA. Additionally, if a Member is eligible for cash assistance, they are automatically eligible for MA. Typically, this card is issued the person who the cash assistance and/or SNAP benefit is directed to, or for MA it is issued to the head of household.

The “Blue Card(s)” are issued only for MA to all other members of the household.



Older MA cards that may still be active are shown here. The green/blue card with yellow “ACCESS” may also serve as the head of household’s EBT card for SNAP and cash assistance, and their MA card. The yellow card is only for MA for all other members of the household.

Until you get your **[MCO Name]** ID card, use your ACCESS or EBT card for your health care services that you get through HealthChoices.

Important Contact Information

The following is a list of important phone numbers you may need. If you are not sure who to call, please contact Member Services for help: **[MCO Member Services Phone Number and TTY]**.

Emergencies

Please see Section 3, Covered Physical Health Services, beginning on page **[xx],** for more information about emergency services. If you have an emergency, you can get help by going to the nearest emergency department, calling 911, or calling your local ambulance service.

Important Contact Information – At a Glance

Name	Contact Information: Phone or Website	Support Provided
Pennsylvania Department of Human Services Phone Numbers		
County Assistance Office/COMPASS	1-877-395-8930 or 1-800-451-5886 (TTY/TTD) or www.compass.state.pa.us or myCOMPASS PA mobile app for smart phones	Change your personal information for Medical Assistance eligibility. See page **[page]** of this handbook for more information.
Fraud and Abuse Reporting Hotline, Department of Human Services	1-844-DHS-TIPS (1-844-347-8477)	Report member or provider fraud or abuse in the Medical Assistance Program. See page **[page]** of this handbook for more information.
Other Important Phone Numbers		
[MCO Name] Nurse Hotline	**[MCO Name Nurse Call Line Phone Number]**	Talk with a nurse 24 hours a day, 7 days a week, about urgent health matters. See page **[page]** of this handbook for information.
Enrollment Assistance Program	1-800-440-3989 1-800-618-4255 (TTY)	Pick or change a HealthChoices plan. See page **[page]** of this handbook for more information.
Insurance Department, Bureau of Consumer Services	1-877-881-6388	Ask for a Complaint form, file a Complaint, or talk to a consumer services representative.

Protective Services	1-800-490-8505	Report suspected abuse, neglect, exploitation, or abandonment of an adult over age 60 or an adult between age 18 and 59 who has a physical or mental disability.

Other Phone Numbers

[MCO to provide list of relevant phone numbers (CAOs, MATP, etc.) in counties of operation here or make reference to an appendix at the end of the manual.]
[The following is a list of resources as an example of what may be included, as appropriate. This is not an exhaustive list.]

Childline	1-800-932-0313
County Assistance Office	**[MCO to provide]**
Crisis Intervention Services	**[MCO to provide]**
Legal Aid	**[MCO to provide]**
Medical Assistance Transportation Program	**[MCO to provide]**
Mental Health/Intellectual Disability Services	**[MCO to provide]**

Suicide and Crisis Lifeline

The 988 Suicide and Crisis Lifeline number is available 24/7

Call: 988
Text: 988
Visit or Chat: 988lifeline.org

If mental health care or support is needed, you can learn more about services in PA at www.dhs.pa.gov/mentalhealthinpa.

Communication Services

[MCO Name] can provide this Handbook and other information you need in languages other than English at no cost to you. **[MCO Name]** can also provide your Handbook and other information you need in other formats such as compact disc, Braille, large print, DVD, electronic communication, and other formats if you need them, at no cost to you. Please contact Member Services at **[MCO Member Services Phone Number and TTY]** to ask for any help you need. Depending on the information you need, it may take up to 5 business days for **[MCO Name]** to send you the information.

[MCO Name] will also provide an interpreter, including for American Sign Language or TTY services, if you do not speak or understand English or are deaf or hard of hearing.

These services are available at no cost to you. If you need an interpreter, call Member Services at **[MCO Member Services Phone Number and TTY]** and Member Services will connect you with the interpreter service that meets your needs. For TTY services, call our specialized number at **[MCO TTY Direct Number]** or call Member Services who will connect you to the next available TTY line.

If your PCP or other provider cannot provide an interpreter for your appointment, **[MCO Name]** will provide one for you. Call Member Services at **[MCO Member Services Phone Number and TTY]** if you need an interpreter for an appointment.

Enrollment

In order to get services in HealthChoices, you need to stay eligible for Medical Assistance. You will get paperwork or a phone call about renewing your eligibility. It is important that you follow instructions so that your Medical Assistance does not end. If you have questions about any paperwork you get or if you are unsure whether your eligibility for Medical Assistance is up to date, call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]** or your CAO.

[MCO to add enrollment information as necessary]

Enrollment Services

The Medical Assistance Program works with the Enrollment Assistance Program (EAP) to help you enroll in HealthChoices. You received information about the EAP with the information you received about selecting a HealthChoices plan. Enrollment specialists can give you information about all of the HealthChoices plans available in your area so that you can decide which one is best for you. If you do not pick a HealthChoices plan, a HealthChoices plan will be chosen for you. Enrollment specialists can also help you if you want to change your HealthChoices plan or if you move to another county.

Enrollment specialists can help you:

- Pick a HealthChoices plan
- Change your HealthChoices plan
- Pick a PCP when you first enroll in a HealthChoices plan
- Answer questions about all of the HealthChoices plans
- Determine whether you have special needs, which could help you decide which HealthChoices plan to pick

- Give you more information about your HealthChoices plan

To contact the EAP, call 1-800-440-3989 or 1-800-618-4225 (TTY).

Changing Your HealthChoices Plan

You may change your HealthChoices plan at any time, for any reason. To change your HealthChoices plan, call the EAP at 1-800-440-3989 or 1-800-618-4225 (TTY). They will tell you when the change to your new HealthChoices plan will start, and you will stay in **[MCO Name]** until then. It can take up to 6 weeks for a change to your HealthChoices plan to take effect. Use your **[MCO Name]** ID card at your appointments until your new plan starts.

Changes in the Household

Call your CAO and Member Services at **[MCO Member Services Phone Number and TTY]** if there are any changes to your household.

For example:

- Someone in your household is pregnant or has a baby
- Your address or phone number changes
- You or a family member who lives with you gets other health insurance
- You or a family member who lives with you gets very sick or becomes disabled
- A family member moves in or out of your household
- There is a death in the family

A new baby is automatically assigned to the mother's current HealthChoices plan. You may change your baby's plan by calling the EAP at **1-800-440-3989**. Once the change is made you will receive a new HealthChoices member ID card for your baby.

Remember that it is important to call your CAO right away if you have any changes in your household because the change could affect your benefits.

What Happens if I Move?

If you move out of your county, you may need to choose a new HealthChoices plan. Contact your CAO if you move. If **[MCO Name]** also serves your new county, you can

stay with **[MCO Name]**. If **[MCO Name]** does not serve your new county, the EAP can help you select a new plan.

If you move out of state, you will no longer be able to get services through HealthChoices. Your caseworker will end your benefits in Pennsylvania. You will need to apply for benefits in your new state.

Loss of Benefits

There are a few reasons why you may lose your benefits completely.

They include:

- Your Medical Assistance ends for any reason. If you are eligible for Medical Assistance again within 6 months, you will be re-enrolled in the same HealthChoices plan unless you pick a different HealthChoices plan.
- You go to a nursing home outside of Pennsylvania.
- You have committed Medical Assistance fraud and have finished all appeals.
- You go to prison or are placed in a youth development center.

There are also reasons why you may no longer be able to receive services through a physical health MCO and you will be placed in the fee-for service program.

They include:

- You are placed in a juvenile detention center for more than 35 days in a row.
- You are 21 years of age or older and begin receiving Medicare Part D (Prescription Drug Coverage).
- You go to a state mental health hospital

You may also become eligible for Community HealthChoices. If you become eligible for Medicare coverage or become eligible for nursing facility or home and community based services, you will be eligible for Community HealthChoices. For more information on Community HealthChoices visit www.healthchoices.pa.gov.

You will receive a notice from DHS if you lose your benefits or if you are no longer able to receive services through a physical health MCO and will begin to receive services through the fee-for-service system or Community HealthChoices.

Information About Providers

The **[MCO Name]**'s provider directory has information about the providers in **[MCO Name]**'s network. The provider directory is located online here: **[MCO Provider Directory Website link].** You may call Member Services at **[MCO Member Services Phone Number and TTY]** to ask that a copy of the provider directory be sent to you or to request information about where a doctor went to medical school or their residency program. You may also call Member Services to get help finding a provider. The provider directory includes the following information about network providers:

- Name, address, website address, email address, telephone number
- Whether or not the provider is accepting new patients
- Days and hours of operation
- The provider's credentials and board certifications
- The provider's specialty and services offered by the provider
- Whether or not the provider speaks languages other than English and, if so, which languages
- Whether or not the provider locations are wheelchair accessible

*The information in the printed provider directory may change. You can call Member Services to check if the information in the provider directory is current. **[MCO Name]** updates the printed provider directory **[Frequency]**. The online directory is updated at least monthly.

Picking Your Primary Care Provider (PCP)

Your PCP is the doctor or doctors' group who provides and works with your other health care providers to make sure you get the health care services you need. Your PCP refers you to specialists you need and keeps track of the care you get by all of your providers.

A PCP may be a family doctor, a general practice doctor, a pediatrician (for children and teens), or an internist (internal medicine doctor). You may also pick a certified

registered nurse practitioner (CRNP) as a PCP. A CRNP works under the direction of a doctor and can do many of the same things a doctor can do such as prescribing medicine and diagnosing illnesses.

Some doctors have other medical professionals who may see you and provide care and treatment under the supervision of your PCP.

Some of these medical professionals may be:

- Physician Assistants
- Medical Residents
- Certified Nurse-Midwives

If you have Medicare, you can stay with the PCP you have now even if your PCP is not in **[MCO Name]**'s network. If you do not have Medicare, your PCP must be in **[MCO Name]**'s network.

If you have special needs, you can ask for a specialist to be your PCP. The specialist needs to agree to be your PCP and must be in **[MCO Name]**'s network.

Enrollment specialists can help you pick your first PCP with **[MCO Name].** If you do not pick a PCP through the EAP within 14 days of when you picked **[MCO Name],** we will pick your PCP for you.

[MCO to provide any additional PCP information needed]

Changing Your PCP

If you want to change your PCP for any reason, call Member Services at **[MCO Member Services Phone Number and TTY]** to ask for a new PCP. If you need help finding a new PCP, you can go to **[MCO website address]**, which includes a provider directory, or ask Member Services to send you a printed provider directory.

[MCO Name] will send you a new ID card with the new PCP's name and phone number on it. The Member Services representative will tell you when you can start seeing your new PCP.

When you change your PCP, **[MCO Name]** can help coordinate sending your medical records from your old PCP to your new PCP. In emergencies, **[MCO Name]** will help to transfer your medical records as soon as possible.

If you have a pediatrician or pediatric specialist as a PCP, you may ask for help to change to a PCP who provides services for adults.

Office Visits

Making an Appointment with Your PCP

To make an appointment with your PCP, call your PCP's office. If you need help making an appointment, please call **[MCO Name]**'s Member Services at **[MCO Member Services Phone Number and TTY]**.

If you need help getting to your doctor's appointment, please see the Medical Assistance Transportation Program (MATP) section on page **[MCO insert page number of MATP information]**, of this Handbook or call **[MCO Name]**'s Member Services at the phone number above.

If you do not have your **[MCO Name]** ID card by the time of your appointment, take your ACCESS or EBT card with you. You should also tell your PCP that you selected **[MCO Name]** as your HealthChoices plan.

Appointment Standards

[MCO Name]'s providers must meet the following appointment standards:

- Your PCP should see you within 10 business days of when you call for a routine appointment.
- You should not have to wait in the waiting room longer than 30 minutes, unless the doctor has an emergency.
- If you have an urgent medical condition, your provider should see you within 24 hours of when you call for an appointment.
- If you have an emergency, the provider must see you immediately or refer you to an emergency room.
- If you are pregnant and
    - In your first trimester, your provider must see you within 10 business days of **[MCO Name]** learning you are pregnant.
    - In your second trimester, your provider must see you within 5 business days of **[MCO Name]** learning you are pregnant.
    - In your third trimester, your provider must see you within 4 business days of **[MCO Name]** learning you are pregnant.
    - Have a high-risk pregnancy, your provider must see you within 24 hours of **[MCO Name]** learning you are pregnant.

Referrals

A referral is when your PCP sends you to a specialist. A specialist is a doctor (or a doctor's group) or a CRNP who focuses his or her practice on treating one disease or medical condition or a specific part of the body. If you go to a specialist without a referral from your PCP, you may have to pay the bill.

If **[MCO Name]** does not have at least 2 specialists in your area and you do not want to see the one specialist in your area, **[MCO Name]** will work with you to see an out-of-network specialist at no cost to you. Your PCP must contact **[MCO Name]** to let **[MCO Name]** know you want to see an out-of-network specialist and get approval from **[MCO Name]** before you see the specialist.

Your PCP will help you make the appointment with the specialist. The PCP and the specialist will work with you and with each other to make sure you get the health care you need.

Sometimes you may have a special medical condition where you need to see the specialist often. When your PCP refers you for several visits to a specialist, this is called a standing referral.

For a list of specialists in **[MCO Name]**'s network, please see the provider directory on our website at **[MCO Provider Directory Website link]** or call Member Services to ask for help or a printed provider directory.

Self-Referrals

Self-referrals are services you arrange for yourself and do not require that your PCP arrange for you to receive the service. You must use a **[MCO Name]** network provider unless **[MCO Name]** approves an out-of-network provider.

The following services do not require referral from your PCP:

- Prenatal visits
- Routine obstetric (OB) care
- Routine gynecological (GYN) care
- Routine family planning services (may see out-of-network provider without approval)
- Routine dental services
- Routine eye exams
- Emergency services

You do not need a referral from your PCP for behavioral health services. You can call your behavioral health managed care organization for more information. Please see section 7 of the handbook, on page **[MCO to add page number]** for more information

After-Hours Care

You can call your PCP for non-emergency medical problems 24 hours a day, 7 days a week. On-call health care professionals will help you with any care and treatment you need.

[MCO Name] has a toll-free nurse hotline at **[MCO Nurse Hotline Phone Number]** that you can also call 24 hours a day, 7 days a week. A nurse will talk with you about your urgent health matters.

Member Engagement

Suggesting Changes to Policies and Services

[MCO Name] would like to hear from you about ways to make your experience with HealthChoices better. If you have suggestions for how to make the program better or how to deliver services differently, please contact **[MCO Contact].**

[MCO Name] Health Education Advisory Committee (HEAC)

[MCO Name] has a Health Education Advisory Committee (HEAC) that includes members and network providers. The Committee provides advice to **[MCO Name]** about the experiences and needs of members like you. For more information about the Committee, please call **[MCO phone number]** or visit the website at **[MCO Name website]**.

[MCO Name] Quality Improvement Program

[MCO to provide description of its quality improvement program including contact information]

Section – 2

Rights and Responsibilities

Member Rights and Responsibilities

[MCO Name] and its network of providers do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.

As a **[MCO Name]** member, you have the following rights and responsibilities.

Member Rights

You have the right:

1. To be treated with respect, recognizing your dignity and need for privacy, by **[MCO Name]** staff and network providers.

2. To get information in a way that you can easily understand and find help when you need it.

3. To get information that you can easily understand about **[MCO Name]**, its services, and the doctors and other providers that treat you.
4. To pick the network health care providers that you want to treat you.
5. To get emergency services when you need them from any provider without **[MCO Name]**'s approval.
6. To get information that you can easily understand and talk to your providers about your treatment options, risks of treatment, and tests that may be self-administered without any interference from **[MCO Name]**.
7. To make all decisions about your health care, including the right to refuse treatment. If you cannot make treatment decisions by yourself, you have the right to have someone else help you make decisions or make decisions for you.
8. To talk with providers in confidence and to have your health care information and records kept confidential.

9. To see and get a copy of your medical records and to ask for changes or corrections to your records.
10. To ask for a second opinion.
11. To file a Grievance if you disagree with **[MCO Name]**'s decision that a service is not medically necessary for you.
12. To file a Complaint if you are unhappy about the care or treatment you have received.
13. To ask for a DHS Fair Hearing.
14. To be free from any form of restraint or seclusion used to force you to do something, to discipline you, to make it easier for the provider, or to punish you.
15. To get information about services that **[MCO Name]** or a provider does not cover because of moral or religious objections and about how to get those services.
16. To exercise your rights without it negatively affecting the way DHS, **[MCO Name],** and network providers treat you.
17. To create an advance directive. See Section 6 on page **[MCO to add page number]** for more information.
18. To make recommendations about the rights and responsibilities of **[MCO name]**'s members.

Member Responsibilities

Members need to work with their health care service providers. **[MCO Name]** needs your help so that you get the services and supports you need.

These are the things you should do:

1. Provide, to the extent you can, information needed by your providers.
2. Follow instructions and guidelines given by your providers.
3. Be involved in decisions about your health care and treatment.
4. Work with your providers to create and carry out your treatment plans.
5. Tell your providers what you want and need.
6. Learn about **[MCO Name]** coverage, including all covered and non-covered benefits and limits.
7. Use only network providers unless **[MCO Name]** approves an out-of-network provider or you have Medicare.

8. Get a referral from your PCP to see a specialist.
9. Respect other patients, provider staff, and provider workers.
10. Make a good-faith effort to pay your co-payments.
11. Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

Privacy and Confidentiality

[MCO Name] must protect the privacy of your protected health information (PHI). **[MCO Name]** must tell you how your PHI may be used or shared with others. This includes sharing your PHI with providers who are treating you or so that **[MCO Name]** can pay your providers. It also includes sharing your PHI with DHS. This information is included in **[MCO Name]**'s Notice of Privacy Practices. To get a copy of **[MCO Name]**'s Notice of Privacy Practices, please call **[MCO Privacy Contact]** or visit **[MCO Website]**.

Co-payments

A co-payment is the amount you pay for some covered services. It is usually only a small amount. You will be asked to pay your co-payment when you get the service, but you cannot be denied a service if you are not able to pay a co-payment at that time. If you did not pay your co-payment at the time of the service, you may receive a bill from your provider for the co-payment.

Co-payment amounts can be found in the Covered Services chart starting on page **[MCO to insert page number]** of this Handbook.

The following members do not have to pay co-payments:

- Members under age 18
- Pregnant women (including 1 year after the child is born (the post-partum period))
- Members who live in a long-term care facility, including Intermediate Care Facilities for the Intellectually Disabled and Other Related Conditions or other medical institution
- Members who live in a personal care home or domiciliary care home
- Members eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program
- Members eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance

The following services do not require a co-payment:

- Emergency services
- Laboratory services
- Family planning services, including supplies
- Hospice services
- Home health services
- Tobacco cessation services
- **[MCO to identify any additional services exempt from co-payment]**

What if I Am Charged a Co-payment and I Disagree?

If you believe that a provider charged you the wrong amount for a co-payment or a co-payment you believe you should not have had to pay, you can file a Complaint with **[MCO Name]**. Please see Section 8, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint, or call Member Services at **[MCO Member Services Phone Number and TTY]**.

Billing Information

Providers in **[MCO Name]**'s network may not bill you for medically necessary services that **[MCO Name]** covers. Even if your provider has not received payment or the full amount of his or her charge from **[MCO Name]**, the provider may not bill you. This is called balance billing.

When Can a Provider Bill Me?

Providers may bill you if:

- You did not pay your co-payment.
- You received services from an out-of-network provider without approval from **[MCO Name]** and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received services that are not covered by **[MCO Name]** and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received a service from a provider that is not enrolled in the Medical Assistance Program.

What Do I Do if I Get a Bill?

If you get a bill from a **[MCO Name]** network provider and you think the provider should not have billed you, you can call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO may add additional steps it would like members to take (call provider, return bill with MCO ID number)]

If you get a bill from a provider for one of the above reasons that a provider is allowed to bill you, you should pay the bill or call the provider.

Third-Party Liability

You may have Medicare or other health insurance. Medicare or your other health insurance is your primary insurance. This other insurance is known as "third party liability" or TPL. Having other insurance does not affect your Medical Assistance eligibility. In most cases, your Medicare or other insurance will pay your PCP or other provider before **[MCO Name]** pays. **[MCO Name]** can only be billed for the amount that your Medicare or other health insurance does not pay.

You must tell both your CAO and Member Services at **[Member Services Phone Number and TTY]** if you have Medicare or other health insurance. When you go to a provider or to a pharmacy you must tell the provider or pharmacy about all forms of medical insurance you have and show the provider or pharmacy your Medicare card or other insurance card, ACCESS or EBT card, and your **[MCO Name]** ID card. This helps make sure your health care bills are paid timely and correctly.

Coordination of Benefits

If you have Medicare and the service or other care you need is covered by Medicare, you can get care from any Medicare provider you pick. The provider does not have to be in **[MCO Name]**'s network**.** You also do not have to get prior authorization from **[MCO Name]** or referrals from your Medicare PCP to see a specialist. **[MCO Name]** will work with Medicare to decide if it needs to pay the provider after Medicare pays first, if the provider is enrolled in the Medical Assistance Program.

If you need a service that is not covered by Medicare but is covered by **[MCO Name]**, you must get the service from a **[MCO Name]** network provider. All **[MCO Name]** rules, such as prior authorization and specialist referrals, apply to these services.

If you do not have Medicare but you have other health insurance and you need a service or other care that is covered by your other insurance, you must get the service from a provider that is in both the network of your other insurance and **[MCO Name]**'s

network. You need to follow the rules of your other insurance and **[MCO Name]**, such as prior authorization and specialist referrals. **[MCO Name]** will work with your other insurance to decide if it needs to pay for the services after your other insurance pays the provider first.

If you need a service that is not covered by your other insurance, you must get the services from a **[MCO Name]** network provider. All **[MCO Name]** rules, such as prior authorization and specialist referrals, apply to these services.

Recipient Restriction/Lock-in Program

The Recipient Restriction/Member Lock-In Program requires a member to use specific providers if the member has abused or overused his or her health care or prescription drug benefits. **[MCO Name]** works with DHS to decide whether to limit a member to a doctor, pharmacy, hospital, dentist, or other provider.

How Does it Work?

[MCO Name] reviews the health care and prescription drug services you have used. If **[MCO Name]** finds overuse or abuse of health care or prescription services, **[MCO Name]** asks DHS to approve putting a limit on the providers you can use. If approved by DHS, **[MCO Name]** will send you a written notice that explains the limit.

You can pick the providers, or **[MCO Name]** will pick them for you. If you want a different provider than the one **[MCO Name]** picked for you, call Member Services at **[Member Services Phone Number and TTY]**. The limit will last for 5 years even if you change HealthChoices plans.

If you disagree with the decision to limit your providers, you may appeal the decision by asking for a DHS Fair Hearing, within 30 days of the date of the letter telling you that **[MCO Name]** has limited your providers.

You must sign the **written** request for a Fair Hearing and send it to:

Department of Human Services
Office of Administration
Bureau of Program Integrity - DPPC
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

If you need help asking for a Fair Hearing, please call Member Services at **[MCO Member Services Phone Number and TTY]** or contact your local legal aid office.

If your appeal is postmarked within 10 days of the date on **[MCO Name]**'s notice, the limits will not apply until your appeal is decided. If your appeal is postmarked more than 10 days but within 30 days from the date on the notice, the limits will be in effect until your appeal is decided. The Bureau of Hearings and Appeals will let you know, in writing, of the date, time, and place of your hearing. You may not file a Grievance or Complaint through **[MCO Name]** about the decision to limit your providers.

After 5 years, **[MCO Name]** will review your services again to decide if the limits should be removed or continued and will send the results of its review to DHS. **[MCO Name]** will tell you the results of the review in writing.

Reporting Fraud or Abuse

How Do I Report Member Fraud or Abuse?

If you think that someone is using your or another member's **[MCO Name]** card to get services, equipment, or medicines, is forging or changing their prescriptions, or is getting services they do not need, you can call the **[MCO Name]** Fraud and Abuse Hotline at **[Insert Phone Number and TTY]** to give **[MCO Name]** this information. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

How Do I Report Provider Fraud or Abuse?

Provider fraud is when a provider bills for services, equipment, or medicines you did not get or bills for a different service than the service you received. Billing for the same service more than once or changing the date of the service are also examples of provider fraud. To report provider fraud you can call the **[MCO Name]**'s Fraud and Abuse Hotline at **[Insert Phone Number]**. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

Section 3 –

Physical Health Services

Covered Services

The chart below lists the services that are covered by **[MCO Name]** when the services are medically necessary. Some of the services have limits or co-payments, or need a referral from your PCP or require prior authorization by **[MCO Name]**. If you need services beyond the limits listed below, your provider can ask for an exception, as explained later in this section. Limits do not apply if you are under age 21 or pregnant.

[MCO to complete table, including additional services that MCO covers]

Service		Children	Adults
Primary Care Provider	Limit		
	Co-payment		
	Prior Authorization / Referral		
Specialist	Limit		
	Co-payment		
	Prior Authorization / Referral		
Certified Registered Nurse Practitioner	Limit		
	Co-payment		
	Prior Authorization / Referral		
Federally Qualified Health Center / Rural Health Center	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Non-Hospital Clinic	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Hospital Clinic	Limit		
	Co-payment		
	Prior Authorization / Referral		
Podiatrist Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Chiropractor Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Optometrist Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Hospice Care	Limit		
	Co-payment		
	Prior Authorization / Referral		
Dental Care Services	Limit		
	Co-payment		
	Prior Authorization / Referral		

Service		Children	Adults
Radiology (ex. X-rays, MRIs, CTs)	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Hospital Short Procedure Unit	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Ambulatory Surgical Center	Limit		
	Co-payment		
	Prior Authorization / Referral		
Non-Emergency Medical Transport	Limit		
	Co-payment		
	Prior Authorization / Referral		
Family Planning Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Renal Dialysis	Limit		
	Co-payment		
	Prior Authorization / Referral		
Emergency Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Urgent Care Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Ambulance Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Inpatient Hospital	Limit		
	Co-payment		
	Prior Authorization / Referral		
Inpatient Rehab Hospital	Limit		
	Co-payment		
	Prior Authorization / Referral		
Maternity Care	Limit		
	Co-payment		
	Prior Authorization / Referral		
Prescription Drugs	Limit		
	Co-payment		
	Prior Authorization / Referral		
Enteral/Parenteral Nutritional Supplements	Limit		
	Co-payment		
	Prior Authorization / Referral		
	Limit		

Service		Children	Adults
Nursing Facility Services	Co-payment		
	Prior Authorization / Referral		
Home Health Care including Nursing, Aide, and Therapy Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Durable Medical Equipment	Limit		
	Co-payment		
	Prior Authorization / Referral		
Prosthetics and Orthotics	Limit		
	Co-payment		
	Prior Authorization / Referral		
Eyeglass Lenses	Limit		
	Co-payment		
	Prior Authorization / Referral		
Eyeglass Frames	Limit		
	Co-payment		
	Prior Authorization / Referral		
Contact Lenses	Limit		
	Co-payment		
	Prior Authorization / Referral		
Medical Supplies	Limit		
	Co-payment		
	Prior Authorization / Referral		
Therapy (Physical, Occupational, Speech)	Limit		
	Co-payment		
	Prior Authorization / Referral		
Laboratory	Limit		
	Co-payment		
	Prior Authorization / Referral		
Tobacco Cessation	Limit		
	Co-payment		
	Prior Authorization / Referral		

[MCO to add any additional information regarding covered services as necessary]

Services That Are Not Covered

There are physical health services that **[MCO Name]** does not cover. If you have any questions about whether or not **[MCO Name]** covers a service for you, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

MCOs may choose to cover experimental medical procedures, medicines, and equipment based on your specific situation.

Second Opinions

You have the right to ask for a second opinion if you are not sure about any medical treatment, service, or non-emergency surgery that is suggested for you. A second opinion may give you more information that can help you make important decisions about your treatment. A second opinion is available to you at no cost other than a co-pay.

Call your PCP to ask for the name of another **[MCO Name]** network provider to get a second opinion. If there are not any other providers in **[MCO Name]**'s network, you may ask **[MCO Name]** for approval to get a second opinion from an out-of-network provider.

What is Prior Authorization?

Some services or items need approval from **[MCO Name]** before you can get the service. This is called Prior Authorization. For services that need prior authorization, **[MCO Name]** decides whether a requested service is medically necessary before you get the service. You or your provider must make a request to **[MCO Name]** for approval before you get the service.

What Does Medically Necessary Mean?

Medically necessary means that a service, item, or medicine does one of the following:

- It will, or is reasonably expected to, prevent an illness, condition, or disability;
- It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;
- It will help you to get or keep the ability to perform daily tasks, taking into consideration both your abilities and the abilities or someone of the same age.

If you need any help understanding when a service, item, or medicine is medically necessary or would like more information, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to add additional prior authorization information as necessary]

How to Ask for Prior Authorization

[Insert detailed steps that MCO requires for prior authorization here, including all contact information.]

If you need help to better understand the prior authorization process, talk to your PCP or specialist or call Member Services at **[MCO Member Services Phone Number and TTY]**.

If you or your provider would like a copy of the medical necessity guidelines or other rules that were used to decide your prior authorization request, **[Insert MCO information here on how to obtain the information.]**

What Services, Items, or Medicines Need Prior Authorization?

The following chart identifies some, but not all services, items, and medicines that require prior authorization.

[Insert chart of covered services, items, and medicines that require prior authorization]

[TO BE ADDED IF MCO DOES NOT HAVE SEPARATE PA AND PE PROCESSES:]

For those services that have limits, if you or your provider believes that you need more services than the limit on the service allows, you or your provider can ask for more services through the prior authorization process.

If you are or your provider is unsure about whether a service, item, or medicine requires prior authorization, call Member Services at **[MCO Member Services Phone Number and TTY].**

Prior Authorization of a Service or Item

[MCO Name] will review the prior authorization request and the information you or your provider submitted. **[MCO Name]** will tell you of its decision within 2 business days of the date **[MCO Name]** received the request if **[MCO Name]** has enough information to decide if the service or item is medically necessary.

If **[MCO Name]** does not have enough information to decide the request, we must tell your provider within 48 hours of receiving the request that we need more information to decide the request and allow 14 days for the provider to give us more information.

[MCO Name] will tell you of our decision within 2 business days after **[MCO Name]** receives the additional information.

You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

"**Prior Authorization of Home Accessibility Durable Medical Equipment**

Home Accessibility Durable Medical Equipment (DME) is equipment and appliances that are used to serve a medical purpose and are generally not useful to a person without a disability, illness or injury. These items can withstand repeated use and can be reusable or removable.

Covered items include:

- Wheelchair lifts
- Stair glides
- Ceiling lifts
- Metal accessibility ramps
- Other items used by a member with a mobility impairment to enter and exit the home
- Are used to support activities of daily activities
- Are removable and reusable

Also covered are:

- Installation costs
- Medically necessary repairs to the equipment
- Parts or supplies recommended by the manufacturer
- Labor to attach or mount the item
- Required permits
- Installing an electrical outlet or connection to an existing electrical source
- Pouring a concrete slab or foundation
- External supports such as bracing a wall
- Removing/replacing an existing railing or banister as needed to accommodate the equipment

Home Modifications, such as home repairs, or changes to the home, are not a covered benefit.
A prior authorization request must include a letter of medical necessity or other clinical information from your doctor telling us:

- Why you need the equipment and/or appliance
- That the equipment and/or appliance can be safely installed
- That you can safely use the equipment and/or appliance
- That you or your caretaker can activate and control the equipment and/or appliance
- That you have an on-going need for the equipment and/or appliance

Required information also needed for the prior authorization is permission from either the property owner or the landlord to perform the installation of the equipment and the total cost and bill for the items."

Prior Authorization of Outpatient Drugs

[MCO Name] will review a prior authorization request for outpatient drugs, which are drugs that you do not get in the hospital, within 24 hours from when **[MCO Name]** gets the request. You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

If you go to a pharmacy to fill a prescription and the prescription cannot be filled because it needs prior authorization, the pharmacist will give you a temporary supply unless the pharmacist thinks the medicine will harm you. If you have not already been taking the medicine, you will get a 72-hour supply. If you have already been taking the medicine, you will get a 15-day supply. Your provider will still need to ask **[MCO Name]** for prior authorization as soon as possible

The pharmacist will not give you the 15-day supply for a medicine that you have been taking if you get a denial notice from **[MCO Name]** 10 days before your prescription ends telling you that the medicine will not be approved again and you have not filed a Grievance.

What if I Receive a Denial Notice?

If **[MCO Name]** denies a request for a service, item, or drug or does not approve it as requested, you can file a Grievance or a Complaint. If you file a Complaint or a Grievance for denial of an ongoing medication, **[MCO Name]** must authorize the medication until the Complaint or Grievance is resolved. See Section 8, Complaints, Grievances, and Fair Hearings, starting on page **[MCO to add page number]** of this Handbook for detailed information on Complaints and Grievances.

Program Exception Process

For those services that have limits, if you or your provider believes that you need more services than the limits on the service allows, you or your provider can ask for a program exception (PE). The PE process is different from the Dental Benefit Limit Exception process described on page **[MCO to insert page number]**.

To ask for a PE, **[MCO to add information on how to request a PE]**

[MCO to add additional Program Exception information as necessary]

Service Descriptions

Emergency Services

Emergency services are services needed to treat or evaluate an emergency medical condition. An emergency medical condition is an injury or illness that is so severe that a reasonable person with no medical training would believe that there is an immediate risk to a person's life or long-term health. If you have an emergency medical condition, go to the nearest emergency room, dial 911, or call your local ambulance provider. You do **not** have to get approval from **[MCO Name]** to get emergency services and you may use any hospital or other setting for emergency care.

Below are some examples of emergency medical conditions and non-emergency medical conditions:

Emergency medical conditions

- Heart attack
- Chest pain
- Severe bleeding
- Intense pain
- Unconsciousness
- Poisoning

Non-emergency medical conditions

- Sore throat
- Vomiting
- Cold or flu
- Backache
- Earache
- Bruises, swelling, or small cuts

If you are unsure if your condition requires emergency services, call your PCP or the **[MCO Name]** Nurse Hotline at **[MCO Nurse Hotline Phone Number]** 24 hours a day, 7 days a week.

[MCO to add any additional information about emergency services as necessary]

Emergency Medical Transportation

[MCO Name] covers emergency medical transportation by an ambulance for emergency medical conditions. If you need an ambulance, call 911 or your local ambulance provider. Do not call MATP (described on page **[MCO to insert page number]** of this Handbook) for emergency medical transportation.

Urgent Care

[MCO Name] covers urgent care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition. This is when you need attention from a doctor, but not in the emergency room.

If you need urgent care, but you are not sure if it is an emergency, call your PCP or the **[MCO Name]** Nurse Hotline at **[MCO Nurse Hotline phone number]** first. Your PCP or the hotline nurse will help you decide if you need to go to the emergency room, the PCP's office, or an urgent care center near you. In most cases if you need urgent care, your PCP will give you an appointment within 24 hours. If you are not able to reach your PCP or your PCP cannot see you within 24 hours and your medical condition is not an emergency, you may also visit an urgent care center or walk-in clinic within **[MCO Name]**'s network. Prior authorization is not required for services at an Urgent Care center.

Some examples of medical conditions that may need urgent care include:

- Vomiting
- Coughs and fever
- Sprains
- Rashes
- Earaches
- Diarrhea
- Sore throats
- Stomach aches

If you have any questions, please call Member Services at **[MCO Member Services Phone Number and TTY].**

[MCO to add any additional information about urgent care services as necessary]

Dental Care Services

[MCO to provide information on DBM if applicable]

Members Under 21 Years of Age

[MCO Name] provides all medically necessary dental services for children under 21 years of age. Children may go to a participating dentist within the **[DBM / MCO Name]** network.

Dental visits for children do not require a referral. If your child is 1 year old or older and does not have a dentist, you can ask your child's PCP to refer your child to a dentist for regular dental checkups. For more information on dental services, contact **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]

Members 21 Years of Age and Older

[MCO Name] covers some dental benefits for members 21 years of age and older through dentists in the **[DBM / MCO Name]** network. Some dental services have limits.

[MCO to include further details and specifics including process for choosing and changing a dentist, covered services, co-payments, and prior authorization and BLE requirements]

Dental Benefit Limit Exception

Some dental services are only covered with a Benefit Limit Exception (BLE). You or your dentist can also ask for a BLE if you or your dentist believes that you need more dental services than the limits allow.

[MCO Name] will approve a BLE if**:**

- You have a serious or chronic illness or health condition and without the additional service your life would be in danger; OR

- You have a serious or chronic illness or health condition and without the additional service your health would get much worse; OR
- You would need more expensive treatment if you do not get the requested service; OR
- It would be against federal law for **[MCO Name]** to deny the exception.

Your dental service may also be covered by a BLE if you have one of the following underlying medical/dental condition(s).

- 1. Diabetes
- 2. Coronary Artery Disease or risk factors for the disease
- 3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin)
- 4. Intellectual Disability
- 5. Current Pregnancy including post-partum period

To ask for a BLE before you receive the service, you or your dentist can call **[MCO/DBM Name]** Member Services at **[MCO/DBM Member Services Phone Number and TTY]** or send the request to:

[MCO/DBM Contact Address].

BLE requests must include the following information:

- Your name
- Your address
- Your phone number
- The service you need
- The reason you need the service
- Your provider's name
- Your provider's phone number

Time Frames for Deciding a Benefit Limit Exception

If you or your provider asks for an exception before you get the service, **[MCO Name]** will let you know whether or not the BLE is approved within the same time frame as the time frame for prior authorization requests, described on page **[MCO to insert page number]**. **[or MCO can repeat the time frame]**.

If your dentist asks for an exception after you got the service, **[MCO Name]** will let you know whether or not the BLE request is approved within 30 days of the date **[MCO Name]** gets the request.

If you disagree with or are unhappy with **[MCO Name]**'s decision, you may file a Complaint or Grievance with **[MCO Name]**. For more information on the Complaint and Grievance process, please see Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings on page **[MCO to insert page number]**.

Vision Care Services

[MCO to provide information on Vision Benefit Manager if applicable]

Members Under 21 Years of Age

[MCO Name] covers all medically necessary vison services for children under 21 years of age. Children may go to a participating vision provider within the **[MCO/VBM Name]** network.

[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]

Members 21 Years of Age and Older

[MCO Name] covers some vision services for members 21 years of age and older through providers within the **[MCO/VBM Name]** network.

[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]

Pharmacy Benefits

[MCO Name] covers pharmacy benefits that include prescription medicines and over-the-counter medicines and vitamins with a doctor's prescription.

Prescriptions

When a provider prescribes a medication for you, you can take it to any pharmacy that is in **[MCO Name]**'s network. You will need to have your **[MCO Name]** prescription ID card with you and you may have a co-payment if you are over the age of 18. **[MCO Name]** will pay for any medicine listed on the Statewide PDL and **[MCO Name]**'s supplemental formulary and may pay for other medicines if they are prior authorized. Either your prescription or the label on your medicine will tell you if your doctor ordered refills of the prescription and how many refills you may get. If your doctor ordered refills, you may only get 1 refill at a time. If you have questions about whether a prescription medicine is covered, need help finding a pharmacy in **[MCO Name]**'s network, or have any other questions, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to add additional information on prescriptions as necessary]

Statewide Preferred Drug List (PDL) and [MCO Name] Supplemental Formulary

[MCO Name] covers medicines listed on the Statewide Preferred Drug List (PDL) and the **[MCO Name]** supplemental formulary. This is what your PCP or other doctor should use when deciding what medicines you should take. Both the Statewide PDL and [MCO Name] supplemental formulary cover both brand name and generic drugs. . Generic drugs contain the same active ingredients as brand name drugs. Any medicine prescribed by your doctor that is not on the Statewide PDL and **[MCO Name]**'s supplemental formulary needs prior authorization. The Statewide PDL and **[MCO Name]**'s supplemental formulary can change from time to time, so you should make sure that your provider has the latest information when prescribing a medicine for you.

If you have any questions or to get a copy of the the Statewide PDL and **[MCO Name]**'s supplemental formulary, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO to insert link to formulary on website]**.

[MCO to add any additional information on the drug formulary as necessary]

Reimbursement for Medication

[MCO to provide description of any potential reimbursement for medication]

Specialty Medicines

The Statewide PDL and **[MCO Name]**'s supplemental formulary includes medicines that are called specialty medicines. A prescription for these medicines needs to be prior authorized **[MCO may remove sentence if prior authorization is not required]**. You may have a co-payment for your medicine. To see the Statewide Preferred Drug List, the **[MCO Name]**'s supplemental formulary and a complete list of specialty medicines, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO to insert link to formulary on website]**.

You will need to get these medicines from a specialty pharmacy. A specialty pharmacy can mail your medicines directly to you and will not charge you for sending you your medicines. The specialty pharmacy will contact you before sending your medicine. The pharmacy can also answer any questions you have about the process. You can pick any specialty pharmacy that is in **[MCO Name]**'s network. For the list of network specialty pharmacies, please call Member Services at **[MCO Member Services Phone Number and TTY]** or see the provider directory on **[MCO Name]**'s website at **[MCO to insert link to provider directory on website].** For any other questions or more information please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Over-the-Counter Medicines

[MCO Name] covers over-the-counter medicines when you have a prescription from your provider. You will need to have your **[MCO Name]** prescription ID card with you and you may have a co-payment. The following are some examples of covered over-the-counter medicines:

- Sinus and allergy medicine
- Tylenol or aspirin
- Vitamins
- Cough medicine
- Heartburn medicine
- **[MCO may add additional items]**

You can find more information about covered over-the-counter medicines by visiting **[MCO Name]**'s website at **[MCO website]** or by calling Member Services at **[Member Services phone number and TTY]**.

Tobacco Cessation

Do you want to quit smoking? [MCO Name] wants to help you quit!

If you are ready to be smoke free, no matter how many times you have tried to quit smoking, we are here to help you.

Medicines

The Statewide PDL covers the following medicines to help you quit smoking.

[MCO to insert chart of tobacco medicines covered and whether they require prior authorization]

Contact your PCP for an appointment to get a prescription for a tobacco cessation medicine.

Counseling Services

Counseling support may also help you to quit smoking. **[MCO Name]** covers the following counseling services: **[MCO to insert specific information on what is covered & how to receive counseling services here.]**

Behavioral Health Treatment

Some people may be stressed, anxious, or depressed when they are trying to become smoke-free. **[MCO Name]** members are eligible for services to address these side effects, but these services are covered by your BH-MCO. You can find the BH-MCO in your county and its contact information on page **[xx]** in this Handbook. You can also call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]** for help in contacting your BH-MCO.

[MCO to provide additional behavioral health treatment for tobacco cessation information as necessary]

Case Management Programs [If Applicable]

[If the MCO offers tobacco cessation as part of any case management programs insert that specific information here.]

Other Tobacco Cessation Resources

[Insert information on services provided by and contact information for tobacco cessation services offered by the PA Free Quit line, PA Cancer Society, and the American Heart Association and the American Lung Association.]

Remember **[MCO Name]** is here to help support you in becoming healthier by becoming smoke-free. Do not wait! Please call Member Services at **[MCO Member Services Phone Number and TTY]** so we can help to get you started.

Family Planning

[MCO Name] covers family planning services. You do not need a referral from your PCP for family planning services. These services include pregnancy testing, testing and treatment of sexually transmitted diseases, birth control supplies, and family planning education and counseling. You can see any doctor that is a Medical Assistance provider, including any out-of-network provider that offers family planning services. There is no co-payment for these services. When you go to a family planning provider that is not in the **[MCO Name]** network, you must show your **[MCO Name]** and ACCESS or EBT card.

For more information on covered family planning services or to get help finding a family planning provider, call Member Services at **[MCO Member Services Phone Number and TTY].**

Maternity Care

Care During Pregnancy

Prenatal care is the health care a woman receives through her pregnancy and delivery from a maternity care provider, such as an obstetrician (OB or OB/GYN) or a nurse-midwife. Early and regular prenatal care is very important for you and your baby's health. Even if you have been pregnant before, it is important to go to a maternity care provider regularly through each pregnancy.

If you think you are pregnant and need a pregnancy test, see your PCP or a family planning provider. If you are pregnant, you can:

- Call or visit your PCP, who can help you find a maternity care provider in the **[MCO Name]**'s network.
- Visit a network OB or OB/GYN or nurse-midwife on your own. You do not need a referral for maternity care.
- Visit a network health center that offers OB or OB/GYN services.
- Call Member Services at **[MCO Member Services Phone Number and TTY]** to find a maternity care provider.

You should see a doctor as soon as you find out you are pregnant. Your maternity care provider must schedule an appointment to see you

- If you are in your first trimester, within 10 business days of **[MCO Name]** learning you are pregnant.
- If you are in your second trimester, within 5 business days of **[MCO Name]** learning you are pregnant.
- If you are in your third trimester, within 4 business days of **[MCO Name]** learning you are pregnant.
- If you have a high-risk pregnancy, within 24 hours of **[MCO Name]** learning you are pregnant.

If you have an emergency, go to the nearest emergency room, dial 911, or call your local ambulance provider.

It is important that you stay with the same maternity care provider throughout your pregnancy and postpartum care (1 year after your baby is born). They will follow your health and the health of your growing baby closely. It is also a good idea to stay with the same HealthChoices plan during your entire pregnancy.

[MCO Name] has specially trained maternal health coordinators who know what services and resources are available for you.

If you are pregnant and are already seeing a maternity care provider when you enroll in **[MCO Name]**, you can continue to see that provider even if he or she is not in **[MCO Name]**'s network. The provider will need to be enrolled in the Medical Assistance Program and must call **[MCO Name]** for approval to treat you.

[MCO to add any additional information on maternity care as necessary]

Care for You and Your Baby After Your Baby is Born

You should visit your maternity care provider between **[MCO may choose preferred time frame]** after your baby is delivered for a check-up unless your maternity care provider wants to see you sooner.

Your baby should have an appointment with the baby's PCP when he or she is 3 to 5 days old, unless the doctor wants to see your baby sooner. It is best to pick a doctor for your baby while you are still pregnant. If you need help picking a doctor for your baby, please call Member Services at **[MCO Member Services Phone Number and TTY].**

MCO Maternity Program [If applicable]

[MCO Name] has a special program for pregnant women called **[Program Name]**.

[Insert information and details here about MCO Maternity Program if applicable].

Durable Medical Equipment and Medical Supplies

[MCO Name] covers Durable Medical Equipment (DME) and medical supplies. DME is a medical item or device that can be used many times in your home or in any setting where normal life activities occur and is generally not used unless a person has an illness or injury. Medical supplies are usually disposable and are used for a medical purpose. Some of these items need prior authorization, and your physician must order them. DME suppliers must be in the **[MCO Name]** network. You may have a co-payment.

[MCO Name] will not be held liable for reimbursement regarding the out of pocket cost for DME (durable medical equipment) purchased from a retail store or online retail dealer (e.g. Amazon). Retail stores and suppliers are not covered by your medical DME benefit for safety reasons. **[MCO Name]** offers a wide network of participating DME providers who are credentialed to meet Medicare and Medicaid standards and requirements.

Examples of DME include:

- Oxygen tanks
- Wheelchairs
- Crutches
- Walkers
- Splints
- Special medical beds

Examples of home accessibility DME include:

- Wheelchair lifts
- Stair glides
- Ceiling lifts
- Metal accessibility ramps

[MCO Name] covers installation of the home accessibility DME, but not home modifications.

Examples of medical supplies include:

- Diabetic supplies (such as syringes, test strips)
- Gauze pads
- Dressing tape
- Incontinence supplies (such as pull ups, briefs, underpads)

If you have any questions about DME or medical supplies, or for a list of network suppliers, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Outpatient Services

[MCO Name] covers outpatient services such as physical, occupational, and speech therapy as well as x-rays and laboratory tests. Your PCP will arrange for these services with one of **[MCO Name]**'s network providers.

[MCO to include further details and specifics, including whether prior authorization is needed]

Nursing Facility Services

[**MCO Name]** covers medically necessary nursing facility services. If you need long term nursing facility services (longer than 30 days), you can apply for the Community HealthChoices Program. You will be evaluated to see if you are eligible for participation in the Community HealthChoices Program. If you have any questions or need more information, please call Member Services at **[phone number and TTY].**

Hospital Services

[MCO Name] covers inpatient and outpatient hospital services. If you need inpatient hospital services and it is not an emergency, your PCP or specialist will arrange for you to be admitted to a hospital in **[MCO Name]**'s network and will follow your care even if you need other doctors during your hospital stay. Inpatient hospital stays must be approved by **[MCO Name]**. To find out if a hospital is in the **[MCO Name]** network, please call Member Services at **[MCO Member Services Phone Number and TTY]** or check the provider directory on **[MCO Name]**'s website at **[website link to provider directory]**.

If you have an emergency and are admitted to the hospital, you or a family member or friend should let your PCP know as soon as possible but no later than 24 hours after you were admitted to the hospital. If you are admitted to a hospital that is not in **[MCO Name]**'s network, you may be transferred to a hospital in **[MCO Name]**'s network. You will not be moved to a new hospital until you are strong enough to be transferred to a new hospital.

It is very important to make an appointment to see your PCP within 7 days after you leave the hospital. Seeing your PCP right after your hospital stay will help you follow any instructions you got while you were in the hospital and prevent you from having to be readmitted to the hospital.

Sometimes you may need to see a doctor or receive treatment at a hospital without being admitted overnight. These services are called outpatient hospital services.

If you have any other questions about hospital services, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to include further details and specifics including if prior authorization or referral from a PCP is required]

Preventive Services

[MCO Name] covers preventive services, which can help keep you healthy. Preventive services include more than just seeing your PCP once a year for a check-up. They also include immunizations (shots), lab tests, and other tests or screenings that let you and your PCP know if you are healthy or have any health problems. Visit your PCP for preventive services. He or she will guide your health care according to the latest recommendations for care.

Women can also go to a participating OB/GYN for their yearly Pap test and pelvic exam, and to get a prescription for a mammogram.

[MCO can include further details and specifics]

Physical Exam

You should have a physical exam by your PCP at least once a year. This will help your PCP find any problems that you may not know about. Your PCP may order tests based on your health history, age, and sex. Your PCP will also check if you are up to date on immunizations and preventive services to help keep you healthy.

If you are unsure about whether or not you are up to date with your health care needs, please call your PCP or Member Services at **[MCO Member Services Phone Number and TTY].** Member Services can also help you make an appointment with your PCP.

New Medical Technology

[MCO Name] may cover new medical technologies such as procedures and equipment if requested by your PCP or specialist**. [MCO Name]** wants to make sure that new medical technologies are safe, effective, and right for you before approving the service.

[Insert MCO information on how new technologies are reviewed and approved. If MCO does not have information, remove entire New Medical Technology section]

If you need more information on new medical technologies, please call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY].**

Home Health Care

[MCO Name] covers home health care provided by a home health agency. Home health care is care provided in your home and includes skilled nursing services; help with activities of daily living such as bathing, dressing, and eating; and physical, speech, and occupational therapy. Your physician must order home health care.

If you are over age 21, there are **[no-MCO to insert whatever is correct]** limits on the number of home health care visits that you can get **[MCO to add the following if has limits: unless you or your provider asks for an exception to the limits.]**

OR

[MCO Name] has a program that includes home health care visits directly relating to a special health care need such as **[MCO to identify programs]**.

OR BOTH

You should contact Member Services at **[MCO Member Services Phone Number and TTY]** if you have been approved for home health care and that care is not being provided as approved.

[MCO to add any additional information as necessary]

Patient Centered Medical Homes

A patient-centered medical home or health home is a team approach to providing care. It is not a building, house, or home health care service.

[MCO to add information on their Patient Centered Medical Home program]

Disease Management

[MCO Name] has voluntary programs to help you take better care of yourself if you have one of the health conditions listed below. **[MCO Name]** has care managers who will work with you and your providers to make sure you get the services you need. You do not need a referral from your PCP for these programs, and there is no co-payment.

[MCO should list and provide a brief description of each of their specific programs here, including HIV/AIDS programs].

By following your provider's plan of care and learning about your disease or condition, you can stay healthier. **[MCO Name]** care managers are here to help you understand how to take better care of yourself by following your doctor's orders, teaching you about your medicines, helping you to improve your health, and giving you information to use in your community. If you have any questions or need help, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Expanded Services

[MCO to provide list and description of any enhanced benefits offered to all members, including requirements for coverage and how to access.]

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT services are available for children under the age of 21. They are sometimes also referred to as well-baby or well-child checkups. Your child may be seen by a pediatrician, family practice doctor, or CRNP. The provider you choose for your child will be your child's PCP. The purpose of this service is to detect potential health problems early and to make sure your child stays healthy. If you have questions or want more information, contact Member Services at **[MCO Member Services Phone Number and TTY]**.

When Should an EPSDT Exam be Completed?

Children and young adults should have their examinations completed based on the schedule listed below. It is important to follow this schedule even if your child is not sick. Your provider will tell you when these visits should occur. Infants and toddlers will need several visits per year, while children between the ages of 3 to 20 will need just 1 visit per year.

Recommended Screening Schedule			
3-5 Days	0-1 Months	2-3 Months	4-5 Months
6-8 Months	9-11 Months	12 Months	15 Months
18 Months	24 Months	30 Months	
Children ages 3-20 should be screened yearly			

What Will the Provider Do During the EPSDT Exam?

Your provider will ask you and your child questions, perform tests, and check how much your child has grown. The following services are some of the services that may be performed during an exam depending on the child's age and needs of the child:

- A complete physical exam
- Immunizations
- Vision test
- Hearing test
- Autism screening
- Tuberculosis screening
- Oral health examination
- Blood pressure check
- Health and safety education
- Check of the child's body mass index (BMI)
- Screen and/or counsel for tobacco and alcohol use and substance use starting at age 11
- Urinalysis screening
- Blood lead screening test
- Developmental screening
- Depression screening starting at age 12
- Maternal depression screening

[MCO Name] covers services that are needed to treat health problems that are identified during the EPSDT exam.

Additional services are available for children with special needs. Talk to your provider about whether or not your child may need these additional services.

Section 4 –

Out-of-Network
and
Out-of-Plan Services

Out-of-Network Providers

An out-of-network provider is a provider that does not have a contract with **[MCO Name]** to provide services to **[MCO Name]**'s members. There may be a time when you need to use a doctor or hospital that is not in the **[MCO Name]** network. If this happens, you can ask your PCP to help you. Your PCP has a special number to call to ask **[MCO Name]** that you be allowed to go to an out-of-network provider. **[MCO Name]** will check to see if there is another provider in your area that can give you the same type of care you or your PCP believes you need. If **[MCO Name]** cannot give you a choice of at least 2 providers in your area, **[MCO Name]** will cover medically necessary services provided by an out-of-network provider.

Getting Care While Outside of [MCO Name]'s Service Area

If you are outside of **[MCO Name]**'s service area and have a medical emergency, go to the nearest emergency room or call 911. For emergency medical conditions, you do not have to get approval from **[MCO Name]** to get care. If you need to be admitted to the hospital, you should let your PCP know.

If you need care for a non-emergency condition while outside of the service area, call your PCP or Member Services at **[MCO Member Services Phone Number and TTY]** who will help you to get the most appropriate care.

[MCO Name] will not pay for services received outside of the United States and its territories.

Out-of-Plan Services

You may be eligible to get services other than those provided by **[MCO Name]**. Below are some services that are available but are not covered by **[MCO Name]**. If you would like help in getting these services, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Non-Emergency Medical Transportation

[MCO Name] does not cover non-emergency medical transportation for most HealthChoices members. **[MCO Name]** can help you arrange transportation to covered service appointments through programs such as Shared Ride or the MATP described below.

[MCO Name] does cover non-emergency medical transportation if:

- You live in a nursing home, and need to go to any medical appointment or an urgent care center or a pharmacy for any Medical Assistance service, DME or medicine
- You need specialized non-emergency medical transportation, such as if you need to use a stretcher to get to your appointment

If you have questions about non-emergency medical transportation, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Medical Assistance Transportation Program

MATP provides non-emergency transportation to and from qualified MA-enrolled medical providers and pharmacies of your choice who are generally available and used by other residents of your community. This service is provided at no cost to you. The MATP in the county where you live will determine your need for services and provide the right type of transportation for you. Transportation services are typically provided in the following ways:

- Where public transportation such as buses, subways or trains are available, MATP provides tokens or passes or repays you for the public transportation fare if you live within ¼ mile of a fixed route service stop.

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- If you or someone else has a car that you can use to get to your appointment, MATP may pay you an amount per mile plus parking and tolls with valid receipts.
- Where public transportation is not available or is not right for you, MATP provides rides in paratransit vehicles, which include vans, vans with lifts, or taxis. Usually the vehicle will have more than 1 rider with different pick-up and drop-off times and locations.

If you need transportation to a medical appointment or to the pharmacy, contact your local MATP to get more information and to register for services. **[MCO to provide list of MATP contacts in counties served or direction to page of handbook were MATP contact list can be found]** A complete list of county MATP contact information can be found here: http://matp.pa.gov/CountyContact.aspx. **(OR)** Please see page _____of this handbook for a complete list of county MATP contact information.

MATP will confirm with **[MCO Name]** or your doctor's office that the medical appointment you need transportation for is a covered service. **[MCO Name]** works with MATP to help you arrange transportation. You can also call Member Services for more information at **[MCO Member Services Phone Number and TTY].**

Women, Infants, and Children Program

The Women, Infants, and Children Program (WIC) provides healthy foods and nutrition services to infants, children under the age of 5, and women who are pregnant, have given birth, or are breastfeeding. WIC helps you and your baby eat well by teaching you about good nutrition and giving you food vouchers to use at grocery stores. WIC helps babies and young children eat the right foods so they can grow up healthy. You can ask your maternity care provider for a WIC application at your next visit or call 1-800-WIC-WINS (1-800-942-9467). For more information visit the WIC website at www.pawic.com

Domestic Violence Crisis and Prevention

Domestic violence is a pattern of behavior where one person tries to gain power or control over another person in a family or intimate relationship.

There are many different types of domestic violence. Some examples include:

- Emotional abuse
- Physical violence
- Stalking
- Sexual violence
- Financial abuse
- Verbal abuse
- Elder Abuse
- Intimate partner violence later in life
- Intimate partner abuse
- Domestic Violence in the LGBTQ+ Community

There are many different names used to talk about domestic violence. It can be called: abuse; domestic violence; battery; intimate partner violence; or family, spousal, relationship or dating violence.

If any of these things are happening to you, or have happened, or you are afraid of your partner, you may be in an abusive relationship.

Domestic violence is a crime and legal protections are available to you. Leaving a violent relationship is not easy, but you can get help.

Where to get help:

National Domestic Violence Hotline

1-800-799-7233 (SAFE)
1-800-787-3224 (TTY)

Pennsylvania Coalition Against Domestic Violence

The services provided to domestic violence victims include: crisis intervention; counseling; going along to police, medical, and court appointments; and temporary emergency shelter for victims and their dependent children. Prevention and educational programs are also provided to lower the risk of domestic violence in the community.

1-800-932-4632 (in Pennsylvania)

Sexual Violence and Rape Crisis

Sexual violence includes any type of unwanted sexual contact, words or actions of a sexual nature that is against a person's will. A person may use force, threats, manipulation, or persuasion to commit sexual violence. Sexual violence can include:

- Rape
- Sexual assault
- Incest
- Child sexual assault
- Date and acquaintance rape
- Grabbing or groping
- Sexting without permission
- Ritual abuse
- Commercial sexual exploitation (for example: prostitution)
- Sexual harassment
- Anti-LGBTQ+ bullying

- Exposure and voyeurism (the act of being viewed, photographed, or filmed in a place where one would expect privacy)
- Forced participation in the production of pornography

Survivors of sexual violence can have physical, mental or emotional reactions to the experience. A survivor of sexual violence may feel alone, scared, ashamed, and fear that no one will believe them. Healing can take time, but healing can happen.

Where to get help:

Pennsylvania rape crisis centers serve all adults and children. Services include:

- Free and confidential crisis counseling 24 hours a day.
- Services for a survivor's family, friends, partners or spouses.
- Information and referrals to other services in your area and prevention education programs.

Call **1-888-772-7227** or visit the link below to reach your local rape crisis center.

Pennsylvania Coalition Against Rape (www.pcar.org/)

Early Intervention Services

While all children grow and develop in unique ways, some children experience delays in their development. Children with developmental delays and disabilities can benefit from the Early Intervention Program.

The Early Intervention Program provides support and services to families with children birth to the age of 5 who have developmental delays or disabilities. Services are provided in natural settings, which are settings where a child would be if the child did not have a developmental delay or disability.

Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family. These services and supports address the following areas:

- Physical development, including vision and hearing
- Cognitive development

- Communication development
- Social or emotional development
- Adaptive development

Parents who have questions about their child's development may contact the CONNECT Helpline at 1-800-692-7288 or visit www.papromiseforchildren.org. The CONNECT Helpline assists families in locating resources and providing information regarding child development for children from birth to age 5. In addition, CONNECT can help parents with contacting their county Early Intervention Program or local preschool Early Intervention Program.

Section 5 –

Special Needs

Special Needs Unit

[MCO Name] wants to make sure all of our members get the care they need. We have trained case managers in the **[MCO Name]** Special Needs Unit that help our members with special needs have access to the care they need. The case managers of the unit help members with physical or behavioral disabilities, complex or chronic illnesses, and other special needs. **[MCO Name]** understands that you and your family may need help with issues that may not be directly related to your health care needs. The Special Needs Unit is able to assist you with finding programs and agencies in the community that can help you and your family address these needs.

[MCO to add any additional information on its special needs unit as necessary]

If you think you or someone in your family has a special need, and you would like the Special Needs Unit to help you, please contact them by calling **[SNU Hotline #, please note if the member has to choose a specific menu option to reach the SNU].** The Special Needs Unit staff members are available **[days and hours of operation].** If you need assistance when the Special Needs Unit staff are not available you may call **[alternate MCO contact]**.

Coordination of Care

The **[MCO Name]** Special Needs Unit will help you coordinate care for you and your family who are members of **[MCO Name]**. In addition, **[MCO Name]** can assist in connecting you with other state and local programs.

If you need help with any part of your care, your child's care, or coordinating that care with another state, county, or local program, please contact the **[MCO Name]** Special Needs Unit for assistance.

The **[MCO Name]** Special Needs Unit will also assist members in transitioning care from services received in a hospital or temporary medical setting to care received at home. We want our members to be able to move back home as soon as possible. Please contact the **[MCO Name]** Special Needs Unit for assistance in help receiving care in your home.

Care Management

[MCO to add language specific to any Care Management]

Home and Community-Based Waivers and Long-Term Services and Supports

The Office of Developmental Programs (ODP) administers the Consolidated Waiver, Community Living Waiver, Person/Family Directed Supports Waiver, Adult Autism Waiver, and the Adult Community Autism Program (ACAP) for individuals with intellectual disabilities or autism. If you have questions regarding any of these programs, you may contact ODP's Customer Service Hotline at 1-888-565-9435, or request assistance from the Special Needs Unit at **[MCO Name].**

The Office of Long-Term Living (OLTL) administers programs for seniors and individuals with physical disabilities. This includes the Community HealthChoices Program (CHC). The CHC Program is a Medical Assistance managed care program for individuals who also have Medicare coverage or who need the services of a nursing facility or home-and community-based wavier.

If you have questions regarding what services are available and how to apply, you may contact OLTL's Participant Helpline at 1-800-757-5042 or request assistance from the **[MCO Name]** Special Needs Unit at **[SNU Contact Information]**.

Medical Foster Care

The Office of Children, Youth, and Families has oversight of medical foster care for children under the authority of county children and youth programs. If you have questions about this program, please contact the Special Needs Unit at **[SNU Contact Information]**.

Section 6 –

Advance Directives

Advance Directives

There are 2 types of advance directives: Living Wills and Health Care Powers of Attorney. These allow for your wishes to be respected if you are unable to decide or speak for yourself. If you have either a Living Will or a Health Care Power of Attorney, you should give it to your PCP, other providers, and a trusted family member or friend so that they know your wishes.

If the laws regarding advance directives are changed, **[MCO Name]** will tell you in writing what the change is within 90 days of the change. For information on **[MCO Name]**'s policies on advance directives, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO Website]**.

Living Wills

A Living Will is a document that you create. It states what medical care you do, and do not, want to get if you cannot tell your doctor or other providers the type of care you want. Your doctor must have a copy and must decide that you are unable to make decisions for yourself for a Living Will to be used. You may revoke or change a Living Will at any time.

Health Care Power of Attorney

A Health Care Power of Attorney is also called a Durable Power of Attorney. A Health Care or Durable Power of Attorney is a document in which you give someone else the power to make medical treatment decisions for you if you are physically or mentally unable to make them yourself. It also states what must happen for the Power of Attorney to take effect. To create a Health Care Power of Attorney, you may but do not have to get legal help. You may contact **[MCO Contact]** for more information or direction to resources near you.

What to Do if a Provider Does Not Follow Your Advance Directive

Providers do not have to follow your advance directive if they disagree with it as a matter of conscience. If your PCP or other provider does not want to follow your advance directive, **[MCO Name]** will help you find a provider that will carry out your wishes. Please call Member Services at **[MCO Member Services Phone Number and TTY]** if you need help finding a new provider.

If a provider does not follow your advance directive, you may file a Complaint. Please see page **[xx]** in Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint; or call Member Services at **[MCO Member Services Phone Number and TTY]**.

Section 7 –

Behavioral Health Services

Behavioral Health Care

Behavioral health services include both, mental health services and substance use disorder services. These services are provided through behavioral health managed care organizations (BH-MCOs) that are overseen by the Department of Human Services' Office of Mental Health and Substance Abuse Services (OMHSAS).
Contact information for the BH-MCO is listed below **[MCO to insert BH-MCO contact list below]**. You can also call Member Services at **[MCO Member Services Phone Number and TTY]** to get contact information for your BH-MCO.

You can call your BH-MCO toll-free 24 hours a day, 7 days a week.

You do not need a referral from your PCP to get behavioral health services, but your PCP will work with your BH-MCO and behavioral health providers to help get you the care that best meets your needs. You should let your PCP know if you, or someone in your family, is having a mental health or drug and alcohol problem.

The following services are covered:

- Behavioral health rehabilitation services (BHRS) (children and adolescent)
- Clozapine (Clozaril) support services
- Drug and alcohol inpatient hospital-based detoxification services (adolescent and adult)
- Drug and alcohol inpatient hospital-based rehabilitation services (adolescent and adult)
- Drug and alcohol outpatient services
- Drug and alcohol methadone maintenance services
- Family based mental health services
- Laboratory (when related to a behavioral health diagnosis and prescribed by a behavioral health practitioner)
- Mental health crisis intervention services
- Mental health inpatient hospitalization
- Mental health outpatient services
- Mental health partial hospitalization services
- Peer support services
- Residential treatment facilities (children and adolescent)
- Targeted case management services

If you have questions about transportation to appointments for any of these services, contact your BH-MCO.

Section 8 –

Complaints, Grievances, and Fair Hearings

Complaints, Grievances, and Fair Hearings

If a provider or **[MCO Name]** does something that you are unhappy about or do not agree with, you can tell **[MCO Name]** or the Department of Human Services what you are unhappy about or that you disagree with what the provider or **[MCO Name]** has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell **[MCO Name]** you are unhappy with **[MCO Name]** or your provider or do not agree with a decision by **[MCO Name]**.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that **[MCO Name]** has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

First Level Complaint

What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Complaint, or
- Write down your Complaint and send it to **[MCO Name]** by mail or fax, or
- If you received a notice from **[MCO Name]** telling you **[MCO Name]**'s decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to **[MCO Name]** by mail or fax.

[MCO Name]'s address and fax number for Complaints:
[MCO address]
[MCO fax number]

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that

- **[MCO Name]** has decided that you cannot get a service or item you want because it is not a covered service or item.
- **[MCO Name]** will not pay a provider for a service or item you got.
- **[MCO Name]** did not tell you its decision about a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.
- **[MCO Name]** has denied your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

New member appointment for your first examination…	**We will make an appointment for you…**
members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a member in **[MCO Name]** unless you are already being treated by a PCP or specialist.
members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than 45 days after you become a member in

members under the age of 21	**[MCO Name]**, unless you are already being treated by a PCP or specialist.
	with PCP for an EPSDT exam no later than 45 days after you become a member in **[MCO Name],** unless you are already being treated by a PCP or specialist.
all other members	
Members who are pregnant:	with PCP no later than 3 weeks after you become a member in **[MCO Name]**.
pregnant women in their first trimester	**We will make an appointment for you . . .** with OB/GYN provider within 10 business days of **[MCO Name]** learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within 5 business days of **[MCO Name]** learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within 4 business days of **[MCO Name]** learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of **[MCO Name]** learning you are pregnant.

Appointment with…	**An appointment must be scheduled . . . . .**
PCP	
urgent medical condition	within 24 hours.
routine appointment	within 10 business days.
health assessment/general physical examination	within 3 weeks.
Specialists (when referred by PCP)	
urgent medical condition	within 24 hours of referral.
routine appointment with one of the following specialists:	

• Otolaryngology • Dermatology • Pediatric Endocrinology • Pediatric General Surgery • Pediatric Infectious Disease • Pediatric Neurology • Pediatric Pulmonology • Pediatric Rheumatology • Dentist • Orthopedic Surgery • Pediatric Allergy & Immunology • Pediatric Gastroenterology • Pediatric Hematology • Pediatric Nephrology • Pediatric Oncology • Pediatric Rehab Medicine • Pediatric Urology • Pediatric Dentistry	within 15 business days of referral
routine appointment with all other specialists	within 10 business days of referral

You may file **all other Complaints at any time.**

What Happens After I File a First Level Complaint?

After you file your Complaint, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Complaint, and about the First Level Complaint review process.

You may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **[MCO Name]**.

You may attend the Complaint review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more **[MCO Name]** staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. **[MCO Name]** will mail you a notice within **[date that is no more than 30 days from receipt of the Complaint]** days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page _____ **[MCO to insert page number of help section]**.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like [MCO Name]'s Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- **[MCO Name]**'s decision that you cannot get a service or item you want because it is not a covered service or item.
- **[MCO Name]**'s decision to not pay a provider for a service or item you got.

- **[MCO Name]**'s failure to decide a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.
- You not getting a service or item within the time by which you should have received it
- **[MCO Name]**'s decision to deny your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice**.

You must ask for a Fair Hearing within **120 days from the mail date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice**.

For information about Fair Hearings, see page _____
For information about external Complaint review, see page ___
If you need more information about help during the Complaint process, see page _____
[MCO to insert page number].

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Second Level Complaint, or
- Write down your Second Level Complaint and send it to **[MCO Name]** by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to **[MCO Name]** by mail or fax.

[MCO Name]'s address and fax number for Second Level Complaints
[MCO address]
[MCO fax number]

What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Complaint, and about the Second Level Complaint review process.

You may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **[MCO Name]**.

You may attend the Complaint review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for **[MCO Name]**, will meet to decide your Second Level Complaint. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. **[MCO Name]** will mail you a notice within **[date that is no more than 45 days from receipt of the Second Level Complaint]** days from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page _____ **[MCO to insert page number of help section]**.

What if I Do Not Like [MCO Name]'s Decision on My Second Level Complaint?

You may ask for an external review from the Pennsylvania Insurance Department's Bureau of Managed Care.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice.**

External Complaint Review

How Do I Ask for an External Complaint Review?

Send your written request for an external review of your Complaint to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Telephone Number: 1-877-881-6388

You can also go to the "File a Complaint Page" at:
https://www.insurance.pa.gov/Consumers/insurance-complaint/Pages/default.aspx

If you need help filing your request for external review, call the Bureau of Consumer Services at 1-877-881-6388.

If you ask, the Bureau of Consumer Services will help you put your Complaint in writing.

What Happens After I Ask for an External Complaint Review?

The Insurance Department will get your file from **[MCO Name]**. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Complaint review is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you, the services or items will continue until a decision is made. If you will be asking for both an external Complaint review and a Fair Hearing, you must request both the external Complaint review and the Fair Hearing within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint decision. If you wait to request a Fair Hearing until after receiving a decision on your external Complaint, services will not continue.

GRIEVANCES

What is a Grievance?

When **[MCO Name]** denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you **[MCO Name]**'s decision.

A Grievance is when you tell **[MCO Name]** you disagree with **[MCO Name]**'s decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or
- Write down your Grievance and send it to **[MCO Name]** by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from **[MCO Name]** and send it to **[MCO Name]** by mail or fax.

[MCO Name]'s address and fax number for Grievances:
[MCO address]
[MCO fax number]

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Grievance, and about the Grievance review process.

You may ask **[MCO Name]** to see any information that **[MCO Name]** used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to **[MCO Name]**.

You may attend the Grievance review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you

decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. If the Grievance is about dental services, the Grievance review committee will include a dentist The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. **[MCO Name]** will mail you a notice within **[date that is no more than 30 days from receipt of the Grievance]** days from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page _____ **[MCO to insert page number of help section]**.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I Do Not Like [MCO Name]'s Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for **[MCO Name].**

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see page _____
For information about external Grievance reviews, see below
If you need more information about help during the Grievance process, see page _____ **[MCO to insert page number]**.

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or
- Write down your Grievance and send it to **[MCO Name]** by mail to: **[MCO address]**.

[MCO Name] will send your request for external Grievance review to the Insurance Department.

What Happens After I Ask for an External Grievance Review?

[MCO Name] will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

[MCO Name] will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within 15 days of filing the request for an external Grievance review.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a letter that is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s Grievance decision, the services or items will continue until a decision is made. If you will be asking for both an external Grievance review and a Fair Hearing, you must

request both the external Grievance review and the Fair Hearing within 10 days of the date on the notice telling you **[MCO Name]**'s Grievance decision. If you wait to request a Fair Hearing until after receiving a decision on your external Grievance, services will not continue.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **[30, unless the MCO will be using a shorter time frame to provide notice of 1st Level Complaint or Grievance decisions or 45, unless the MCO will be using a shorter time frame to provide notice of 2nd Level Complaint decisions]** days to get a decision about your Complaint or Grievance, could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask **[MCO Name]** for an early decision by calling **[MCO Name]** at **[Member Services Phone Number and TTY]**, faxing a letter or the Complaint/Grievance Request Form to **[MCO fax number],** or sending an email to **[PH-MCO e-mail]**.

- Your doctor or dentist should fax a signed letter to **[MCO fax number]** within 72 hours of your request for an early decision that explains why **[MCO Name]** taking **[30, unless the MCO will be using a shorter time frame for 1st Level Complaint or Grievance decisions or 45, unless the MCOS will be issuing a shorter time frame for 2nd level Complaint decisions]** days to tell you the decision about your Complaint or Grievance could harm your health.

If **[MCO Name]** does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, **[MCO Name]** will decide your Complaint or Grievance in the usual time frame of **[45, unless the MCO will be using a shorter time frame to provide notice of 1st Level Complaint or Grievance decisions]** days from when **[MCO Name]** first got your Complaint or Grievance.

Expedited Complaint and Expedited External Complaint

A committee of 3 or more people, including a licensed doctor, will meet to decide your Complaint. If the Complaint is about dental services, the expedited Grievance review committee will include a dentist. The **[MCO Name]** staff on the committee will not have

been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference **[MCO to include videoconferencing only if available]** because **[MCO Name]** has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

[MCO Name] will tell you the decision about your Complaint within 48 hours of when **[MCO Name]** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within 72 hours from when **[MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[MCO Name]** to take more time to decide your Complaint. You can ask **[MCO Name]** to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Insurance Department within **2 business days from the date you get the expedited Complaint decision notic**e. To ask for expedited external review of a Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Complaint, or
- Send an email to **[MCO Name]** at **[MCO email address]**, or
- Write down your Complaint and send it to **[MCO Name]** by mail or fax: **[MCO Address and fax number for requesting expedited external review of a Complaint]**.

Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference **[MCO to include videoconferencing only if available**] because **[MCO Name]** has a short amount of time to decide the expedited Grievance. If you

decide that you do not want to attend the Grievance review, it will not affect our decision.

[MCO Name] will tell you the decision about your Grievance within 48 hours of when **[MCO Name]** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when **[MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[MCO Name]** to take more time to decide your Grievance. You can ask **[MCO Name]** to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review within **2 business days from the date you get the expedited Grievance decision notic**e. To ask for expedited external review of a Grievance:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or
- Send an email to **[MCO Name]** at **[MCO email address]**, or
- Write down your Grievance and send it to **[MCO Name]** by mail or fax: **[MCO address and fax number for requesting expedited external review of a Grievance]**.

[MCO Name] will send your request to the Insurance Department within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of **[MCO Name**] will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell **[MCO Name]**, in writing, the name of that person and how **[MCO Name]** can reach him or her.

You or the person you choose to represent you may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call **[MCO Name]**'s toll-free telephone number at **[Member Services Phone Number and TTY]** if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at **[MCO insert Phone Number]** or call the Pennsylvania Health Law Project at 1-800-274-3258.

Persons Whose Primary Language Is Not English

If you ask for language services, **[MCO Name]** will provide the services at no cost to you.

Persons with Disabilities

[MCO Name] will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by **[MCO Name]** at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something **[MCO Name]** did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after **[MCO Name]** decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked within **120 days from the date on the notice** telling you **[MCO Name]**'s decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- **[MCO Name]**'s failure to decide a First Level Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name**] got your Complaint or Grievance.
- The denial of your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that **[MCO Name]** failed to decide a First Level Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter, it needs to include the following information:

- Your (the member's) name and date of birth;

- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair hearings
PO Box 2675
Harrisburg, PA 17105-2675

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

[MCO Name] will also go to your Fair Hearing to explain why **[MCO Name]** made the decision or explain what happened.

You may ask **[MCO Name]** to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **[MCO Name]**, not including the number of days between the date on the written notice of the **[MCO Name]**'s First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because **[MCO Name]** did not tell you its decision about a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer]** days from when **[MCO Name]** got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **[MCO Name]**, not including the number of days between the date on the notice

telling you that **[MCO Name]** failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339 or by faxing a letter or the Fair Hearing Request Form to 717-772-6328. Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call **[MCO Name]**'s toll-free telephone number at **[MCO Number]** if you need help or have questions about Fair Hearings, you can contact your local legal aid office

at **[MCO insert Phone Number]** or call the Pennsylvania Health Law Project at 1-800-274-3258.

EXHIBIT GG

EXHIBIT GG

COMPLAINT, GRIEVANCE, AND FAIR HEARING PROCESSES

A. General Requirements

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

2. The PH-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances as they relate to the MA population and must make these policies and procedures available to members upon request.

3. The PH-MCO must maintain an accurate written record of each Complaint and Grievance and the actions taken by the PH-MCO to resolve each Complaint and Grievance. The record must include at least the following:

    a. The name of the Member on whose behalf the Complaint or Grievance was filed;

    b. The date the Complaint or Grievance was received;

    c. A description of the reason for the Complaint or Grievance;

    d. The date of each review or review meeting;

    e. The date of resolution of the Complaint or Grievance and how the Complaint or Grievance was resolved; and

    f. A copy of any documents or records reviewed.

    The PH-MCO must provide the record of each Complaint and Grievance and the actions taken by the PH-MCO to resolve each Complaint and Grievance to the Department and CMS upon request.

4. The PH-MCO must submit a log of all Complaint and Grievance decisions in a format specified by the Department and must include review of the Complaint and Grievance processes in its QM and UM programs as outlined in Exhibit M(1) Quality Management and Utilization Management Program Requirements.

5. The PH-MCO must have a data system to process, track, and trend all Complaints and Grievances.

6. The PH-MCO must designate and train sufficient staff as reported in the Operating Procedures Report (OPS) 11 Provider Education, to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements specified in this Exhibit.

7. PH-MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training, and experience to make an informed, accurate and impartial determination regarding issues assigned to them.

8. The PH-MCO must provide information about the Complaint and Grievance process to all Providers and Subcontractors when the PH-MCO enters into a contract or agreement with the Provider or Subcontractor.

9. The PH-MCO may not use the time frames or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Member from receiving Medically Necessary care in a timely manner.

10. The PH-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not a subordinate of an individual who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

11. The PH-MCO may not charge Members a fee for filing a Complaint or a Grievance.

12. The PH-MCO must allow the Member and the Member's representative to have access to all relevant documentation pertaining to the subject of the Complaint or Grievance free of charge and sufficiently in advance of the time frame for resolution of the Complaint or Grievance outlined in this Exhibit.

13. The PH-MCO must maintain the following information in the Member's case file:

    a. Medical records;

    b. Any documents or records relied upon or generated by the PH-MCO in connection with the Complaint or Grievance, including any Medical Necessity guidelines used to make a decision or information on coverage limits relied upon to make a decision; and

    c. Any new or additional evidence considered, relied upon, or generated by the PH-MCO in connection with the Complaint or Grievance.

14. The PH-MCO must ask the Member if the Member needs interpreter services. The PH-MCO must provide language interpreter services at no cost when requested by a Member. The PH-MCO must include in the Complaint or Grievance record documentation that the Member was asked if the Member needed an interpreter and if an interpreter was provided.

15. The PH-MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/TDD for telephone inquiries and Complaints and Grievances from Members who are deaf or hearing impaired; Braille; tape; computer disk; and other commonly accepted alternative forms of communication. The PH-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitations of Members

with disabilities or language barriers, so they treat these individuals with patience, understanding, and respect.

16. The PH-MCO must provide Members with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Member. This includes but is not limited to:

    a. Providing qualified sign language interpreters for Members who are deaf or hearing impaired;

    b. Providing information submitted on behalf of the PH-MCO at the Complaint or Grievance review in an alternative format accessible to the Member or Member's representative, filing the Complaint or Grievance. The alternative format version must be supplied to the Member at or before the review, so the Member can discuss and/or refute the content during the review; and

    c. Providing personal assistance to a Member filing the Complaint or Grievance who has other physical limitations in copying and presenting documents and other evidence.

17. The PH-MCO must offer Members the assistance of a PH-MCO staff member throughout the Complaint and Grievance processes at no cost to the Member.

18. The PH-MCO must provide Members with a toll-free number to file a Complaint or Grievance, request information about the Complaint or Grievance process, and ask any questions the Member may have about the status of a Complaint or Grievance.

19. The PH-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances at one location within each of its zones of operation. If a Member requests an in-person review, the PH-MCO must notify the Member of the location of the review and who will be present at the review, using the template specified by the Department.

20. The PH-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.

21. The PH-MCO must notify the Member when the PH-MCO fails to decide a first level Complaint or a Grievance within the time frames specified in this Exhibit, using the template specified by the Department. The PH-MCO must mail this notice to the Member one (1) day following the date the decision (day 31).

22. The PH-MCO must notify the Member when it denies payment 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, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

23. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the service or item provided is not a covered

service for the Member, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

24. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the PH-MCO determined that the service or item was not Medically Necessary, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

25. The PH-MCO must notify the Member when it denies the Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

26. The PH-MCO must use all templates specified by the Department, which are available in Docushare. The PH-MCO may not modify the templates. The PH-MCO must follow the instructions in the templates for including detailed, specific information related to the Complaint or Grievance.

B. Complaint Requirements

Complaint: 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.

The term does not include a Grievance.

1. First Level Complaint Process

a. A PH-MCO must permit a Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a first level Complaint either in writing or verbally. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member and must provide the written Complaint to the Member or Member's representative for signature. The signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process.

b. If the first level Complaint disputes one of the following, the Member must file a Complaint within sixty (60) days from the date of the incident complained of or the date the Member receives written notice of a decision:

i. a denial because the service or item is not a covered service;

ii. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;

iii. the failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment after the service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;

v. a denial of payment after the service or item has been delivered because the service or item provided is not a covered service for the Member; or

vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities,

For all other Complaints, there is no time limit for filing a first level Complaint.

c. A Member who files a first level Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not a covered service must continue to receive the disputed service or item at the previously authorized level pending resolution of the first level Complaint, if the first level Complaint is made verbally, hand delivered, faxed, submitted via secure web portal, or post-marked within ten (10) days from the mail date on the written notice of decision.

d. Upon receipt of the Complaint, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a first level Complaint acknowledgment letter, using the template specified by the Department. The first level Complaint acknowledgment letter must be sent no later than three (3) business days after receipt of the Complaint.

e. The first level Complaint review for Complaints not involving a clinical issue must be conducted by a first level Complaint review committee, which must include one or more employees of the PH-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

f. The first level Complaint review for Complaints involving a clinical issue must be conducted by a first level Complaint review committee, which must include one or more employees of the PH-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The first level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the first level Complaint.

g. A committee member who does not personally attend the first level Complaint review meeting may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

h. The PH-MCO must afford the Member or Member's representative, a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

i. The PH-MCO must give the Member at least ten (10) days advance written notice of the first level Complaint review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the first level Complaint review committee by telephone or videoconference.

j. The Member may elect not to attend the first level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present. All Complaint review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the Complaint record.

k. If a Member requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review is held and the other members of the first level Complaint review committee must participate in the review through the use of videoconferencing.

l. The decision of the first level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered in the initial determination of the issue.

m. Prior to the start of the first level Complaint review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the Complaint review committee (including the Member's comments) being recorded, the testimony must be recorded and transcribed verbatim and maintained as part of the Complaint record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the Complaint record and the first level Complaint review meeting must proceed without the testimony being recorded.

n. The first level Complaint review committee must complete its review of the Complaint as expeditiously as the Member's health condition requires.

o. The first level Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.

p. The PH-MCO must send a written notice of the first level Complaint decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date the PH-MCO received the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Member.

q. If the Complaint disputes one of the following, the Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:

   i. a denial because the service or item is not a covered service;

   ii. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;

   iii. the failure of the PH-MCO to decide the Complaint or Grievance within the specified time frames;

iv. a denial of payment by the PH-MCO after the service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;

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

vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

The Member or Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the PH-MCO's first level Complaint decision.

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an external review in writing with PID's BMC within fifteen (15) days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

For all other Complaints, the Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a second level Complaint either in writing or verbally within forty-five (45) days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

2. Second Level Complaint Process

a. A PH-MCO must permit a Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a second level Complaint either in writing or verbally for any Complaint for which a Fair Hearing and external review is not available.

b. Upon receipt of the second level Complaint, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a second level Complaint acknowledgment letter using the template specified by the Department. The second level Complaint acknowledgement letter must be sent no later than three (3) business days after the receipt of the second level Complaint.

c. The second level Complaint review for Complaints not involving a clinical issue must be conducted by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are

not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

d. The second level Complaint review for Complaints involving a clinical issue must be conducted by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The second level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the second level Complaint.

e. At least one-third of the second level Complaint review committee members may not be employees of the PH-MCO or a related subsidiary or Affiliate.

f. A committee member who does not personally attend the second level Complaint review meeting may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

g. The PH-MCO must afford the Member a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

h. The PH-MCO must give the Member at least fifteen (15) days advance written notice of the second level Complaint review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the second level Complaint review committee by telephone or videoconference.

i. The Member may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present. All second level Complaint review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the second level Complaint record.

j. If a Member requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review is held and the other members of the second level Complaint review committee must participate in the review through the use of videoconferencing.

k. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.

l. Prior to the start of the second level Complaint review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the second level Complaint review committee (including the Member's comments) being recorded, the testimony must be tape-recorded and transcribed verbatim and maintained as part of the second level Complaint record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the second level Complaint record and the second level Complaint review meeting must proceed without the testimony being recorded.

m. The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Member's health condition requires.

n. The PH-MCO must send a written notice of the second level Complaint decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within forty-five (45) days from the date the PH-MCO received the second level Complaint.

o. The Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization of the representative to be involved and/or act of the Member's behalf, may file in writing a request for an external review of the second level Complaint decision with PID's BMC within fifteen (15) days from the date the Member receives the written notice of the PH-MCO's second level Complaint decision.

3. External Complaint Process

a. If a Member files a request directly with PID's BMC for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not a covered service, the Member must continue to receive the disputed service or item at the previously authorized level pending resolution of the external review, if the request for external review is hand-delivered or post-marked within ten (10) days from the mail date on the written notice of the PH-MCO's first or second level Complaint decision.

b. Upon the request of PID's BMC, the PH-MCO must transmit all records from the PH-MCO's Complaint review to PID's BMC within thirty (30) days

from the request in the manner prescribed by PID's BMC. The Member, the Provider, or the PH-MCO may submit additional materials related to the Complaint.

4. Expedited Complaint Process

a. The PH-MCO must conduct expedited review of a Complaint if the PH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a Member or Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, provides the PH-MCO with a certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification must include the Provider's signature.

b. A request for an expedited review of a Complaint may be filed orally, or in writing via mail, fax, email, or secure web portal.

c. Upon receipt of an oral or written request for expedited review, the PH-MCO must inform the Member of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.

d. If the Provider certification is not included with the request for an expedited review and the PH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, the PH-MCO must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Member's request for expedited review, the PH-MCO must decide the Complaint within the standard time frames as set forth in this Exhibit, unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Member. If the PH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the PH-MCO must make a reasonable effort to give the Member prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.

e. A Member who files a request for expedited review of a Complaint that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not a covered service must continue to receive the disputed service or item at

the previously authorized level pending resolution of the Complaint, if the request for expedited review is made verbally, hand delivered, faxed, emailed, submitted via secure web portal, or post-marked within ten (10) days from the mail date on the written notice of decision.

f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. If the Complaint is related to dental services, the expedited Complaint review committee must include a dentist. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint. The members of the expedited Complaint review committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

g. Prior to the start of the expedited Complaint review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the Complaint review committee (including the Member's comments) being recorded, the testimony must be recorded and transcribed verbatim and maintained as part of the Complaint record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the Complaint record and the expedited review meeting must proceed without the testimony being recorded.

h. The PH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Complaint has been extended by up to fourteen (14) days at the request of the Member. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one in writing, the service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

i. The Member or the Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the PH-MCO's expedited Complaint decision.

j. The Member, or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an expedited external Complaint review with the PH-MCO within two (2) business days from the date the Member receives the PH-MCO's expedited Complaint decision. A Member who files a request for an expedited Complaint review that disputes a decision to discontinue,

reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Complaint review.

k. A request for an expedited external Complaint review may be filed orally, or in writing via mail, fax, email, or secure web portal.

l. The PH-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external Complaint reviews.

m. The PH-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Member's request for expedited review of a Complaint.

C. Grievance Requirements

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's decision to

1. deny, in whole or in part, payment for a service or item;

2. deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item;

3. reduce, suspend, or terminate a previously authorized service or item;

4. deny the requested service or item but approve an alternative service or item; and

5. deny a request for a BLE.

The term does not include a Complaint.

1. Grievance Process

a. A PH-MCO must permit a Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a Grievance either in writing or verbally. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member and must provide the written Grievance to the Member or the Member's representative for signature. The signature may be obtained at any point in the process, and the failure to obtain a signed Grievance may not delay the Grievance process.

b. A Member must file a Grievance within sixty (60) days from the date the Member receives written notice of decision.

c. A Member who files a Grievance that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the Grievance is made verbally, hand delivered, faxed, submitted via secure web portal, or post-marked within ten (10) days from the mail date on the written notice of decision.

d. Upon receipt of the Grievance, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a Grievance acknowledgment letter, using the template specified by the Department. The Grievance acknowledgement letter must be sent no later than three (3) business days after receipt of the Grievance.

e. A Member who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Member may rescind consent throughout the process upon written notice to the PH-MCO and the Provider.

f. In order for the Provider to represent the Member in the conduct of a Grievance, the Provider must obtain the written consent of the Member and submit the written consent with the Grievance. A Provider may obtain the Member's written permission at the time of treatment. The PH-MCO must assure that a Provider does NOT require a Member to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

   i. The name and address of the Member, the Member's date of birth and identification number;

   ii. If the Member is a minor, or is legally incompetent, the name, address, and relationship to the Member of the person who signed the consent;

   iii. The name, address, and PH-MCO identification number of the Provider to whom the Member is providing consent;

   iv. The name and address of the PH-MCO to which the Grievance will be submitted;

   v. An explanation of the specific service or item which was provided or denied to the Member to which the consent will apply;

   vi. The following statement: "The Member or the Member's representative may not submit a Grievance concerning the service or item listed in this consent form unless the Member or the Member's representative rescinds consent in writing. The Member or

the Member's representative has the right to rescind consent at any time during the Grievance process.";

vii. The following statement: "The consent of the Member or the Member's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.";

viii. The following statement: "The Member or the Member's representative, if the Member is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The Member or the Member's representative understands the information in the Member's consent form."; and

ix. The dated signature of the Member, or the Member's representative, and the dated signature of a witness.

g. The Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. At least one-third of the Grievance review committee may not be employees of the PH-MCO or a related subsidiary or Affiliate.

i. The Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. If the Grievance is related to dental services, the Grievance review committee must include a dentist. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.

j. A committee member who does not personally attend the Grievance review may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.

k. The PH-MCO must afford the Member or Member's representative a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

l. The PH-MCO must give the Member at least ten (10) days advance written notice of the review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the

Member to communicate with the Grievance review committee by telephone or videoconference.

m. The Member may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Member was present. All Grievance review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the Grievance record.

n. If a Member requests an in-person Grievance review, at a minimum, a member of the Grievance review committee must be physically present at the location where the Grievance review is held and the other members of the Grievance review committee must participate in the review through the use of videoconferencing.

o. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of the Grievance review committee must be based solely on the information presented at the review.

p. Prior to the start of the Grievance review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the Grievance review committee (including the Member's comments) being recorded, the testimony must be recorded and transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the Grievance record and the Grievance review meeting must proceed without the testimony being recorded.

q. The Grievance review committee must complete its review of the Grievance as expeditiously as the Member's health condition requires.

r. The PH-MCO must send a written notice of the Grievance decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date the PH-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Member.

s. The Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review.

The Member or Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the PH-MCO's Grievance decision.

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for a representative to be involved and/or act on the Member's behalf, may file a request with the PH-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed by PID's BMC. The request must be filed in writing or verbally within fifteen (15) days from the date the Member receives the written notice of the PH-MCO's Grievance decision.

2. External Grievance Process:

a. The PH-MCO must process all requests for external Grievance review. The PH-MCO must follow the protocols established by PID's BMC in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Member, Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider.

b. A Member who files a request for an external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of the PH-MCO's Grievance decision.

c. Within five (5) business days of receipt of the request for an external Grievance review, the PH-MCO must notify the Member, the Member's representative, if the Member has designated one in writing, the Provider if the Provider filed the request for the external Grievance review, and PID's BMC that the request for external Grievance review has been filed.

d. The external Grievance review must be conducted by a CRE not affiliated with the PH-MCO.

e. Within two (2) business days from receipt of the request for an external Grievance review, PID's BMC will randomly assign a CRE to conduct the review and notify the PH-MCO and assigned CRE of the assignment.

f. Within two (2) business days of receipt of notice of the assignment of the CRE, the PH-MCO must notify the member, using the template as suggested by PID's BMC, of the name and contact information of the assigned CRE.

g. If PID's BMC fails to select a CRE within two (2) business days from receipt of a request for an external Grievance review, the PH-MCO may designate a CRE to conduct a review from the list of CREs approved by PID's BMC. The PH-MCO may not select a CRE that has a current contract or is negotiating a contract with the PH-MCO or its Affiliates or is otherwise affiliated with the PH-MCO or its Affiliates.

h. The PH-MCO must forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the CRE conducting the external Grievance review. The PH-MCO must transmit this information within fifteen (15) days from receipt of the Member's request for an external Grievance review.

i. Within fifteen (15) days from receipt of the request for an external Grievance review by the PH-MCO, the Member or the Member's representative, or the Member's Provider, may supply additional information to the CRE conducting the external Grievance review for consideration. Copies must also be provided at the same time to the PH-MCO so that the PH-MCO has an opportunity to consider the additional information.

j. Within sixty (60) days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to the PH-MCO, the Member, the Member's representative, PID's BMC and the Provider (if the Provider filed the Grievance with the Member's consent) that includes the basis and clinical rationale for the decision. The standard of review must be whether the service or item is Medically Necessary and appropriate under the terms of this Agreement.

k. The external Grievance decision may be appealed by the Member, the Member's representative, or the Provider to a court of competent jurisdiction (Commonwealth Court) within sixty (60) days from the date the Member receives notice of the external Grievance decision.

3. Expedited Grievance Process

a. The PH-MCO must conduct expedited review of a Grievance if the PH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or if a Member or Member representative, with proof of the Member's written authorization for a representative to be involved and/or act on the Member's behalf, provides the PH-MCO with a certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the Provider's signature.

b. A request for expedited review of a Grievance may be filed orally, or in writing via mail, fax, email, or secure web portal.

c. The expedited review process is bound by the same rules and procedures as the Grievance review process with the exception of time frames, which are modified as specified in this section.

d. Upon receipt of an oral or written request for expedited review, the PH-MCO must inform the Member of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.

e. If the Provider certification is not included within the request for an expedited review and the PH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, the PH-MCO must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Member's request for expedited review, the PH-MCO must decide the Grievance within the standard time frames as set forth in this Exhibit, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Member. If the PH-MCO decides that expedited consideration with the initial or extended time frame is not warranted, the PH-MCO must make a reasonable effort to give the Member prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.

f. A Member who files a request for expedited review of a Grievance that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.

g. Expedited review of a Grievance must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. At least one-third of the expedited Grievance review committee may not be employees of the PH-MCO or a related subsidiary or Affiliate.

i. The expedited Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. If the Grievance is related to dental services, the expedited Grievance review committee must include a dentist. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.

j. Prior to the start of the expedited Grievance review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the Grievance review committee (including the Member's comments) being recorded, the testimony must be recorded and transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the expedited Grievance record and the expedited Grievance review meeting must proceed without the testimony being recorded.

k. The PH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Member. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

l. The Member or the Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the PH-MCO's expedited Grievance decision.

m. The Member, or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an expedited external Grievance review with the PH-MCO within two (2) business days from the date the Member receives the PH-MCO's expedited Grievance decision. A Member who files a request for an expedited external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Grievance review.

n. A request for an expedited external Grievance review may be filed orally, or in writing via mail, fax, email, or secure web portal.

o. The PH-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external Grievance reviews.

p. The PH-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Member's request for expedited review of a Grievance.

D. Department's Fair Hearing Requirements

Fair Hearing: A hearing conducted by the Department's Bureau of Hearings and Appeals (BHA) or a Department designee.

1. Fair Hearing Process

a. A Member or Member's representative must file a Complaint or Grievance with the PH-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the PH-MCO fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

b. The Member or the Member's representative may request a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the PH-MCO's first level Complaint decision or Grievance decision for any of the following:

i. the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;

ii. the denial of a requested service or item because the service or item is not a covered service;

iii. the reduction, suspension, or termination of a previously authorized service or item;

iv. the denial of a requested service or item but approval of an alternative service or item;

v. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;

vi. the failure of a PH-MCO to decide a Complaint or Grievance within the specified time frame;

vii. the denial of payment 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;

viii. the denial of payment after a service or item has been delivered because the service or item is not a covered service for the Member;

ix. the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

c. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the PH-MCO failed to provide written notice of the Complaint or Grievance decision within the time frames specified in this Exhibit.

d. A Fair Hearing may be requested as follows:

i. Fax: 1-717-772-6328

ii. Mail: Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

e. A Member who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered, faxed, or post-marked within ten (10) days from the mail date on the written notice of decision.

f. Upon receipt of the request for a Fair Hearing, BHA or the Department's designee will schedule a hearing. The Member and the PH-MCO will receive notification of the hearing date by letter at least ten (10) days before the hearing date, or a shorter time if requested by the Member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

g. The PH-MCO is a party to the hearing and must be present. The PH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. BHA's decision is based solely on the evidence presented at the hearing. The absence of the PH-MCO from the hearing will not be reason to postpone the hearing.

h. The PH-MCO must provide Members, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

i. BHA will issue an adjudication within ninety (90) days of the date the Member filed the first level Complaint or the Grievance with the PH-MCO,

not including the number of days before the Member requested the Fair Hearing. If BHA fails to issue an adjudication within ninety (90) days of receipt of the initial request of the first level complaint or grievance, less the time it took the member to request a Fair Hearing, the PH-MCO must comply with the requirements at 55 Pa. Code § 275.4 regarding the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process, the time limit by which BHA must issue the adjudication prior to interim assistance being afforded will be extended by the length of the delay attributed to the Member.

j. BHA's adjudication is binding on the PH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of the BHA adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the PH-MCO.

2. Expedited Fair Hearing Process

a. A Member or the Member's representative may file a request for an expedited Fair Hearing with the Department either in writing or orally.

b. A Member must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.

c. BHA will conduct an expedited Fair Hearing if a Member or a Member's representative provides the Department with a signed written certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process or if the Provider provides testimony at the Fair Hearing which explains why using the usual time frames would place the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function in jeopardy.

d. A Member who files a request for an expedited Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is made orally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.

e. Upon the receipt of the request for an expedited Fair Hearing, BHA or the Department's designee will schedule a hearing.

f. The PH-MCO is a party to the hearing and must be present. The PH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The absence of the PH-MCO from the hearing will not be reason to postpone the hearing.

g. The PH-MCO must provide the Member, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

h. BHA will issue an adjudication within three (3) business days from receipt of the Member's oral or written request for an expedited review.

i. BHA's adjudication is binding on the PH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the PH-MCO.

E. Provision of and Payment for Service or Item Following Decision

1. If the PH-MCO, BHA, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair Hearing process, the PH-MCO must authorize or provide the disputed service or item as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed. If the PH-MCO requests reconsideration, the PH-MCO must authorize or provide the disputed service or item pending reconsideration unless the PH-MCO requests a stay of the BHA decision and the stay is granted.

2. If the PH-MCO, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Member received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, the PH-MCO must pay for the service or item that the Member received.

If a Member requests both an external appeal/review and a Fair Hearing, and the decisions rendered as a result of the external review and Fair Hearing 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 must submit the matter to the Department's Grievance and Appeals Coordinator for review and resolution.

EXHIBIT KK

EXHIBIT KK

REPORTING SUSPECTED FRAUD, WASTE, AND ABUSE

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

Reporting Requirements:

PH-MCOs are required to report to the Department any act by Providers/Recipients/Caregivers/Employees that may affect the integrity of the HealthChoices Program under the Medical Assistance Program. Specifically, if the PH-MCO suspects that either Fraud, Abuse or Waste (as discussed in Section V.O.4, Fraud and Abuse, of the Agreement) may have occurred, the PH-MCO must report the issue to the Department's Bureau of Program Integrity (BPI). In addition to referrals to the Department, the PH-MCO is required to simultaneously submit fraud referrals to the Pennsylvania Office of Attorney General Medicaid Fraud Control Section in accordance with 42 C.F.R. §438.608(a)(7). The referrals shall be submitted using the Department's PH-MCO Referral Form. Fraud referrals submitted to the Department using the PH-MCO Referral Form will be automatically sent to the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section. The PH-MCO must have a process to notify BPI of any adverse actions and/or provider disclosures taken during the credentialing/re-credentialing process. Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review or suspend payments to avoid unnecessary expenditures during the review process.

After the referral form is submitted, the PH-MCO is required to upload the supporting documentation to the Department using DocuShare. The PH-MCO is also required to upload the same supporting documentation to the Office of Attorney General, Medicaid Fraud Control Section through ShareFile.

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.

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

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

Failure to comply with the requirements of Exhibit KK will result in sanctions and or corrective action as stated in the HealthChoices Agreement. The Department must suspend all Medicaid payments to a provider after a determination that there is a credible allegation of fraud for which an investigation is pending against an individual or entity unless the Department has good cause not to suspend payments or to suspend payments in part. (42 C.F.R. 455.23 (a)). Upon notification from the Department of the imposition of a payment suspension, the PH-MCO, at a minimum, must also suspend payments to the provider.

The following processes are required for Provider/Caregiver and Employee referrals, unless prior approval is received from BPI. Reports must be submitted online using the PH-MCO Referral Form. Fraud allegations will result in an automatic dual referral to the Office of Attorney General and the Department. The instructions and form templates are located on the HealthChoices extranet website under Managed Care Programs/Fraud and Abuse.

Once completed, the PH-MCO must electronically submit the form to BPI. Additionally, the following information must be submitted to BPI electronically using a DocuShare folder designated by BPI:

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

The same information must be uploaded to the Office of Attorney General, Medicaid Fraud Control Section ShareFile system.

If DocuShare is inaccessible for any reason, the PH MCO will notify the BPI contract monitor, then mail the supporting information above to the below address:

Department of Human Services
Bureau of Program Integrity – DPPC/DPR
P.O. Box 2675
Harrisburg, PA 17105-2675

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

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

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

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

Checklist of Supporting Documentation for Referrals

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

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

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

Example of materials for pharmacy referrals –

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

Example of materials for RTF referrals –

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

Example of materials for behavioral health referrals –

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

Example of materials for DME referrals –

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

_____

EXHIBIT NN

EXHIBIT NN

SPECIAL NEEDS UNIT

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

- Require care and/or services of a type or amount that is beyond what is typically required;
- Require extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve the level of functioning for the individual;
- May require that primary care be managed by a specialist, due to the nature of the condition;
- May incur higher morbidity without intervention and coordination in the care of the individual;
- Require care and/or services that necessitate coordination and communication among Network Providers and/or Out-of-Network Providers including, but not limited to, housing, food, and employment challenges;
- Require care and/or services that necessitate coordination and collaboration with public and private community services organizations outside the PH-MCO;
- Require coordination of care and/or services between the acute inpatient setting and other facilities and Community Providers;
- Result in the Member requiring assistance to schedule or make arrangements for appointments or services, including arranging for transportation to and from appointments;
- Result in the need for language, communication, or mobility accommodations; or
- Result in the need for a Member to be accompanied or assisted while seeking or receiving care by an individual who may act on the Member's behalf.

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

- Children who are in the custody of Office of Children, Youth and Families (OCYF) or known to have an open case with OCYF.

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

Structure and Staffing Requirements of the Special Needs Unit

The PH-MCO will be required to develop, train, and maintain a unit within its organizational structure that will be responsible to provide support and case management services to members with Special Needs in a timely manner.

This unit will be headed by a Special Needs Coordinator who must have access to and periodically consult with the Medical Director.

The PH-MCO Special Needs Unit case manager must function as the single point of contact to coordinate all health care needs including social determinates of health needs for vulnerable populations.

The case management staff must follow the Case Management Society of America standards of practice.

Individual case management staff that are eligible should be certified case managers or be working toward certification. Staff who are not currently certified or are not eligible to become certified must be supervised by a certified case manager.

The staff members will work in close collaboration with the BMCO SNU and the Enrollment Assistance Program Contractor's Special Needs contact person.

The Department expects the PH-MCO's Special Needs Unit to be staffed by individuals with either a medical and/or social services background, in sufficient number to initiate a response to a Member's inquiry within two (2) Business Days or sooner in urgent situations.

The Department expects the core staff members of the Special Needs Unit to be responsible primarily for the functions and operations associated with the unit, including the primary case management and care coordination for members and families receiving special needs services.

The Department also expects that at times the Special Needs Unit staff will have access to the resources of other departments within the PH-MCO to supplement the Special Needs Unit in assisting Members with Special Needs. The PH-MCO must show evidence of their access to and use of individuals with expertise in the treatment of Members with Special Needs to provide consultation to the Special Needs Unit staff, as needed.

The PH-MCO shall use knowledgeable and independent organizations such as consumer groups, disability advocacy groups, Special Needs consumers, and the Department of Health District Offices, when providing training to its Special Needs Unit staff, whenever possible.

Special Needs Unit Functions and Requirements

The primary purpose of the Special Needs Unit is to ensure that each Member with Special Needs receives access to appropriate primary care, access to specialists trained and skilled in the needs of the Member including behavioral health and substance use disorder services, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the Member's condition or circumstance, including pharmaceuticals and DME, and access to needed community services to support housing, food and employment needs.

The Special Needs Unit must have a direct link to the Utilization Management functions of the PH-MCO and have input into the case review process. The PH-MCO must have procedures in place that ensure the proactive identification of and outreach to Members with Special Needs who may not self-identify as having a Special Need.

In the event that a Member is not satisfied with PH-MCO performance in any area, the Special Needs Unit case manager will be responsible for facilitating dispute resolution and for informing the Member of the Complaint, Grievance, and DHS Fair Hearing mechanisms that are available and assisting in that process as needed or requested.

Members with Special Needs determined to have ongoing needs for assistance will be assigned to a particular Special Needs Unit case manager and will have ready access to their Special Needs Unit case manager as long as they are enrolled in the PH-MCO. This case manager will be responsible to develop and maintain a Plan of Care (POC) for the member according to standards set forth in the CMSA standards of case management.

Members with Special Needs are permitted to change case managers as needed during their enrollment.

The Special Needs Unit will perform the following functions:

- Conduct necessary training for all PH-MCO staff to acquaint them with the purpose and function of the Special Needs Unit and the need to coordinate within departments to serve Members with Special Needs.

- Work towards education and training in the use of LifeCourse™ tools.

- Meet face-to-face at least twice a year with the child and family and/or caregivers for the most complex members receiving shift care services. At least one of the face-to-face visits must be at the time of initial or recertification of shift care

services. The PH-MCO staff must be appropriate licensed Special Needs Unit case management staff.

- Provide case management services for children in the custody of OCYF or known to have an active case.

- Ensure coordination between the PH-MCO and other health, education, and human services systems including County Children and Youth Services Offices, County Office of Intellectual Disability Services Offices and Juvenile Justice Offices. For a more inclusive list see Exhibit OO.

- The coordination between the PH-MCO and other health education, and human services systems may include coordination with the state level offices for these agencies as well. For example, the PH-MCOs would be expected to work with the Office of Developmental Programs (ODP) state office and the Family Facilitator on efforts to discharge children in a pediatric residential setting.

- Educate families with children in a pediatric residential setting on the role of ODP's Family Facilitator and the support that can be provided to the family and the member to ensure the best long-term plan for their child.

- Ensure adherence to state and federal laws, regulations, Departmental agreements and court requirements relating to individuals with Special Needs.

- A contact within the Special Needs Unit must be designated to act as a liaison with the BMCO SNU staff and the Enrollment Assistance Program contractor's Special Needs contact person.

- The PH-MCO must develop an appropriate automated process to operationalize the information on Special Needs individuals supplied by the Enrollment Assistance Program contractor.

- Sufficient telephone and alternative communication channels must be established to allow ready and timely interactions between the PH-MCO Special Needs Unit Coordinator, case managers, the Office of Medical Assistance Programs, the Enrollment Assistance Program contractor, Members with Special Needs, Providers (Network and Out-of-Network) and other health, education, and human services systems servicing Members with Special Needs and involved agencies.

- 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.

- Appropriate arrangements must be made to effectively assist Members with Special Needs who speak languages other than English in accordance with the RFP and Agreement requirements. In addition, efforts must be made to match

Members with communication barriers due to disability or linguistic background with Providers with whom they can effectively communicate.

- Serve on interagency teams upon request by a Member or their family to facilitate and coordinate delivery of Physical Health Services contained in treatment plans for children and/or adults including, but not limited to, Individual Family Service Plans, Individual Educational Plans, Individual Habilitation Plans, and Individual Behavioral Health Treatment Plans.

- Special Needs Unit case managers must have a working knowledge of Children and Adolescent Support Services Program (CASSP) and the Community Support Program (CSP) principles and principles of drug and alcohol treatment.

- Ensure cooperation of the PH-MCO's Provider Network. Special Needs Unit case managers must facilitate communication and coordinate service delivery between primary care, specialty, ancillary, substance use disorder and behavioral health Providers to ensure Member's timely and uninterrupted access to care.

- Assist in the development of adequate Provider Networks, such as pediatric specialists, to serve Special Needs populations. Special Needs Unit case managers must assist and support Members with Special Needs in making an informed choice between Providers of equivalent services within the network. When adequate network capacity does not exist to allow for choice between network Providers of equivalent services, case managers must facilitate and coordinate services rendered by Out-of-Network Providers.

- Conduct necessary training for PCPs to assist them in providing services to diverse populations including the identification of the PH-MCO's Special Needs Unit contact persons.

- Provide ongoing coordination with PCPs to continually serve Special Needs population’s Members.

- Attend ad hoc meetings, workgroups, etc., hosted by the Department that require mandatory attendance by Special Needs Unit staff.

- Attend public/community sponsored meetings with the Department’s representative(s) at the discretion of the PH-MCO.

- If the PH-MCO chooses to subcontract any of the Special Needs Unit functions, the PH-MCO must maintain accountability by assigning responsibility for oversight of the subcontract to a senior executive within the organization.

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

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

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

- Provide assistance to any member needing help transitioning from a pediatric to an adult provider. Proactively identify individuals between the ages of 18 and 21 that may be considered to be medically fragile members and provide enhanced assistance to them in transitioning to an adult provider. During this transitioning process ensure that they can receive care from a Pediatrician and adult Primary Care Provider at the same time to facilitate a seamless transition to adult care. These youth should be provided case management, at a minimum, until a successful transition is complete.

- Work in coordination with the Department's Resource Facilitation Team (RFT), other Department of Human Services Program Offices, and Service Coordinators to provide transition assistance to members receiving home shift care services under EPSDT into Home and Community Based Waivers and adult systems of support. This will include functioning as a liaison between the RFT and the member and family.

- For members in inpatient or residential facilities, the SN case manager will be responsible to take the lead with discharge planning to ensure the member is transitioning not only to the most appropriate and community-based environment for the child as possible, but to ensure that the environment and supports such as shift care, DME, and available community supports are in place in the new setting prior to any discharge occurring. Provide all necessary oversight including home or site visits with family or other caregivers to ensure adequate supports are in place for a safe discharge. Members in residential facilities will be required to be in active case management by a SNU PH-MCO case manager until the member is successfully discharged home or to another community or other care setting.

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

The PH-MCO will develop, implement, and maintain a targeted Quality Management component focused on Members with Special Needs that is integrated into the Quality Management/Utilization Management Program as outlined in Exhibit M(1), Quality Management, Utilization Management and Quality Improvement Program Requirements.

The Special Needs Unit will provide data as required for special needs related to existing and new Operations (OPS) Reports and ad hoc requests concerning members with special needs.

The PH-MCO must collaborate with the Department to implement recommendations put forth in the white paper “Improving Pennsylvania’s Pediatric Shift Care Nursing Through Collaboration”.

EXHIBIT WW

EXHIBIT WW

HEALTHCHOICES AUDIT CLAUSE

AUDITS

Annual Agreement Audits

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

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

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

Annual Entity-Wide Financial Audits

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

Other Financial and Performance Audits

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

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

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

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

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

4. The Commonwealth must periodically, but no less frequently than once every three (3) years, conduct or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the PH-MCO.

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

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

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

2. Upon issuance of the final report to the entity, the entity shall prepare and submit, within thirty (30) calendar days after issuance of the report, a Corrective Action Plan for each observation or finding contained therein. The Corrective Action Plan shall include a brief description of the finding, the specific steps to be taken to correct the situation or specific reasons why corrective action is not necessary, a timetable for performance of the corrective action steps, and a description of the monitoring to be performed to ensure that the steps are taken.

Record Availability, Retention and Access

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

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

Audits of Subcontractors

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

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

EXHIBIT AAA

EXHIBIT AAA

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

The PH-MCO must consider the following in establishing and maintaining its Provider Network:

- The anticipated MA enrollment,
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the PH-MCO,
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted MA services,
- The number of Network Providers who are not accepting new MA patients, and
- The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

The PH-MCO must adhere to CMS network adequacy standards as outlined in 42 C.F.R. §438.68(b)(1)(viii), 438.68(b)(3), and 438.206. The PH-MCO must ensure that its Provider Network is adequate to provide its Members in this HealthChoices Zone with access to quality Member care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the PH-MCO must supply geographic access maps using Member level data detailing the number, location and specialties of their Provider Network to the Department in order to verify accessibility of Providers within their Network in relation to the location of its Members. The Department may require additional numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The PH-MCO must also have a process in place which ensures that the PH-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The PH-MCO must make all reasonable efforts to honor a Member's choice of Providers who are credentialed in the Network. If the PH-MCO is unable to ensure a Member's access to provider or specialty provider services within the PH-MCO's network, within the travel times set forth in this Exhibit, the PH-MCO must make all reasonable efforts to ensure the Member's access to these services within the travel times herein through out-of-network providers. In locations where the PH-MCO can provide evidence that it has conducted all reasonable efforts to contract with providers and specialists and can provide verification that no providers or specialists exist to ensure a Member's access to these services within the travel times set forth in this Exhibit, the PH-MCO

must work with Members to offer reasonable provider alternatives. Additionally, the PH-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire HealthChoices Zone in which the PH-MCO operates if providers exist:

a. PCPs

Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available. Members may, at their discretion, select PCPs located further from their homes.

b. Pediatricians as PCPs

Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (30 minutes Urban, 60 minutes Rural).

c. Specialists

i. For the following provider types, the PH-MCOs operating in Lehigh Capital, Southeast, and Southwest must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

General Surgery
Obstetrics & Gynecology
Oncology
Physical Therapy
Radiology
Opioid Use Disorder
Centers of Excellence
Cardiology
Pharmacy
Orthopedic Surgery
General Dentistry
Pediatric Dentistry

PH-MCOs operating in Northeast and Northwest must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

General Surgery
Obstetrics & Gynecology
Orthopedic Surgery
General Dentistry
Cardiology
Pharmacy
Pediatric Dentistry
Opioid Use

Disorder Centers
of Excellence

ii. For the following provider types, the PH-MCOs operating in Lehigh/Capital, Southeast, and Southwest must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the HealthChoices Zone:

Oral Surgery	Urology
Nursing Facility	Neurology
Dermatology	Otolaryngology

The PH-MCOs operating in Northeast and Northwest must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice within the HealthChoices Zone:

Oral Surgery	Urology
Nursing Facility	Neurology
Dermatology	Otolaryngology
Oncology	Radiology
Physical Therapy	

iii. For all other specialists and subspecialists, the PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.

d. Hospitals

Ensure at least one (1) hospital within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice within the HealthChoices Zone.

e. Special Health Needs

Ensure the provision of services to persons who have special health needs or who face access barriers to health care. If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services. For children with special health needs, the PH-MCO must offer

at least two (2) pediatric specialists or pediatric sub-specialists.

f. Anesthesia for Dental Care

For Members needing anesthesia for dental care, the PH-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay out of Network.

g. Rehabilitation Facilities

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this HealthChoices Zone.

h. Pediatric Congregate Care Facilities

Include in its Provider Network at least one (1) facility located within the HealthChoices zone that is licensed as either a Child Residential and Day Treatment Facility by the Office of Children Youth and Families or as a Community Home for Individuals with an Intellectual Disability or Autism by the Office of Developmental Programs and provides medical care to technology-dependent or otherwise medically complex children. This requirement will not apply to the extent that no such facility exists within the HealthChoices zone.

i. CNMs / CRNPs, Other Health Care Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. In accordance with RX for PA Principles, the PH-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

j. Qualified Providers

The PH-MCO must limit its PCP Network to appropriately qualified Providers. The PH-MCO's PCP Network must meet the following:

- No less than seventy-five percent (75) of the Network consists of

PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics; and

- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

k. Members Freedom of Choice

The PH-MCO must demonstrate its ability to offer its Members freedom of choice in selecting a PCP. At a minimum, the PH-MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Recipients. For the purposes of this section, a full- time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Members to the panel. The number of Members assigned to a PCP may be decreased by the PH-MCO if necessary to maintain the appointment availability standards.

l. PCP Composition and Location

The PH-MCO and the Department will work together to avoid the PCP having a caseload or medical practice composed predominantly of HC Members. In addition, the PH-MCO must organize its PCP Sites so as to ensure continuity of care to Members and must identify a specific PCP or PCP group for each Member. The PH-MCO may apply to the Department for a waiver of these requirements. The Department may waive these requirements for good cause demonstrated by the PH-MCO. The PH- MCO will comply with the program standards regarding PCP assignment as set forth in Section V.Q. of the Agreement, Assignment of PCPs.

m. FQHCs / RHCs

The PH-MCO must include in its Provider Network every FQHC and RHC that are willing to accept PPS rates as payment in full and are located

within the operational HealthChoices Zones in which the PH-MCO has an agreement. If the PH-MCO's primary care Network includes FQHCs and RHCs, these sites may be designated as PCP sites.

n. Medically Necessary Emergency Services

The PH-MCO must comply with the provisions of Act 112 of 1996 (H.B. 1415, P.N. 3853, signed July 11, 1996), the Balanced Budget Reconciliation Act of 1997 and Act 68 of 1998, the Quality Health Care Accountability and Protection Provisions, 40 P.S. 991.2101 et seq. pertaining to coverage and payment of Medically Necessary Emergency Services. The definition of such services is set forth herein at Section II of this Agreement, Definitions.

o. ADA Accessibility Guidelines

The PH-MCO must inspect the office of any PCP or dentist who seeks to participate in the PH-MCO's Provider Network (excluding offices located in hospitals) to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

The PH-MCO must submit quarterly reports to the Department, in a format to be specified by the Department, on the results of the inspections.

If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the PH-MCO's Provider Network provided that the PCP or dentist: 1) requests and is determined by the PH-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within six (6) months after the PH-MCO identified the barrier.

The PH-MCO must document its efforts to determine architectural accessibility. The PH-MCO must submit this documentation to the Department upon request.

p. Laboratory Testing Sites

The PH-MCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number in accordance with CLIA 1988. Those laboratories

with certificates of waiver will provide only the eight (8) types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The PCP must provide all required demographics to the laboratory when submitting a specimen for analysis.

q. PH-MCO Discrimination

The PH-MCO must not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph must not be construed to prohibit a PH-MCO from including Providers only to the extent necessary to meet the needs of the organization's Members or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the PH-MCO.

r. Declined Providers

If the PH-MCO declines to include individual Providers or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision.

s. Second Opinions

The PH-MCO must provide for a second opinion from a qualified Health Care Provider within the Network, at no cost to the Member. If a qualified Health Care Provider is not available within the Network, the PH-MCO must assist the Member in obtaining a second opinion from a qualified Health Care Provider outside the Network, at no cost to the Member, unless co-payments apply.

t. American Indians and Indian Healthcare Providers

Consistent with 42 C.F.R. §438.14(b)(1-3), The PH-MCO must:

- Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the Agreement for Indian enrollees who are eligible to receive services from such providers;

- Pay I/T/U providers, whether participating in the network or not, for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either at a rate negotiated between the PH-MCO and the I/T/U provider, or if there is no negotiated rate, at a rate no less

than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

- Permit any Indian who is enrolled in a non-Indian MCO and eligible to receive services from a participating I/T/U provider to choose to receive covered services from that I/T/U provider and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services.

Consistent with 42 C.F.R. §438.14(b)(5-6), the PH-MCO must permit American Indian members to access out of state IHCPs; or permit an out-of-network IHCP to refer an American Indian member to a network provider.

When an IHCP is enrolled in Medicaid as an FQHC, but not a participating provider of the PH-MCO, the IHCP must be paid an amount equal to the amount the PH-MCO would have paid to a network FQHC. When the IHCP is not enrolled in Medicaid as an FQHC, the PH-MCO must reimburse the IHCP at the same rate as the IHCP's applicable encounter rate published annually in the Federal Register by the Indian Health Service. If there is no published encounter rate, the IHCP must receive the amount it would have been reimbursed if the services were provided under the Pennsylvania MA FFS FQHC payment methodology.

2. Appointment Standards

The PH-MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

a. General

PCP scheduling procedures must ensure that:

i. Emergency Medical Condition cases must be immediately seen or referred to an emergency facility.

ii. Urgent Medical Condition cases must be scheduled within twenty- four (24) hours.

iii. Routine appointments must be scheduled within ten (10) Business Days.

iv. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.

v. The PH-MCO must provide the Department with its protocol for ensuring that a Member's average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical need. The Member must be informed of scheduling time frames through educational outreach efforts.

vi. The PH-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room visits.

b. Persons with HIV/AIDS

The PH-MCO must have adequate PCP scheduling procedures in place to ensure that an appointment with a PCP or specialist must be scheduled within seven (7) days from the effective date of Enrollment for any person known to the PH-MCO to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the Member is already in active care with a PCP or specialist.

c. Supplemental Security Income (SSI)

The PH-MCO must make a reasonable effort to schedule an appointment with a PCP or specialist within forty-five (45) days of Enrollment for any Member who is an SSI or SSI-related consumer unless the Member is already in active care with a PCP or specialist.

d. Specialty Referrals

For specialty referrals, the PH-MCO must be able to provide for:

i. Emergency Medical Condition appointments immediately upon referral.

ii. Urgent Medical Condition care appointments within twenty-four (24) hours of referral.

iii. Scheduling of appointments for routine care within fifteen (15) business days for the following specialty provider types:

Otolaryngology Orthopedic Surgery
Dermatology Pediatric Allergy &
Immunology Pediatric Endocrinology Pediatric
Gastroenterology Pediatric General Surgery Pediatric
Hematology
Pediatric Infectious Disease Pediatric Nephrology
Pediatric Neurology Pediatric Oncology
Pediatric Pulmonology Pediatric Rehab
Medicine Pediatric Rheumatology Pediatric Urology
Dentist Pediatric Dentistry

iv. Scheduling of appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.

e. Pregnant Women

Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members as follows:

i. First trimester — within ten (10) Business Days of the Member being identified as being pregnant.

ii. Second trimester — within five (5) Business Days of the Member being identified as being pregnant.

iii. Third trimester — within four (4) Business Days of the Member being identified as being pregnant.

iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the PH-MCO or maternity care Provider, or immediately if an emergency exists.

f. EPSDT

EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations.

The PH-MCO must distribute quarterly lists to each PCP in its Provider Networks which identify Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in this Exhibit, or Members who have not complied with EPSDT periodicity and immunization schedules for children. The PH-MCO must contact such Members, documenting the reasons for noncompliance and documenting its efforts for bringing the Members' care into compliance.

3. Policies and Procedures for Appointment Standards

The PH-MCO will comply with the program standards regarding service accessibility standards that are set forth in this Exhibit and in Section V.S. of the Agreement, Provider Agreements.

The PH-MCO must have written policies and procedures for disseminating its appointment standards to all Members through its Member handbook and through other means. In addition, the PH-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The PH-MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

4. Compliance with Access Standards

a. Mandatory Compliance

Per 42 C.F.R. §438.68(b)(1)(viii), the PH-MCO must adhere to any time and distance access standards established by CMS. The PH-MCO must comply with the access standards in accordance with this Exhibit and Section V.S of the Agreement, Provider Agreements. If the PH-MCO fails to meet any of the access standards by the dates specified by the Department, the Department may terminate this Agreement.

b. Reasonable Efforts and Assurances

The PH-MCO must make reasonable efforts to honor a Member's choice of Providers among Network Providers as long as:

i. The PH-MCO's agreement with the Network Provider covers the services required by the Member; and

ii. The PH-MCO has not determined that the Member's choice is clinically inappropriate.

The PH-MCO must provide the Department adequate assurances that

the PH-MCO, with respect to each zone of operation, has the capacity to serve the expected Enrollment in each zone of operation. The PH-MCO must provide assurances that it will offer the full scope of covered services as set forth in this Agreement and access to preventive and primary care services. The PH-MCO must also maintain a sufficient number, mix and geographic distribution of Providers and services in accordance with the standards set forth in this Exhibit and Section V.S. of the Agreement, Provider Agreements.

c. PH-MCO's Corrective Action

The PH-MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a termination action or other sanction by the Department, the PH-MCO will be given the opportunity to institute a corrective action plan. The PH-MCO must submit a corrective action plan to the Department for approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the PH-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the PH-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the PH-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the PH-MCO must submit a revised corrective action plan within fifteen (15) days of notification. If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the PH-MCO, in accordance with Section VIII.H. of the Agreement, Sanctions. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in this Agreement.

EXHIBIT BBB

EXHIBIT BBB

DRUG SERVICES

1. General Requirements

a. All requirements in this Exhibit apply to all Covered Drugs regardless of the setting in which the drug is dispensed or administered, the billing provider type, or how the PH-MCO makes payment for the drug (pharmacy benefit and/or medical benefit).

b. The amount, duration, and scope of Covered Drugs must be consistent with coverage under the Fee-for-Service (FFS) program. The PH-MCO must cover all Covered Drugs listed on the Center for Medicare and Medicaid Services (CMS) Quarterly Drug Information File when determined to be Medically Necessary, unless otherwise excluded from coverage. (See 2. Coverage Exclusions below for exclusions.) This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers enrolled in the MA program, and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.

c. The PH-MCO must provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C.A. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature.

d. Unless financial responsibility is otherwise assigned, all Covered Drugs are the payment responsibility of the Member's PH-MCO. The only exception is that the behavioral health managed care organization (BH-MCO) is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO service Providers.

e. All Covered Drugs must be dispensed through PH-MCO Network Providers. This includes Covered Drugs prescribed by both the PH- MCO and the BH-MCO Providers.

f. Under no circumstances will the PH-MCO permit the therapeutic substitution of an drug by a pharmacist without explicit authorization from the licensed prescriber.

g. All proposed Covered Drug policies, programs and drug utilization management programs, such as but not limited to prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, mail order, 90-day supply programs, limited pharmacy networks, medication therapy management programs, etc. must be submitted to the Department for review and written approval prior to implementation, prior to implementation of any changes, and annually thereafter.

h. The PH-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will,

   i. Apply, regardless of whether the Covered Drug is provided as an drug benefit or as a "medical benefit" incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).

   ii. Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-reviewed medical literature, Statewide Preferred Drug List (PDL) prior authorization guidelines, if applicable, and FFS guidelines to determine medical necessity of drugs that require prior authorization in the MA FFS Program, when designated by the Department.

i. The PH-MCO must submit for review and approval a policy for each section of Exhibit BBB that includes the requirements in the respective section and the PH-MCO's procedures to demonstrate compliance.

j. The PH-MCO must agree to adopt the same requirements for prior authorization and some or all of the same guidelines to determine medical necessity of selected drugs or classes of drugs as those adopted by the MA FFS Program when designated by the Department.

k. The PH-MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2117 regarding continuity of care requirements and 28 PA Code Ch. 9. The PH-MCO must also comply with the procedures outlined in MA Bulletin 99-03-13 and MA Bulletin # 99-96-01. The PH-MCO policy and procedures for continuity of care for drugs, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the PH-MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to drugs that the Member was prescribed before enrolling in the PH-MCO.

l. The PH-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Drug either by addition to the Statewide PDL or MCO Formulary for drugs and products not included in the Statewide PDL, or through prior authorization, within ten (10) days from their availability in the marketplace.

m. The PH-MCO must comply with 1902(a)(85); Section 1004 of the Substance

UseDisorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The PH-MCO will implement prospective safety edits on subsequent fills of opioid prescriptions, as specified by the state, which may include edits to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness.

2. Coverage Exclusions

a. In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. 1396r-8, the PH-MCO must exclude coverage for any drug marketed by a drug company (or labeler) who does not participate in the Medicaid Drug Rebate Program. The PH-MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide rebates to the Medicaid agency. This requirement does not apply to vaccines, compounding materials, certain vitamins and minerals or diabetic supplies.

b. The PH-MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

c. The PH-MCO must exclude coverage of noncompensable drugs in accordance with 55 PA Code §1121.54.

3. Formularies and Preferred Drug Lists (PDLs)

a. The PH-MCO must utilize the Statewide PDL developed by the Department's Pharmacy and Therapeutics (P&T) Committee.
If the PH-MCO fails to meet Statewide PDL quarterly compliance of 95% (excluding TPL) a financial sanction consistent with the difference in net cost using PH-MCO actual compliance rate and the net cost if compliance rate was 95%. The minimum penalty of $25,000 per quarter will be imposed. The PH-MCO is responsible for submitting prior authorization approval and denial information in a format designated by the Department.

b. The PH-MCO must implement use of the Statewide PDL, any changes to the Statewide PDL, the Statewide PDL prior authorization guidelines, and any changes to the Statewide PDL prior authorization guidelines on the effective date provided by the Department.

c. The PH-MCO must apply Statewide PDL prior authorization guidelines to all drugs and products included on the Statewide PDL. The PH-MCO may not impose additional prior authorization requirements for drugs and products included on the Statewide PDL. Quantity limits can be no more restrictive than the Department's quantity limits.

The PH-MCO must submit the policies, procedures, and guidelines to determine medical necessity of drugs included on the Statewide PDL to the Department. Submissions must occur prior to the effective date of the changes as determined by the Department and at least annually.

d. The PH-MCO may use a Formulary or PDL to manage MA covered drugs and products that are outside the scope of the Statewide PDL as long as the Department has prior approved it and the Formulary or PDL meets the clinical needs of the MA population.

   The Formulary or PDL must be developed and reviewed at least annually by the PH-MCO's P&T Committee, as defined in Section 6 of this Exhibit.

e. The PH-MCO must allow access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy), in accordance with Prior Authorization of Services Section V. B.1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and this Exhibit.

f. The PH-MCO must receive written approval from the Department of the Formulary or PDL, the list of specialty drugs, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs and products not included on the Statewide PDL that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred, prior to implementation of the Formulary or PDL, the designation of specialty, and the requirements. PH-MCOs may add drugs to the specialty drug list that are in therapeutic classes already included on the specialty drug list prior to receiving approval from the Department. However, these additions must be included in the specialty drug designations submitted to the Department for written approval. Submissions for annual reviews must occur at least thirty (30) days before effective date of the updated information.

g. The PH-MCO must submit all Formulary or PDL deletions for drugs and products outside the scope of the Statewide PDL to the Department for review and written approval prior to implementation.

h. The PH-MCO must submit written notification of any Formulary or PDL additions for drugs outside the scope of the statewide PDL to the Department within fifteen (15) days of implementation.

i. In addition to providing a link to the Statewide PDL on the PH-MCO's website, the PH-MCO must make available on the website in a machine readable file and format, information about its drug formulary or PDL, listing which medications are covered, including both brand and generic names.

4. Prior Authorization of Drugs

a. For Covered Drugs that require Prior Authorization (including step therapy) as a condition of coverage or payment:

   i. The PH-MCO must provide a response to the request for prior authorization by telephone or other telecommunication device indicating approval or denial of the prescription within twenty-four (24) hours of the request, and

   ii. If a Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the PH-MCO must instruct the pharmacist to dispense either a:

      - Fifteen (15) day supply if the prescription qualifies as an Ongoing Medication,

      - A seventy-two (72) hour supply of a new medication.

b. For drugs not able to be divided and dispensed into individual doses, the PH-MCO must instruct the pharmacist to dispense the smallest amount that will provide at least a seventy-two (72) hour or fifteen (15) day supply, whichever is applicable.

c. The requirement that the Member be given at least a seventy-two (72) hour supply for a new medication or a fifteen (15) day supply for an Ongoing Medication does not apply when a pharmacist determines that the taking of the prescribed medication, either alone or along with other medication that the Member may be taking, would jeopardize the health or safety of the Member.

d. In such an event, the PH-MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber.

e. If the PH-MCO denies the request for prior authorization, the PH-MCO must issue a written denial notice to Member and Provider, using the appropriate Drug Denial Notice template within twenty-four (24) hours of receiving the request for prior authorization. The specific reason(s) for denial must be included in the notice of decision. If additional information is required to approve the request, the specific documentation needed must be listed in the notice.

f. If the PH-MCO approves the request for prior authorization, the PH-MCO must issue a written approval notice to Member and Provider including the drug name and strength, effective and end dates of the approval within twenty-four (24) hours of receiving the request for prior authorization.

g. If the Member files a Grievance or DHS Fair Hearing request from a denial of

an Ongoing Medication, the PH-MCO must authorize the medication until the Grievance or DHS Fair Hearing request is resolved.

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

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

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

    ii. That the service or item is not medically necessary, after making a reasonable effort to contact the prescriber prior to issuing a denial for the requested service. The reasonable effort to contact the prescriber must be documented in writing.

j. When medication is authorized due to the PH-MCO's obligation to continue services while a Member's Grievance or Fair Hearing is pending, and the final binding decision is in favor of the PH-MCO, a request for subsequent refill of the prescribed medication does not constitute an Ongoing Medication.

k. The PH-MCO guidelines to determine medical necessity of Covered Drugs outside the scope of the Statewide PDL cannot be more stringent than the FFS guidelines. The PH-MCO must follow the Statewide PDL Prior Authorization guidelines for drugs and products included on the Statewide PDL.

l. The PH-MCO must comply with the requirements for Prior Authorization of Services, Section V. B. 1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and receive written approval from the Department prior to implementation and annually thereafter. If a PH-MCO covers a specific drug through both their medical and pharmacy benefits, the PH-MCO must apply the same Department approved prior authorization guidelines to prior authorization requests.

5. Provider and Member Notification

The PH-MCO must have policies and procedures for notification to Providers and Members of changes to the Statewide PDL or MCO Formulary used by the PH-MCO for drugs and products outside the scope of the Statewide PDL, Prior Authorization requirements and other requirements for Covered Drugs such as, but not limited to, specialty program requirements.

a. Written notification for changes to requirements must be provided to all affected Providers and Members at least thirty (30) days prior to the effective date of the change.

b. The PH-MCO must provide all other Providers and Members written notification of changes to the requirements upon request.

c. The PH-MCO also must generally notify Providers and Members of changes through Member and Provider newsletters, its web site, or other regularly published media of general distribution.

d. Member notices must be submitted to the Department for review and approval prior to mailing.

6. PH-MCO Pharmacy & Therapeutics (P&T) Committee

a. The P&T Committee membership must include physicians, including a minimum of two (2) behavioral health physicians, pharmacists, MA program consumers and other appropriate clinicians. MA program consumer representative membership must include the following:

i. One (1) physical health consumer representative. The physical health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, or a physical health consumer advocate designated by consumers enrolled in the PH-MCO to represent them.

ii. One (1) behavioral health consumer representative. The behavioral health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, a behavioral health consumer advocate, or a family member designated by consumers enrolled in the PH-MCO to represent them.

b. The PH-MCO must submit a P&T Committee membership list for Department review and approval upon request.

c. When the P&T Committee addresses specific drugs or entire drug classes requiring medical expertise beyond the P&T Committee membership, specialists with knowledge appropriate to the drug(s) or class of drugs being addressed must be added as non-voting, ad hoc members.

d. The minutes from each PH-MCO P&T Committee meeting must be posted for public view on the PH-MCO's website within thirty (30) days of the date of the meeting at which the minutes are approved. Minutes will include vote totals.

7. Pharmacy Provider Network

a. The PH-MCO or Subcontractor must contract on an equal basis with any pharmacy qualified to participate in the MA Program that is willing to comply with the PH-MCO's payment rates and terms and to adhere to quality standards established by the PH-MCO as required by 62 P.S. 449.

i. The provisions for any willing pharmacy apply if the PH-MCO or Subcontractor enters into agreements with specific pharmacies to provide defined drugs or services such as but not limited to, specialty, mail order, and 90-day supplies. PH-MCOs are required to contract on an equal basis with any pharmacy qualified to participate in the MA program that is willing to accept the same payment rate(s) and comply with the same terms and conditions for quality standards and reporting.

ii. Subcontracts and agreements with specific pharmacies contracted to provide defined drugs or services must be submitted to the Department for advance written approval. Any changes to subcontracts or agreements must also be submitted to the Department for advance written approval.

iii. The PH-MCO must submit annually the list of specific pharmacies contracted to provide defined drugs or services, and a list of the drugs or services each pharmacy is contracted to provide, to the Department for review and written approval. Submissions for annual reviews must occur at least thirty (30) days before the effective date of the updated information.

iv. The PH-MCO must notify the Department on an ongoing basis of the following: (1) specific pharmacies that are no longer contracted to provide defined drugs or services and the reason why, (2) pharmacies that request contracting to provide defined drugs or services but are not admitted into the specific pharmacy network and the reason why, (3) any pharmacies that are only contracted to provide a limited scope of defined drugs or services and the reason why.

b. The PH-MCO must develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy’s acquisition cost, professional services and cost to dispense the prescription to a Medicaid beneficiary. The PH-MCO must submit to the Department the policies and procedures for development of network pharmacy payment methodology including the process to ensure that brand and generic payment rates reflect the pharmacy’s acquisition cost (from a readily available distributor doing business in Pennsylvania) and the professional dispensing fee accurately reflects the pharmacist’s professional services and cost to dispense the prescription to a Medicaid beneficiary.

c. The PH-MCO or subcontractor must submit to the Department for review and approval all changes to the payment methodology prior to implementation.

d. The PH-MCO or subcontractor must report all changes to the payment methodology and rates, including but not limited to the maximum allowable cost rates, to network pharmacy providers.

e. (1) If a network pharmacy's claim is approved through the adjudication process, the PH-MCO and any subcontractor may not retroactively deny or modify the payment unless any of the following:

i. The claim was fraudulent.
ii. The claim was duplicative of a previously paid claim.
iii. The pharmacy did not render the service.

(2) Nothing in 7.e.(1) shall be construed to prohibit the modification of or recovery of an adjudicated claim that was determined to be an overpayment or underpayment resulting from audit, review or investigation by a federal or state agency or PH MCO.

f. The PH-MCO and any subcontractor will not charge a fee related to a network pharmacy's claim unless the amount of the fee is disclosed and applied at the time of claim adjudication.

8. Drug Rebate Program

Under the provisions of Section 1927 of the Social Security Act 42 U.S.C.A. 1396r-8, drug companies that wish to have their products covered through the MA Program (both FFS and managed care) must sign an agreement with the federal government to provide rebates to the State. The Affordable Care Act (ACA) provides for federal drug rebates for drugs paid for by the PH-MCOs.

a. In order to ensure full compliance with the provisions of the ACA, PH-MCOs must report the necessary Drug Encounter Data in order for the Department to invoice drug manufacturers for rebates for all Covered Drugs. This includes physician-administered drugs, drugs dispensed by 340B covered entities or contract Pharmacies, and drugs dispensed to PH-MCO Members with private or public pharmacy coverage and the PH-MCO provided secondary coverage.

b. The PH-MCO must report all drug information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by the Department.

If the PH-MCO fails to submit Drug Encounter Data when invoiced to manufacturers for rebate, at least 90% are collectable within 90 calendar days of invoicing by the Commonwealth a sanction of $25,000 per quarter shall be imposed until the PH-MCO reaches the 90% threshold.

The PH-MCO or subcontractor may not negotiate rebates and discounts for Covered Drugs. The PH-MCO or subcontractor may not negotiate its own rebates and discounts for non-drug products included on the Statewide PDL. If the PH-MCO negotiates and collects its own rebates and discounts for non-drug products that are not included on the Statewide PDL, the PH-MCO must report to the Department the

full value of the rebates and discounts in a format designated by the Department. If the PH-MCO assigns responsibility for negotiating and/or collecting the rebates and discounts for non-drug products not included on the Statewide PDL to a subcontractor, the subcontractor must pass the full value of all rebates and discounts on drugs dispensed to the PH-MCO's Members back to the PH-MCO. The subcontractor may not retain any portion of the rebates or discounts. The PH-MCO must report the full value of all the rebates and discounts to the Department in a format designated by the Department.

9. Drug Encounters

a. The PH-MCO shall submit all Drug Encounters to the Department within 30 days (for NCPDP) and 90 days (for 837P and 837I) of the adjudication date of the claim to the MCO for payment.

b. The PH-MCO shall provide all Drug Encounter data and supporting information as specified by the Department to collect rebates through the Medicaid Drug Rebate Program and the Statewide PDL. For all Drug Encounter data including pharmacy point-of-sale (NCPDP), physician-administered drugs (837P), hospital drugs (837I), and drugs dispensed by 340B covered entities and contract pharmacies, the following data elements are required:

i. Valid NDC for the drug dispensed.

- The PH-MCO shall also include the HCPCS code associated with the NDC for all 837P and 837I encounters where payment was made by the MCO based on the HCPCS code and HCPCS code units.

- The PH-MCO shall also include the diagnosis codes associated with the NDC for all 837P and 837I encounters where payment was made by the PH-MCO based on the HCPCS code and HCPCS code units.

ii. Valid NDC units for the drug dispensed

- The PH-MCO shall also include the HCPCS units associated with the NDC for all 837P and 837I encounters where payment was made by the PH-MCO based on the HCPCS code and HCPCS code units.

iii. Actual paid amount by the PH-MCO, or the PH-MCO's PBM, to the provider for the drug dispensed.

iv. Actual TPL amount paid by the Member's primary pharmacy coverage to the provider for the drug dispensed.

v. Actual copayment paid by the Member to the provider for the drug dispensed.

vi. Actual dispensing fee paid by the PH-MCO, or the PH-MCO's PBM, to the

provider for the drug dispensed.

vii. The billing provider's:

- NPI and/or Medical Assistance Identification Number
- Full address and phone number associated with the NPI

viii. The prescribing provider's:

- NPI and/or Medical Assistance Identification Number
- Full address and phone number associated with the NPI

ix. The date of service for the dispensing of the drug by the billing provider.

x. The date of payment by the PH-MCO, or the PH-MCO's PBM, to the provider for the drug.

xi. Any other data elements identified by the Department to invoice for drug rebates.

c. The PH-MCO shall edit and validate claim transaction submissions and Drug Encounter data for completeness and accuracy in accordance with claim standards such as NCPDP. The actual paid amount by the PH-MCO, or the PH-MCO's PBM, to the dispensing provider must be accurately submitted on each Drug Encounter to the Department.

d. The PH-MCO shall ensure that the NDC on all Drug Encounters is appropriate for the HCPCS code based on the NDC and units billed.

e. The Department will review the Drug Encounters and remove applicable 340B covered entity encounters from the drug rebate invoicing process.

f. The PH-MCO shall meet Drug Encounter Data accuracy requirements by submitting PH-MCO paid Drug Encounters with no more than a 3% error rate, calculated for a month's worth of Encounter submissions. The Department will monitor the PH-MCO's corrections to denied Encounters by random sampling performed quarterly and over the term of this Agreement. The PH-MCO shall have corrected and resubmitted 75% of the denied Encounters for services covered under this Agreement included in the random sample within 30 calendar days of denial.

g. If the PH-MCO fails to submit Drug Encounter data within timeframes specified, the Department shall assess civil monetary penalties upon the PH-MCO. These penalties shall be $2,000 for each calendar day that the Drug Encounter data is not submitted. The Department may waive these sanctions if it is determined

that the PH-MCO was not at fault for the late submission of the data.

10. Prospective Drug Utilization Review (Pro-DUR)

a. The PH-MCO must provide for a review of drug therapy before each prescription is filled or delivered to a Member at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.

b. The PH-MCO must provide for counseling of Members receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

11. Retrospective Drug Utilization Review (Retro-DUR)

a. The PH-MCO must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and Members.

b. The PH-MCO shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.

c. The PH-MCO shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.

12. Annual Drug Utilization Review (DUR) Report

The PH-MCO must submit an annual report on the operation of its Pennsylvania Medicaid Drug Utilization Review (DUR) program in a format designated by the Department. The format of the report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

13. Drug Utilization Review Board (DUR Board)

The Department maintains a DUR Board that reflects the structure of the health

care delivery model that includes both a managed care and a fee-for-service delivery system. Each PH-MCO and BH-MCO is required to include a representative to serve as a member of the DUR Board. The DUR Board is a standing advisory committee that recommends the application of predetermined standards related to Pro-DUR, Retro-DUR, and related administrative and educational interventions designed to protect the health and safety of the MA program recipients. The Board reviews and evaluates pharmacy claims data and prescribing practices for efficacy, safety, and quality against predetermined standards using nationally recognized drug compendia and peer reviewed medical literature as a source. The Board recommends appropriate utilization controls and protocols including prior authorization, automated prior authorization, system edits, guidelines to determine medical necessity, generic substitution, and quantity limits for individual medications or for therapeutic categories.

14. Pharmacy Benefit Manager (PBM)

The PH-MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions in Section XII: Subcontractual Relationships and has received advance written approval by the Department. The standards for Network composition and adequacy for drug services includes the requirements for any willing pharmacy as described above. The PH-MCO must indicate the intent to use a PBM, and identify the proposed PBM Subcontract, the PH-MCO's payment methodology or methodologies (ingredient cost and dispensing fee) for payment to the PBM Subcontractor, the PBM's payment methodology or methodologies (ingredient cost and dispensing fee) for actual payment to the providers of covered drugs, and the ownership of the proposed PBM subcontractor. The PBM subcontract must be submitted to the Department for review and written approval prior to implementation, prior to implementation of any changes, and annually thereafter. Changes that only impact non-HealthChoices lines of business do not need to be submitted for Department approval. The final Department-approved and fully executed PH-MCO and PBM subcontract must be submitted to the Department.

If the PBM is owned wholly, in part, or by the same parent company as a PH-MCO, retail pharmacy Provider, chain drug store or pharmaceutical manufacturer, the PH-MCO must submit a written description of the assurances and procedures that will be put in place under the proposed PBM Subcontract, such as an independent audit, to assure confidentiality of proprietary information. These assurances and procedures must be submitted and receive advance written approval by the Department prior to initiating the PBM Subcontract. The Department will allow the continued operation of existing PBM Subcontracts while the Department is reviewing new contracts.

The PH-MCO must:

a. Report the PBM's payment methodology, or methodologies for actual payment to all network pharmacy providers of covered drugs, including community

pharmacies, long-term care pharmacies, network pharmacies contracted to provide specialty drugs, and dispensing prescribers for existing PBM Subcontractors and new PBM Subcontractors.

b. Include on each drug encounter the PBM received amount (amount paid to the PBM by the PH-MCO [ingredient cost and dispensing fee]) and the provider received amount (the actual amount paid by the PBM [ingredient cost and dispensing fee] to the dispensing pharmacy or prescribing provider).

c. Report differences between the amount paid by the PH-MCO to the PBM and the amount paid by the PBM to the providers of covered drugs as administrative fees.

d. Report all PBM administrative fees, including the differences in amounts paid as described in d. above, in a format designated by the Department.

e. Submit a written description of the procedures that the PH-MCO will put in place to monitor the PBM for compliance with the term and conditions of the Agreement related to covered drugs and actual payments to the providers of covered drugs.

f. Upon request by the Department, conduct an independent audit of the PBM's transparent pricing arrangement in compliance with the provision in Exhibit WW HealthChoices Audit Clause.

g. Ensure that the PBM is fully compliant with the requirements in Section V. K. Provider Dispute Resolution System.

h. Develop, implement, and maintain a Second Level PBM Provider Pricing Dispute Resolution Process that provides for settlement of a PBM network Provider's pricing dispute with the PBM, on the condition that the PBM's network Provider exhausted all of its remedies against the PBM.

i. Submit to the Department, prior to implementation, the PH-MCO's policies and procedures relating to the resolution of PBM Provider pricing disputes.

    i. The PH-MCO must submit any changes to the policies and procedures to the Department for approval prior to implementation of the changes.

    ii. 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 that 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 the Department approves the new or revised version.

j. At a minimum, include in the PH-MCO's Second Level PBM Provider Pricing Dispute Resolution policies and procedures the following:

    i. The process for submission and settlement of Second Level PBM Provider Pricing Disputes;

ii. A requirement that the PBM Provider must exhaust all of its remedies against the PBM before requesting a PH-MCO Second Level PBM Provider Pricing Dispute Resolution;

iii. Acceptance and usage of the Department's definition/delineation of Provider Disputes;

iv. Timeframes for submission and resolution of Second Level PBM Provider Pricing Disputes;

v. Processes to ensure equal treatment of all PBM providers in the resolution of pricing disputes.

vi. Process to ensure the paid amount reflects the pharmacy's drug acquisition cost, professional services, and cost to dispense the prescription to an MA beneficiary.

vii. A requirement for both the PBM Provider and the PBM to provide documentation supporting each entity's position(s) related to the pricing dispute;

viii. Designation of PH-MCO staff responsible for resolution of the PBM Provider Pricing Dispute who have:

- The knowledge and expertise to address and resolve PBM Provider Pricing Disputes;
- Access to data and documentation of the informal resolution of the PBM Provider Dispute and the formal PBM Provider Appeal and decisions necessary to assist in making decisions; and

ix. Mechanisms and timeframes for reporting PH-MCO PBM Provider Pricing Dispute decisions to the PBM Provider, the PBM and the Department. If the dispute is denied by the PH-MCO, the Provider Pricing Dispute decisions must include the specific rationale for the denial;

k. Require the PBM and the PBM provider to abide by the final decision of the PH-MCO. If the Provider Pricing Dispute is overturned by the PH-MCO, adjustment must be made to the appealed claim and to future claims for the appealed drug. The PBM/PH-MCO must update their payment methodology for the appealed drug; and

l. Require the PBM to inform all PBM providers of the process and conditions to request a Second Level PBM Provider Pricing Dispute.

15. Requirements For PH-MCO and BH-MCO Interaction and Coordination of Drug Services

a. BH-MCO prescribing Providers must comply with the PH-MCO requirements for utilization management of behavioral health drugs.

b. The BH-MCO will be required to issue an initial list of BH-MCO Providers to the PH-MCO, and quarterly updates that include additions and terminations. Should the PH-MCO receive a request to dispense medication prescribed by a BH Provider not listed on the BH-MCO's Provider file, the PH-MCO must work through the appropriate BH-MCO to identify the Provider. The PH-MCO is prohibited from denying prescribed medications solely on the basis that the BH-MCO Provider is not clearly identified on the BH-MCO Provider file.

c. Payment for inpatient pharmaceuticals during a BH admission is the responsibility of the BH-MCO and is included in the hospital charge.

d. The PH-MCO may deny payment of a claim for a Covered Drug prescribed by a BH-MCO Provider only if one of the following occurs:

   i. The drug is not being prescribed for the treatment of substance abuse/dependency/ addiction or mental illness and any side effects of psychopharmacological agents. Those drugs are to be prescribed by the PH-MCO's PCP or specialists in the Member's PH-MCO Network.

   ii. The prescription has been identified as a case of Fraud, Abuse, or gross overuse, or the dispensing pharmacist determined that taking the medication either alone or along with other medications that the Member may be taking, would jeopardize the health and safety of the Member.

e. The PH-MCO must receive written approval from the Department of the policies and procedures for the PH-MCO and BH-MCO to:

   i. When deemed advisable, require consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records.

   ii. Timely resolve disputes which arise from the payment for or use of drugs, including a mechanism for timely, impartial mediation when resolution between the PH-MCO and BH-MCO does not occur.

   iii. Share independently developed Quality Management/Utilization Management information related to drug services, as applicable.

   iv. Collaborate in adhering to a drug utilization review program approved by the Department. Collaborate in identifying and reducing the frequency of

patterns of Fraud, Abuse, gross overuse, inappropriate or medically unnecessary care among physicians, pharmacists and Members associated with specific drugs.

EXHIBIT DDD

Exhibit DDD

PATIENT CENTERED MEDICAL HOME (PCMH) PROGRAM

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

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

A. The PH-MCO will educate members what the PCMH model is and inform members of the resources available through the PCMH.

B. The PH-MCO will ensure the PCMH provider meets the following requirements:

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

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

3. Will join a Pennsylvania Patient and Provider Network (P3N) certified health information organization (HIO) in order to share health related data.

    - A newly designated PCMH will have six (6) months to connect to a P3N certified HIO. If the PCMH is not connected to a P3N certified HIO within six (6) months, the PCMH will no longer be eligible to participate in the PCMH program and are no longer eligible for a PCMH incentive payment.

4. Will deploy a community-based care management team as described below:

    The PCMH must deploy a community-based care management (CBCM) team that consists of licensed professionals such as nurses, pharmacists or social workers and unlicensed professionals such as peer recovery specialists, peer specialists, community health workers or medical assistants. The CBCM team's activities can replicate but not duplicate already existing and CBCM reimbursed care management services. The care management team will work within their local community to accept individuals with complex care needs from local emergency departments, physical and behavioral health hospitals, specialty

providers, and PH-MCO. Through actively engaging patients and taking into account their preferences and personal health goals, the CBCM team will develop care plans that help individuals with complex chronic conditions to stay engaged in comprehensive treatment regimens that include, but are not limited to physical health, substance use disorder and mental health treatments. The CBCM team will also connect individuals as needed to community resources and social support services through "warm hand off" referrals for assistance with problems such as food insecurity and housing instability.

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

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

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

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

9. Will see 75% of patients within seven days of discharge from the hospital with an ambulatory sensitive condition. This includes a follow-up visit with a Specialist provider. The Specialist provider must share the patient's follow-up visit notes with the PCMH to meet this requirement,

10. Will participate in a PCMH learning network,

11. Will complete a Social Determinants of Health assessment, at least annually and more frequent for patients who screen positive, using a Nationally recognized tool focusing on the following domains: food insecurity; health care/medical access/affordability; housing; transportation; childcare; employment; utilities; clothing and financial strain and submit ICD-10 diagnostic codes for all patients with identified needs. For patients with identified needs, the PCMH must assist the member with obtaining the needed services and monitor the outcome of the referral The PCMH must track referrals and outcomes and be able to submit to the PH-MCO via claims submission the outcome of every Social Determinants of Health assessment performed using the HCPCS codes of G9919 (positive screening result) or G9920 (negative screening result) as well as providing the PH-MCO and Department a report of the SDOH assessment outcomes as may be requested,

12. Will educate and disclose to patients through low-literacy appropriate material the practice is a PCMH that has a community-based care management team available to help patients manage complex care needs,

13. Will refer any patient who reports having a special need to the patient's PH-MCO's Special Needs Unit, and

14. Will provide Tobacco Cessation Counseling (TCC) services or demonstrate referral of patients who are seeking TCC services.

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

D. The PH-MCO's PCMH network will include high volume adult and pediatric providers that serve the percentage of total membership and percentage of members that fall within the top 5th percentile of medical costs.

   PCMHs' must serve at least 20% of their total membership and at least 33% of members that fall within the top 5th percentile of medical costs.

E. The PH-MCO will collect key quality metrics from the PCMHs and report those results annually to the Department.

F. The PH-MCO will reward PCMHs with quality-based enhanced payments focusing on key performance measures defined by the Department. Current provider pay for performance dollars may be used for these quality-based payments.

G. The PH-MCO will develop a quarterly regional learning network that includes all PCMHs, patient advocates or family team members, and PH-MCOs in a HealthChoices region. At least one of the PCMH Learning Collaboratives needs to be face-to-face.

H. Data Sharing

   The PH-MCO must provide timely and actionable data to its PCMHs. This data should include, but is not limited to, the following:

   1. Identification of high risk patients;

   2. Comprehensive care gaps inclusive of gaps related to quality metrics used in the value-based payment arrangement; and

   3. Service utilization and claims data across clinical areas such as inpatient admissions, outpatient facility (SPU/ASC), emergency department, radiology

services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.

I. The PH-MCO must work towards developing a value-based arrangement with Person-Centered Ambulatory Intensive Care Centers (PC-AICCs) in each zone they operate, unless the PH-MCO demonstrates to OMAP's satisfaction that the PH-MCO is not able to reach an agreement with the PC-AICC. A PC-AICC is a practice that provide comprehensive physical and behavioral health care to those individuals who are high cost and in high need of medical and social services. These practices serve individuals who demonstrate non-episodic impactable medical costs over $30,000 and are typically the costliest 2 - 3% of individuals who account for up to 40% of the PH-MCOs medical spend.

PCMH – PEDIATRIC NURSING CARE (PNC) PROGRAM

The Patient Centered Medical Home - Pediatric Nursing Care (PCMH – PNC) is a medical home designed to provide comprehensive coordination of care for children receiving pediatric shift care nursing services. PCMH-PNCs deliver whole person, family-centered care for children receiving shift care nursing services through comprehensive case management and team-based care planning.

The PH-MCO's network of PCMH-PNCs will include existing PCMHs that serve at least 20 children who have been authorized by the PH-MCO and are receiving shift care nursing services under HCPCS procedure codes S9122, S9123, S9124, T1000, T1002, T1003, or T1019.

J. The PH-MCO shall:
   1. Develop processes and criteria for recognizing PCMHs who wish to become a PCMH-PNC. The PH-MCO will share information on the PCMH-PNC program with existing PCMH providers as applicable.
   2. Ensure that the network of contracted providers with the PCMH-PNC recognition is sufficient to provide reasonable access to any child receiving pediatric shift nursing services pursuant to the requirements of Exhibit AAA to this Agreement.
   3. Collect and report annually clinical quality and financial outcomes data from the PCMH-PNCs as required in Operations Report 19, separating reporting for general PCMHs from reporting for PCMH-PNCs.
   4. Work with other PH-MCOs to develop a learning network that provides curriculum and training specific to the needs of PCMH-PNCs.
   5. Provide outreach and access to families and members who are eligible for participation in a PCMH-PNC. The PH-MCO will educate members what a PCMH-PNC is and services provided to families at the first authorization for any of the pediatric shift care nursing services, or, the next re-authorization of those services.

6. Create and distribute educational and promotional material as necessary to assure that the parents/guardians of potential PCMH-PNC members are aware of any PCMH-PNC in their region and the benefits of using the PCMH-PNC.
7. Verify that a connection exists between the PCMH-PNC and the Pediatric Complex Care Centers (PCCRC) located within the same HealthChoices Zone as the PCMH-PNC, once the PCCRCs are operationalized. The PCCRs are established to assist providers and families in coordinating care among multiple providers and to provide education and training for families and providers as needs are identified.

K. The PH-MCO will ensure the PCMH provider meets the following requirements:
   1. Completes assessments and screenings, which will include a comprehensive physical, mental, and social evaluation including use of tools for behavioral health assessment and SDOH. Assessments and screenings will be performed by appropriately trained staff. Assessments must be completed at least semi-annually or when there is a major change in member's care. Examples of major changes include hospitalization, emergency room visit, or change in the member's medical condition.
   2. Provides high-touch case management and serves as the single point of access to ensure care integration, including integration of services across all systems that align with the child's shared care plan to meet the child's medical, social, education, legal, therapeutic, Durable Medical Equipment (DME), skilled nursing, and mental/behavioral health (BH) needs.
   3. Employs sufficient numbers of case managers to meet all case management obligations and assigns a case manager to each child. The PCMH-PNC case manager will:
      i. Convene care team meetings at least quarterly.
      ii. Maintain the child's shared plan of care, as described below.
      iii. Make warm hand-off referrals to providers of services to meet the needs identified in the assessments described above.
      iv. Coordinate all additional case management services, including those related to a PH-MCO case management or Special Needs Unit, HHA (home health agency) services, DME, Early Intervention, BH, and education.
   4. Assembles a care team that includes the child's family, case manager, PCP, pediatrician, other specialists, DME company coordinator, BH specialist, HHA clinical supervisor/nurse, and representatives from other agencies/community resources as identified by the assessments described above. The care team is expected to work collaboratively with the child and family to develop a family-centered care plan. The PCMH-PNC and the care team, with the guidance of the case manager and the involvement of the child/family, will:

i. Maintain medical orders and initiate and maintain necessary and authorized services.
ii. Ensure that all care team members are working from the most current version of the shared plan of care and carrying the plan of care out in an integrated fashion.
iii. Assist the HHA(s) with scheduling of shifts by identifying appropriate skills needed by nurse/ home health aide to provide quality care to the child.

5. Develop and maintain a Family-Centered Plan of Care that is shared by the entire care team and is reviewed at least annually, unless there is a major change in the member's care, by the care team as defined above. The shared Family-Centered Plan of Care must be developed based on the results of the assessments described above and must include, at a minimum, the following:
    i. Medical details such as diagnostic information, baseline vitals, treatments, allergies, and DNR status
    ii. Shift care services including hours authorized, the skilled nursing care schedule, and the family's and HHA's shared needs and expectations for nurses and home health aides.
    iii. DME details, including changing schedules and frequency, a list of supplies required, and specific settings for DME
    iv. BH assessment results, referrals, diagnoses and treatment plan details
    v. SDOH assessment results and referrals made to community resources
    vi. Caregiver, family and home environment information, such as work schedules, cultural preferences, and preferred language spoken
    vii. Emergency protocols, such as asthma risk plan, seizure control, and emergency contacts
    viii. Transportation needs
    ix. School details, such as method of transportation, time in school, and instructions for the school nurse
    x. Activities of daily living with which the child requires assistance, such as bathing, toileting, grooming, eating (including nutrition information) and exercise
    xi. Social and communication abilities
    xii. Personal and family goals, such as more shared mealtime or school attendance
    xiii. Contact information for all members of the care team
    xiv. Plans for transitioning to adulthood

6. Has policies and procedures in place to communicate with other clinicians/specialists and ensure that referrals are completed and documented.
7. Works collaboratively with the PCCRC to facilitate coordination of care and referrals including educational and training needs and informs the child's family about the PCCRC, its purpose, and potential benefits of association.