Appendix B
Draft CHIP Agreement

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) AGREEMENT

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SECTION I: INCORPORATION OF DOCUMENTS

A. Operative Documents

The Request for Agreement, which is attached hereto as Appendix 1, and the Application, 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 Application, 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 Application, 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. **CHIP Transmittals and Policy Clarifications**. The Department issues CHIP transmittals and policy clarifications via the CHIP Collaboration Room to provide clarifications to requirements applicable to CHIP. The CHIP-MCO must routinely check the CHIP Collaboration Room. CHIP transmittals and policy clarifications are vehicles to clarify operational policies and procedures and are not to amend the terms of the Agreement.

2. **CHIP Collaboration Room and HealthChoices Extranet.** To access the CHIP Collaboration Room, the CHIP-MCO shall establish connectivity with the Department.

   In addition to the policy transmittals and clarifications, the CHIP Collaboration Room contains current information on managed care systems policies and procedures, which include, but are not limited to, information on eligibility, enrollment and reimbursement procedures, encounter data submission requirements and information on pending changes and systems notices.

   Detailed in the Procedure Handbook are all the Resource Accounts for CHIP

SECTION II: DEFINITIONS

Abuse — Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to CHIP, 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 law or federal regulations) for health care in a managed care setting. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider or entity has not knowingly or intentionally misrepresented facts to obtain payment. The Abuse can be committed by the CHIP-MCO, Subcontractor, Provider, State employee, or an Enrollee, among others. Abuse also includes Enrollee practices that result in unnecessary cost to CHIP, the CHIP-MCO, a Subcontractor, or Provider.

Actuarily Sound Capitation Rate — Actuarially sound Capitation rates are projected to provide reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the Primary Contractor for the time period and the population covered under the terms of the contracts, and such Capitation rates are developed in accordance with the requirement in 42 C.F.R. §§457.1203.

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

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

Actuarially sound rates are developed using sound methods and assumptions, that are reasonably attainable by the CHIP-MCOs in the relevant Agreement year and meet the standards of the Actuarial Standards Board.

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

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

Administrative denial - An adverse benefit determination of prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy. The term does not include an adverse benefit determination subject to the external review.

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 CHIP-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 CHIP-MCO or its parent(s), directors, or subsidiaries of CHIP- 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.

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 provided as part of CHIP and outlined within the CHIP Stat Plan.

Behavioral Health Services Provider — A Provider, practitioner, or vendor/supplier which contracts to provide Behavioral Health Services or ordering or referring those services and is legally authorized to do so by the Department..

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 CHIP-MCO on behalf of each Enrollee 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 Enrollee 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 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.

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 CHIP-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 MA Recipients and CHIP Enrollees. The data base contains demographic and eligibility information for all CHPI Enrollees and MA 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).

Complaint —
1. A Complaint regarding an adverse benefit determination: A dispute or objection regarding:

- a denial because the requested service or item is not a covered service;
- the failure of the CHIP-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the CHIP-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the CHIP-MCO after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in CHIP;
- a denial of payment by the CHIP-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Enrollee; or
- a denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

2. A Complaint without an adverse benefit determination is an expression of dissatisfaction about any matter other than an adverse benefit determination. Complaints may include, but are not limited to, the quality of care of services provided, and aspect of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Complaint includes an enrollee's right to dispute an extension of time proposed by the CHIP-MCO to make an authorization decision. These types of complaints do not have a filing timeframe.

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 CHIP-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 CHIP, on the local level. Department staff in these offices perform necessary functions such as determining and maintaining Enrollee eligibility.

Outpatient Drug — A brand name drug, a generic drug, or an OTC drug which:

1. Is approved by the Federal Food and Drug Administration.
2. May be dispensed only upon prescription in CHIP.
3. Has been prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice.
4. Is dispensed or administered in an outpatient setting.

The term includes biological products and insulin.

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

Daily 834 Eligibility File — An electronic file in a HIPAA compliant 834 format using data from CIS/eCIS that is transmitted to the CHIP-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 CHIP-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 CHIP-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.

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 an Enrollee's ability to receive services from a CHIP-MCO is terminated.

DHS Fair Hearing — A hearing conducted by the Department's Bureau of Hearings and Appeals for CHIP regarding an eligibility determination.

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

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 a disability, illness or injury (d) can be reusable or removable and (e) is appropriate for use in any setting in which normal life activities take place.

Early Intervention Services — 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 CHIP benefits. An Eligibility Period is indicated by the eligibility start and end dates on CIS/eCIS.

Eligibility Verification System — An automated system available to CHIP Providers and other specified organizations for automated verification of CHIP Enrollee's current and past (up to three hundred sixty-five [365] days) MA and CHIP eligibility, CHIP-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 Enrollee Issue — A problem of a CHIP-MCO Enrollee, including problems related to whether an individual is an Enrollee, 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 Enrollee 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 42 U.S.C 1397bb 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, or other methods of compensation regardless of whether payment is due or made.

Enrollee — An individual who is enrolled with a CHIP-MCO under CHIP and for whom the CHIP-MCO has agreed to arrange the provision of CHIP Services under the provisions of CHIP.

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 CHIP-MCO that is subject to the requirements of 42 CFR §438.242 and 42 CFR §438.818.

Enrollment — The process by which an Enrollee's coverage by a CHIP-MCO is initiated.

Enrollment Assistance Program — The program that provides Enrollment Specialists to assist eligible persons in selecting a CHIP-MCO and PCP and in obtaining information regarding CHIP.

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

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

Expanded Services — Any service, not covered under the CHIP State Plan which is provided to Enrollees to improve health and wellbeing. CHIP-MCOs do not utilize capitation payments for the provision of these services to members.

Experimental Procedures — 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 42 CFR §457.1250 for independent, external review body to perform an annual review of the quality of services furnished by MCOs, including the evaluation of quality outcomes, timeliness and access to services.

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

Family Planning Services — Services which enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies.

Federally Qualified Health Center — An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under the above-mentioned sections of the Act.

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

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

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 CHIP-MCO, a subcontractor, a Provider, or an Enrollee, 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

CHIP- MCO. This individual acts as the day-to-day manager of Agreement and operational issues and works within the CHIP-MCO and with the Department to facilitate compliance, solve problems, and implement corrective action.

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

Health Care-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 or 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 Information Organization- An organization that serves as a Health Information Exchange that allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically.

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

Incentive Arrangement — Any payment mechanism under which a CHIP-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 CFR §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.

State Plan Services — Services which required by the Pennsylvania Children's Health Insurance State Plan.

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

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

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.

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 requirements of 42 CFR § 489 Subpart I or (2) Makes the services it provides its CHIP enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to tother CHIP beneficiaries within the area served by the entity; and (3) meets the solvency standards of 42 CFR § 438.116.

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

Security Act.

Managed Care Program Zones (MCP Zone) — A multiple-county area in which CHIP has been implemented to provide mandatory managed care to CHIP Enrollees in Pennsylvania.

Market Share — The percentage of Enrollee enrolled with a particular CHIP-MCO when compared to the total of Enrollees enrolled in all the CHIP-MCOs within a Managed Care Program 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.

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.

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

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

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

- The service, item, procedure, or level of care will assist the Enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollee and those functional capacities that are appropriate for Enrollees of the same age.

Member Record — A record on the Daily 834 Eligibility File or the Monthly 834 Eligibility File that contains information on CHIP eligibility, managed care coverage, and the category of assistance, which help establish the covered services for which an Enrollee is eligible.

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 CIS/eCIS that is transmitted to the CHIP-MCO on a monthly basis.

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

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

Non-participating Provider — A Health Care Provider not enrolled in the Pennsylvania Medicaid or CHIP.

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

Nursing Facility — A general, county or hospital-based nursing facility, which is licensed by the DOH.

OMAP Hotlines — Department phone lines designed to address and facilitate resolution of issues encountered by Enrollees and their advocates or Providers according to CHIP-MCO policies and procedures. OMAP Hotlines include the CHIP Hotline.

Ongoing Medication — A medication that has been previously dispensed to the Enrollee 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 Enrollee 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.

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 Enrollee under one (1) or more of the following circumstances:

- An Emergency Medical Condition that occurs while outside the Enrollee's

Managed Care Program Zone;

- The health of the Enrollee would be endangered if the Enrollee returned to his or her Managed Care Program Zone for needed services;

- The Provider is located outside the Enrollee's Managed Care Program Zone, but regularly provides medical services to Enrollees at the request of the CHIP-MCO; or

- The needed medical services are not available in the Enrollee's Managed Care Program Zone.

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

Out-of-Plan Services — Services which are non-plan, non-capitated and are not the responsibility of the CHIP-MCO under the CHIP State Plan.

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 Children's Health Insurance State Plan- The Centers for Medicare and Medicaid approved template outlining services and administrative requirements for the Children's Health Insurance Program in Pennsylvania.

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 MCOs. The Department is currently using IRM Standards.

Physical Health Services — Those medical and other related services, provided to Enrollees, for which the CHIP-MCO has assumed coverage responsibility under this Agreement and as outlined in the CHIP State Plan.

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 CHIP Enrollees enrolled in the MCO.

Potential Enrollee — A CHIP beneficiary who is subject to enrollment in a given CHIP-MCO but is not yet an enrollee of a specific.

Preferred Drug List — A list of Department-approved outpatient drugs designated as preferred products because they were determined to have a significant,

clinically meaningful therapeutic advantage in terms of safety, effectiveness and cost for the CHIP-MCO Enrollees by the CHIP-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. (42 CFR 457.1207 referencing CFR§ 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 CHIP, 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 an Enrollee.

Prior Authorization — A determination made by the CHIP-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 an Enrollee prior to the Provider's initiation or continuation of the requested service.

Prior Authorized Services — State Plan Services, determined to be Medically Necessary, the utilization of which the CHIP-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 CHIP-MCO and a Provider to provide medical or professional services to Enrollees to fulfill the requirements of this Agreement.

Provider Appeal — A request from a Provider for reversal of a determination by the CHIP-MCO, with regard to:

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

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

Provider Reimbursement and Operations Management Information System electronic (PROMISe™) — The Department's current MMIS claims processing and management system that supports the CHIP, 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.

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.

Enrollment Month — One Enrollee covered by CHIP 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 CHIP-MCO or subcontracting CHIP-MCO and (1) performs some of the CHIP-MCO or subcontracting CHIP-MCO's management functions under contract or delegation; or (2) furnishes services to Enrollees under a written agreement; or (3) leases real property or sells materials to the CHIP-MCO or subcontracting CHIP-MCO at a cost of more than $2,500.00 during any year of a CHIP 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.

Retrospective Review — A review conducted by the CHIP-MCO, DHS, or DHS vendor or designee to determine whether services were delivered as prescribed and consistent with the CHIP-MCO's payment policies and procedures in accordance with this 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.

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

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

School-Based Health Center — A health care site located on school building premises which provides, at a minimum, on-site, age-appropriate primary and preventive health services with parental consent, to children in need of primary health care and which participates in CHIP and adheres to Bright Futures 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 childcare 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.

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

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 CHIP-MCO to a Network Provider for each Enrollee identified as being in their capitation group, whether or not the Enrollee received medical services.

Subcontract — A contract between the CHIP-MCO and an individual, business, university, governmental entity, or nonprofit organization to perform part or all of the CHIP-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 CHIP-MCO that relates directly or indirectly to the performance of the CHIP-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 CHIP-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.

Third Party Liability — An individual entity or program's (e.g., Medicare) other than the CHIP-MCO financial responsibility for all or part of an Enrollee'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 an Enrollee. 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.

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).

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.
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 Health care 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
CHIP- Children's Health Insurance Program
CHIP-MCO – Children's Health Insurance Program Managed Care Organization
CHS — Contract Health Services
CIS/eCIS — Client Information System
CLIA — Clinical Laboratory Improvement Amendment
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)
DSH — Disproportionate Share Hospital
DUR — Drug Utilization Review
EAP — Enrollment Assistance Program
EHR — Electronic Health Record
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
GME — Graduate Medical Education
HEDIS — Healthcare Effectiveness Data and Information Set
HHS-OIG — U.S. Department of Health and Human Services-Office of Inspector General
HIO — Health Information Organization
HIPAA — Health Insurance Portability and Accountability Act
HIV — Human Immunodeficiency Virus
HMO — Health Maintenance Organization
ICN – Internal Control Number
IHS — Indian Health Service
IRM — Information Resource Management
I/T/U — Indian Tribe, Tribal Organization, or Urban Indian Organization
LEIE — HHS-OIG List of Excluded Individuals and Entities
LEP — Limited English Proficiency
LTSS — Long-term Services and Supports
MA — Medical Assistance
MCO — Managed Care Organization
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
OCDEL — Office of Child Development and Early Learning
OMAP — Office of Medical Assistance Programs Services
OTC — Over the Counter
P&T — Pharmacy & Therapeutics
PA CHIP State Plan- Pennsylvania Children's Health Insurance Program State Plan
PAHP — Prepaid Ambulatory Health Plan
PBM — Pharmacy Benefit Manager
PCP — Primary Care Practitioner
PCMH — Patient Centered Medical Home
PDL — Preferred Drug List
PH — Physical Health
PHDHP — Public Health Dental Hygiene Practitioners

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
PPR — Prepayment Review
PPS — Prospective Payment System
PROMISe™ — Provider Reimbursement (and) Operations Management Information System electronic (format)
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
RFA- Request for Agreement
RHC — Rural Health Centers/Clinics
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
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
WIC — Women, Infants and Children (Program)

SECTION III: RELATIONSHIP OF PARTIES

A. Basic Relationship

The Children's Health Insurance Program Managed Care Organization (CHIP-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 CHIP-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 CHIP-MCO herein. The CHIP-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 CHIP-MCO is responsible for all taxes and withholdings of its employees. In the event that any employee or representative of the CHIP-MCO is deemed an employee of the Department by any taxing authority or other governmental agency, the CHIP-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 CHIP-MCO must arrange for the provision of medical and related services to Members through qualified Providers in accordance with this Agreement. In administering CHIP, the CHIP-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 CHIP-MCO herein.

The Secretary for DHS will determine the number of CHIP-MCOs operating in CHIP 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 CHIP-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 CHIP-MCO may not employ or enter into a contractual relationship with a Health Care Provider who is precluded from participation in the MA Program, CHIP 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 CHIP

In compliance with ARRA 5006(a), the CHIP-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).

The CHIP-MCO shall participate in CHIP, must arrange for the provision of Physical Health Services, Behavioral Health Services and related medical services essential to the medical care of its Enrollees, and must comply with all applicable federal and Pennsylvania laws governing participation in CHIP. The CHIP-MCO must provide services in the manner prescribed by 42 U.S.C. § 1397aa et seq., 42 U.S.C. § 300e and 40 P.S. § 991.2301-A et seq. The CHIP-MCO shall comply with all applicable rules, regulations, and transmittals promulgated under such laws including, but not limited to 42 CFR Part 457 and 45 C.F.R Parts 75, 80, 84, 91 and 93.

In compliance with ARRA 5006(a), the CHIP-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).

C. General Laws and Regulations

1. The CHIP-MCO must comply with all applicable Federal and State laws and regulations including but not limited to: 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.; Section 1557 of the Patient Protection and Affordable Care Act (ACA), [42 CFR § 457.1201 referencing 438.3(f)(1); 42 CFR § 457.1220 referencing § 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 CFR. Parts 160, 162, and 164 (HIPAA Regulations); the Pennsylvania Human Relations Act of 1955, 71 P.S. §§941 et seq.; Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. §§991.2102 et seq.; and Drug and Alcohol Use and Dependency Coverage Act 106 of 1989, 40 P.S. §§908-1 et seq.

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

2. The CHIP-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 CHIP-MCO.

3. The CHIP-MCO must comply with all applicable laws, regulations, and policies of the Pennsylvania DOH and the PID.

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

   The CHIP-MCO shall draft and enforce policies that recognize and protect Enrollee rights, including the rights to (a) receive information in accordance with 42 CFR § 457.1207 referencing § 438.10; (b) be treated with respect and due consideration for his or her dignity and privacy; (c) receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand; (d) participate in decisions regarding his or her health care, including the right to refuse treatment; (e) be free from any form of restraint or seclusion as specified in federal regulations on the use of restraints and seclusion; (f) request and receive a copy of his or her medical records and request that they be amended or corrected as required by the HIPAA Regulations; (g) be furnished with health care services as required by 42 CFR § 457.1230 referencing §§ 438.206 – 438.210; and (h) have privacy rights protected as provided by 42 CFR § 457.1110. An Enrollee's or Parent's exercise of an Enrollee's rights and protections may not adversely affect the manner in which the Enrollee is treated by the CHIP-MCO or its Network Providers.

   The CHIP-MCO may not restrict a Provider, acting within his or her scope of practice, from advising or advocating on behalf of an Enrollee concerning the Enrollee's health status, medical care, treatment options including alternate treatments, information necessary to decide on treatment options, the risks, benefits and consequences of treatment and non-treatment and the Enrollee's right to participate in decisions concerning his or her healthcare.

4. The CHIP-MCO and its Subcontractors must respect the conscience rights of individual Providers, as long as said conscience rights are made known to the CHIP-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 CHIP-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 CHIP-MCO must furnish information about the services not covered in accordance with the

provisions of 42 CFR § 457.1222 referencing §438.102(b)

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

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

5. The CHIP-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 CHIP at the time such services are provided.

7. The CHIP-MCO must comply with all applicable Federal regulations, including 42 CFR § 457.1270 referencing §§438.726 and 438.730 describing conditions under which CMS may deny payments for new enrollees.

8. The CHIP-MCO shall comply with all applicable federal regulations pertaining to Provider screening, disclosure and enrollment, including 42 CFR § 457.1285.

9. The CHIP-MCO is required under 42 CFR §457.935 42 CFR §455.436 to check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents, and managing employees of the provider on the U.S. Department of Health and Human Services- Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the 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 CHIP-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 CHIP-MCO must comply with the requirements of 42 CFR § 457.1216, referencing to 438.62), the Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicaid Managed Care Plans.

11. The CHIP-MCO shall be located within the United States and may not pay any Claim to a Provider, subcontractor, or financial institution outside of the United States.

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 CHIP-MCO will comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in CHIP.

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

The CHIP-MCO will comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in CHIP 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 CHIP-MCO to support the HIT initiative or to meet the requirements under the SMHP as approved by CMS, the CHIP-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 CHIP-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 CHIP-MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, CHIP-MCO will not be paid for that work. If the CHIP-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 CHIP-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 CHIP-MCO, The CHIP-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. CHIP State Plan Services, Co Pays and Premiums

1. General

The CHIP-MCO must provide all State Plan Services as described in the CHIP State Plan, Appendix 2. All CHIP State Plan Services are available to CHIP Enrollees upon enrollment with the CHIP-MCO. The CHIP-MCO must ensure that all services provided are Medically Necessary. At a minimum, the CHIP-MCO must provide services in the amount, duration and scope set forth in the Section 6 and Appendix B of the CHIP State Plan, Appendix 2 to this Agreement.

The CHIP-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 are added to the PA CHIP State Plan or enrollees or if covered services or eligible consumers are expanded or eliminated, implementation by the CHIP- MCO must be on the same day as the established implementation date within the CHIP State Plan, unless the CHIP-MCO is notified by the Department of an alternative implementation date.

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

Pursuant to 42 CFR §457.1201 referring to §438.3(e)(2)(i) – (iii), the CHIP-MCO may cover services or settings for enrollees that are in lieu of those covered under the CHIP 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 CHIP State Plan.
- The State determines that the alternative service or setting is a cost-effective substitute for the covered service or setting under the CHIP State Plan.
- The enrollee is not required by the CHIP-MCO to use the alternative service or setting.
- The approved in lieu of services are authorized and identified in the CHIP-MCO contract.
- The approved in lieu of services are offered to enrollees

at the option of the CHIP-MCO.

The CHIP-MCO must make all PA CHIP State Plan services and benefits available to enrollees starting on the first date of enrollment. CHIP State Plan Services include physical health, mental and behavioral health, dental and vision services. CHIP State Plan services are listed in Section 6 and Appendix B of the CHIP State Plan, Appendix 2 to this Agreement.

The CHIP-MCO must apply co-pays as established in the CHIP State Plan. Premiums charged by the MCO must not exceed amounts established in accordance with the CHIP RFA and subsequent rate setting agreements. CHIP MCOs must collect premiums in accordance with 40 P.S. 2301-A – 2309-A. CHIP-MCOs must report premium collection amounts to the Department upon request. THE CHIP-MCO must report an enrollee's failure to pay premiums within ten (10) days to the CAO. The CHIP-MCO must disenroll members who fail to pay premiums once notified by the CAO that eligibility in eCIS has been terminated.

2. Pharmacy Services

The CHIP-MCO must comply with the Department's outpatient drug services standards and requirements described in the CHIP State Plan and Exhibit AA, Outpatient Drug Services.

3. Bright Futures Requirement

The CHIP-MCO network providers must complete the recommendations outlined in the American Academy of Pediatrics Bright Futures periodicity schedule, Appendix 3, also located at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

4. Environmental Lead Testing

The CHIP-MCO must provide for necessary comprehensive environmental lead investigations as part of covered blood lead treatment services. The CHIP-MCO must contract with the necessary number of MA-enrolled Comprehensive Lead Investigation Providers to ensure access to this service in all Managed Care Program Zones in which the CHIP-MCO operates. The CHIP-MCO will ensure that results of environmental lead investigations are shared with the referring provider and the Enrollee (or Enrollee's guardian).

B. Expanded Services

The CHIP-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 an Enrollee's health status and are not required under the PA CHIP State Plan. Expanded services 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 Enrollees within a CHIP-MCO and must be made available at all appropriate Network Providers. Such services cannot be tied to specific Enrollee performance; however, the Department may grant exceptions when it believes that such performance will produce significant health improvements for Enrollees.

In order for information about expanded services to be included in any Enrollee information provided by the CHIP-MCO, the CHIP-MCO must make the expanded services available for a minimum of one (1) full year or until the Enrollee information is revised, whichever is later. Upon sixty (60) days advance notice to the Department, the CHIP-MCO may modify or eliminate any expanded service. Such services as modified or eliminated shall supersede those specified in the Application. The CHIP-MCO must send written notice to Enrollees 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.

C. Referrals

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

D. Self-Referral/Direct Access

The CHIP-MCO may not require referrals from a PCP for certain services as established by the CHIP State Plan, federal or state law. An Enrollee may self-refer for vision, dental care, obstetrical and gynecological (OB/GYN) services, providing the Enrollee obtains the services within the Provider Network and physical therapy services in accordance with the amended Physical Therapy Act (63 P.S. §§1301 et seq.) The CHIP-MCO may not use either the referral process or Prior Authorization to manage the utilization of Family Planning Services. The CHIP-MCO may not restrict the right of an Enrollee 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. Enrollees may access at a minimum, health education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures as described in Exhibit E, Family Planning Services Procedures. The CHIP-MCO must pay for Out-of-Network Family Planning Services.

The CHIP-MCO must provide Enrollees 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 CHIP-MCO must permit Enrollees 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 Enrollee is pregnant and already receiving care from an Out-of-Network OB-GYN specialist at the time of Enrollment, the Enrollee 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.

E. Examinations to Determine Abuse or Neglect

1. Upon notification by the County Children and Youth Agency system, the CHIP-MCO must provide Enrollees 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**.**

2. The CHIP-MCO must ensure that emergency department staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for Enrollees 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.

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

F. Maternal Home Visiting Program

G. Benefit Limits and Benefit Limit Exceptions (BLEs)

CHIP-MCO must follow the benefit limits established in the CHIP State Plan. The MCO may exceed benefit limit if the enrollee has a medical necessity for additional services exceeding established limits. The medical necessity must be documented in the Enrollees medical record. The CHIP MCO may not establish benefit limits unless the benefit limit is listed in the CHIP State Plan. For those services that are covered in an Enrollee's benefit package with an approved BLE, the CHIP-MCO must use the same criteria as the Department or may use criteria less restrictive for its review of BLE requests.

The CHIP-MCO must establish and maintain written policies and procedures for its BLE process. The CHIP-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 CHIP-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 CHIP. Unless otherwise required by law, the CHIP-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 CHIP-MCO operations surrounding these BLE requests.

If the CHIP-MCO imposes benefit limits as listed in the CHIP state plan, the CHIP-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 Enrollees.

The time frames for notices of decisions for prior authorization set forth at Section V.G. and V.H.2 apply to requests for BLEs. If the CHIP-MCO denies a BLE request, the CHIP-MCO must issue a written denial notice, using the appropriate template available in Docushare.

If the Enrollee 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 an External Grievance review that is filed with the CHIP-MCO within fifteen (15) days

of receipt of denial, the CHIP-MCO must continue to provide the service until a decision is made.

Enrollees with approved BLEs are in a course of treatment. As such, the Continuity of Care requirements in Section V(I) apply. The CHIP-MCOs will honor all approved BLE requests issued by CHIP-MCOs.

H. Prior Authorization of Services

1. General Prior Authorization Requirements

If the CHIP-MCO wishes to require Prior Authorization of any services, the CHIP-MCO must establish and maintain written policies and procedures which must have advance written approval by the Department. Prior Authorization requirements cannot conflict with CHIP State Plan. In addition, the CHIP-MCO must include a list and scope of services for referral and Prior Authorization, which must be included in the CHIP-MCO's Provider manual and Enrollee handbook. The CHIP-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 F, Prior Authorization Guidelines for Participating Managed Care Organizations in the CHIP, and Exhibit G, Quality Management and Utilization Management Program Requirements. The Department will consider Prior Authorization policies and procedures approved under previous CHIP agreements approved under this Agreement. The CHIP-MCO's submission of new or revised policies and procedures for review and approval shall not act to void any existing, previously approved policies and procedures. Unless otherwise required by law, the CHIP-MCO may continue to operate under such existing policies and procedures until such time as the Department 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 CHIP-MCO improperly implements any Prior Authorization policy or procedure or implements such policy or procedure without Department approval.

When the CHIP-MCO denies a request for services, the CHIP-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 CHIP-MCO must make the notice available in accessible formats for individuals with visual impairments and for persons with limited English proficiency. If the CHIP-MCO receives a request from the Enrollee, 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 CHIP-MCO mails the translated and/or accessible notice of denial to the Enrollee.

The Department will use its best efforts to review and provide feedback to the CHIP-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 CHIP-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

The CHIP-MCO must process each request for Prior Authorization of a service and notify the Enrollee of the decision as expeditiously as the Enrollee'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 CHIP-MCO must mail written notice of the decision to the Enrollee, the Enrollee's PCP, and the prescribing Provider within two (2) Business Days after the decision is made. The CHIP-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 CHIP-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 CHIP-MCO requests additional information, the CHIP-MCO must notify the Enrollee on the date the additional information is requested, using the template, N(7) Request for Additional Information Letter available in Docushare.

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

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

In all cases, the CHIP-MCO must make the decision to approve or deny a covered service or item and the Enrollee must receive written notification of the decision no later than twenty-one (21) days from the date the CHIP-MCO received the request, or the service or item is automatically approved. To satisfy the twenty- one (21) daytime period, the CHIP-MCO may mail written notice to the Enrollee, the Enrollee'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 CHIP-MCO must hand deliver the notice to the Enrollee, or the request is automatically approved.

If the Enrollee is currently receiving a requested service and the CHIP-MCO decides to deny the Prior Authorization request, the CHIP-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 Enrollee fraud has been verified, the period of advance notice is shortened to five (5) days. The CHIP-MCO is not required to provide advance notice when it has factual information on the following:

- confirmation of the death of an Enrollee;
- receipt of a clear written statement signed by an Enrollee 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 Enrollee has been admitted to an institution where she or he is ineligible under the CHIP-MCO for further services;
- the Enrollee's whereabouts are unknown, and the post office returns mail directed to him or her indicating no forwarding address;
- the CHIP-MCO established the fact that the Enrollee has other health insurance

- The CHIP-MCO established the fact the Enrollee been accepted for MA or CHIP by another State; or

- a change in the level of medical care is prescribed by the Enrollee's physician.

3. Prior Authorization of Outpatient Drug Services

The CHIP-MCO must comply with the requirements of Exhibit AA, Outpatient Drug Services.

I. Continuity of Care

The CHIP-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 CHIP-MCO must implement a transition of care policy consistent with the above requirements and compliant with 42 CFR 457.1216, referencing to 42 CFR 438.62.

J. Coordination of Care

The CHIP-MCO must coordinate care for its Enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208. The CHIP-MCO must provide for seamless and continuous coordination of care across a continuum of services for the Enrollee with a focus on improving health care outcomes. The continuum of services may include the State Plan comprehensive service package including behavioral health, out-of-plan services, and non-CHIP covered services. Coordination of Care must also be maintained when transitioning Enrollee between CHIP-MCOs, and between CHIP-MCO and MA.

K. CHIP-MCO Responsibility for Reportable Conditions

The CHIP-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 CHIP-MCO must designate a single contact person to facilitate the implementation of this requirement.

L. Member Enrollment and Disenrollment

1. General

The CHIP-MCO is prohibited from restricting its Members from

changing CHIP-MCOs for any reason. The CHIP Enrollee has the right to initiate a change in CHIP-MCOs at any time.

The CHIP-MCO is prohibited from offering or exchanging financial payments, incentives, commissions, etc., to any other CHIP-MCO (not receiving an agreement to operate under CHIP or not choosing to continue a relationship with the Department) for the exchange of information on the terminating CHIP-MCO's membership. This includes offering incentives to a terminating CHIP-MCO to recommend that its enrollees join the CHIP-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 Enrollees from a CHIP-MCO when there is a change in residence which places the Enrollee outside the Managed Care Program Zone covered by this Agreement, as indicated on the individual county file maintained by the Department's Office of Income Maintenance.

The Department has implemented a process to enroll Enrollees transferring from one Managed Care Program Zone to another with the same CHIP-MCO, provided that the CHIP-MCO operates in both Managed Care Program Zones.

2. CHIP-MCO Enrollment Procedures

The CHIP-MCO must have in effect written administrative policies and procedures for newly enrolled Enrollees. The CHIP-MCO must also provide written policies and procedures for coordinating Enrollment information with the Department's EAP broker. The CHIP-MCO must receive advance written approval from the Department regarding these policies and procedures. The CHIP-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 Managed Care Program Zone. Unless otherwise required by law, the CHIP-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 CHIP-MCO must enroll any eligible Enrollee who selects or is assigned to the CHIP-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 O, 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, , health status, pre-existing condition, physical or mental disability or anticipated need for health care.

3. Enrollment of Newborns

The CHIP-MCO must have written administrative policies and procedures to enroll and provide all Medically Necessary services to newborn infants of Enrollees, effective from the time of birth, without delay, in accordance with Section V.L.8, Services for New Enrollees. The CHIP-MCO must receive advance written approval from the Department regarding these policies and procedures.

The CHIP-MCO must notify the Department if there are errors or inconsistencies in the newborn's MA or CHIP-MCO eligibility dates per the established procedures found on the Pennsylvania HealthChoices Extranet.

For pregnant members, the CHIP-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.

4. Transitioning Enrollees Between CHIP-MCOs

It may be necessary to transition an Enrollee between CHIP-MCOs. When and Enrollee is transferring between CHIP-MCOs, the losing MCO must contact the County Assistance Office to initiate the transfer with the EAP. The losing MCO and the gaining MCO must cooperate with the CAO and EAP to seamlessly transition the Enrollee to the gaining MCO.

5. Change in Status

The CHIP-MCO must report the following to the Department on a weekly Enrollment/Disenrollment/Alert file: death (not on CIS/eCIS), newborn (not on CIS/eCIS) and return mail alerts in accordance with Section VIII.A.5, Alerts.

The CHIP-MCO must report Enrollee 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, failure to pay premiums and family addition/deletion. The CHIP-MCO must also provide a detailed explanation of how the information was verified.

6. Membership Files

a. Monthly File

The Department will provide a Monthly 834 Eligibility File each month for the previous month. The file contains the CHIP Eligibility Period, other CHIP enrollee demographic information. It will contain only the most current record for each CHIP enrollee. The CHIP-MCO must reconcile this membership file against its internal membership data and notify the Department of any discrepancies within thirty (30) Business Days.

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

b. Daily File

The Department will provide a Daily 834 Eligibility File to the CHIP-MCO that contains one record for each action taken in CIS/eCIS for each CHIP Enrollee where data for that Enrollee has changed that day. The file will contain add, termination and change records. The file contains demographic changes, eligibility changes, Enrollment changes, Enrollees enrolled through the automatic assignment process, and TPL information. The CHIP-MCO must process this file within twenty-four (24) hours of receipt.

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

7. Enrollment and Disenrollment Updates

a. Weekly Enrollment/Disenrollment/Alert Reconciliation File

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

Alerts submitted to the Department.

b. Disenrollment Effective Dates

Enrollee disenrollment will become effective on the date specified by the Department. The CHIP-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.

8. Services for New Enrollees

The CHIP-MCO must make available the full scope of benefits as outlined Section 6 and Appendix B of the CHIP State Plan, Appendix 2, to which an Enrollee is entitled from the effective Enrollment date provided by the Department.

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

The CHIP-MCO must use pertinent demographic information about the Enrollee, i.e., Special Needs data collected through the EAP or directly indicated to the CHIP-MCO by the Enrollee after Enrollment, upon the new Enrollee's effective Enrollment date in the CHIP-MCO. If a Special Need is indicated, the CHIP-MCO must refer the member to the Medical Assistance Children with Special Needs (PH95) Program Referral Process. The CHIP-MCO must ensure the provider cooperates with the PH95 Program Referral Process.

The CHIP-MCO must comply with access standards as required in Exhibit Z, Provider Network Composition/Service Access as applicable, and follow the appointment standards described in Exhibit Z, as applicable, when an appointment is requested by an Enrollee.

9. New Enrollee Orientation

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

- Orienting new Enrollees 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 CHIP-MCO identification 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 CHIP-MCO;
- How to register a Complaint, file a Grievance, request an external review, or request a DHS Fair Hearing.

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

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

10. CHIP-MCO Identification Cards

The CHIP-MCO must issue its own identification car to Enrollees. The CHIP-MCO identification card cannot differentiate a CHIP-Enroll from other MCO product enrollment through visual depiction or other marking. Providers must use this card to verify the Member's eligibility in the CHIP-MCO.

11. Enrollee Disenrollment

The CHIP-MCO may not request Disenrollment of an Enrollee because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished

mental capacity, or uncooperative or disruptive behavior resulting from his or her Special Needs. The CHIP-MCO may not reassign or remove Enrollees involuntarily from Network Providers who are willing and able to serve the Enrollee.

M. CHIP-MCO Outreach

1. CHIP-MCO Outreach Materials

Upon request by the Department, the CHIP-MCO must develop outreach materials such as pamphlets and brochures which can be used by the EAP broker to assist Enrollees in choosing a CHIP-MCO and PCP. The CHIP-MCO must develop such materials for the CHIP 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 CHIP-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 CHIP-MCO must comply with the following guidelines and/or restrictions.

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

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

The CHIP-MCO must not directly or indirectly conduct door-to- door, telephone, email, texting, or other cold-call marketing activities.

The CHIP-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 N, CHIP-MCO Guidelines for Advertising, Sponsorships, Marketing and Outreach.

2. CHIP-MCO Outreach Activities

a. The MCO produces outreach materials and activities to identify and inform potentially eligible families of the program and aid in the choosing of a CHIP-MCO.

b. The CHIP-MCO must comply with the marketing and outreach requirements of 42 CFR 1207 and 457.1224, which incorporate 42 CFR 438.10 and 438.104.

c. Marketing consists of any communications from an MCO to an individual not enrolled with the MCO that can reasonably be interpreted as intended to influence the individuals to enroll in that particular MCO or to not enroll or disenroll from another MCO.

d. The CHIP-MCO, either individually or as a joint effort with other CHIP-MCOs in the Managed Care Program 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 CHIP-MCO must 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 CHIP-MCO must obtain from the Department advance written approval of any advertising placed in mass media for any reason by the CHIP-MCO.

e. The CHIP-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.

f. The CHIP-MCO may offer items of little or no intrinsic value (i.e., trinkets with promotional CHIP-MCO logo(s)at health fairs or other approved community events. Such items must be made available to the general public, not to exceed $5.00 in retail value. All such items are subject to advance written approval by the Department.

g. The CHIP-MCO may offer Enrollees 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.B., Expanded Services.

h. The CHIP-MCO may offer Enrollees 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 CHIP-MCO must receive advance written approval from the Department prior to offering an Enrollee incentive.

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

j. The Department may review any and all outreach activities and advertising materials and procedures used by the CHIP- MCO, including all outreach activities, advertising materials, and corporate initiatives that are likely to reach CHIP Enrollees or Potential Enrollees. In addition to any other sanctions, the Department may impose monetary or restricted Enrollment sanctions should the CHIP-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 Enrollees. Such suspensions may be imposed for a period of up to sixty (60) days from notification by the Department to the CHIP-MCO citing the violation.

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

l. The CHIP-MCO must not, under any conditions use the Department's CIS/eCIS to identify and market to Enrollees participating in another CHIP-MCO. The CHIP-MCO must not share or sell Enrollee lists with other organizations for any purpose, with the limited permissible exception of sharing Enrollee information with affiliated entities and/or Subcontractors under Department- approved arrangements to fulfill the requirements of this Agreement.

m. The CHIP-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 N, CHIP-MCO Guidelines for Advertising, Sponsorships, Marketing and Outreach.

n. MCOs must include the following statement on all marketing and outreach materials:

Your managed care plan may not cover all your health care expenses. Read your member handbook carefully to determine which health care services are covered. The notice shall be followed by a telephone number to contact the CHIP MCO.

3. Informational Materials

The CHIP-MCO must distribute Enrollee newsletters at least three times each year to each Enrollee household. The CHIP-MCO may provide Enrollee newsletters in formats other than hard copy but must provide a hard copy to an Enrollee who asks for one. The CHIP- 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 CHIP-MCO must post the Department-approved Enrollee newsletters in an easily accessible location on the CHIP-MCO's website. The CHIP-MCO must notify all Enrollees of the availability and methods to access each Enrollee newsletter.

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

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

If the CHIP-MCO uses any of the terms included in Exhibit P, Managed Care Definitions for Enrollee Communications, in a written communication with a potential Enrollee or an Enrollee, the CHIP-MCO's use of the term must be consistent with the definition included in Exhibit P.

N. Additional Addressee

The CHIP-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 Enrollee. The CHIP-MCO must develop plans to process such individual requests and for obtaining the necessary releases signed by the Enrollee to ensure that the Enrollee's rights regarding confidentiality are maintained.

O. Limited English Proficiency (LEP) Requirements

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

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

The CHIP-MCO must make all vital documents disseminated to English speaking Enrollees available in alternative languages, upon request of an Enrollee. 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 Enrollee Handbooks. The CHIP-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 CHIP-MCO's web site.

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

P. Alternate Format Requirement

The CHIP-MCO must provide alternative methods of communication for Enrollees who are visually or hearing impaired, including Braille, audio tapes, large print (minimum 18-point font), compact disc, DVD, and/or electronic communication. The CHIP-MCO must, upon request from the Enrollee, make all written materials disseminated to Enrollees accessible to visually impaired Enrollees. The CHIP-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Enrollees who are deaf or hearing impaired, upon request.

The CHIP-MCO must include appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternate format. The MCO must follow the below listed alternative format requirements:

- These materials must be in a format that is readily accessible.

- The information must be placed in a location on the CHIP-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 CHIP-MCO must notify the enrollee that the information is available in paper form without charge upon request.

- The CHIP-MCO must provide, upon request, the information in paper form within five (5) business days.

Q. Enrollee Handbook

1. General

The CHIP-MCO must provide the Enrollee Handbook (Exhibit Q), and other written materials, with information on Enrollee rights and protections and how to access services, in the appropriate language or alternate format to Enrollees within five (5) Business Days of an Enrollee's effective date of Enrollment. The CHIP-MCO may provide the Enrollee handbook in formats other than hard copy. If this option is exercised, the CHIP-MCO must inform Enrollees what formats are available and how to access each format. The CHIP-MCO must maintain documentation verifying that the Enrollee handbook is reviewed for accuracy at least once a year, and that all necessary modifications have been made. The CHIP-MCO must notify all Enrollees on an annual basis of any changes made, and the formats and methods available to access the handbook. Upon request, the CHIP-MCO must provide a hard copy version of the Enrollee handbook to the Enrollee. The CHIP-MCO is required to provide the Enrollee's parent or legal guardian with written information on advance directives policies and include description of applicable state law. The CHIP-MCO is required to reflect changes in state law in its written advance directive's information as soon as possible, but no later than 90 days after the effective date of the change.

2. Enrollee Handbook Requirements

i. The CHIP-MCO must provide that the Enrollee handbook is written at no higher than a sixth-grade reading level and includes, at a minimum, the information outlined in the CHIP-

MCO Enrollee Handbook Template as issued by DHS.

ii. The CHIP-MCO must notify members at least thirty (30) days in advance of the effective date of a significant change in the Enrollee handbook.

iii. The CHIP-MCOs must have written policies guaranteeing each enrollee's righto be treated with respect and with due consideration for his or her dignity and privacy.

iv. The CHIP-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 CHIP-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 CHIP-MCOs must have written policies guaranteeing each enrollee's right to be free from any form of restrain t or seclusion used as a means of coercion, discipline, convenience, or retaliation.

vii. The CHIP-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 CHIP-MCOs must ensure that each enrollee is free to exercise his or her rights without the CHIP-MCO or its network providers treating the enrollee adversely.

3. Department Approval

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

R. Provider Directories

The CHIP-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 CHIP-MCO must utilize a web-based Provider directory. The CHIP-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 CHIP-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 CHIP-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 CHIP- 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 CHIP-MCO's Network;
- The location where the PCP will see Enrollees, as well as whether the PCP has evening and/or weekend hours;
- Wheelchair accessibility of Provider sites; and
- Language indicators including non-English language spoken by current Providers in the Member's service area.
- The Provider directory must be in a machine-readable format.

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

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

S. Member Services

1. General

The CHIP-MCO's Enrollee 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 Enrollees. The CHIP-MCO must have arrangements to receive, identify, and resolve in a timely manner Emergency Enrollee Issues on a twenty-four (24) hour, seven (7) day-a-week basis. The CHIP-MCO's Enrollee services functions must include, but are not limited to, the following:

- Explaining the operation of the CHIP-MCO and assisting Enrollees in the selection of a PCP.
- Assisting Members with making appointments and obtaining services, including interpreter services, as needed.
- Receiving, identifying and resolving Emergency Enrollee Issues.

Under no circumstances will unlicensed Enrollee services staff provide health-related advice to Enrollees requesting clinical information. The CHIP-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.

2. CHIP-MCO Internal Member Dedicated Hotline

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

The CHIP-MCO must provide the Department with the capability

to monitor the CHIP-MCO's Enrollee services and internal Enrollee dedicated hotline from each of the CHIP-MCO's offices. The Department will only monitor calls from CHIP Enrollees or their representatives and will cease all monitoring activity as soon as it becomes apparent that the call is not related to a CHIP Enrollee.

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

- Provides for a dedicated phone line for its Enrollees.

- 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 services which the CHIP-MCO is required to make available to all Enrollees; and
  - The availability of social services within the community.

- 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.

T. CHIP Hotline

The CHIP-MCO will cooperate with the functions of the CHIP Hotline, which is intended to address benefit related issues encountered by Enrollees and their advocates or Providers.

U. Member Complaint, Grievance, External Reviews and DHS Fair Hearing Process

1. Member Complaint, Grievance, External Review and DHS Fair Hearing Process

The CHIP-MCO must develop, implement, and maintain a Complaint and Grievance process that provides for settlement of Enrollee's Complaints and Grievances as outlined in Exhibit S, Complaint, Grievance, External Reviews and DHS Fair

Hearing Processes. The CHIP-MCO must use the required templates to inform Enrollees regarding decisions and the process. Templates GG(1) through GG(20) are available in Docushare. The CHIP-MCO must have written policies and procedures approved by the Department, for resolving Enrollee Complaints and for processing Grievances, External Reviews and DHS Fair Hearing requests, that meet the requirements established by the Department and the provisions of 40 P.S. §991.2101 et seq. (known as Act 68), Pennsylvania DOH regulations (28 Pa. Code Chapter 9), PID regulations (31 Pa. Code Chs. 154 and 301) and 42 CFR §431.200 et seq. The CHIP-MCO must also comply with 55 Pa. Code Chapter 275 regarding DHS Fair Hearing Requests and 42 CFR §457.1260 referencing 438 Subpart F.

The CHIP-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 CHIP-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version.

The CHIP-MCO must require each of its Subcontractors to comply with the Enrollee Complaint Grievance, External Review and DHS Fair Hearings Process as appropriate. This includes reporting requirements established by the CHIP-MCO, which have received advance written approval by the Department. The CHIP-MCO must provide to the Department for approval, its written procedures governing the resolution of Complaints and Grievances, and the processing of External Grievance and DHS Fair Hearing requests. There must be no delegation of the Complaint, Grievance External Reviews and Fair Hearing processes to a Subcontractor without prior written approval of the Department.

CHIP-MCO must adhere to the mechanisms and timeframes for reporting Enrollee complaints and grievances to the Department in the manner The Department has determined.

The CHIP-MCO must abide by the final decision of the PID when and Enrollee has filed an external appeal of a second level Complaint decision.

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

The CHIP-MCO must abide by the final decision of PID or BHA for those cases when an Enrollee has requested and External review of DHS Fair Hearing, unless requesting reconsideration by the Secretary of the Department. DHS Fair Hearings are available to Enrollees when appealing a County Assistance Office decision regarding eligibility including failure to pay premium payment disenrollment notices. Only the Enrollee may appeal to Commonwealth Court. The decisions of the Secretary and the Court are binding on the CHIP-MCO. The CHIP-MCO must follow the requirements outlined.

2. DHS Fair Hearing Process for Enrollees

When a member has a grievance regarding their eligibility in CHIP including failure to pay premiums disenrollment, the Enrollee has the right to request a Fair Hearing with the Department. The CHIP-MCO must comply with the DHS Fair Hearing Process requirements defined in Exhibit S of this Agreement, Complaint, Grievance, External Reviews and DHS Fair Hearing Processes.

A request for a DHS Fair Hearing does not prevent an Enrollee from also utilizing the CHIP-MCO's Complaint or Grievance process.

V. Provider Dispute Resolution Process

The CHIP-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 CHIP-MCO.

Prior to implementation, the CHIP-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 CHIP-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 CHIP-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 CHIP-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 timeframes for reporting Provider Appeal decisions to CHIP-MCO administration, QM, Provider Relations, and the Department; and
- Establishment of a CHIP-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.

W. Certification of Authority and County Operational Authority

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

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

X. Executive Management

The CHIP-MCO Executive Management structure must include the following. These full-time positions must be assigned to the PA CHIP with the exception of the CHIP manager, the full-time positions listed below may also be assigned to commercial MCO operations. The positions below may not also

work for the MCO's MA line of business if the MCO has an MA line of business.

- An Administrator with authority over the entire operation of the CHIP-MCO.

- A CHIP Manager to oversee the operation of the Agreement, if different than the Administrator.

- A Medical Director who is a current Pennsylvania-licensed physician. The Medical Director must be actively involved in all major clinical program components of the CHIP-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 CHIP-MCO to provide timely medical decisions, including after-hours consultation, as needed.

- A Pharmacy Director who is a current Pennsylvania-licensed pharmacist.

- A Dental Director who is a current Pennsylvania-licensed Doctor of Dental Medicine or Doctor of Dental Surgery. The Dental Director may be a consultant or employee but must be available at a minimum of 30 hours per week. 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 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 CFO to oversee the budget and accounting systems implemented by the CHIP-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.

- An 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 CHIP-MCO's entire program and operation, as well as the technical expertise to answer questions related to the operation of the information system.

Y. Other Administrative Components

The CHIP-MCO must provide for each of the administrative functions listed below. For those positions not indicated as full time, the CHIP-MCO may combine or split the functions as long as the CHIP-MCO can demonstrate that the duties of these functions conform to the Agreement requirements.

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

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

- A Government Liaison who serves as the Department's primary point of contact with the CHIP-MCO for the day-to-day management of contractual and operational issues. The CHIP-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/Bright Futures 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 Bright Futures services.

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

- A Provider Services Manager who oversees staff to coordinate communications between the CHIP-MCO and its Providers. There must be sufficient CHIP-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 External Review and DHS Fair Hearing Coordinator whose qualifications demonstrate the ability to assist Members throughout the Complaint, Grievance and External Review 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 CHIP-MCO.

- A Contract Compliance Officer who ensures that the CHIP-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 CHIP-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 CHIP-MCO must update job descriptions for each of the positions if responsibilities for these positions change.

The CHIP-MCO's staffing should represent the racial, ethnic, and cultural diversity of the Program and comply with all requirements of Exhibit C, IT Terms and Conditions. Cultural Competency may be reflected by the CHIP-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 CHIP-MCO must have in place sufficient administrative staff and organizational components to comply with the requirements of this Agreement. The CHIP-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 CHIP-MCO's size of Enrollment. The Department has the right to make the final determination regarding whether or not the CHIP-MCO is in compliance.

The CHIP-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 CHIP-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, Sub-contractual Relationships. The CHIP-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.

Z. Administration

The CHIP-MCO must have an administrative office within each Managed Care Program Zone covered by this Agreement. The Department may grant exceptions to this requirement on an individual basis if the CHIP-MCO has administrative offices elsewhere in Pennsylvania and the CHIP-MCO is in compliance with all standards set forth by the DOH and PID.

The CHIP-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 CHIP key personnel must be accessible.

1. Contracts and Subcontracts

CHIP-MCO may, as provided below, rely on Subcontractors to perform and/or arrange for the performance of services to be provided to Enrollees on whose behalf the Department makes Capitation payments to CHIP-MCO. Notwithstanding its use of Subcontractor(s), CHIP-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 Enrollees 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 CHIP-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 CFR § 457.1233 referencing 438.230(3)(i).

e. The CHIP-MCO shall require Subcontractors to comply with all CHIP 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 CFR § 457.1233 referencing §438.230(3) for services provided pursuant to the Agreement.

The above notwithstanding, if the CHIP-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 CHIP-MCO, the CHIP-MCO is responsible for any obligation by the Subcontractor to a Provider for services rendered to Enrollees 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 CHIP-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 CHIP-MCO, where such amounts past due equal or exceed one percent of the revenue received by the CHIP-MCO in the prior calendar year from the Department under this or any other HealthChoices Agreement. Any such obligation of the CHIP-MCO to a provider under this section shall be considered satisfied if payment thereof is made by the Subcontractor.

CHIP-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 Enrollees under this Agreement for which a Subcontractor is the primary obligor, except to the extent that the CHIP-MCO and/or Subcontractor has acted with respect to such Provider Claims in accordance with the terms of this Agreement.

The CHIP-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 C of this Agreement, Required Contract Terms for Administrative Subcontractors.

In accordance with Exhibit C, the CHIP-MCO must submit for prior approval subcontracts between the CHIP-MCO and any individual, firm, corporation, or any other entity to perform part or all of the selected CHIP-MCO's responsibilities under this Agreement. This provision includes, but is not limited to, contracts for vision services, dental services, Claims processing, Enrollee services, and pharmacy services.

2. Records Retention

The CHIP-MCO will comply with the program standards regarding records retention, which are set forth in federal and state law and regulations and in Exhibit C, IT Terms and Conditions, 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 CHIP-MCO must provide copies of all records to the Department at the CHIP-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 CHIP-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.

3. Fraud, Waste, and Abuse

The CHIP-MCO must develop a written compliance plan that contains the following elements described in 42 CFR §457.1285 referencing 42 CFR §438.608(a)(1)(i-vii) 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 CHIP-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 CHIP-MCO must establish a Fraud, Waste and Abuse Unit comprised of experienced Fraud, Waste and Abuse reviewers as required in 42 CFR §457.1285 referencing §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, Enrollees, Caregivers, Employees, or other third parties with whom the CHIP-MCO contracts. If the CHIP-MCO has multiple lines of business, the Fraud, Waste and Abuse Unit is required to have a dedicated full time CHIP investigator to Member ratio of at least one investigator per 60,000 members devoted to CHIP's Fraud, Waste and Abuse activities. The Department will make the final determination regarding whether or not the CHIP-MCO is in compliance with these requirements in accordance with 42 CFR § 457.1285 referencing 42 CFR §438.608(a)(7)).

b. Written Policies

The CHIP-MCO must create and maintain written policies and procedures for the prevention, detection, investigation, reporting and referral of suspected Fraud, Waste and Abuse, including any and all fraud and abuse policies delineated under state and or federal mandate including but not limited to 42 CFR §457.1285 referencing §438.608(a)(1)(i).

c. Access to Provider Records

The CHIP-MCO's Fraud, Waste and Abuse policies and procedures must provide and certify that the CHIP-MCO's Fraud, Waste and Abuse unit as well as the entire Department, and the Pennsylvania Office of Attorney General Medicaid Fraud Control Section has timely access to records of Network Providers, subcontractors, and the CHIP-MCOs, as outlined in this Agreement.

d. Procedure for Identifying Fraud, Waste and Abuse

The CHIP-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 Enrollees whether services billed by providers were received, as required by 42 CFR §457.1285 referencing CFR §438.608(a)(5) and 438.608(d)(1)(i-iv).

iii. Process to recover overpayments or otherwise sanction Providers as required by 42 CFR §457.1285 referencing 42 CFR §§438.608(a)(5) and 438.608(d)(1)(i-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 CFR § 457.935 referring to Part 455, subpart B of the same chapter, and 42 CFR §457.1285 referencing 24 CFR 438.608(a)(8).

iv. Policies and procedures to initiate a prepayment review of a network provider's services where a review indicates billings are inconsistent with federal regulations or CHIP-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.

e. Referral to the Department

The CHIP-MCO must establish a policy for prompt, as defined in Exhibit U, referral of suspected Fraud, Waste and Abuse to the Department and the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section as required in 42 CFR §457.1285 referencing 42 CFR§438.608(a)(7). A standardized referral process is outlined in Exhibit U of this Agreement, Reporting Suspected Fraud, Waste and Abuse to the Department.

The CHIP-MCO must report to the Department and to the Pennsylvania Office of Attorney General Medicaid Fraud Control Section all cases of suspected fraud, waste, or abuse, in the manner specified by the Department. If a CHIP-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.

f. Education Plan

The CHIP-MCO must create and disseminate written materials for the purpose of educating its employees, Providers, subcontractors, and subcontractors' employees about healthcare Fraud laws, the CHIP-MCO's policies and procedures for preventing and detecting Fraud, Waste, and Abuse and the rights of individuals to act as whistleblowers. CHIP-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.

g. Referral to Senior Management

The CHIP-MCO must develop a certification process that demonstrates the policies and procedures were reviewed and approved by the CHIP-MCO's senior management on an annual basis.

h. 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 CHIP-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.

i. Duty to Cooperate with Oversight Agencies

The CHIP-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 Enrollees.

j. Hotline Information

The CHIP-MCO must distribute the Department's toll-free MA Provider Compliance Hotline number and

accompanying explanatory statement to its Enrollees and Providers through its Enrollee 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), childcare, 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.

k. Duty to Notify

i. Department's Responsibility

The Department will provide the CHIP-MCO with prompt notice via electronic transmission or access to Medicheck listings or upon request if a Provider with whom the CHIP-MCO has entered into a Provider Agreement is subsequently suspended or terminated from participation in CHIP, MA or Medicare Programs. Upon notification from the Department that a Network Provider is suspended or terminated from participation in the CHIP, MA or Medicare Programs, the CHIP-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 CHIP-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 CFR §457.935 references Chapter 455, Subpart B of the same chapter.

ii. CHIP-MCO's Responsibility

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

- An individual who is barred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, 48 CFR Parts 1-51, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual who is an Affiliate of a person described above.

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

- A director, officer, or partner of the CHIP-MCO.
- A person with beneficial ownership of five percent (5%) or more of the CHIP-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 CHIP-MCO's obligations under this Agreement with the Department.

The CHIP-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 CHIP or MA program as a result of suspected or confirmed Fraud, Waste or Abuse. The CHIP-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 CHIP-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. CHIP-MCOs who fail to report such information are subject to sanctions, penalties, or other actions. The Department's enforcement guidelines are outlined in Exhibit V, Guidelines for Sanctions Regarding Fraud, Waste and Abuse.

The CHIP-MCO must also notify the Department if it recovers overpayments or improper payments related to Fraud, Waste or Abuse of CHIP 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 Enrollees or services of a PCP.

l. Sanctions

The Department will impose sanctions or take other actions if it determines that a CHIP-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 V, 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.

m. Subcontractor and Provider Agreements

i. The CHIP-MCO will require via written agreements that all Network Providers and all Subcontractors take such actions as are necessary to permit the CHIP-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 § 457.915, 925, 930, 935, and 1285 referencing 438.608.

ii. To the extent that the CHIP-MCO delegates oversight responsibilities to a third party (such as a Pharmacy Benefit Manager), the CHIP-MCO must require that such third party complies with the applicable

provisions of this Agreement relating to Fraud, Waste and Abuse.

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

iv. The CHIP-MCO must suspend payment to a Network Provider when the Department determines there is a credible allegation of fraud, waste, or abuse against that Network Provider, unless the Department determines there is good cause for not suspending such payments pending the investigation.

v. The CHIP-MCO shall require its Subcontractors to comply with the requirements of 42 CFR §457.1233 referencing §438.230(c)(3).

vi. The CHIP-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 CHIP 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.

n. 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.

o. Provider Reviews and Overpayment Recovery

- The CHIP-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 §457.1285 referencing 438.608(c)(3).

- The CHIP-MCO shall audit, review, and investigate Providers within its network through prepayment and retrospective payment reviews. The CHIP-MCO shall cost avoid or recover any overpayments directly from its Network Providers for audits, reviews or investigations conducted solely by the CHIP-MCO or through Network Provider self-audits.

    - The CHIP-MCO will void encounters for those claims involving full recovery of the payment and adjust encounters for partial recoveries.

    - The CHIP-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 CHIP services.

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

    - The Department developed a vetting process to coordinate audits, reviews, or investigations of the CHIP-MCO's Network Providers to avoid duplication of effort.

    - Through the vetting process, the CHIP-MCO must provide information to BPI as requested including, but not limited to the CHIP-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 CHIP-MCO must provide this information within fifteen (15) business days of the Department's request. The CHIP-MCO must respond to Urgent requests within two business days.

    - The CHIP-MCO cannot initiate a review of a Network Provider after the Department advises the CHIP-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 CHIP-MCO will not notify providers/Enrollees of the Department's intention to initiate a review.

- The Department will inform the CHIP-MCO and the Provider(s) of its request for records, preliminary and final findings related to BPI's review of the CHIP-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 CHIP-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 CHIP-MCO should recoup overpayments resulting from audits, reviews, or investigations conducted independently by the Department, from its Network Provider after the CHIP-MCO receives notice of the final findings from the Department.

    - The Department will deduct the restitution demanded from a future payment to the CHIP-MCO after 45 days from the mail date of the Department's notice of final findings.

    - The CHIP-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 CHIP-MCO to withhold payment to a Network Provider or to initiate a pre-payment review as a result of law enforcement reviews and activities or the Department's audits, reviews or investigations as required in 42 CFR §457.1285 referencing §438.608(a)(8) and §457.935 referencing §455.23.

- The CHIP-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 CHIP-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 CHIP-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 CHIP-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 CHIP-MCO's audits, reviews, and investigations of CHIP Providers/Enrollees within the CHIP-MCO's network.

4. Management Information Systems

The CHIP-MCO must have a 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 CHIP-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.

b. The CHIP-MCO must have an MIS sufficient to support data reporting requirements specified in this Agreement.

c. The CHIP-MCO's enrollment management system must have the capability to receive, update and maintain enrollment files consistent with specifications provided by the Department. The CHIP-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 enrollment information.

d. The CHIP-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 CHIP-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 CHIP-MCO.

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

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

f. The CHIP-MCO's Prior Authorization system must be linked with its Claims processing component.

g. The CHIP-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 CHIP-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 G, Quality Management and Utilization Management Program Requirements.

i. The CHIP-MCO must have sufficient telecommunication capabilities, including email, to meet the requirements of this Agreement.

j. The CHIP-MCO must have the capability to electronically exchange files with the Department and the EAP broker. The CHIP-MCO must use a secure FTP product that is compatible with the Department's product.

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

CHIP-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 CHIP-MCO must be prepared to document its ability to expand claims processing or MIS capacity should either be exceeded through the enrollment of Enrollees.

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

o. Subcontractors must meet the same MIS requirements as the CHIP-MCO and the CHIP-MCO will be held responsible for MIS errors or noncompliance resulting from the action of a Subcontractor. The CHIP-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 CHIP-MCO's MIS shall be subject to review and approval during the Department's CHIP Readiness Review process as referenced in Section VI of this Agreement, Program Outcomes and Deliverables.

q. Prior to any major modifications to the CHIP-MCO's MIS, including upgrades and new purchases, the CHIP-MCO must inform the Department in writing of the potential changes at least six (6) months prior to the change. The CHIP-MCO must provide a workplan detailing recovery efforts and the use of parallel systems testing.

r. The CHIP-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 CHIP-MCO on a routine basis to allow it to effectively meet its obligation to provide services and record information consistent with requirements in this Agreement. Information about these files is available on the Pennsylvania HealthChoices Extranet site If the CHIP-MCO chooses not to use these files, it must document the use of comparable files to meet its obligation with this Agreement.

t. The Department will supply Provider files on a routine basis to allow the CHIP-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 CHIP-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 CHIP or MA cannot be enrolled as a participating provider in the CHIP-MCO. Discrepancies must be addressed with the provider.

CHIP-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 CHIP-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 CHIP-MCO must reconcile the 820 Capitation Payment file with its internal enrollment information and report any discrepancies to the Department within thirty (30) days.

w. To support CHIP-MCOs in meeting the requirements of this agreement, the Department will provide access to the following systems:

- Client Information System (CIS/eCIS);
- Pennsylvania HealthChoices Extranet;
- The Department's MMIS;
- Docushare; and
- CHIP Collaboration Room.

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

5. Department Access and Availability

Upon request by the Department, the CHIP-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 CHIP-MCO's MIS;

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

AA. Assignment of PCPs

The CHIP-MCO must have written policies and procedures for Enrollees and parents, guardians, or others acting in loco parentis for Enrollees, who require assistance in the selection of a PCP. The CHIP-MCO must receive advance written approval by the Department regarding these policies and procedures. The CHIP-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 CHIP-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 CHIP-MCO must ensure that the process includes, at a minimum, the following features:

- The CHIP-MCO must honor an Enrollee's selection of a PCP

through the EAP broker upon commencement of CHIP-MCO coverage. If the CHIP-MCO is not able to honor the selection, the CHIP-MCO must follow the guidelines described further under this provision.

- The CHIP-MCO may allow selection of a PCP group. Should the CHIP-MCO permit selection of a PCP group and the Enrollee has selected a PCP group in the CHIP-MCO's Network through the Enrollment Specialist, the CHIP-MCO must honor upon commencement of the CHIP-MCO coverage, the Enrollee's selection. In addition, the CHIP-MCO is permitted to assign a PCP group to an Enrollee if the Enrollee has not selected a PCP or a PCP group at the time of Enrollment.

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

- If an Enrollee does not select a PCP within fourteen (14) Business Days of Enrollment, the CHIP-MCO must make an automatic assignment. The CHIP-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 Enrollee, language needs, area of residence and access to transportation. The CHIP-MCO must then notify the Enrollee by telephone or in writing of his/her PCP's name, location, and office telephone number. The CHIP-MCO must make every effort to determine PCP choice and confirm this with the Enrollee prior to the commencement of the CHIP-MCO coverage in accordance with Section V.L., Enrollee Enrollment and Disenrollment, so that new Enrollees do not go without a PCP for a period of time after Enrollment begins.

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

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

- The CHIP-MCO must have written policies and procedures for

allowing Enrollees to select or be assigned to a new PCP whenever requested by the Enrollee when a PCP is terminated from the CHIP-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 CHIP-MCO must immediately inform Enrollees assigned to that PCP to allow them to select another PCP prior to the PCP's termination effective date. In cases where an Enrollee fails to select a new PCP, re-assignment must take place prior to the PCP's termination effective date.

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

- If an Enrollee 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 CHIP-MCO must, upon request from a family member, assist with the transition to a PCP who provides services for adults.

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

BB. Provider Services

The CHIP-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 Enrollee eligibility status.

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

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

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

- Providing to PCPs a monthly list of Enrollee who are under their care, including identification of new and deleted Enrollees. 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 CHIP-MCO must keep its Network Providers up to date with the latest policy and procedures changes as they affect the CHIP. The key to maintaining this level of communication is the publication of a Provider manual. The CHIP-MCO must distribute copies of the Provider manual in a manner that makes them easily accessible to all Network Providers. The CHIP-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 CHIP-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 W of this Agreement, Provider Manuals.

CC. Provider Network

The CHIP-MCO must establish and maintain adequate Provider Networks to serve its eligible CHIP population in each Managed Care Program 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 Z, Provider Network Composition/Service Access, as applicable.

If the CHIP-MCO's Provider Network is unable to provide necessary medical services covered under the Agreement, to a particular Enrollee, the CHIP-MCO must adequately and timely cover these services out-of-network, for the Enrollee for as long as the CHIP-MCO is unable to provide them and must coordinate with the Out-of-Network Provider with respect to payment.

1. Provider Agreements

The CHIP-MCO must have written Provider Agreements with a sufficient number of Providers to ensure Enrollee access to all Medically Necessary services covered by the CHIP.

The requirements for these Provider Agreements are set forth in Exhibit BB, CHIP-MCO Provider Agreements.

2. Cultural Competency

Both the CHIP-MCO and Network Providers must demonstrate Cultural Competency and must understand that racial, ethnic and cultural differences between Provider and Enrollee 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 Enrollee's racial, ethnic or cultural background and which may be equally or more effective and appropriate for the particular Enrollee; 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 an Enrollee of a particular culture than to another of a differing culture.

3. Primary Care Practitioner Responsibilities

The CHIP-MCO must have written policies and procedures for ensuring that every Enrollee is assigned to a PCP. The PCP must serve as the Enrollee's initial and most important point of contact regarding health care needs. At a minimum, the CHIP-MCO Network PCP are responsible for:

a. Providing primary and preventive care and acting as the Enrollee'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 Enrollee's health care.

d. Communicating effectively with the Enrollee 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 Enrollee. Services must be free of charge to the Enrollee. 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 Enrollee, including documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services.

The CHIP-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

An Enrollee 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 CHIP-MCO must allow Enrollees to access school-based health centers for primary care services regardless of PCP on record.

The CHIP-MCO must adopt and maintain procedures by which an Enrollee with a life-threatening, degenerative, or disabling disease or condition shall, upon request, receive an evaluation and, if the CHIP- 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 Enrollee's primary and specialty care.

The referral to or designation of a specialist must be pursuant to a treatment plan approved by the CHIP-MCO, in consultation with the PCP, the Enrollee and, as appropriate, the specialist. When possible, the specialist must be a Health Care Provider participating in the CHIP-MCO's Network. If the specialists not a Network Provider, the CHIP-MCO may require the specialist to meet the requirements of the CHIP-MCO's Network Providers, including the CHIP-MCO's credentialing criteria and QM/UM Program policies and procedures.

Information for Enrollees must include a description of the procedures that an Enrollee 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 Enrollee's primary and specialty care.

The CHIP-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 CHIP-MCO must establish and maintain its own credentialing and recredentialing policies and procedures to ensure compliance with these specifications.

The CHIP-MCO must require that Providers credentialed as specialists and as PCPs agree to meet all of the CHIP-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 CHIP-MCO preventive care guidelines, including routine preventive care, and to provide those specialty medical services consistent with the Enrollee's "special need" in accordance with the CHIP-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 CHIP-MCO's Network.

5. Hospital Related Party

The Department requires that a CHIP-MCO that is a Related Party to a Hospital or system must ensure that the Related Party is willing to negotiate in good faith with other CHIP-MCOs regarding the provision of services to Enrollees. The Department reserves the right to terminate this Agreement with the CHIP-MCO if it determines that a hospital related to the CHIP-MCO has refused to negotiate in good faith with other CHIP-MCOs.

6. Mainstreaming

The CHIP-MCO must prohibit Network Providers from intentionally segregating their Enrollees in any way from other persons receiving services.

The CHIP-MCO must investigate Complaints and take affirmative action so that Enrollees 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 or CHIP 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 an Enrollee any CHIP covered service or availability of a facility within the CHIP-MCO's Network. The CHIP- 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 Enrollee objects to such care on his/her own behalf.

- Subjecting an Enrollee to segregated, separate, or different treatment, including a different place or time from that provided to other Enrollees, public or private patients, in any manner related to the receipt of any CHIP 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 enrollment, language, MA or CHIP 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 CHIP-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 CHIP-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 CHIP-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 CHIP-MCO must have procedures to address changes in its Network that impact Enrollee access to services, in accordance with the requirements of Exhibit Z, as applicable, Network Composition, of this Agreement. Failure of the CHIP-MCO to address changes in Network composition that negatively affect Enrollee access to services may be grounds for termination of this Agreement.

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

b. Provider Terminations

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

c. The Commonwealth must screen, enroll, and periodically revalidate all CHIP providers. The CHIP-MCO may execute network provider agreements pending the outcome of the revalidation process of up to 120 days. The CHIP-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 CHIP-MCO must notify affected members in accordance with the provider termination requirements of this agreement.

8. Other Provider Enrollment Standards

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

The CHIP-MCO must require all Network Providers to be enrolled in the Commonwealth's CHIP and possess an active MMIS Provider ID for each location at which they provide services for the CHIP-MCO. The CHIP-MCO must be able to store and utilize the MMIS Provider ID and NPI stored in the Department's MMIS for each location.

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

9. Twenty-Four Hour Coverage

It is the responsibility of the CHIP-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 CHIP-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 CHIP-MCO must have written policies and procedures on how Enrollees 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 Enrollee in accordance with the time frame specified in Exhibit Z, as applicable, under Appointment Standards, or 2) the Enrollee must be referred to an urgent care clinic which can see the Member in accordance with the time frame specified in Exhibit Z, as applicable, under Appointment Standards.

10. Health Information Organization

CHIP-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 CHIP-MCOs effort in complying with this requirement. The CHIP-MCO will work with the department and HIOs to establish a resource and referral tool.

DD. QM and UM Program Requirements

1. Overview

The CHIP-MCO must comply with the Department's QM and UM Program standards and requirements described in Exhibit G,

Quality Management and Utilization Management Program Requirements, Exhibit I, External Quality Review, and Exhibit J, Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CHIP-MCO must comply with the Quality Management/Utilization Management Reporting Requirements in the CHIP Procedures Handbook. The Department retains the right of advance written approval and to review on an ongoing basis all aspects of the CHIP-MCO QM and UM programs, including subsequent changes. The CHIP-MCO must comply with all QM and UM program reporting requirements and must submit data in formats to be determined by the Department.

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

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

The CHIP-MCO must submit HEDIS® data to the Department by June 15th of the current year.as outlined in Exhibit J, 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 CHIP-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 I, 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 may conduct a Pay for Performance (P4P) Program that provides financial incentives for CHIP-MCOs that meet quality goals.

5. QM/UM Program Reporting Requirements

The CHIP-MCO must comply with all QM and UM program reporting requirements and time frames outlined in Exhibit G, Quality

Management and Utilization Management Program Requirements and in the CHIP Procedures Handbook. 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 CHIP. The CHIP-MCO must comply with all requested changes to the report information and formats as deemed necessary by the Department. The Department will provide the CHIP-MCO with at least sixty (60) days- notice of changes to the QM/UM reporting requirements. Information regarding CHIP QM and UM reporting requirements may be found in the CHIP Procedures Handbook.

6. Delegated Quality Management and Utilization Management Functions

The CHIP-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 Enrollee.

7. Confidentiality

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

The CHIP-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 CHIP-MCO.

Release of data by the CHIP-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 Enrollee or those releases required by court order, subpoena, or law.

8. Department Oversight

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

The CHIP-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 CHIP with any entity.

9. Centralized Credentialing

The CHIP-MCO must utilize the centralized credentialing vendor when selected by the Department to credential and recredential providers seeking to become a CHIP-enrolled CHIP-MCO Network Provider. The centralized credentialing vendor will facilitate the gathering of administrative materials needed for provider credentialing and recredentialing, perform primary source verifications, and provide the results of the primary source verification to the CHIP-MCO. The CHIP-MCO will evaluate the information provided by the centralized credentialing vendor and make the final determination of whether a provider will be credentialed or recredentialed with the CHIP-MCO and added to the CHIP- MCO's Network. The CHIP-MCO must establish agreements and cooperate with the Commonwealth-procured centralized credentialing vendor to support the activities of the vendor, including but not limited to data exchange, receipt of verified application materials and other information, marketing, and notification of the outcome of the CHIP-MCO's credentialing and recredentialing decisions. The CHIP-MCO will continue to be responsible for meeting the credentialing and recredentialing requirements as per Exhibit G, Quality Management and Utilization Management Program Requirements, Standard VIII in of this Agreement unless otherwise specified by the Department.

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

SECTION VI: PROGRAM OUTCOMES AND DELIVERABLES

The CHIP-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 CHIP-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 CHIP-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 re-procurement, to document the CHIP-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 CHIP-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, the following applies:

1. Risk Protection Reinsurance for High-Cost Cases

If the CHIP-MCO is eligible for inclusion in the High-Cost Risk Pool, for every Managed Care Program Zone of operation, per Appendix 3k, then risk protection reinsurance is not required. Reinsurance is also not required if the CHIP-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 CHIP-MCO must obtain reinsurance to cover, at a minimum, eighty (80) percent of inpatient costs incurred by one (1) Enrollee 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 CHIP-MCO proposes an alternative risk protection arrangement that the Department determines is acceptable.

   The CHIP-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 CHIP-MCO must provide the Department with a detailed plan for risk protection after the current arrangement expires, including any planned changes. The CHIP-MCO must submit each risk protection arrangement to the Department for prior approval. If the risk protection arrangement is an annual agreement, the CHIP-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 CHIP-MCO has been operational (providing medical benefits to any type of consumer) for less than three (3) years; or

ii. The CHIP-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 CHIP-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 CHIP-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 CHIP-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 CHIP-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 CHIP-MCO must meet the Equity and solvency protection requirements set forth below.

The CHIP-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 CHIP-MCO with PID to determine Equity amounts.

The CHIP-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 CHIP-MCO may elect this alternative equity requirement. This alternative requirement has three parts:

a. CHIP-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 CHIP-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 CHIP-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 CHIP-MCO must maintain an RBC ratio of 2.0.

4. Prior Approval of Payments to Affiliates

With the exception of payment of a Claim, the CHIP-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 CHIP-MCO's RBC ratio was below the requirement in Section VII.A. 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 CHIP-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. After the proposed transaction took place, the CHIP-MCO would not be in compliance with the Agreement Equity and solvency protection requirement; or

c. Subsequent adjustments are made to the CHIP-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 CHIP-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 CHIP-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 CHIP-MCO must disclose the nature of the disagreement or dispute.

6. Modified Current Ratio

The CHIP-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 VII.D.2 of this Agreement, if the CHIP-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 CHIP-MCO's management;

- Suspend payments or a portion of payments for Enrollees 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 CHIP-MCO to submit and implement a corrective action plan;

- Suspend some or all Enrollment of Enrollees into the CHIP-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. Enrollee Liability

In accordance with 42 CFR §457.1226 referring to 42 CFR §438.106, the CHIP-MCO must provide that Enrollees are not held liable for the following:

a. Debts of the CHIP-MCO in the event of the CHIP-MCO's

insolvency.

b. Services provided to the Enrollee in the event of the CHIP-MCO fails to receive payment from the Department.

c. Services provided to the Enrollee in the event of a Health Care Provider with a contractual, referral or other arrangement with the CHIP-MCO fails to receive payment from the Department or the CHIP-MCO for such services.

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

9. Related Party Hospitals

The CHIP-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 CHIP-MCO that has an Agreement with the Department to operate in the applicable Managed Care Program Zone. The Department may waive this requirement if the CHIP-MCO satisfies the Department that a sufficient number of CHIP-MCOs are unwilling to contract with the hospital at reasonable terms.

B. Commonwealth Capitation Payments

1. Payments for State Plan Services

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

a. **Capitation Payments**

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

ii. The Department will compute monthly Capitation payments. The Department will make a monthly payment to the CHIP-MCO for each Enrollee enrolled in the CHIP-MCO, for the first day in the month the Enrollee is enrolled in the CHIP-MCO and

for each subsequent day, through and including the last day of the month.

iii. The Department will not make a Capitation payment for an Enrollee Month if the Department notifies the CHIP-MCO before the first of the month that the individual's CHIP-MCO Enrollment ends prior to the first of the month.

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

v. Upon notice to the CHIP-MCO, and for those months specified by the Department, by the fifteenth (15th) of each month, the Department will make a Capitation payment for each Enrollee for all dates of Enrollment indicated on the Department's CIS/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 CHIP-MCO.

vi. Unless paragraph vi. above applies, by the fifteenth (15th) of each month, the Department will make a Capitation payment for each Enrollee for all dates of Enrollment indicated on the Department's CIS/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 CHIP-MCO.

vii. The Department will recover Capitation payments made for Enrollees 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.

2. Program Changes

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

If the scope of Enrollees or services, inclusive of limitations on those services that are the responsibility of the CHIP-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 CHIP-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 CHIP-MCO is changed, upon request by the CHIP-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 CHIP-MCO has reviewed the rates as set forth in the Rate Appendices in this Agreement, Capitation Rates, and accepts the rates for the relevant Agreement period.

D. Claims Processing Standards, Monthly Report and Assessments

These requirements and assessments are applied separately by Managed Care Program Zone.

1. Timeliness Standards

The CHIP-MCO must adjudicate Provider Claims consistent with the requirements below. These requirements apply collectively to Claims processed by the CHIP-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 CHIP-MCO; however, if under investigation by the CHIP-MCO, the Department must have immediate written notification of the investigation.

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

The amount of time required to adjudicate a paid Claim is computed by comparing the date the Claim is received with the check date or the MCO bank notification date for electronic payment. The check date is the date printed on the check. The amount of time required to adjudicate a Denied Claim is computed by comparing the date the Claim is received with the date the denial notice was created or the transmission date of an electronic denial notice. The CHIP-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 CHIP-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 CHIP-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 CHIP-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 CHIP-MCO, or if the CHIP-

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

The Department will reduce the assessments in the charts below by one-third if the CHIP-MCO has 1,801 to 3,600 Enrollees and by two-thirds if the CHIP-MCO has less than 1,800 Enrollees.

The total assessment for the current month will increase to $10,000 if the following conditions exist:

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

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

CLAIMS ADJUDICATION MONTHLY ASSESSMENT CHART

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

Percentage of Clean Claims Adjudicated in 30 Days	Assessment
88.0 – 89.9	$1,000
80.0 – 87.9	$3,000
70.0 – 79.9	$5,000
60.0 – 69.9	$8,000
50.0 – 59.9	$10,000
Less than 50.0	$15,000

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

E. Other Financial Requirements

1. Physician Incentive Arrangements

a. If a CHIP-MCO enters into a contract which includes Physician Incentive Plans (PIP), then the CHIP-MCO must comply with the PIP requirements included under 42 CFR §§ 422.208 and 422.210, which apply to CHIP under 42 CFR 457.1201(i) referencing 42 CFR §438.3.

b. CHIP-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 an Enrollee; and 2) the disclosure, computation of Substantial Financial Risk, Stop- Loss Protection, and Enrollee survey requirements of this section are met.

c. CHIP-MCOs must provide information specified in the regulations to the Department and CMS, upon request. In addition, CHIP-MCOs must provide the information on their PIPs to any Enrollee, upon request. CHIP-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. CHIP-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 Enrollees and unenrolled addressing their satisfaction with the quality of services

and their ability to access services.

d. CHIP-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 Enrollees 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 Enrollees/unenrolled survey requirements apply, the CHIP-MCOs must provide the survey results.

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

2. Retroactive Eligibility Period

The CHIP-MCO shall not be responsible for any payments owed to Providers for services that were rendered prior to the effective date of an Enrollee's Enrollment into the CHIP-MCO.

3. Payment for Services Provided by In-Network Providers

The CHIP-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 CHIP-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 CHIP-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

b. The CHIP-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 CHIP-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 Enrollee is covered by a third-party carrier and the Non-participating or Out-of-Network Provider prescriber and the pharmacy are the Enrollee's third-party providers.

The CHIP-MCO must assume financial responsibility, in accordance with applicable law, for emergency services as defined in 42 CFR §457.1228 that are obtained by its Enrollees from Providers and suppliers outside the CHIP-MCO's Provider Network even in the

absence of the CHIP-MCO's prior approval.

5. Payments to FQHCs and RHCs

Payments to FQHCs and RHCs

a. The CHIP-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 CHIP-MCOs, upon notification from the Department of the date that the FQHC/RHC has opt-out, the CHIP-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 CHIP-MCO may negotiate and pay the opted-out FQHC/RHC at rates that are no less than what the CHIP-MCO pays to other providers who provide comparable services within the CHIP-MCO's Provider Network.

c. The CHIP-MCO must also make a payment separate from the PPS rate(s) to any FQHC that has opted–in to the Alternative Payment Methodology for inpatient deliveries.

d. The CHIP-MCO must also include in its Provider Network every FQHC and RHC in the county in which the CHIP-MCO operates its Program in that is willing to accept PPS rates as payment in full.

e. The CHIP-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 CHIP-MCO, as required by Section V.O.2.

f. The CHIP-MCOs will have 90 days from the date of the Department's notification to the CHIP-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 CHIP-MCO must send notification to the Department no later than 10 working days after the completion of the required claims reprocessing.

    i. 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 CHIP-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 CHIP-MCO to the Department and recovered by the Department from the CHIP-MCO through a reduction to a future payment.

6. Prohibited Payments

a. In compliance with Section 2107(e)(1)(L) of the Social Security Act, 42 U.S.C. 1397gg, the CHIP-MCO is prohibited from paying for: Medically necessary medical services or products provided or dispensed to Enrollees 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 CFR §457.935 referencing 42 CFR §455.23.

v. Exception – When the medically necessary medical service or product is provided as an emergency service to the Enrollee.

b. The CHIP-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 CHIP-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 CHIP State Plan.

d. The CHIP-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.

7. Value Based Purchasing (VBP)

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.

CHC-MCOs, BH-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 applications 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 Enrollee sub-population or the total Enrollee 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 Enrollee sub- population or the total Enrollee 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 an Enrollee 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.

    i. 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.

ii 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.

iii 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:

i. 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 Enrollee. ACO models may include shared savings, shared risk, or global payments.

Required Model:

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:

Patient Centered Medical Home (PCMH): The MCO must include all requirements for PCMHs as defined in Exhibit CC 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 VII.E.7, 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.

c. Financial Goals

The financial goals for the VBP strategies for each calendar year are based on a percentage of the CHIP-MCO's expenditures to the medical portion of the risk adjusted capitation without consideration of risk sharing risk pools, P4P or other revenue or revenue adjustments. These goals apply collectively to all CHIP Agreements between the CHIP-MCO and the Department in all Managed Care Program 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 CHIP-MCO must achieve the following percentages through VBP arrangements:

i. Contract year 1 – 10% of the medical portion of the capitation rate must be expended through VBP. At least 50% of the 15% must be from a combination of strategies 8.a.ii. through 8.a. v.

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

ii. By Contract Year 2, at least 20% of VBP Payment Strategies that are medium risk and high risk must incorporate at least one CBO that addresses at least one SDOH Domain.
iii. By Contract Year 3, at least 30% of VBP Payment Strategies that are medium risk and high risk must incorporate at least one CBO that addresses at least one SDOH Domain.
iv. By Contract Year 4, at least 50% of VBP Payment Strategies that are medium risk and high risk must incorporate at least one CBO that addresses at least one SDOH Domain, and 25% of VBP Payment Strategies that are medium risk and high risk must incorporate one or more CBOs that together address 2 or more SDOH Domains.

The CHIP-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:

i. Childcare access and affordability
ii. Clothing
iii. Employment
iv. Financial Strain
v. Food insecurity
vi. Housing instability/ homelessness
vii. Transportation
viii. Utilities

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

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

The MCO must incorporate CBOs into VBP arrangements by either:

i. 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
ii. Contracting with a Network Provider that subcontracts with a CBO.

b. Reporting

The Department will measure compliance through required reports that have been submitted by the CHIP-MCO and accepted by the Department. By January 1 of each calendar year, the CHIP-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 CHIP-MCO. By the last work day of every quarter, the CHIP-MCO must submit a progress report.

By June 30 of the subsequent calendar year, the CHIP-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 Enrollees 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 CHIP-MCO for Enrollees of the provider's panel during the time period of the calendar year the Enrollee 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 CHIP-MCO for Enrollees of the provider's panel during the time period of the calendar year the Enrollee 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 CHIP-MCO for Enrollees of the provider's panel inclusive of any previous (bonus) payments during the time period of the calendar year the Enrollee 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 CHIP-MCO for Enrollees of the provider's panel during the time period of the calendar year the Enrollee was attributed to the provider's panel.

c. New Agreements

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

d. Assessment

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

Not later than 60 calendar days after receipt from the CHIP-MCO of the annual report on VBP accomplishments, the Department will notify the CHIP-MCO of its determination about compliance with the goal for the preceding year. The CHIP-MCO may provide a response within 30 calendar days. After considering the response from the CHIP-MCO, if any, the Department will notify the CHIP-MCO of its final determination of compliance.

If the CHIP-MCO fails to provide a timely and adequate report on VBP accomplishments, the Department may determine that the CHIP-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 CHIP-MCO for December of the prior calendar year.

e. Data Sharing

The CHIP-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.

8. Financial Obligations when the Agreement has Ended

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

9. Liability During an Active Grievance or Appeal

The CHIP-MCO shall not be liable to pay Claims to Providers if the validity of the Claim is being challenged by the CHIP-MCO through a Grievance or appeal, unless the CHIP-MCO is obligated to pay the Claim or a portion of the Claim through a separate agreement with the Provider.

10. Telephonic Psychiatric Consultation Team Services

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

11. Confidentiality

The Department may from time to time share with the CHIP-MCO an internal Business Requirements Document (BRD) or an internal Business Design Document (BDD). The Department may also elect to share cost-to-charge ratio information with the CHIP-MCO. The CHIP-MCO shall not use this information for a purpose other than support for the CHIP-MCO's mission to perform its responsibilities per its Agreement with the Department and related responsibilities provided by law. The CHIP-MCO may share a BRD, a BDD, or the 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 CHIP-MCO's mission to perform its responsibilities per this Agreement and any other related responsibilities provided by law.

12. Audits

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

13. Restitution for Overpayments

The CHIP-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 CHIP-MCO under this Agreement whether such overpayment is discovered by the CHIP- MCO, the Department, or other third party.

F. Third Party Liability

The CHIP-MCO must comply with the TPL procedures defined by Section 2107 of the Social Security Act, 42 U.S.C. 1397gg(a) implemented by the Department. Under this Agreement, the TPL responsibilities of the Department will be allocated between the Department and the CHIP-MCO.

1. Cost Avoidance Activities

a. The CHIP-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 CHIP-MCO must not pay claims 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 CHIP-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 CHIP-MCO and its Subcontractors must pay, and then chase all Clean Claims for preventive pediatric care (including Bright Futures services to children), and services to children having medical coverage under a Title IV-D child support order to the extent the CHIP-MCO is notified by the Department of such support orders or to the extent the CHIP-MCO becomes aware of such orders, and then seek reimbursement from liable third parties. The CHIP-MCO recognizes that cost avoidance of these claims is prohibited with the exception of hospital delivery claims, which may be cost-avoided.

c. The CHIP-MCO may not deny, or delay approval of otherwise covered treatment or services based upon TPL

considerations. The CHIP-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 CHIP-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 Enrollee and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The CHIP-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 CHIP- MCO from a Provider, the CHIP-MCO shall return all casualty funds to the Department. CHIP-MCOs shall not instruct providers to send funds directly to the Department. These third-party payments shall not be held by the CHIP-MCO for more than 30 calendar days. If the casualty funds received by the Department must be returned to the CHIP-MCO for any reason, for example, an outdated check or the amount of the check does not match supporting documentation, the CHIP- MCO shall have 60 calendar days to return all casualty funds to the Department using the

established format.

The CHIP-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 CHIP-MCO's untimely submission of notice of legal involvement where the CHIP-MCO has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the CHIP-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 CHIP-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 CHIP-MCO.

f. The CHIP-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 CHIP-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 CHIP-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 C H I P - 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 CHIP-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 CHIP-MCO has identified the cases to be pursued, the CHIP-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 CHIP- 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 CHIP-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 CHIP-MCO from a Provider, the CHIP-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 will not be held by the MCO for more than thirty (30) calendar days. If the provider funds received by the Department must be returned to the CHIP-MCO for any reason, for example, an outdated check or the amount of the check does not match supporting documentation, the CHIP-MCO shall have sixty (60) calendar days to return all provider funds to the Department using the established format.

3. Requests for Additional Data

The CHIP-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 CHIP-MCO must provide this information within fifteen (15) calendar days of the Department's request. The CHIP-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.

4. Accessibility to TPL Data

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

5. Third Party Resource Identification

The CHIP-MCO must supply to the Department's TPL Division Third Party Resources identified by the CHIP-MCO or its Subcontractors, which do not appear on the Department's TPL database, within two weeks of its receipt by the CHIP-MCO. In addition to newly identified resources, the CHIP-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 CHIP-MCO. A web- based referral is only to be submitted in the following instance: the CHIP-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 CHIP-MCO must use an exact replica of the TPL resource referral form supplied by the Department. For electronic submissions, the CHIP-MCO must follow the required report format, data elements, and specifications supplied by the Department.

The Department will contact the CHIP-MCO when the validity of a resource is in question. The CHIP-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 CHIP-MCO must respond by the close of business that day to avoid a potential access to care issue for the Enrollee.

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

6. Estate Recovery

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

SECTION VIII: REPORTING REQUIREMENTS

A. General

The CHIP-MCO must comply with state and federal reporting requirements that are set forth in this section and throughout this Agreement.

The CHIP-MCO must certify data submitted to the Department as required by 42 CFR § 457.1285 referencing §438.604, whether in written or electronic form. The CHIP-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 CHIP-MCO will provide the certification via hard copy or electronic format, on the form provided by the Department.

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

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

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

a. Data Format

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

The CHIP-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
- Outpatient Drug
- LTC

837D
- Dental

NCPDP D.2
- Pharmacy

b. **Timing of Data Submittal**

i. Provider Claims

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

The CHIP-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 CHIP-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 CHIP-MCO and approved by the Department's MMIS on or before the last calendar day of the third month after the adjudication calendar month in which the CHIP-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 CHIP-MCO. These records must be corrected and resubmitted as "new" Encounter records within the timeframes referenced above.

Corrections and resubmissions must pass all edits before they are approved by the Department.

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

iii. Encounter File Specifications

The CHIP-MCO must adhere to the file size, format specifications, and file submission schedule.

iv. Response Files

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

c. **Data Completeness**

The CHIP-MCO must submit Encounter Data each time an Enrollee has an Encounter with a Provider. The CHIP-MCO must have a data completeness monitoring program in place that:

i. Demonstrates that all Claims and Encounters submitted to the CHIP-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 CHIP-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.

The CHIP-MCO must submit upon request from the Department a Data Completeness Plan for review and approval. This plan must include the three elements listed above.

d. **Financial Sanctions**

The CHIP-MCO must provide complete, accurate, and timely Encounter Data to the Department. In addition, the CHIP-MCO must maintain complete medical service history data.

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

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

e. **Data Validation**

The CHIP-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 CHIP-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 CHIP-MCO and its agents for the sole purpose of operating the Children's Health Insurance Program. The CHIP-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 CHIP-MCO or its agents in the routine operation of a managed care plan.

2. Third Party Liability Reporting

Third Party Resources identified by the CHIP-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 CHIP-MCO. The Department will contact the CHIP-MCO when the validity of a resource is in question. The CHIP-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 CHIP-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 CHIP-MCO for its individual use. For electronic submissions, the CHIP-MCO must follow the required report format, data elements, and specifications supplied by the Department. For hardcopy submissions, the CHIP-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 CHIP-MCO for correction and subsequent resubmission.

3. PCP Assignment for Enrollees

The CHIP-MCO must provide a weekly file (EVS/PCP) to the Department's MMIS containing PCP assignments for all its Enrollees. This file is used to update the Department's Eligibility Verification System.

The CHIP-MCO must provide this file at least weekly or more frequently if requested by the Department. The CHIP-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 CHIP-MCO must comply with the file submission requirements found on the Pennsylvania HealthChoices Extranet.

4. Provider Network

The CHIP-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 CHIP-MCO must confirm the information is consistent with all requirements by utilizing the response report (PRM640M) provided by the Department. The CHIP-MCO must use this report to reconcile and correct any errors. The CHIP-MCO must comply with the file submission requirements on the Pennsylvania HealthChoices Extranet.

5. Alerts

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

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

B. Operations Reporting

The CHIP-MCO must submit reports as specified by the Department to enable the Department to monitor the CHIP-MCO's internal operations and service delivery. These reports include, but are not limited to, the following:

1. Fraud and Abuse

The CHIP-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 CHIP-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/CHIP preclusion;
- Overpayments recovered; and
- Cost avoidance issues related to identifying and/or identified fraud, waste, and abuse (42 CFR 457.1285, cross referencing 42 CFR 438.608(a)(2)).

C. Financial Reports

The CHIP-MCO will submit such reports as specified by the Department to assist the Department in assessing the CHIP-MCO's financial viability and compliance with this Agreement.

The Department will distribute financial reporting requirements to the CHIP-MCO. The CHIP-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 CHIP financial reporting requirements issued by the Department on the Pennsylvania HealthChoices Extranet at Managed Care Program/*Program Information-Reporting Requirements.*

D. Equity

Not later than May 25, August 25, and November 25 of each Agreement year, the CHIP-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 CHIP-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.

E. Claims Processing Reports

The CHIP-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 CHIP-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.

F. Presentation of Findings

The CHIP-MCO must obtain advance written approval from the Department before publishing or making formal public presentations of statistical or analytical material based on its CHIP enrollment.

G. Sanctions

1. Sanctions may be imposed when a CHIP-MCO acts or fails to act as follows:

- Fails substantially to arrange for Medically Necessary services that the CHIP-MCO is required to provide under law or under this Agreement to an Enrollee covered under the Agreement.

- Imposes on Enrollee premiums or charges that are in excess of the premiums or charges permitted under the Children's Health Insurance Program.

- Acts to discriminate among Enrollees on the basis of their health status or need for health care services.

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

- Fails to comply with requirements for PIPs as set forth in 42 CFR §457.1201(h), referencing to 42 CFR 438.3(i) referencing 42 CFR 422.208 and 422.210.

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

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

- 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 in 42 C.F.R. 457.1270. 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 Children's Health Insurance Program, the Department will recoup any funds inappropriately expended by the CHIP-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 Enrollees;

e. Suspension of payments;

f. Temporary management subject to applicable federal or state law;

g. Termination of the Agreement: The Department may terminate a CHIP-MCO Agreement and enroll its Enrollees in another CHIP-MCO.

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 Assessments.

b. Report or File Reports, exclusive of Audit Reports: If the CHIP-MCO fails to provide any report or file that is specified by this Agreement by the applicable due date, or if the CHIP-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 CHIP-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 CHIP-MCO provides a report or file on or before the due date, and if the Department notifies the CHIP-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 CHIP-MCO.

c. Encounter Data Reporting: The Sanctions related to the submission of Encounter Data are set forth in Section VIII.B, Operations Reporting and Exhibit Y, Encounter Data Submission Requirements and Penalty Applications.

d. Marketing: The sanctions for engaging in unapproved marketing practices are described in Section V.M.2, CHIP-MCO Outreach Activities.

e. Access Standard: The sanction for noncompliance with the access standard is set forth in Exhibit Z, as applicable, Provider Network Composition/Service Access, Part 4, Compliance with Access Standards.

f. Subcontractor Prior Approval: The CHIP-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 each Enrollee served for each day that the Subcontractor was in effect without the Department's approval.

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

h. Pursuant to 42 CFR §457.1270 relating to 438.704(c)CFR, if the State imposes a civil monetary penalty on the CHIP-MCO for charging premiums or charges in excess of the amounts permitted under CHIP, the State will deduct the amount of the overcharge from the penalty and return it to the affected enrollee.

H. Non-Duplication of Financial Penalties

The Department will not assess duplicate financial sanctions for non-

compliance where financial sanctions have already been issued.

SECTION IX: REPRESENTATIONS AND WARRANTIES OF THE CHIP-MCO

A. Accuracy of Application

The CHIP-MCO warrants that all information submitted to the Department in or with the Application is true, accurate and complete in all material respects. The CHIP-MCO agrees that these representations are continuing ones, and that the CHIP-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 Application submission, which affects the truth, accuracy, or completeness of such representations.

B. Disclosure of Interests

1. The CHIP-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 CHIP-MCO;

    b. Inform the Department, in writing, of any change in or addition to the ownership or control of the CHIP-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 CHIP-MCO and its subcontractors;

    d. Submit to the Department other tax identification number of any corporation with an ownership or control interest in the CHIP-MCO and any subcontractor in which the CHIP-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 CHIP-MCO is related to another person with ownership or control interest in the CHIP-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 CHIP-MCO has a five percent (5%) or more interest is related to another person with ownership or control interest in the CHIP-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 CHIP-MCO.

2. In accordance with 42 CFR §457.935 referencing § 455.104, the CHIP-MCO must disclose the following information to the state for any person or corporation with ownership or control interest in the CHIP-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 CHIP-MCO or a CHIP-MCO subcontractor is related to another person with ownership or control interest in the CHIP-MCO as a spouse, parent, child, or sibling;

    e. The name of any other CHIP 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 CHIP-MCO.

    Such disclosure must be made within thirty (30) calendar days of any change or addition. The CHIP-MCO agrees that any failure to comply with this provision in any material respect or making of any misrepresentation which would cause the CHIP-MCO to be precluded from participation in the MA Program, shall entitle the Department to recover all payments made to the CHIP-MCO subsequent to the date of the misrepresentation.

    The CHIP-MCO will make reports of any transactions between the CHIP-MCO and parties in interest that are provided to the State or other agencies available to CHIP-MCO Enrollees upon reasonable request.

C. Disclosure of Change in Circumstances

The CHIP-MCO will report to the Department, as well as the DOH and PID, within ten (10) Business Days of the CHIP-MCO's notice of same, any change in circumstances that may have a material adverse effect upon financial or operational conditions of the CHIP-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 CHIP-MCO, CHIP-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 CHIP-MCO's Equity.

3. Notice of an intent to suspend, debar, or exclude issued by any state or the federal government to CHIP-MCO, CHIP-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 CHIP-MCO, CHIP-MCO's parent(s), or any Affiliate or Related Party of either, which would have a material impact upon the CHIP-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 C, IT 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 C, IT 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 CHIP-MCO. If the CHIP-MCO notifies the Department of its intent to terminate or terminates an agreement with the Department to provide services for any Physical Health Managed Care Program Zone, any HealthChoices Program, including the Behavioral Health HealthChoices Program, Community HealthChoices Program or the CHIP Managed Care Program Zone, 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 CHIP-MCO. The effective date of the termination shall be the last day of the month in which the one hundred twentieth (120th) day falls. The Department is not required to provide one hundred twenty (120) days advance notice if the Department and the CHIP-MCO are entering into a new agreement the in the same Managed Care Program Zone.

2. Termination for Cause

Under Section 18.c of Exhibit C, IT Terms and Conditions, 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 X.A.2.b below, shall provide the CHIP-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 C, IT Terms and Conditions,

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 C, IT Terms and Conditions, 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 Children's Health Insurance Program; or

c. Notification that the federal approvals necessary to operate the Children's Health Insurance Program shall not be retained; or

d. Notification by the PID or DOH that the authority under which the CHIP-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 CHIP-MCO

The CHIP-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 CHIP-MCO Upon Termination

1. Continuing Obligations

Termination or expiration of this Agreement shall not discharge the CHIP-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 CHIP-MCO or the CHIP-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 CHIP-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 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 CHIP-MCO and subsequently approved upon appeal by the Provider;

e. Be financially responsible for Enrollee appeals of adverse decisions rendered by the CHIP-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 Grievance or External Review proceeding; and

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

2. Notice to Members

In the event that this Agreement is terminated, or expires without a new Agreement in place, the CHIP-MCO must notify all Enrollees 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 Enrollees with limited English proficiency. The CHIP-MCO must coordinate the continuation of care prior to termination or expiration for Enrollees who are undergoing treatment for an acute condition.

3. Submission of Invoices

Upon termination or expiration, the CHIP-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-3e.

4. Termination Requirements

Within one year (365 days) of expiration or termination of the Agreement as well as in addition to the termination requirements specified in this section, the CHIP-MCO must also provide the Department with all outstanding Encounter Data. If either the Department or the Contractor provides written notice of termination, the Department will withhold ten percent (10%) of one (1) month's Capitation payment. Once the Department determines that the Contractor has substantially complied with the requirements in this section, the Department will pay the withheld portion of the Capitation payment to the CHIP-MCO. The Department will not unreasonably delay or deny a determination that the CHIP-MCO has substantially complied. The Department will share with the CHIP-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 CHIP-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 CHIP-MCO and the Department have not entered into a new Agreement for any of the Managed Care Program Zones covered by this Agreement, the Department will develop a transition plan. During the transition period, the CHIP-MCO must cooperate with any subsequent CHIP-MCO and the Department. As part of the transition plan, the Department will define the program information and the working relationship between the CHIP-MCOs. The Department will consult with the CHIP-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 CHIP-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 CHIP-MCO must provide necessary information to a CHIP-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 CHIP-MCOs involved.

SECTION XI: RECORDS

A. Financial Records Retention

1. The CHIP-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.Z.2, Records Retention.

2. The CHIP-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 CHIP-MCO's business transactions which are related to the provision of services for the Children's Health Insurance Program which shall include full and complete information regarding:

    a. The CHIP-MCO's ownership of any Subcontractor with whom the CHIP-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 CHIP-MCO and any wholly owned supplier or between the CHIP-MCO and any Subcontractor during the five (5) year period ending on the date of the request.

3. The CHIP-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 CHIP-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.Z.2, Records Retention.

C. Medical Records Retention

The CHIP-MCO must maintain and must cause its Subcontractors to maintain all medical records in accordance with the procedures outlined in Section V.Z.2, Records Retention.

The CHIP-MCO must provide Enrollees' medical records, subject to this Agreement, to the Department or designee within fifteen (15) Calendar Days of the Department's request. The CHIP-MCO must mail copies of such records to the Department if requested.

D. Review of Records

1. The CHIP-MCO must make all records relating to the Children's Health Insurance 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 CHIP-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 CHIP- MCO.

   On request, and consistent with state and federal confidentiality obligations, the CHIP-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 CHIP-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 CHIP-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 CHIP-MCO's location, but in any case, before the expiration of the retention period, the CHIP-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 CHIP-MCO will comply with the procedures set forth in Section V.Z.1, Contracts and Subcontracts and in Exhibit T, Required Contract Terms for Administrative Subcontractors.

Prior to the award of a contract or Subcontract, the CHIP-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 CHIP-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 G, Quality Management and Utilization Management Program Requirements using the denial notice templates provided in Docushare. In addition, the CHIP-MCO must include in its contracts or Subcontracts that cover the provision of medical services to the CHIP-MCO's Enrollee 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 CHIP-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 Enrollees, 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 Enrollees.

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.H.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 CHIP-MCO must make all necessary revisions to its Subcontracts to be in compliance with the requirements set forth in Section XII.A, Compliance with Program Standards. The CHIP-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 CHIP-MCO within the time frames specified in Section VIII.A, Operations Reporting.

B. Consistency with Regulations

The CHIP-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 CHIP-MCO agrees to comply with applicable federal and state laws regarding the confidentiality of medical information, as it more fully set forth below. The CHIP-MCO must also cause that each of its Subcontractors comply with such applicable laws. The federal and state laws with regard to confidentiality of medical records includes but are not limited to: Mental Health Procedures Act, 50 P.S. 7101 et seq.; Confidentiality of HIV-Related Information Act, 35 P.S. 7601 et seq.; 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information); and the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. 1690.101 et seq and 42 CFR 457.1110.

B. The CHIP-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 CHIP-MCO in relation to the CHIP-MCO's systems, staff, or other area of responsibility.

C. The CHIP-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 CHIP-MCO is prohibited from using material for any purpose after the expiration or termination of this Agreement.

SECTION XIV: INDEMNIFICATION AND INSURANCE

A. Indemnification

In addition to Section 14 of Exhibit C, IT Terms and Conditions, the CHIP-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 CHIP-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 CHIP-MCO and allow the CHIP-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 CHIP-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 CHIP-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 CHIP-MCO must require that each of the Health Care Providers with which the CHIP-MCO contracts maintains professional malpractice and all other types of insurance in such amounts as required by all applicable laws. The CHIP-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 CHIP-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 CHIP-MCO within thirty (30) calendar days of the CHIP-MCO's written request. That interpretation shall be final, conclusive, and binding on the CHIP-MCO, and unreviewable in all respects unless the CHIP-MCO within twenty (20) calendar days of its receipt of said interpretation, delivers a written appeal to the Secretary of the Department. Unless the CHIP-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 CHIP-MCO's written appeal and shall be final, conclusive, and binding, and the CHIP-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 CHIP- MCO in the Department's BHA in accordance with 67 Pa.C.S. §§101 – 1106 and 55 Pa. Code Chapter 41.

SECTION XVI: GENERAL

A. Suspension From Other Programs

In the event that the CHIP-MCO learns that a Health Care Provider with whom the CHIP-MCO contracts is suspended or terminated from participation in any federally funded health care program, the CHIP-MCO must promptly notify the Department, in writing, of such suspension or termination.

The CHIP-MCO shall not make any payment any services rendered by a Health Care Provider during the period the CHIP-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 CHIP-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 CHIP-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
Office of Children's Health Insurance Program (CHIP)
P.O. Box 2675
Harrisburg, Pennsylvania 17105

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

Department of Human Services
Office of Children's Health Insurance Program (CHIP)
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

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.

EXHIBIT A

CHIP-MCO PAY FOR PERFORMANCE

This Exhibit A defines a potential payment obligation by the Department to the CHIP-MCO for Quality Performance Measures achieved per HEDIS® as defined below. This Exhibit is effective only if the CHIP-MCO operates a CHIP program under this Agreement of the last month of each program year. If the CHIP-MCO does not operate a CHIP program under this Agreement in the last month of each program year, the Department may choose to adjust the payments made under this Exhibit proportionally for the months within the program year that the CHIP-MCO operated the CHIP program.

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

The Department selected three HEDIS health care performance measures for the MCO P4P program. The Department chose these measures based on an analysis of past data indicating the need for improvement across the CHIP as well as the potential to improve health care for a broad base of the CHIP population. The three (3) HEDIS measures are:

1. Lead Screening in Children (LSC) ≥ 50th Percentile – 74.67%
2. Asthma Medication Ratio (AMR) ≥ 90th Percentile – 76.09%
    a. This will be for the Total Rate for ages 5-18 years
3. Child and Adolescent Well-Care Visits (WCV) ≥ 75th Percentile – 63.46%
    a. This will be for the Total Rate for ages 3-18 years

The MCO P4P Program measures Benchmark Performance in the initial program year and Benchmark and Improvement Performance in all subsequent program years.

NOTE: NCQA issues HEDIS technical specifications annually for the measures identified above. For the above measures, the Department will use the NCQA specifications that apply to the given HEDIS year under review.

A. Benchmark Performance*:*

a. For the initial program year, the Department will award a Benchmark Performance payout amount for each measure in Section I that will range from 0% up to and including 100% of the measure's value, defined as the CHIP-MCO's Maximum Program Payout amount, as calculated in Section III, divided by three (3). The Department will make Benchmark Performance payouts for performance relative to the given HEDIS year for all measures.

b. For all subsequent years the Department will award a Benchmark Performance payout amount for each measure in Section I that will range from 0% up to and including 100% of the measure's value, defined as fifty percent (50.0%) of the CHIP-MCO's Maximum Program Payout amount (equivalent to 0.5 multiplied by the amount calculated in Section III) divided by three (3). The Department will make Benchmark Performance payouts for performance relative to the given HEDIS year for all measures.
c. The Department will distribute the payouts, as determined by Section I.A(a) and I.A(b) (above), according to the following criteria:

1. HEDIS Measures Benchmark Scale

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

B. Improvement Performance*:* Beginning with the second program year and continuing with all subsequent years*,* 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, defined as fifty percent (50.0%) of the CHIP-MCO's Maximum Program Payout amount (equivalent to 0.5 multiplied by the amount calculated in Section II) divided by three (3).

The improvement performance payout scales will be applied contingent on the CHIP-MCO achieving the required benchmark percentile performance for each measure (see Section I.B.1.).

1. The Department will make Improvement Performance payouts for incremental performance improvement are determined by subtracting the current HEDIS year rate from the previous HEDIS year rate.

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

2. Limitation on Payout Amounts
The total awarded payout amount to a CHIP-MCO, which includes

Benchmark Performance (I.A.) and Improvement Performance (I.B.), cannot exceed the Maximum Program Payout amount, as identified in Section II. below.

II. Quality Withhold Amount

The Department will withhold 1.0 percent (1.0%) from each per-member-per-month Base Capitation Rate which will be used to determine the Maximum Payout Amount for each CHIP-MCO under this Exhibit. The Quality Withhold Amount that applies to each Base Capitation Rate can be found on Appendix 3f.

III. CHIP-MCO Maximum Payout Amount

The Department will determine the CHIP-MCO's Maximum Payout Amount by multiplying the Quality Withhold Amount on Appendix 3f by the total member months for each rating group for the applicable program year.

IV. Payment for MCO Pay for Performance

The Department will inform the CHIP-MCO of the Maximum Program Payout amount no later than 6 months after the end of the program year. For the purposes of Section IV of this Exhibit, the term Agreement refers to this Agreement and also any other Agreement between the CHIP-MCO or a predecessor CHIP-MCO and the Department to operate a CHIP program for a similar population with one or more program months during each program year. If there is more than one Agreement between the CHIP-MCO or a predecessor CHIP-MCO and the Department to operate a CHIP program for a similar population with one or more program months during the program year, the Department will make a payment only per the terms of the more recent Agreement.

Transition in CHIP Agreements or in CHIP-MCOs will not lead to double counting of any Maximum Program Payout Amounts.

If the Department has a payment obligation to the CHIP-MCO pursuant to this Exhibit, the Department will issue the payment to the CHIP-MCO by no later than August 31 of the year following the HEDIS year.

EXHIBIT B

CHIP-MCO REQUIREMENTS FOR PROVIDER TERMINATIONS

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

I. Termination by the CHIP-MCO

A. Notification to Department

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

If the provider serves more than 2,000 CHIP enrollees, the CHIP-MCO must submit a Provider termination work plan and supporting documentation within ten (10) Business Days of the CHIP-MCO notifying the Department of the termination and must provide weekly updates to this information. The requirements for the workplan and supporting documentation are found in this Exhibit, under 3. Workplans and Supporting Documentation.

B. Continuity of Care

The CHIP-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 Pa. Code § 9.684. The MCO must comply with both this section and the PADOH requirements found at 28 Pa. Code § 9.684, PID requirements at 31 Pa.Code § 154.14 and federal regulations at 42 CFR §457. 1216 incorporating 42 CFR 438.62(b).

Unless the Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), the CHIP-MCO must allow an Enrollee to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Enrollee is notified by the CHIP-MCO of the termination or pending termination of the Provider. An Enrollee is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve (12) months the Enrollee was treated by the Provider for a condition that requires follow-up care or additional treatment, or the services have been Prior Authorized. An Enrollee with a previously scheduled appointment, including a well child visit, shall be

determined to be in receipt of an ongoing course of treatment from the provider. Per Department of Health regulation Title 28, §9.684(d), the transitional period may be extended by the CHIP-MCO if the extension is determined to be clinically appropriate. The CHIP-MCO shall consult with the Enrollee and the health care provider in making the determination. The CHIP-MCO must also allow an Enrollee who is pregnant to continue to receive care from the Provider that is being terminated through the completion of the Enrollee's postpartum care.

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

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

C. Notification to Enrollees

If the Provider that is being terminated from the Network is a PCP, the CHIP-MCO, using the template notice titled C(1) Provider Termination Template For PCPs found in Docushare, must notify all Enrollees who receive primary care services from the Provider thirty (30) days prior to the effective date of the Provider's termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. Enrollees who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Enrollee is notified by the CHIP-MCO of the termination or pending termination of the Provider.

If the Provider that is being terminated from the Network is not a PCP or a hospital, the CHIP-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found in Docushare, must notify all Enrollees who have received services from the Provider during the previous twelve (12) months, as identified through referral and claims data; all Enrollees who are scheduled to receive services from the Provider; and all Enrollees who have a pending or approved prior authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. Enrollees who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Enrollee is notified by the CHIP-MCO of the termination or pending termination of the Provider.

If the Provider that is being terminated from the Network is a hospital (including a

specialty unit within a facility or hospital), the CHIP-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination found in Docushare, must notify all Enrollees assigned to a PCP with admitting privileges at the hospital, all Enrollees assigned to a PCP that is owned by the hospital, and all Enrollees who have utilized the hospital's services within the past twelve (12) months thirty (30) days prior to the effective date of the hospital's termination. The MCO must utilize claims data to identify these Enrollees.

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

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

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

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

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

II. Termination by the Provider

A. Notification to Department

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

If the provider serves more than 2000 Enrollees, then the CHIP-MCO must submit a Provider termination work plan within ten (10) Business Days of the CHIP-MCO notifying the Department of the termination and must provide weekly status updates to the workplan. The requirements for the workplan are found in this Exhibit, under 3. Workplans and Supporting Documentation.

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

B. Notification to Enrollees

If the Provider that is terminating its participation in the Network is a PCP, the PH-MCO, using the template notice titled C(1) Provider Termination Template For PCPs, in Docushare, must notify all Enrollees who receive primary care services from the Provider.

If the Provider that is terminating its participation in the Network is a hospital or specialty unit within a facility, the CHIP-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination, found in Docushare, must notify all Enrollees assigned to a PCP with admitting privileges at the hospital, all Enrollees assigned to a PCP that is owned by the hospital, and all Enrollees who have utilized the terminating hospital's services within the past twelve (12) months at least thirty (30) days prior to the effective date of the Hospital's termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. The MCO must use referral and claims data to identify these Enrollees.

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

If the Provider that is terminating its participation in the Network is not a PCP nor a hospital, the CHIP-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found in Docushare, must notify all Enrollees, who have received services from the Provider during the previous twelve (12) months; all Enrollees who were scheduled to receive services from the terminating Provider; and all Enrollees who have a pending or approved Prior Authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. The CHIP-MCO must use referral and claims data to identify these Enrollees.

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

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

III. Workplans and Supporting Documentation

A. Workplan Submission

The CHIP-MCO must submit a Provider termination work plan if the provider serves more than 2,000 CHIP Enrollees. The CHIP MCO must submit the provider termination work plan within ten (10) Business Days of the CHIP-MCO notifying the Department of the termination and must provide weekly updates to the workplan. The workplan must provide detailed information on the tasks that will take place to ensure the termination is tracked from the time it is first identified until the termination effective date. The workplan should be organized by Task, Responsible Person(s), Target Dates, Completed Date and Status. The workplan should define the steps within each of the Tasks. The Tasks may include, but not be limited to:

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

B. Supporting Documentation

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

1. Background Information

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

2. Enrollee Access to Provider Services

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

3. Enrollee Identification and Notification Process

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

4. Enrollee Services

a. Submit for Department prior approval, the call center script to be used for the termination.
b. Identify the plan for handling increased call volume in the call center while maintaining call center standards.
c. Submit to the Department a call center report for the reporting of summary

call center statistics, if requested as part of the termination. This call center report should include, at a minimum, the following elements:

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

5. Affected Enrollees in Care Management

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

6. Enrollment Services

Submit final, approved member notices to the Department, the Enrollee notices should be on CHIP-MCO letterhead.

7. News Releases

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

8. Website Update

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

EXHIBIT C
IT TERMS AND CONDITIONS

1. TERM OF GRANT

The term of the Agreement shall commence on the Effective Date and shall end on the Expiration Date identified in the Agreement, subject to the other provisions of the Agreement. The Agreement shall not be a legally binding Agreement until fully executed by the CHIP-MCO and by the Commonwealth and all approvals required by Commonwealth and federal procurement procedures have been obtained. No agency employee has the authority to verbally direct the commencement of any work under this Agreement. The Commonwealth may, upon notice to the CHIP-MCO, extend the term of the Agreement for up to three (3) months upon the same terms and conditions, which will be utilized to prevent a lapse in Agreement coverage and only for the time necessary, up to three (3) months, to enter into a new Agreement.

2. COMPLIANCE WITH LAW

The CHIP-MCO shall comply with all applicable federal and state laws, regulations and policies and local ordinances in the performance of the Agreement. If existing laws, regulations, or policies are changed or if any new law, regulation, or policy is enacted that affects the services provided under this Agreement, the Parties may modify this Agreement as may be reasonably necessary.

3. ENVIRONMENTAL PROVISIONS

In the performance of the Agreement, the CHIP-MCO shall minimize pollution and shall strictly comply with all applicable environmental laws and regulations, including the Clean Streams Law, Act of June 22, 1937 (P.L. 1987, No. 394), as amended, 35 P.S. § 691.601 et seq; the Pennsylvania Solid Waste Management Act, Act of July 7, 1980 (P.L. 380, No. 97), as amended, 35 P.S. § 6018.101 et seq; and the Dam Safety and Encroachment Act, Act of November 26, 1978 (P.L. 1375, No. 325), as amended, 32 P.S. § 693. .

4. POST-CONSUMER RECYCLED CONTENT; RECYCLED CONTENT ENFORCEMENT

Except as waived in writing by the Department of General Services, any products that are provided to the Commonwealth as a part of the performance of the Agreement must meet the minimum percentage levels for total recycled content as specified by the Environmental Protection Agency in its Comprehensive Procurement Guidelines, which can be found at https://www.epa.gov/smm/comprehensive-procurement-guideline-cpg- program.

5. COMPENSATION/EXPENSES

The CHIP-MCO shall perform the specified services at the prices provided for in the Agreement. All services shall be performed within the time periods specified in the Agreement. The CHIP-MCO shall be compensated only for work performed to the satisfaction of the Commonwealth. The CHIP-MCO shall not be allowed or paid travel or per diem expenses.

6. PAYMENT

The Commonwealth shall put forth reasonable efforts to make payment by the required payment date. Payment should not be construed as acceptance of the service performed. The Commonwealth may conduct further inspection after payment, but within a reasonable time after performance, and reject the service if such post payment inspection discloses a defect or a failure to meet specifications. The CHIP-MCO agrees that the Commonwealth may set off the amount of any state tax liability or other obligation of the CHIP-MCO or its subsidiaries to the Commonwealth against any payments due the CHIP-MCO under any Agreement with the Commonwealth.

7. TAXES – FEDERAL, STATE AND LOCAL

The Commonwealth is exempt from all excise taxes imposed by the Internal Revenue Service and has registered with the Internal Revenue Service to make tax free purchases under Registration No. 23740001-K. With the exception of purchases of the following items, no exemption certificates are required, and none will be issued: undyed diesel fuel, tires, trucks, gas guzzler emergency vehicles, and sports fishing equipment. The

Commonwealth is also exempt from Pennsylvania state sales tax, local sales tax, public transportation assistance taxes and fees and vehicle rental tax.

The Department of Revenue regulations provide that exemption certificates are not required for sales made to governmental entities and none will be issued. Nothing in this paragraph is meant to exempt a construction contractor from the payment of any of these taxes or fees that are required to be paid with respect to the purchase, use, rental, or lease of tangible personal property or taxable services used or transferred in connection with the performance of a construction contract.

8. WARRANTY

The CHIP-MCO warrants that all services performed by the CHIP-MCO, its agents and subcontractor shall be performed in a professional and workmanlike manner and in accordance with prevailing professional and industry standards using the utmost care and skill. Unless otherwise stated in the Agreement, all services are warranted for a period of one year following completion of performance by the CHIP-MCO and acceptance by the Commonwealth. The CHIP-MCO shall correct any problem with the service without any additional cost to the Commonwealth.

9. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The CHIP-MCO warrants that it is the sole owner or author of or has entered into a suitable legal agreement for: a) the design of any product or process provided or used in the performance of the Agreement that is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law and b) any copyrighted matter provided to the Commonwealth. The CHIP-MCO shall defend any suit or proceeding brought by a third party against the Commonwealth, its departments, offices, and employees for the alleged infringement of United States or foreign patents, copyrights, trademarks, or misappropriation of trade secrets arising out of the performance of the Agreement. The Commonwealth will provide prompt notification in writing of such suit or proceeding; full right, authorization, and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, the Commonwealth may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by the Commonwealth at the CHIP-MCO's written request, it shall be at the CHIP-MCO's expense, but the responsibility for such expense shall be only that within the CHIP-MCO's written authorization. The CHIP-MCO shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the CHIP-MCO or the Commonwealth may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights. If any of the products provided by the CHIP-MCO in such suit or proceeding are held to constitute infringement and the use is enjoined, the CHIP-MCO shall, at its own expense and at its option, either procure the right to continue use of such products, replace them with non-infringing equal performance products or modify them so that they are no longer infringing. If the CHIP-MCO is unable to do any of the preceding, the CHIP-MCO shall remove all the equipment or software, which are obtained contemporaneously with the infringing product, or, at the option of the Commonwealth, only those items of equipment or software that are held to be infringing, and to pay the Commonwealth: 1) any amounts paid by the Commonwealth towards the purchase of the product, less straight line depreciation; 2) any license fee paid by the Commonwealth for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee representing the time remaining in any period of maintenance paid for. The obligations of the CHIP-MCO under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the CHIP-MCO without its written consent.

10. OWNERSHIP RIGHTS

The Commonwealth shall have unrestricted authority to reproduce, distribute, and use any submitted report, document, data, or material, and any software or modifications and any associated documentation that is designed or developed and delivered to the Commonwealth as part of the performance of the Agreement.

11. ASSIGNMENT OF ANTITRUST CLAIMS

The CHIP-MCO and the Commonwealth recognize that in actual economic practice, overcharges by the CHIP-MCO's suppliers resulting from violations of state or federal antitrust laws are in fact borne by the Commonwealth. As part of the consideration for the award of the Agreement, and intending to be legally bound, the CHIP-MCO assigns to the Commonwealth all right, title and interest in and to any claims the CHIP-MCO now has, or may acquire, under state or federal antitrust laws relating to the products and

services that are the subject of this Agreement.

12. HOLD HARMLESS PROVISION

The CHIP-MCO shall indemnify the Commonwealth against any and all third party claims, demands and actions based upon or arising out of any activities performed by the CHIP-MCO and its employees and agents under this Agreement provided the Commonwealth gives the CHIP-MCO prompt notice of any such claim of which it learns. The Office of Attorney General ("OAG") has the sole authority to represent the Commonwealth in actions brought against the Commonwealth. The OAG may, however, in its sole discretion and under such terms as it deems appropriate, delegate its right of defense. If OAG delegates the defense, the Commonwealth will cooperate with all reasonable requests of the CHIP-MCO made in the defense of such suits. Neither party shall enter into any settlement without the other party's written consent, which shall not be unreasonably withheld. The Commonwealth may, in its sole discretion, allow the Contractor to control the defense and any related settlement negotiations.

13. AUDIT PROVISIONS

In addition to audit requirements of the Agreement, the Commonwealth shall have the right, at reasonable times and at a site designated by the Commonwealth, to audit the books, documents, and records of the CHIP-MCO to the extent that the books, documents, and records relate to costs or pricing data for the Agreement. The CHIP-MCO shall maintain records that support the prices charged and costs incurred for the Agreement. The CHIP-MCO shall preserve books, documents, and records that relate to costs or pricing data for the Agreement for a period of five (5) years from date of final payment or such longer period as required by the Agreement. The CHIP-MCO shall give full and free access to all records to the Commonwealth and state and federal oversight agencies and their authorized representatives.

14. DEFAULT

a. The Commonwealth may, subject to the provisions of Paragraph 15, Force Majeure, and in addition to its other rights under the Agreement, declare the CHIP-MCO in default by written notice to the CHIP-MCO, and terminate (as provided in Section XI of the Agreement and Paragraph 16, Termination Provisions) the whole or any part of this Agreement for any of the following reasons:

   1) Failure to begin services within the time specified in the Agreement or as otherwise specified;
   2) Failure to perform the services with sufficient labor, equipment, or material to complete the specified work in accordance with the Agreement terms;
   3) Unsatisfactory performance of services;
   4) Discontinuance of services without approval;
   5) Failure to resume discontinued services within a reasonable time after notice to do so;
   6) Insolvency or bankruptcy;
   7) Assignment made for the benefit of creditors;
   8) Failure or refusal within 10 days after written notice, to make payment or show cause why payment should not be made, of any amounts due for materials furnished, labor supplied or performed, for equipment rentals, or for utility services rendered;
   9) Failure to protect, to repair, or to make good any damage or injury to property;
   10) Failure to comply with the representations made in its application; or
   11) Breach of any provision of the Agreement.

b. In the event that the Commonwealth terminates this Agreement in whole or in part, the Commonwealth may procure, upon such terms and in such manner as it determines, services similar or identical to those so terminated, and the CHIP-MCO shall be liable to the Commonwealth for any reasonable excess costs for such similar or identical services included within the terminated part of the Agreement.

c. If the Agreement is terminated as provided in Subparagraph a. above, the Commonwealth, in addition to any other rights provided in this paragraph, may require the CHIP-MCO to transfer title and deliver immediately to the Commonwealth in the manner and to the extent directed by the Department, such partially completed work, including, where applicable, reports, working papers and other documentation, as the CHIP-MCO has specifically produced or specifically acquired for the performance of such part of the Agreement as has been

terminated. Except as provided below, payment for completed work accepted by the Commonwealth shall be at the Agreement price. Except as provided below, payment for partially completed work including, where applicable, reports and working papers, delivered to, and accepted by the Commonwealth shall be in an amount agreed upon by the CHIP-MCO and the Department. The Commonwealth may withhold from amounts otherwise due the CHIP-MCO for such completed or partially completed works, such sum as the Department determines to be necessary to protect the Commonwealth against loss.

d. The rights and remedies of the Commonwealth provided in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Agreement.

e. The Commonwealth's failure to exercise any rights or remedies provided in this paragraph shall not be construed to be a waiver of its rights and remedies in regard to the event of default or any succeeding event of default.

15. FORCE MAJEURE

Neither party will incur any liability to the other if its performance of any obligation under this Agreement is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but are not limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, general strikes throughout the trade, and freight embargoes.

The CHIP-MCO shall notify the Commonwealth orally within five (5) days and in writing within ten (10) days of the date on which the CHIP-MCO becomes aware, or should have reasonably become aware, that such cause would prevent or delay its performance. Such notification shall (i) describe fully such cause(s) and its effect on performance, (ii) state whether performance under the Agreement is prevented or delayed and (iii) if performance is delayed, state a reasonable estimate of the duration of the delay. The CHIP-MCO shall have the burden of proving that such cause delayed or prevented its performance despite its diligent efforts to perform and shall produce such supporting documentation as the Commonwealth may reasonably request. After receipt of such notification, the Commonwealth may elect to cancel the Agreement or to extend the time for performance as reasonably necessary to compensate for the delay.

In the event of a declared emergency by competent governmental authorities, the Commonwealth by notice to the CHIP-MCO, may suspend all or a portion of the Agreement.

16. TERMINATION PROVISIONS

In addition to the reasons set forth in the Agreement, the Commonwealth may terminate the Agreement for any of the following reasons. Termination shall be effective upon written notice to the CHIP-MCO and in accordance with the Agreement terms.

a. **TERMINATION FOR CONVENIENCE:** The Commonwealth may terminate the Agreement, in whole or part, for its convenience if the Commonwealth determines termination to be in its best interest. The CHIP- MCO shall be paid for services satisfactorily completed prior to the effective date of the termination and all actual and reasonable costs incurred as a result of the termination. The CHIP-MCO will not be entitled to recover anticipated profit, loss of use of money or administrative or overhead costs.

b. **NON-APPROPRIATION:** The Commonwealth's obligation to make payments during any Commonwealth fiscal year succeeding the current fiscal year shall be subject to availability and appropriation of funds. When funds (state, federal or both) are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal year period, the Commonwealth may terminate the Agreement, in whole or part. The CHIP-MCO shall be reimbursed in the same manner as described in subsection a to the extent that appropriated funds are available.

c. **TERMINATION FOR CAUSE:** In addition to other rights under the Agreement, the Commonwealth may terminate the Agreement for default under Paragraph 14, Default, upon written notice to the CHIP- MCO. The Commonwealth shall also have the right, upon written notice to the CHIP-MCO, to terminate the Agreement for other cause as specified in the Agreement or by law. If it is later

determined that the Commonwealth erred in terminating the Agreement for cause, then, at the Commonwealth's discretion, the Agreement shall be deemed to have been terminated for convenience under the Subparagraph 18.a.

17. ASSIGNABILITY AND SUBCONTRACTS

a. Subject to the terms and conditions of this section, this Agreement shall be binding upon the parties and their respective successors and assigns.

b. The CHIP-MCO may subcontract with third parties approved by the Department to perform all or any part of the services to be performed, which approval may be withheld at the sole and absolute discretion of the Department. The existence of any subcontract shall not change the obligations of Contractor to the Commonwealth under this Contract. The Commonwealth may, for good cause, require that the CHIP-MCO remove a subcontractor from the Project. The Commonwealth will not be responsible for any costs incurred by the CHIP-MCO in replacing the subcontractor if good cause exists

c. The CHIP-MCO may not assign, in whole or in part, the Agreement or its rights, duties, obligations, or responsibilities without the prior written consent of the Department, which consent may be withheld at the sole and absolute discretion of the Department.

d. The CHIP-MCO may, without the consent of the Department, assign its rights to payment to be received under the Agreement, provided that the CHIP-MCO provides written notice of such assignment to the Department together with a written acknowledgement from the assignee that any such payments are subject to all of the terms and conditions of the Agreement.

e. For the purposes of this Agreement, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the CHIP-MCO; however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company.

f. Any assignment consented to by the Department shall be evidenced by a written assignment agreement executed by the CHIP-MCO and its assignee in which the assignee agrees to be legally bound to all of the terms and conditions of the Agreement and to assume the duties, obligations, and responsibilities being assigned.

g. A change of name by the CHIP-MCO, following which the CHIP-MCO's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. The CHIP-MCO shall give the Department written notice of any such change of name.

18. NONDISCRIMINATION/SEXUAL HARASSMENT CLAUSE

In addition to any other nondiscrimination provision of the Agreement, the CHIP-MCO shall:

a. In the hiring of any employee(s) for the manufacture of supplies, performance of work, or any other activity required under the Agreement or any contract, or subcontract, the CHIP-MCO, subgrantee, contractor, subcontractor, and any person acting on behalf of the CHIP-MCO shall not discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the Pennsylvania Human Relations Act (“PHRA”) and applicable federal laws, against any citizen of this Commonwealth who is qualified and available to perform the work to which the employment relates.

b. The CHIP-MCO, and any subgrantee, contractor, subcontractor and any person on their behalf shall not in any manner discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the PHRA and applicable federal laws, against or intimidate any of their employees.

c. Neither the CHIP-MCO nor any subgrantee, contractor, and subcontractor nor any person on their behalf shall in any manner discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the PHRA and applicable federal laws, in the provision of services under the Agreement, or any subgrant, contract or subcontract.

d. Neither the CHIP-MCO nor any subgrantee, contractor, subcontractor nor any person on their behalf shall in any manner discriminate against employees by reason of participation in or decision to refrain from participating in labor activities protected under the Public Employee Relations Act, Pennsylvania Labor Relations Act or National Labor Relations Act, as applicable and to the extent determined by entities charged with such Acts' enforcement, and shall comply with any provision of law establishing organizations as employees' exclusive representatives.

e. The CHIP-MCO, and any subgrantee, contractor and subcontractor shall establish and maintain a written nondiscrimination and sexual harassment policy and shall inform their employees in writing of the policy. The policy must contain a provision that sexual harassment will not be tolerated and employees who practice it will be disciplined. Posting this Nondiscrimination/Sexual Harassment Clause conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where services are performed shall satisfy this requirement for employees within an established work site.

f. The CHIP-MCO, and any subgrantee, contractor and subcontractor shall not discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the PHRA and applicable federal laws, against any subgrantee, contractor, subcontractor or supplier who is qualified to perform the work to which the Agreement relates.

g. The CHIP-MCO and each subgrantee, contractor and subcontractor represent that it is presently in compliance with and will maintain compliance with all applicable federal, state, and local laws and regulations relating to nondiscrimination and sexual harassment. The CHIP-MCO and each subgrantee, contractor and subcontractor further represent that it has filed a Standard Form 100 Employer Information Report ("EEO-1") with the U.S. Equal Employment Opportunity Commission ("EEOC") and shall file an annual EEO-1 report with the EEOC as required for employers' subject to Title VII of the Civil Rights Act of 1964, as amended, that have 100 or more employees and employers that have federal government contracts or first-tier subcontracts and have 50 or more employees. The CHIP-MCO, and any subgrantee, contractor or subcontractor shall, upon request and within the time periods requested by the Commonwealth, furnish all necessary employment documents and records, including EEO-1 reports, and permit access to their books, records, and accounts to the agency and the DGS Bureau of Diversity, Inclusion and Small Business Opportunities for the purpose of ascertaining compliance with the provisions of this Nondiscrimination/Sexual Harassment Clause.

h. The CHIP-MCO, and any subgrantee, contractor and subcontractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subgrant agreement, contract, or subcontract so that those provisions applicable to subgrantees, contractors or subcontractors will be binding upon each subgrantee, contractor or subcontractor.

i. The CHIP-MCO's and each subgrantee's, contractor's and subcontractor's obligations pursuant to these provisions are ongoing from and after the effective date of the Agreement through its termination date. The CHIP-MCO and each subgrantee, contractor and subcontractor shall have an obligation to inform the Commonwealth if, at any time during the term of the Agreement, it becomes aware of any actions or occurrences that would result in violation of these provisions.

j. The Commonwealth may cancel or terminate the Agreement and all money due or to become due under the Agreement may be forfeited for a violation of the terms and conditions of this Nondiscrimination/Sexual Harassment Clause. In addition, the agency may proceed with debarment or suspension and may place the CHIP-MCO, subgrantee, contractor, or subcontractor in the Contractor Responsibility File.

19. INTEGRITY PROVISIONS

It is essential that those who have agreements with the Commonwealth observe high standards of honesty and integrity and conduct themselves in a manner that fosters public confidence in the integrity of the Commonwealth contracting and procurement process.

1. DEFINITIONS. For purposes of these provisions, the following terms have the meanings found in this Section:

a. **"Affiliate"** means two or more entities where (a) a parent entity owns more than fifty percent of the voting stock of each of the entities; or (b) a common shareholder or group of shareholders owns more than fifty percent of the voting stock of each of the entities; or c) the entities have a common proprietor or general partner.

b. **"Consent"** means written permission signed by a duly authorized officer or employee of the Commonwealth, provided that where the material facts have been disclosed, in writing, by prequalification, bid, application, or contractual terms, the Commonwealth shall be deemed to have consented by virtue of the execution of this contract.

c. **"Contractor"** means the individual or entity, that has entered into this Agreement with the Commonwealth.

d. **"Contractor Related Parties"** means any Affiliates of the Contractor and the Contractor's executive officers, officers and directors, or owners of 5 percent or more interest in the Contractor.

e. **"Financial Interest"** means either:

(1) Ownership of more than a five percent interest in any business; or

(2) Holding a position as an officer, director, trustee, partner, employee, or holding any position of management.

f. **"Gratuity"** means tendering, giving, or providing anything of more than nominal monetary value including, but not limited to, cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. The exceptions set forth in the *Governor's Code of Conduct, Executive Order 1980-18*, the *4 Pa. Code §7.153(b)*, shall apply.

g. **"Non-bid Basis"** means an agreement awarded or executed by the Commonwealth with Contractor without seeking applications, bids or applications from any other potential bidder or offeror.

2. In furtherance of this policy, Contractor agrees to the following:

a. Contractor shall maintain the highest standards of honesty and integrity during the performance of this Agreement and shall take no action in violation of state or federal laws or regulations or any other applicable laws or regulations, or other requirements applicable to Contractor or that govern procurement with the Commonwealth.

b. Contractor shall establish and implement a written business integrity policy, which includes, at a minimum, the requirements of these provisions as they relate to the activity with the Commonwealth and Commonwealth employees and beneficiaries, and which is made known to all Contractor employees. Posting these Integrity Provisions conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where services are performed shall satisfy this requirement.

c. Contractor, its Affiliates, agents, employees and anyone in privity with Contractor shall not accept, agree to give, offer, confer, or agree to confer or promise to confer, directly or indirectly, any gratuity or pecuniary benefit to any person, or to influence or attempt to influence any person in violation of any federal or state law, regulation, executive order of the Governor of Pennsylvania, statement of policy, management directive or any other published standard of the Commonwealth in connection with performance of work under this Agreement except as provided in this Agreement.

d. Contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material under this Agreement, unless the financial interest is disclosed to the Commonwealth in writing and the Commonwealth consents to Contractor's financial interest

prior to Commonwealth execution of the Agreement. Contractor shall disclose the financial interest to the Commonwealth at the time of application submission, or if no bids or applications are solicited, no later than Contractor's submission of the Agreement signed by Contractor.

e. Contractor certifies to the best of its knowledge and belief that within the last five (5) years Contractor or Contractor Related Parties have not:

(1) been indicted or convicted of a crime involving moral turpitude or business honesty or integrity in any jurisdiction;

(2) been suspended, debarred, or otherwise disqualified from entering into any contract with any governmental agency;

(3) had any business license or professional license suspended or revoked;

(4) had any sanction or finding of fact imposed as a result of a judicial or administrative proceeding related to fraud, extortion, bribery, bid rigging, embezzlement, misrepresentation, or anti-trust; and

(5) been, and is not currently, the subject of a criminal investigation by any federal, state, or local prosecuting or investigative agency or civil anti-trust investigation by any federal, state or local prosecuting or investigative agency. If Contractor cannot so certify the above, it must submit along with its application a written explanation of why such certification cannot be made and the Commonwealth will determine whether an Agreement may be entered into with the Contractor. The Contractor's obligation pursuant to this certification is ongoing from and after the effective date of the Agreement through its termination date. The Contractor shall have an obligation to immediately notify the Commonwealth in writing if at any time during the term of the Agreement it becomes aware of any event that would cause the Contractor's certification or explanation to change. Contractor acknowledges that the Commonwealth may, in its sole discretion, terminate the Agreement for cause if it learns that any of the certifications made are currently false due to intervening factual circumstances or were false or should have been known to be false when entering into the Agreement.

Contractor shall comply with the requirements of the *Lobbying Disclosure Act (65 Pa.C.S.§13A01 et seq.)* regardless of the method of award. If this Agreement was awarded on a Non-bid Basis, Contractor must also comply with the requirements of the *Section 1641 of the Pennsylvania Election Code (25 P.S. §3260a).*

f. When Contractor has reason to believe that any breach of ethical standards as set forth in law, the Governor's Code of Conduct, or these Integrity Provisions has occurred or may occur, including but not limited to contact by a Commonwealth officer or employee which, if acted upon, would violate such ethical standards, Contractor shall immediately notify the project officer or the Office of the State Inspector General in writing.

g. Contractor, by submission of its application and execution of this Agreement and by the submission of any requests for payment pursuant to the Agreement, certifies and represents that it has not violated any of these Integrity Provisions in connection with the submission of the application, during any negotiations or during the term of the Agreement, to include any extensions. Contractor shall immediately notify the Commonwealth in writing of any actions for occurrences that would result in a violation of these Integrity Provisions. Contractor agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of the State Inspector General for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the Commonwealth that results in the suspension or debarment of the Contractor. Contractor shall not be responsible for investigative costs for investigations that do not result in the Contractor's suspension or debarment.

h. Contractor shall cooperate with the Office of the State Inspector General in its investigation of any alleged Commonwealth agency or employee breach of ethical standards and any alleged

Contractor non- compliance with these Integrity Provisions. Contractor agrees to make identified Contractor employees available for interviews at reasonable times and places. Contractor, upon the inquiry or request of an Inspector General, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Office of the State Inspector General to Contractor's integrity and compliance with these provisions. Such information may include, but shall not be limited to, Contractor's business or financial records, documents or files of any type or form that refer to or concern this Agreement. Contractor shall incorporate this paragraph in any agreement, contract or subcontract it enters into in the course of the performance of this Agreement solely for the purpose of obtaining subcontractor compliance with this provision. The incorporation of this provision in a subcontract shall not create privity of contract between the Commonwealth and any such subcontractor, and no third party beneficiaries shall be created thereby.

i. For violation of any of these Integrity Provisions, the Commonwealth may terminate this and any other Agreement with Contractor, claim liquidated damages in an amount equal to the value of anything received in breach of these Provisions, claim damages for all additional costs and expenses incurred in obtaining another contractor to complete performance under this Agreement, and debar and suspend Contractor from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or non-use of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.

20. CHIP-MCO RESPONSIBILITY PROVISIONS

a. The CHIP-MCO certifies, for itself and all subgrantees and subcontractors, that as of the date of its execution of this Agreement, that neither it, nor any subgrantees, subcontractors nor any suppliers are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority and, if the CHIP-MCO cannot so certify, then it shall submit, along with its application, a written explanation of why such certification cannot be made.

b. The CHIP-MCO also certifies, that as of the date of its execution of the Agreement, it has no tax liabilities or other Commonwealth obligations.

c. The CHIP-MCO's obligations pursuant to these provisions are ongoing from and after the effective date of the Agreement through its termination date. The CHIP-MCO shall inform the Commonwealth if, at any time during the term of the Agreement, it becomes delinquent in the payment of taxes, or other Commonwealth obligations, or if it or any of its subgrantees or subcontractors are suspended or debarred by the Commonwealth, the federal government, or any other state or governmental entity. Such notification shall be made within 15 days of the date of suspension or debarment.

d. The failure of the CHIP-MCO to notify the Commonwealth of its suspension or debarment by the Commonwealth, any other state, or the federal government shall constitute an event of default.

e. The CHIP-MCO agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of State Inspector General for investigations of its compliance with the terms of this or any other agreement between the CHIP-MCO and the Commonwealth, which results in the suspension or debarment of the CHIP-MCO. Such costs shall include, but shall not be limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The CHIP-MCO shall not be responsible for investigative costs for investigations that do not result in the CHIP-MCO's suspension or debarment.

f. The CHIP-MCO may obtain a current list of suspended and debarred Commonwealth entities by either searching the internet at **htfp://www.dgs.state.pa.us** or contacting the:

Department of General
Services Office of Chief

Counsel
603 North Office Building
Harrisburg, PA 17125
Telephone No. (717) 783-6472
FAX No. (717) 787-9138

21. AMERICANS WITH DISABILITIES ACT

a. Pursuant to federal regulations promulgated under the authority of The Americans With Disabilities Act, 28 CFR § 35.101 et seq., the CHIP-MCO understands and agrees that no individual with a disability shall be excluded from participation in this Agreement or from activities provided for under the Agreement on the basis of the disability. As a condition of accepting and executing this Agreement, the CHIP-MCO agrees to comply with the "General Prohibitions Against Discrimination," 28 CFR § 35.130, and all other regulations promulgated under Title II of The Americans With Disabilities Act, which are applicable to all benefits, services, programs, and activities provided by the Commonwealth of Pennsylvania through Agreements with outside entities.

b. The CHIP-MCO shall be responsible for and agrees to indemnify and hold harmless the Commonwealth from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the Commonwealth of Pennsylvania as a result of the CHIP-MCO's failure to comply with the provisions of subparagraph a above.

22. COVENANT AGAINST CONTINGENT FEES

The CHIP-MCO warrants that no person or selling agency has been employed or retained to solicit or secure the Agreement upon an agreement or understanding of a commission, percentage, brokerage, or contingent fee, except bona fide employees or bona fide established commercial or selling agencies maintained by the CHIP-MCO for the purpose of securing business. For breach or violation of this warranty, the Commonwealth shall have the right to terminate the Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

23. GOVERNING LAW

This Agreement shall be governed by and interpreted and enforced in accordance with the laws of the Commonwealth of Pennsylvania without giving effect to conflict of law provisions and the decisions of the Pennsylvania courts. The CHIP-MCO consents to the jurisdiction of any court of the Commonwealth of Pennsylvania and any federal courts in Pennsylvania, waiving any claim or defense that such forum is not convenient or proper. The CHIP-MCO agrees that any such court shall have in personam jurisdiction over it, and consents to service of process in any manner authorized by Pennsylvania law.

24. INTEGRATION

The Agreement, including all referenced documents, constitutes the entire agreement between the parties. No agent, representative, employee or officer of either the Commonwealth or the CHIP-MCO has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with the Agreement, which in any way can be deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of the Agreement. No modifications, alterations, changes, or waiver to the Agreement or any of its terms shall be valid or binding unless accomplished by a written amendment signed by both parties.

25. CHANGES

The Commonwealth may issue change orders at any time during the term of the Agreement or any renewals or extensions thereof: 1) to increase or decrease the quantities resulting from variations between any estimated quantities in the Agreement and actual quantities; 2) to make changes to the services within the scope of the Agreement; 3) to notify the CHIP-MCO that the Commonwealth is exercising any renewal or extension option; and 4) to modify the time of performance that does not alter the scope of the Agreement

to extend the completion date beyond the Expiration Date of the Agreement or any renewals or extensions thereof. Any such change order shall be in writing signed by the Project Officer. The change order shall be effective as of the date appearing on the change order unless the change order specifies a later effective date. Such increases, decreases, changes, or modifications will not invalidate the Agreement, nor, if performance security is being furnished in conjunction with the Agreement release the security obligation. The CHIP-MCO agrees to provide the service in accordance with the change order.

26. RIGHT TO KNOW LAW 8-K-1580

a. The CHIP-MCO and its subgrantees and subcontractors understand that this Agreement and records related to or arising out of the Agreement are subject to requests made pursuant to the Pennsylvania Right-to- Know Law, 65 P.S. §§ 67.101-3104, ("RTKL"). For the purpose of these provisions, the term "the Commonwealth" shall refer to the Department.

b. If the Commonwealth needs the CHIP-MCO, subgrantee or subcontractor's assistance in any matter arising out of the RTKL request related to this Agreement, it shall notify the CHIP-MCO, subgrantee, or subcontractor using the legal contact information provided in the Agreement. The CHIP-MCO, subgrantee, or subcontractor at any time, may designate a different contact for such purpose upon reasonable prior written notice to the Commonwealth.

c. Upon written notification from the Commonwealth that it requires assistance in responding to a RTKL request for information related to this Agreement that may be in the CHIP-MCO, a subgrantee or subcontractor's possession, constituting, or alleged to constitute, a public record in accordance with the RTKL ("Requested Information"), CHIP-MCO shall:
   1. Provide the Commonwealth, within ten (10) calendar days after receipt of written notification, access to, and copies of, any document or information in the CHIP-MCO, subgrantee or subcontractor's possession that the Commonwealth reasonably believes is Requested Information and may be a public record under the RTKL; and
   2. Provide such other assistance as the Commonwealth may reasonably request, in order to comply with the RTKL with respect to this Agreement.

d. If the CHIP-MCO, subgrantee or subcontractor considers the Requested Information to include a request for a Trade Secret or Confidential Proprietary Information, as those terms are defined by the RTKL, or other information that the CHIP-MCO, subgrantee or subcontractor considers exempt from production under the RTKL, the CHIP-MCO, subgrantee or subcontractor must notify the Commonwealth and provide, within seven (7) calendar days of receiving the written notification, a written statement signed by a representative of the CHIP-MCO, subgrantee or subcontractor explaining why the requested material is exempt from public disclosure under the RTKL.

e. The Commonwealth will rely upon the written statement in denying a RTKL request for the Requested Information unless the Commonwealth determines that the Requested Information is clearly not protected from disclosure under the RTKL. Should the Commonwealth determine that the Requested Information is clearly not exempt from disclosure, the CHIP-MCO, subgrantee or subcontractor shall provide the Requested Information within five (5) business days of receipt of written notification of the Commonwealth's determination.

f. If the CHIP-MCO, subgrantee or subcontractor fails to provide the Requested Information within the time period required by these provisions, the CHIP-MCO shall indemnify and hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of the failure, including any statutory damages assessed against the Commonwealth.

g. The Commonwealth will reimburse the CHIP-MCO, subgrantee or subcontractor for any costs associated with complying with these provisions only to the extent allowed under the fee schedule established by the Office of Open Records or as otherwise provided by the RTKL if the fee schedule is inapplicable.

h. The CHIP-MCO, subgrantee or subcontractor may file a legal challenge to any Commonwealth decision to release a record to the public with the Office of Open Records, or in the Pennsylvania Courts; however, the CHIP-MCO, subgrantee or subcontractor shall indemnify the Commonwealth for any legal expenses incurred by the Commonwealth as a result of such a challenge and shall hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of the CHIP-MCO, subgrantee or subcontractor's failure, including any statutory damages assessed against the Commonwealth, regardless of the outcome of

such legal challenge. As between the parties, the CHIP-MCO, subgrantee and subcontractor waive all rights or remedies that may be available to it as a result of the Commonwealth's disclosure of Requested Information pursuant to the RTKL.

i. The CHIP-MCO, subgrantee and subcontractor's duties relating to the RTKL are continuing duties that survive the expiration of this Agreement and shall continue as long as the Requested Information in its possession.

27. ENHANCED MINIMUM WAGE

a. Enhanced Minimum Wage. The CHIP-MCO shall pay no less than $12.00 per hour to its employees for all hours worked directly performing the services required by this Agreement, and for all hours performing ancillary services necessary for the performance of the Agreement services when an employee spends at least twenty per cent (20%) of their time performing ancillary services for the Agreement in a given work week.

b. Adjustment. Beginning July 1, 2019, and annually thereafter, the CHIP-MCO shall increase the enhanced minimum wage rate required by subsection a. by $0.50 until July 1, 2024, when the minimum wage reaches $15.00. Thereafter, the CHIP-MCO must increase the required enhanced minimum wage rate by the annual cost-of-living adjustment using the percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) for Pennsylvania, New Jersey, Delaware, and Maryland. The applicable adjusted amount shall be published in the Pennsylvania Bulletin by March 1 of each year to be effective the following July 1.

c. Exceptions. These Enhanced Minimum Wage Provisions shall not apply to employees:

(i) exempt from the minimum wage under the Minimum Wage Act of 1968;

(ii) covered by a collective bargaining agreement;

(iii) required to be paid a higher wage under another state or federal law governing the services, including the Prevailing Wage Act and Davis-Bacon Act; and

(iv) required to be paid a higher wage under any state or local policy or ordinance.

d. Notice. The CHIP-MCO shall post these Enhanced Minimum Wage Provisions for the entire period of the Agreement in conspicuous easily-accessible and well-lighted places customarily frequented by employees at or near where the services are performed.

e. Records. The CHIP-MCO must maintain and, upon request and within the time periods requested by the Commonwealth, furnish all employment and wage records necessary to document compliance with these Enhanced Minimum Wage Provisions.

f. Sanctions. Failure to comply with these Enhanced Minimum Wage Provisions may result in the imposition of sanctions, which may include, but shall not be limited to, termination of the Agreement, nonpayment, debarment or referral to the Office of General Counsel for appropriate civil or criminal referral.

g. Subcontractors. The CHIP-MCO shall include the provisions of these Enhanced Minimum Wage Provisions in every Subcontract so that these provisions will be binding upon Subcontractors.

EXHIBIT D
DEPARTMENT OF HUMAN SERVICES ADDENDUM TO STANDARD GRANT TERMS AND CONDITIONS

A. **APPLICABILITY**

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

B. **CONFIDENTIALITY**

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

C. **INFORMATION**

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

D. **CERTIFICATION AND LICENSING**

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

E. **PROGRAM SERVICES**

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

F. **CHILD PROTECTIVE SERVICE LAWS**

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

G. **PRO-CHILDREN ACT OF 1994**

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

H. **MEDICARE/MEDICAID REIMBURSEMENT**

1. To the extent that services are furnished by contractors, subcontractors, or organizations related to the contractor/subcontractor and such services may in whole or in part be claimed by the Commonwealth for Medicare/Medicaid reimbursements, contractor/subcontractor agrees to comply with 42 CFR,Part 420, including:

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

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

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

I. **TRAVEL AND PER DIEM EXPENSES**

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

J. **INSURANCE**

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

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

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

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

to work performed for the Commonwealth.

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

K. PROPERTY AND SUPPLIES

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

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

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

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

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

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

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

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

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

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

L. DISASTERS

If, during the terms of this contract, the Commonwealth's premises are so damaged by flood, fire or other Acts of God as to render them unfit for use; then the Agency shall be under no liability or

obligation to the contractor hereunder during the period of time there is no need for the services provided by the contractor except to render compensation which the contractor was entitled to under this agreement prior to such damage.

M. SUSPENSION OR DEBARMENT

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

N. COVENANT AGAINST CONTINGENT FEES

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

O. CONTRACTOR'S CONFLICT OF INTEREST

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

P. INTEREST OF THE COMMONWEALTH AND OTHERS

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

Q. CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS

(Applicable to contracts $25,000 or more)

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

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

3. The contractor, within 10 days of receiving the notice to proceed, must register in the

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

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

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

R. TUBERCULOSIS CONTROL

As recommended by the Centers for Disease Control and the Occupational Safety and Health Administration, effective August 9, 1996, in all State Mental Health and Intellectual Disability Facilities, all full-time and part-time employees (temporary and permanent), including contract service providers, having direct patient contact or providing service in patient care areas, are to be tested serially with PPD by Mantoux skin tests. PPD testing will be provided free of charge from the state MH/ID facility. If the contract service provider has written proof of a PPD by Mantoux method within the last six months, the MH/ID facility will accept this documentation in lieu of administration of a repeat test. In addition, documented results of a PPD by Mantoux method will be accepted by the MH/ID facility. In the event that a contractor is unwilling to submit to the test due to previous positive reading, allergy to PPD material or refusal, the risk assessment questionnaire must be completed. If a contractor refuses to be tested in accordance with this new policy, the facility will not be able to contract with this provider and will need to procure the services from another source.

S. ACT 13 APPLICATION TO CONTRACTOR

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

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

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

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

Investigation for the criminal history record check required under subsection 2.

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

T. LOBBYING CERTIFICATION AND DISCLOSURE
(applicable to contracts $100,000 or more)

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

U. AUDIT CLAUSE
(applicable to contracts $100,000 or more)

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

EXHIBIT E

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))
- Removal, Implantable contraceptive capsules
- Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant)
- 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; cryocautery, 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
- ParaGard 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
- Medication for Vaginal Infection
- Breast cancer screen
- Mammography, bilateral
- Genetic Risk Assessment

EXHIBIT F

PRIOR AUTHORIZATION GUIDELINES FOR PARTICIPATING MANAGED CARE ORGANIZATIONS IN CHIP

A. General Requirement

The CHIP-MCOs must submit to the Department all written policies and procedures for the Prior Authorization of services. The CHIP-MCO must adhere to all prior authorization requirements listed in the CHIP State Plan. The CHIP-MCO must receive advance written approval from the Department to require the Prior Authorization of any services. For each service to be Prior Authorized, the CHIP-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 CHIP RFA, CHIP Agreement, and federal regulations;
- Ensure that 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 application. 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 CHIP-MCO to comply may result in sanctions and/or penalties by the Department. The Department defines prior authorization as a determination made by a CHIP-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 an Enrollee prior to the Provider's initiation or continuation of the requested service.

B. Guidelines for Review

1. Basic Requirements:

   a. The CHIP-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 CHIP-MCO must identify all populations who will be affected by the application for Prior Authorization.

   c. The CHIP-MCO must verify that prior authorization is permitted under the CHIP State Plan.

2. Medically Necessary Requirements:

   a. The CHIP-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 CHIP-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 CHIP contract definition for a service or benefit that is Medically Necessary. All criteria must be submitted to the Department for evaluation and approval under URCAP prior to implementation.

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

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

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

d. CHIP-MCO guidelines to determine medical necessity of all drugs that require prior authorization must be posted for public view on the CHIP-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 CHIP-MCO reviewers will consider when determining medical necessity including requirements for step therapy.

e. The CHIP-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 CHIP RFA, the CHIP Agreement, and applicable legal settlements must make the determination of Medically Necessary services.

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 Enrollee'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. The reasonable efforts to contact the prescriber must be documented in writing.

3. Administrative Requirements

a. The CHIP-MCO's written policies and procedures must identify the time frames for review and decisions and the CHIP-MCO must demonstrate that the timeframes 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 CHIP-MCO's written policies and procedures must demonstrate how the CHIP-MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

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

4. Notification and Grievance External review and DHS Fair Hearing Requirements

The CHIP-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 requirements of the CHIP RFA and Agreement.

EXHIBIT G

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS

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

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

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

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

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

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

F. Allow for the timely, complete, and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including HEDIS and CAHPS as outlined in Exhibit J, 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 CHIP-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 CHIP-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.G, Sanctions, of the Agreement.

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

1. The CHIP-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 CHIP-MCO must submit to the Department an expiration of the accreditation and future accreditation surveys.

I. Attain NCQA Multicultural Health Care Distinction by meeting the requirement guidelines set forth by NCQA for multicultural health care. The CHIP-MCO must submit a workplan and timeline to the Department depicting their progress in achieving NCQA Multicultural Distinction at least annually.

J. Determine whether algorithms used for case management, disease management, quality management, or decisions about which Enrollees receive additional support from the CHIP-MCO, contain racial bias. If any racial bias is identified, the CHIP-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 CHIP-MCO will work with the 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 and UM programs must be comprehensive in nature; allow for improvement and be consistent with the Department's goals related to access, availability and quality of care. At a minimum, the CHIP-MCO's QM and UM programs, must:

A. Adhere to current CHIP CMS guidelines.

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

C. Ensure that all QM and UM activities and initiatives undertaken by the CHIP-MCO are based upon clinical and financial analysis of Encounter Data, Enrollee 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 CHIP-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 CHIP-MCO's QM and UM programs. The written program description must, at a minimum:

1. Include standards and mechanisms for ensuring the accessibility of primary care services, specialty care services, urgent care services, hospitals

and Member services in accordance with timeframes outlined in Exhibit Z, 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 Enrollees, and utilization of services over time.

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

    a. Studies and activities undertaken; including the rationale, methodology and results;

    b. Subsequent improvement actions; and

    c. Aggregate clinical and financial analysis of Encounter, HEDIS, CAHPS, Pennsylvania Performance Measures, other data on the quality of care rendered to Enrollees and utilization of services.

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

    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 CHIP-MCO performance in improving access to care, the quality of care provided to Enrollees and utilization of services.

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

a. Provider Relations;

b. Member Services; and

c. Management Information Systems

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

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

L. Include mechanisms and processes which allow for the development and implementation of CHIP-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 CHIP-MCO must ensure that:

A. The Governing Body:

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

2. Regularly receives written reports on the QM and UM program activities that describe actions taken, progress in meeting objectives and improvements made. The governing body formally reviews, on at least an annual basis, a written evaluation of the QM and UM program activities that includes studies undertaken, results of studies, and subsequent improvement actions taken.

   The written evaluation must include aggregate clinical and financial analysis of quality and utilization data, including HEDIS, CAHPS, and Pennsylvania Performance Measures.

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

B. The Quality Management Committee (QMC):

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

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

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

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

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

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

D. The Medical Director:

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

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

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

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

9. Has knowledge of risk management standards;

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

11. Oversees and is accountable for:

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

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

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

Standard III: The CHIP-MCO QM and UM programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services provided to Members through quality of care studies and related activities with a focus on identifying and pursuing opportunities for continuous and sustained improvement.

A. The QM and UM programs must adopt 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;
3. Based on scientific evidence;
4. Adopted in consultation with contracting health care professionals;

5. Applicable to Providers for the delivery of certain types or aspects of health care;
6. Considering the needs of the MCO's enrollees; and
7. Are reviewed and updated periodically as appropriate.

B. The QM and UM 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 CHIP-MCO Enrollees and must address the full range of health care needs of the

populations served by the CHIP-MCO. (per 42 CFR 438.236 (b)(2)).

The clinical areas addressed must include, but are not limited to:

1. Pediatric and adolescent preventive care with a focus on Bright Futures periodicity schedule;

2. Obstetrical care including a requirement that Enrollees be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;

3. Selected diagnoses and procedures relevant to the enrolled population;

4. Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the CHIP-MCO's membership; and

5. Dental care,

6. Behavioral and mental health services.

D. The CHIP-MCO QM and UM 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 Enrollees or Potential Enrollees upon request. (per 42 CFR §457.1233 referencing 438.236 (c)).

E. The CHIP-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 CHIP-MCO wide Provider performance over time;

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

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

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

1. Processes that allow for the identification, investigation and resolution of quality

of care concerns including Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care patterns;

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

3. Use of progressive sanctions as indicated;

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

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

    a. Education;

    b. Follow-up monitoring and re-evaluation;

    c. Changes in processes, structures, forms;

    d. Informal counseling;

    e. Procedures for terminating the affiliation with the physician or other health professional or Provider;

    f. Assessment of the effectiveness of the actions taken; and

    g. Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care).

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

H. The QM and UM programs must contain procedures for Member satisfaction surveys that are conducted on at least an annual basis including the collection of annual Member satisfaction data through application of the CAHPS instrument as outlined in Exhibit J, Healthcare Effectiveness Data and Information Set (HEDIS).

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

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

Standard IV: The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided

to Enrollees through utilization review activities with a focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization.

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

    1. Utilization information on Enrollee 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 Bright Futures requirements.

B. CHIP-MCO must submit to the department on an annual basis network provider profiles.

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

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

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

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

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

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

D. Include performance indicators that allow for the objective measurement and analysis of individual and CHIP-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.

Standard VI: The QM and UM programs must have mechanisms to ensure that Enrollees 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 CHIP-MCOs; and

C. The CHIP-MCO and other third-party insurers.

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

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

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

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

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

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

A. The CHIP-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types. Recredentialing activities must be conducted by the CHIP-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 CHIP program;

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

4. Evidence of malpractice/liability insurance;

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

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

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

B. For purposes of credentialing and recredentialing, the CHIP-MCO must perform a check on all PCPs and other physicians by contacting the National Practitioner Data Bank (NPDB). If the CHIP-MCO does not meet the statutory requirements for accessing the NPDB, then CHIP-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 Enrollee;

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; and

7. Attend at least one MCO sponsored provider education training session.

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 CHIP records pertaining to sanctions and/or settlement to the CHIP-MCO and the Department.

F. The Department will recoup from the CHIP-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 CHIP-MCO in a manner that is not consistent with the Provider's licensure. In addition, the CHIP-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.

G. The CHIP-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 CHIP-MCO's credentialing practices.

H. Any economic profiles used by the CHIP-MCOs to credential Providers should be adjusted to adequately account for factors that influence utilization independent of the Provider's clinical management, including Enrollee age, Enrollee sex, Provider case-mix and Enrollee severity. The CHIP-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 CHIP-MCO renders an adverse credentialing decision, the

CHIP-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 CHIP-MCO are final and may not be appealed to the Department.

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

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

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

3. Provider applications submitted to the CHIP-MCO for credentialing must be completed within sixty (60) calendar days of the CHIP-MCO, Dental Benefit Manager (DBM) or Vision Benefit Manager (VBM) receipt of a complete application packet.

4. The CHIP-MCO, DBM or VBM must notify the provider of the status of their credentialing application as follows:

    a. First Correspondence: The CHIP-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 CHIP-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 CHIP-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 CHIP-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.G to include retrospective payments to the provider as directed by the Department.

Standard IX: The CHIP-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 F, Prior Authorization Guidelines for Participating Managed Care Organizations in CHIP.

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 CHIP 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 CHIP-MCO must base its determination on medical information provided by the Enrollee, the Enrollee's family/parent/guardian, and the PCP, as well as any other Providers, programs and agencies that have evaluated the Enrollee. Medical necessity determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement. Satisfaction of any one of the following standards will result in authorization of the service:

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

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

3. The service or benefit will, assist the Enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollee and those functional capacities that are

appropriate for Enrollees of the same age.

C. If the CHIP-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 CHIP'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.H, 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/External Review;

4. Comply with state/federal regulations;

5. Comply with CHIP Agreement 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 CHIP-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 CHIP definition of Medically Necessary;

2. Allow for determinations of medical necessity that are consistent with the CHIP 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 CHIP-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 Enrollee's condition or disease;

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

3. Are made in accordance with established time-frames outlined in the Agreement for routine, urgent, or emergency care; and

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

F. The CHIP-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 CHIP-MCO must have written policies and procedures that address how Members and Providers can make contact with the CHIP-MCO to receive instruction or Prior Authorization, as necessary

G. Additional Prior Authorization requirements can be found in Exhibit F, Prior Authorization Guidelines for Participating Managed Care Organizations in CHIP.

H. The CHIP-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 CHIP-MCO must ensure that sources of utilization criteria are provided to the Enrollees and Providers upon request.

J. The UM program must contain procedures for providing written notification to Enrollees 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 processes must:

1. Meet requirements outlined in Exhibit S, Complaints, Grievances, External Reviews and DHS Fair Hearing Process.

2. Provide for written notification to Enrollees of denials, terminations, reductions and changes in medical services at least ten (10) days before the effective date.
3. Include notification to Enrollees of their right to file a Complaint, Grievance, External Review, or DHS Fair Hearing as outlined in Exhibit S, Complaints, Grievances, External Review 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, or Federal regulations as a means of informing a member of a service or item denial.

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

1. Submission of a log of all denials issued using formats to be specified by the Department.

2. Submission of denial notices for review as requested by the Department.

3. Submission of utilization review records and documentation as requested by the Department.

4. Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.

5. Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department prior to implementation.

Standard X: The CHIP-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 CHIP-MCO's decision to deny payment for services already rendered by the Provider to an Enrollee.

B. QM/UM sanctions

C. Adverse credentialing/recredentialing decisions

D. Provider Terminations

Standard XI: The CHIP-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM and UM program activities are documented and reported to appropriate individuals within the CHIP-MCO for use in other management activities.

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

1. CHIP-MCO Provider Network changes;

2. Benefit changes;

3. Medical management systems (e.g., pre-certification); and

4. Practices feedback to Providers.

Standard XII: The CHIP-MCO must have written policies and procedures for conducting prospective and retrospective Drug Utilization Review (DUR) that meet requirements outlined in Exhibit AA, Outpatient Drug Services.

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

A. The CHIP-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 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 CHIP-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 CHIP-MCO must ensure access of the Enrollee to his/her medical record at no charge and upon request. The Enrollee'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) must be afforded prompt access to all Enrollee's 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 an Enrollee before requesting the Enrollee'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 CHIP-MCO's contract. Medical records must be made available in paper form upon request.

H. When an Enrollee changes PCPs, the CHIP-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 CHIP-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

I. When an Enrollee changes CHIP-MCOs, the CHIP-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new CHIP-MCO within seven (7) business days from the effective date of enrollment in the gaining CHIP-MCO. In emergency situations, the CHIP-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

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

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

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

2. To be provided with information about the CHIP-MCO, its services, the practitioners providing care, and Enrollees rights and responsibilities;

3. To be able to choose Providers, within the limits of the CHIP-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. Be free from any form or restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on use restraints and seclusion;

6. 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 Enrollee 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 CHIP-MCO;

7. To file a Grievance about the CHIP-MCO or care provided;

8. To file an External Review with the Department;

9. To formulate advance directives including:
   a. The description of State law, if applicable.
   b. The process for notifying the Participant of any changes in applicable state law as soon as possible, but no later than ninety (90) days after the effective date of the changes.
   c. Any limitation the MCO has regarding implementation of advanced directives as a matter of conscience.
   d. The process for Participants to file a complaint concerning noncompliance with the advanced directive requirements with the MCO and the State survey and certification agency.
   e. How to request written information on advance directive policies.

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

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

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

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

3. Enrollees 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, Enrollees will remain anonymous to the greatest extent possible.

C. The CHIP-MCO's policies on Enrollee rights and responsibilities must be provided

to all participating Providers.

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

1. Rights and responsibilities of Enrollees;

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 Enrollees if applicable;

d. Benefits and services excluded.

e. Provisions for after-hours, urgent and emergency coverage;

f. The CHIP-MCO's policy on referrals for specialty care;

g. CHIP-MCO Procedures for notifying, in writing, those Enrollees 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 Enrollee's coverage, benefits or relationship to the CHIP-MCO;

i. Information about OMAP's Hotline functions;

j. Procedures for changing practitioners;

k. Procedures for disenrolling from the CHIP-MCO;

l. Procedures for filing Complaints and/or Grievances; External Reviews; and

m. Procedures for recommending changes in policies and services.

E. The CHIP-MCO must have policies and procedures for resolving Enrollee Complaints and Grievances that meet all requirements outlined in Exhibit S, Complaints, Grievances, and External Review 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 Enrollees to offer suggestions for changes in policies and procedures.

G. The CHIP-MCO must take steps to promote accessibility of services offered to Enrollees. These steps must include identification of the points of access to primary care, specialty care and hospital services. At a minimum, Enrollees 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. Enrollee information (for example, Enrollee brochures, Enrollee denials, announcements, and handbooks) must be written in language that is readable and easily understood.

The CHIP-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 as outlined in Exhibit N, CHIP-MCO Guidelines for Advertising, Sponsorships, Marketing and Outreach.

I.

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

A. The CHIP-MCO must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM and UM programs.

B. The CHIP-MCO must adhere to all systems requirements as outlined in Section V.Z.3.o.4, Management Information Systems, and Section VIII.B, Operations Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the HealthChoices Extranet.

C. The CHIP-MCO must adhere to all Encounter Data requirements as outlined in Section VIII.A.1, Encounter Data Reporting, of the Agreement.

EXHIBIT I

EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under 42 CFR § 457.1250 for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations, including the evaluation of quality outcomes, timeliness, and access to services. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members. "Quality", as it pertains to EQR, means the degree to which a CHIP-MCO maintains or improves the health outcomes of its Enrollees through its structural and operational characteristics and through the provision of services. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight. The Department requires that the CHIP-MCOs:

A. Actively participate in planning and developing the measures to be utilized with the Department and the EQRO.

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

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

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

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

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

G. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR § 457.1250.

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

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

EXHIBIT J

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 CHIP-MCOs:

A. Must produce rates for all specified reporting measures, as determined 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 CHIP-MCO's HEDIS® results used in public reporting. The CHIP-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 on the CHIP website 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 (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 Enrollees from the MCO and summarizes satisfaction with the experience of care through ratings and composites.

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 the Child CAHPS® survey. The CHIP-MCO must generate a sample frame for the 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 CHIP-MCOs are also required to have the certified vendor submit Enrollee level data files to NCQA for calculation of HEDIS® and CAHPS® survey results. The Department requires that the MCOs:

A. Must conduct the Child CAHPS® survey using the current version of CAHPS®.
B. Must add the following supplemental questions, from the Supplemental Items for Child Questionnaires:

M1. If you were concerned about your child's mental health, which provider would you be most likely to contact?

□ My child's primary care provider
□ A mental health provider
□ A school counselor

M2. In the last twelve months, how often did your family get the help you wanted for your child's mental health from any provider?

□ Never
□ Sometimes
□ Usually
□ Always
□ My child did not require any help for mental health related conditions

M3. If your child received service from a professional mental health provider in the last twelve months, how often was it easy to get the counseling or treatment you thought your child needed?

□ Never

□ Sometimes
□ Usually
□ Always
□ My child did not require any help for mental health related conditions

M4. In the last six months, how often was it hard to find a personal doctor who speaks your child's language?

□ Not Applicable
□ Did not have a problem
□ My child does not have a personal doctor
□ Never
□ Sometimes
□ Usually
□ Always

M5. In the last six months, how often was it hard to find a personal doctor who knows your child's culture?

□ Not Applicable
□ Did not have a problem
□ My child does not have a personal doctor
□ Never
□ Sometimes
□ Usually
□ Always

C. Must forward CAHPS® data to the Department's EQRO and to the Department electronically in the format determined by the Department.

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

The Department annually releases a CHIP Transmittal that contains detailed information regarding the submission of HEDIS® and CAHPS®.

EXHIBIT K

NOTICE OF DENIAL

A written notice of denial must be issued to the Enrollee for the following:

a. The denial or limited authorization of a requested service, including the type or level of service.

b. The reduction, suspension or termination of a previously authorized service.

c. The denial of a requested service because it is not a covered service for the Enrollee.

d. The denial of a requested service but approval of an alternative service

Please refer to Templates N(1) through N(6) for denial notice templates and Template N(7) Request for Additional Information Letter template which are available in Docushare.

EXHIBIT L

WRITTEN COORDINATION AGREEMENTS BETWEEN CHIP-MCO AND SERVICE PROVIDERS

Any written coordination agreements entered into between the CHIP-MCO, and service Providers must contain, at a minimum:

- A requirement that all providers and other practitioners who order, refer or prescribe items or render services to Enrollees must enroll with the Department as a CHIP provider.

- Provisions for ongoing communications; exchange of relevant enrollment and individual health related information; service needs among the CHIP-MCO, PCP and the community Provider, including a process to monitor such activity; and the Quality Management and Utilization Management program responsibilities of each entity.

- Provisions which govern referral, collaboration and coordination of diagnostic assessment and treatment, prescribing practices and other treatment issues necessary for optimal health and disease prevention, including coordination of specialized service plans for Enrollees with special health needs.

- Provisions for requiring interaction by the PCP for prompt treatment, coordination of care or referral of Enrollees for other identified services that are not the responsibility of the community Provider.

- Provisions for jointly identifying the services to be delivered and monitoring by the CHIP-MCO to determine the quality of the service delivered.

- Provisions for the CHIP-MCO and the community Provider to work cooperatively to establish programmatic responsibility for each Enrollee.

- Provisions for serving on interagency teams, when requested.

- Provisions for mutual intensive outreach efforts to Enrollees identified as needing service (processes to conduct outreach and the measurement of the outreach efforts must be documented in the procedures governing the execution of the written agreement).

- Provisions for a timely resolution of any disputes.

- Provisions for training and consultations between both parties to facilitate continuity of care and the cost-effective use of resources.

- Provisions for assisting, when appropriate, in the development of an adequate Provider Network to serve Enrollees with chronic and complex medical conditions.

- Provisions for obtaining the appropriate releases necessary to share clinical information and provide health records to each other as requested consistent with state and federal laws.

- Provisions for the designation of a CHIP-MCO representative who will function as the liaison between the CHIP-MCO and the community Provider, if appropriate.

- Provisions for the development and implementation of corrective action plans in the event the provisions of the agreement are not being met.

- Provisions for the adherence to the Americans with Disabilities Act (ADA) (42 U.S.C. Section 12101 et seq) and the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et seq).

- Provisions for the maintenance and confidentiality of medical records and other information considered confidential, including provisions for resolving confidentiality problems.

- Provisions for the collection of information on the service(s) delivered to be shared with the Department, upon request.

- Provisions for collaboration on identifying and reducing the frequency of Fraud, Abuse, overuse, under use, inappropriate or unnecessary medical care.

- Provisions for the reporting of health-related information to the appropriate regulatory agency, if necessary.

- A requirement that participating ER staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for the county;

- A requirement that each provider furnishing services to enrollees maintains and shares, as appropriate, the Enrollee health record in accordance with professional standards;

- A requirement that the CHIP-MCO must not exclude or terminate a provider from participation in the CHIP-MCO's provider network due to the fact that the provider has a practice that includes a substantial number of patients with expensive medical conditions;

- A requirement that the MCO must not exclude a provider from the CHIP-MCO's provider network because the provider advocated on behalf of an Enrollee for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable provider practicing according to the applicable medical standard of practice;

- Notification of the prohibition and sanctions for submission of false claims and statements;

- The definition of medically necessary from this Agreement;

- A requirement that the MCO cannot prohibit or restrict a provider acting within the lawful scope of practice from discussing care and advising or advocating appropriate medical care with or on behalf of an enrollee including:
    - Information regarding the nature of treatment options; risks of treatment;
    - Alternative treatments; or
    - The availability of alternative therapies, consultation or tests that may be self-administered;

- A requirement that the MCO cannot prohibit or restrict a provider acting within the lawful scope of practice from providing information the enrollee needs in order to decide among all relevant treatment options, the risks, benefits, and consequences of treatment or non-treatment and the enrollee's right to participate in the health care decisions;

- A requirement that the MCO cannot terminate a contract or employment with a provider for filing a grievance on an Enrollee's behalf;

- A clause which specifies that the agreement will not be construed as requiring the CHIP-MCO to provide, reimburse for, or provide coverage of, a counseling or referral service if the provider objects to the provision of such services on moral or religious grounds as well as the requirements if a provider elects not to provide these services;

- A requirement securing cooperation with the QM and UM program requirements (See Appendix H, Quality Management and Utilization Management Program Requirements);

- A requirement for cooperation for the submission of encounter data for all services provided within the time frames as required in this handbook, no matter whether reimbursement for these services is made by the CHIP-MCO either directly or indirectly through capitation;

- A continuation of benefits provision which states that the provider agrees that in the event of the CHIP-MCO's insolvency or other cessation of operations, the provider must continue to provide benefits to the CHIP-MCO's Enrollees, including Enrollees in an inpatient setting, through the period for which the Capitation has been paid;

- A requirement that the PCPs responsible for conducting all Bright Futures screens for CHIP enrollees. Should the PCP be unable to conduct the necessary Bright Futures screens, the PCP arranges to have the necessary

screens conducted by another network provider and ensures that all relevant medical information, including the results of the screens, are incorporated into the Enrollee's PCP medical record.

- A requirement that PCPs report encounter data associated with Bright Futures screens to the MCO within ninety (90) days from the date of service;

- A requirement that PCPs contact new enrollees who have not had an encounter within the first six (6) months of enrollment, or who have not complied with the Bright Futures periodicity and immunization schedules for children. The PCP must document the reasons for noncompliance, where possible, and document its efforts to bring the enrollee's care into compliance;

- A requirement that ensures each physician providing services to enrollees eligible for CHIP under the CHIP State Plan has a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act;

- Language that requires the provider to disclose annually any Physician Incentive Plan or risk arrangements it may have with physicians either within the group practice or other physicians not associated with the group practice even if there is not substantial financial risk between the MCO and the physician or physician group;

- A provision that the CHIP-MCO's UM Departments are mandated by the Department to monitor the progress of an enrollee's inpatient hospital stay. This must be accomplished by the CHIP-MCO's UM department receiving appropriate clinical information from the hospital that details the enrollee's admission information, progress to date, and any pertinent data within two (2) business days from the time of admission; and

- The CHIP-MCO's providers must agree to the MCO's UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the MCO's medical director. As part of the concurrent review process and for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the CHIP-MCO must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

Exhibit M

TELEPHONIC PSYCHIATRIC CONSULTATION TEAM SERVICES

The CHIP-MCO has the responsibility to coordinate the care of children who require therapeutic interventions and medication to treat mental health conditions. In order to improve the quality of care for children that require psychotropic medication, the CHIP-MCO will contract with a telephonic Psychiatric Consultation Team (PCT) that will provide real time telephonic consultative services to PCPs and other prescribers of psychotropic medications for children (referred to as PCPs throughout this exhibit). **The CHIP-MCO will work with all other CHIP-MCOs within the Geographic Service Areas to collaboratively choose one PCT for each Geographic Service Areas.**

The PCT must consist of a team of staff including one (1) full-time equivalent child psychiatrist, one (1) full-time equivalent behavioral health therapist, and one (1) full-time equivalent care coordinator.

Qualifications and key responsibilities for team staff are listed below:

(i) Child Psychiatrist

The full-time equivalent position of child psychiatrist may consist of one or more individuals as follows- child psychiatrists must be Board certified or Board eligible and skilled in psychopharmacology. At least one child psychiatrist shall be on call providing continuous coverage from 9:00 a.m. to 5:00 p.m., Monday through Friday, and shall at all times while on call carry a pager and/or cell phone and be accessible to a caller within thirty (30) minutes. The on-call team member shall not be engaged in any activity from which he/she cannot be interrupted within thirty (30) minutes. A child psychiatrist team member shall make an on-site visit to high volume participating PCPs defined by the MCOs in the Managed Care Program Zone at least once per year. One child psychiatrist will be designated as the PCT's lead medical director with responsibility to assure consistent quality of care, convene periodic team meetings, assure team productivity and timely regional coverage of PCPs, and participate in quarterly meetings with all CHIP-MCOs within the Geographic Service Area.

(ii) Behavioral Health Therapist

The one (1) full-time equivalent position of behavioral health therapist may consist of one or more individuals as follows: licensed clinical social workers ("LCSW"), licensed mental health counselor, or licensed psychologists. The behavioral health therapist team member's activities must be limited to consultative or short-term transitional care. The therapist(s) must be knowledgeable of local behavioral health resources and work as a team with the care coordinator to match a specific youth/family with the most appropriate and available community resource.

(iii) Care Coordinator

The care coordinator supports the team members by coordinating and maintaining schedules, managing registration and billing of patients requiring face-to-face visits, arranging appointments with local behavioral health providers and oversees collection of any encounter data. The care coordinator must be in constant contact with the CHIP-MCOs.

The PCT will perform consultative services and provider outreach services as described below.

Consultation Services

The PCT will be available at all times between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding Provider's holidays), to PCPs and other designated providers in the Managed Care Program Zone to provide immediate consultations by telephone concerning children and adolescent behavioral health matters. In the event that PCT is unable to consult with the PCP at the time of the PCP's initial inquiry, the PCT shall respond to the PCP within thirty (30) minutes of PCP's initial inquiry call. The telephone consultation will result in one of the following outcomes dependent upon the needs of the PCP's patient and patient's family-

(1) Resolution of the PCP's inquiry to the satisfaction of the PCP;

(2) Referral to the PCT care coordinator to assist the family in accessing routine local behavioral health services with such referral stating the average anticipated wait time for visits;

(3) Referral to PCT's child psychiatrist for an acute psychopharmacological or diagnostic consultation within two (2) weeks or as agreed with the Enrollee's family; or

(4) Referral to the PCT's social worker to provide diagnostic consultation and/or transitional face-to-face care or telephonic support to the patient and family until the family can access routine local behavioral health services.

The PCT shall maintain an appropriate clinical setting for its staff to care for patients needing face-to-face consultative or transitional services.

The PCT shall maintain records on all consultations and maintain a single designated telephone number with paging ability or PCT person answering the telephone for PCPs to access consultation services.

For all encounters requiring the care coordinator to assist the family with access to routine local behavioral health services, the PCT will follow up with the family to ascertain whether the appointment was made and continue to assist the family as appropriate if the appointment was not made. The care coordinator will contact the CHIP-MCO to make it aware of any barriers to timely care.

The PCT will send to PCPs a written or electronic record of all face-to-face visits including results of any follow up contacts within 48 hours of the visit. The PCT is encouraged to provide verbal feedback to the PCP from all face-to-face visits requiring follow up. The PCT will also send to PCPs a written or electronic record of all telephonic care coordination encounters including results or any follow up contact within 48 hours of encounter.

The PCT will generate quarterly reports detailing the activity of participating PCPs and identifying which PCPs are not utilizing the service. The PCT will outreach to engage PCPs who are not utilizing the service. This may include but is not limited to outreach by telephone, e-mail, continuing education sessions, or visits to the office. The quarterly reports will detail the number of telephonic and face to face encounters participating PCPs have with Enrollees, the number of unique Enrollees using the service, the number of Enrollees referred for additional services with community BH providers, the number of Enrollees who showed up for referred services, and the number of unique Enrollees discussed with the CHIP-MCO.

Provider Outreach Services

The PCT will sequentially contact PCPs and other targeted prescribers of psychotropic medications in the Managed Care Program Zone to inform them of the PCT program and encourage them to participate. The PCT will provide PCPs in the Geographic Service Area with training and behavioral health continuing education at PCP offices on how to access and use the consultation program, orientation to community behavioral health services, and guidelines for prescribing and monitoring side effects of common psychotropic medications.

EXHIBIT N

CHIP-MCO GUIDELINES FOR ADVERTISING, SPONSORSHIPS, MARKETING AND OUTREACH

I. Overview

The CHIP-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with the guidelines outlined in this exhibit.

II. CHIP Outreach Procedures

CHIP-MCOs must adhere to the following guidelines and all the requirements specified in Section V.M, CHIP-MCO Outreach Materials and this Exhibit of the Agreement when submitting outreach and marketing materials, policies and procedures to the Department.

III. General Requirements

a. CHIP-MCOS may use CHIP Graphic Standards Manual, CHIP logos, additional camera-ready reproduction art, and electronic files available on the CHIP website for advertising, marketing and outreach materials.

b. The Department may impose monetary or restricted enrollment sanctions on a CHIP-MCO for the use of unapproved or prohibited outreach materials or practices.

c. The Department may suspend all marketing and outreach activities. If the MCO uses unapproved marketing and outreach materials/activities, the MCO reports administrative costs to the Department to ensure the Department did not pay for those costs.

d. All form and report templates are available on CHIP DocuShare site.

IV. CHIP-MCOs Required Activities

a. MCOs must:

i. Include the following statement on all marketing and outreach materials: Your managed care plan may not cover all your health care expenses. Read your member handbook carefully to determine which health care services are covered. The notice shall be followed by a telephone number to contact the CHIP MCO.

ii. Submit marketing and outreach materials, activities, and advertisements for review and written approval by the Department prior to production or distribution;

iii. Use the most up-to-date CHIP logo on all marketing and outreach materials;
- Follow the CHIP Graphic Standards Manual found at https://www.chipcoverspakids.com/chip-resources/Documents/etoolkit_graphics_standard_manual.pdf ;

iv. Display materials utilizing CHIP and the CHIP-MCO's name using the phrase, "CHIP, brought to you by _____";

v. Follow all applicable laws and regulations, including but not limited to the Electronic Transactions Act, 73 P.S. §§2260.101; 31 Pa. Code Ch. 146a; 31 Pa. Code Ch. 146b, and 42 CFR 457.1207, which incorporates 438.10(c)(6) when transmitting written materials electronically;

vi. Forward requests to the Department via the standard programmatic request process when implementing electronic transmissions in place of written materials;

vii. Distribute marketing materials throughout its entire services area;

viii. Create materials that comply with information requirements of the contract (as amended), the CHIP procedures handbook, and federal regulations.

V. CHIP-MCO OPTIONAL ACTIVITIES:

a. The CHIP-MCOs may:

i. Use agents and subcontractors in marketing and outreach activities, as long as the agents and subcontractor follow CMS regulations;

ii. Offer health related services to members within the CHIP-MCO network and feature expanded services in approved materials.

iii. Provide items of little or no intrinsic value at approved events. Items must not exceed $5.00 in retail value and cannot be associated with the CHIP-MCO's enrollment activity;

iv. Offer consumer incentives that directly relate 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. Additionally, the incentive cannot exceed the total cost of service; and

v. Use commonly accepted media advertising. These include television, radio, billboard, print, transportation, social media and the internet of quality initiatives, educational outreach and health-related materials and activities.

VI. CHIP-MCO Prohibited Activities

a. The CHIP-MCOs may not:

i. Distribute, directly or through any agent, outreach materials that contain false or misleading information;

ii. Use the Department's CIS or eCIS systems to identify and market to eligible children or enrollees enrolled with another CHIP-MCO;

iii. Sell or share a CHIP-MCO consumer list with other organizations;

iv. Directly or indirectly engage in door-to-door, telephone, email, texting or other cold-call marketing activities, which is defined as any unsolicited personal contact by the CHIP-MCO with a Potential Enrollee for purposes of marketing;

v. Issue charts which compare another CHIP-MCO to itself, which is disparaging to the other CHIP-MCO;

vi. Engage in any marketing activities associated with enrollment in counties where the CHIP-MCO does not have a Provider Network;

vii. Seek compensation from CHIP for marketing and outreach;

viii. Influence enrollment in conjunction with the sale or offering of any private insurance (this excludes Qualified Health Plans);

ix. Include any statement that an enrollee must enroll in the CHIP-MCO to obtain benefits or not lose benefits or that the CHIP-MCO is endorsed by CMS, the federal government or the Commonwealth.

VII. Written Materials

a. Written materials distributed to potential and existing enrollees must meet the following requirements:

i. Use easily understood language, no higher than a 6th grade level and format;

ii. Use a font size no smaller than twelve (12) point;

iii. Makes available in alternative formats and through auxiliary aids and services considering the needs of those with disability and LEP; and

iv. Include a tagline (no smaller than eighteen (18) point font) that contains information on how to request auxiliary aids and services, including the availability of alternate formats.

VIII. Limited English Proficiency (LEP) Requirements

i. The CHIP-MCO must identify enrollees who speak a language other than English as their first language.

ii. Upon an enrollee's request, the CHIP-MCO provides, at no cost to the enrollee, oral interpretation services in the requested language or sign language interpreter services to meet the enrollee's needs. Translation and interpretation services include all services by federal requirements for translation services.

iii. The CHIP-MCO makes all vital documents disseminated to English speaking enrollees available in alternative languages, upon request and at no cost to the enrollee. Vital documents are documents critical to obtaining services and include, but are not limited to:

1. Provider directories;

2. Enrollee handbooks;

3. Grievance and Complaint notices; and

4. Denial and termination notices.

iv. The CHIP-MCO includes appropriate instructions on all written materials about how to access or receive assistance with accessing desired materials in an alternate language. This information must also be posted on the CHIP-MCO's website.

v. The CHIP-MCO must include taglines on all written material in the prevalent non-English languages, as identified by the Department, and in a size no smaller than eighteen (18) point font that explain the availability of written translation or oral interpretation services and the toll free and TTY/TDY number of the CHIP-MCO.

IX. Alternate Format Requirements

i. The CHIP-MCO must provide alternative methods of communication for enrollees who are visually or hearing impaired, including Braille,

audio tapes, large print, compact disc, DVD, computer diskette, and/or electronic communication.

ii. Upon the request of the enrollee, the CHIP-MCO must make all written materials disseminated to enrollees accessible to visually impaired enrollees.

iii. The CHIP-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for enrollees who are deaf or hearing impaired, upon request.

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

X. FREQUENCY

The CHIP-MCO submits marketing, outreach materials, and activities requiring prior approval as soon as the MCO has the materials and activities available. Materials must be submitted a minimum of two (2) weeks prior to the marketing or outreach material usage for the review and approval.

The Department allows a minimum of ten (10) business days to begin the review. The Department has a minimum of thirty (30) days to review and approve. Programmatic Change submissions will be rejected if the MCO fails to respond to requests for additional information within 30 days.

XI. FORMAT

i. The MCO submits materials requiring prior approval via the Department's "MCO Report on Company or Programmatic Changes" form (PCF).

ii. All advertisements, including but not limited to the media identified above, are submitted to the Department for review and approval prior to production and again in final form.

iii. Television and radio advertisements are submitted via media file compatible with Windows Media Player.

iv. Advance notices regarding television and radio advertising media, including a brief description of the medium the MCO is using, are reported via the Department's "MCO Report on Company or Programmatic Changes" form (PCF), available on DocuShare.

v. The Department responds to an MCO's marketing and outreach approval requests via the CHIP Approval section on the submitted Programmatic Change form.

vi. Requests for prior approval and notices of marketing and outreach materials must be submitted via the Programmatic Change Form through the CHIP DocuShare portal.

XII. CHIP-MCO REPORTS ON MARKETING, OUTREACH AND ADVERTISING ACTIVITIES

A. Company and Programmatic Changes Report

i. The CHIP-MCO must submit a Company and Programmatic Changes report when operational or structured changes occur within the MCO's company; if there are changes in the MCO's key personnel, benefits/services, or service area; or the MCO has marketing/outreach materials that need approval.

ii. The Company and Programmatic Changes report is submitted when changes occur. However, changes imposed by the Department or state/federal mandates need not be reported on this form.

iii. The CHIP-MCO must submit the report in the format provided by the Department. No alternative format will be accepted.

B. INTENDED MARKETING AND OUTREACH SUMMARY

i. The Intended Marketing and Outreach Summary describes marketing and outreach activities planned for the upcoming quarter.

ii. In an effort to strengthen coordination between the Department's marketing and outreach activities with those of the CHIP-MCOs, CHIP-MCOs must report intended marketing and outreach activities to the Department on a quarterly basis.

iii. The Intended Marketing and Outreach Summary report must include any future marketing and outreach activities already planned for the quarter and an informal description of other marketing and outreach plans as of the submission date.

iv. The CHIP-MCO must issue a report that outline planned activities and non-activity (i.e.- did not conduct any planned activities in the quarter).

v. The report is issued on a quarterly basis.

vi. The MCO is required to use the report form provided to them by the Department.

vii. The MCO submits this report, designate planned/unplanned marketing and outreach activity, and provides an informal summary of planned activities to the marketing outreach coordinator through CHIP DocuShare.

viii. Where television, cable, or radio advertising is planned, the MCO must list the relevant station, channel, program, flight dates, and time period information, if available.

ix. The CHIP-MCO must submit the report even when no reportable activity is planned.

x. The Intended Marketing and Outreach Summary are submitted to the Department at the beginning of each quarter in accordance with the following schedule:

Quarter reporting on	**Dates quarter includes**	**Due Date**
First quarter	January 1-March 31	December 15
Second quarter	April 1-June 30	March 15
Third quarter	July 1-September 30	June 15
Fourth quarter	October 1-December 31	September 15

xi. If the due date occurs on a Saturday, Sunday or holiday, then the report is due by close of business on the first working day following the non-working day.

C. COMPLETED MARKETING AND OUTREACH ACTIVITY AND EXPENDITURE REPORT

i. To strengthen coordination between the Department's marketing and outreach activities with those of the CHIP-MCOs, CHIP-MCOs must report on a quarterly basis to the Department marketing and outreach activities that have occurred. This report itemizes all the quarter's completed marketing and outreach activities and corresponding expenditures.

ii. The CHIP-MCO must submit a quarterly notification of completed activity as well as non-activity using this report.

iii. MCOs must submit this report, designate completed/non-active marketing and outreach activity, and provide an informal summary, describing the highlights of the marketing and outreach activities for the completed quarter.

iv. The CHIP-MCO must use the report form prescribed by the Department.

v. The Completed Marketing and Outreach Activity and Expenditure Report must outline total expenditures by category, corresponding to the activities reported.

vi. MCOs report aggregate costs for each report category. The aggregate cost for materials is determined by multiplying each individual cost per item by the number of those items which were distributed or mailed during the quarter. MCOs may not report the aggregate cost for number of items merely taken to events. MCOs may not report the aggregate costs paid for materials during the quarter. MCOs may not include the costs of producing or mailing any materials related to contractual obligations.

vii. Completed Marketing and Outreach Activity and Expenditure Reports must submit to the Department two months after the quarter in accordance with the following schedule:

Quarter reporting on	**Dates quarter includes**	**Due date**
First quarter	January 1-March 31	May 31
Second quarter	April 1-June 30	August 31
Third quarter	July 1-September 30	November 30
Fourth quarter	October 1-December 31	February 28

viii. If the due date occurs on a Saturday, Sunday, or holiday, then the report is due by close of business on the first working day following the non-working day.

ix. The MCO is not required to submit a report for each marketing area or Managed Care Zone, but it is required to submit a Completed Marketing and Outreach Activity and Expenditure Report that designates for which marketing areas or Managed Care Zones there was activity and, if any, for which marketing areas or Managed Care Zones there was no activity.

EXHIBIT O

AUTOMATIC ASSIGNMENT

Any Enrollee who does not select a Children's Health Program -managed care organization (CHIP-MCO) and is enrolled into the Children's Health Insurance Program will be subject to the auto- assignment process as described below. The auto-assignment process does not negate the Enrollee's option to change his/her CHIP-MCO at any time. An Enrollee who has not made a CHIP-MCO selection and who has a case record that also includes another active member in the case with an active CHIP-MCO record will be assigned to that same CHIP-MCO. These Enrollees will not count toward the percentages designated for auto-assignment. Enrollees in a family unit will be assigned together to a CHIP-MCO. All remaining Enrollees, who have not voluntarily selected a CHIP-MCO, will be considered in the pool of Enrollees who will be equally auto-assigned to the active CHIP-MCOs in their county. The formula will direct an equal distribution of the auto-assignment pool in all Managed Care counties monthly based on the number of CHIP-MCOs in that county. For example, if there are five CHIP-MCOs in the county, each CHIP-MCO would receive 20%.

A. Enrollee Re-Assignment Following Resumption of Eligibility: Enrollees who lose eligibility and regain it within six (6) months will automatically be re-enrolled in their previously selected CHIP-MCO, as long as the Enrollee's eligibility status or geographical residence is still valid for participation in that same CHIP-MCO.

   If the Enrollee loses eligibility and regains it after six (6) months, s/he may be enrolled in the same CHIP-MCO as the payment name, the case payment name or any other Enrollee in the case that has an active CHIP-MCO record. If there is no active CHIP-MCO record in the case, s/he will automatically become enrolled in a CHIP-MCO through the automatic assignment process.

   Prior to the future begin date for the auto-assigned CHIP-MCO, the Enrollee may select a different CHIP-MCO and override the auto-assigned CHIP-MCO by contacting the EAP Contractor. When the Consumer contacts the EAP Contractor to make this change, it will be the EAP Contractor's responsibility to enroll the Enrollee in the CHIP-MCO of his/her choice. The EAP Contractor will process the enrollment into the new CHIP-MCO through the weekly enrollment process.

B. Continuing Enrollment When Moving Between Zones: Eligible Enrollees who move from one Managed Care Program Zone to another will remain in the CHIP-MCO in which they were enrolled prior to their move, if the CHIP-MCO is also operational in the Zone to which they move.

The Department reserves the right to reassess the distribution process and to modify it in accordance with sound programmatic management principles. The Department shall institute such modifications at any time following appropriate notification to the CHIP-MCOs via executive correspondence.

EXHIBIT P

MANAGED CARE DEFINITIONS FOR MEMBER COMMUNICATIONS

The 2016 CMS "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability" final rule established a requirement (42 CFR § 457.1207 referencing 438.10(c)(4)(i)) that mandated that all states which contract with MCOs for delivery of Medicaid and CHIP services must develop standardized definitions for a set of managed care related terms to be utilized by MCOs in communications with Enrollees. The state developed definitions were required to be written at no higher than a sixth grade reading level and are to be utilized by CHIP-MCOs for communications with Enrollees such as newsletters, informational pamphlets, Enrollee handbooks, etc.

When using any of the terms below in communications to Enrollees, CHIP-MCOs must utilize the terms with the same intent as defined by the state.

Managed Care Definitions

1) **Appeal-** To file a Complaint, Grievance, or request an external review or DHS Fair Hearing.

2) **Complaint**- When a Member tells an MCO that he or she is unhappy with the MCO or his or her provider or does not agree with a decision by the MCO.

3) **Co-Payment-** A co-payment is the amount an Enrollee pays for some covered services. It is usually only a small amount.

4) **Durable Medical Equipment**- A medical item or device that can be used in an Enrollee home or in any setting where normal life activities occur and is generally not used unless a person has an illness or injury.

5) **Emergency Medical Condition**- 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.

6) **Emergency Medical Transportation**- Transportation by an ambulance for an emergency medical condition.

7) **Emergency Room Care**- Services needed to treat or evaluate an emergency medical condition in an emergency room.

8) **Emergency Services**- Services needed to treat or evaluate an emergency medical condition.

9) **Excluded Services**- Term should not be used. MCO should use "Services That Are Not Covered" instead.

10) **Grievance**- When an Enrollee tells an MCO that he or she disagrees with an MCO's decision to deny, decrease, or approve a service or item different than the service or item the Enrollee requested because it is not medically necessary.

11) **Habilitation Services and Devices**- Term should not be used by MCO. MCO should define specific service.

12) **Health Insurance**- A type of insurance coverage that pays for certain health care services. (If used by MCO, should be used to refer only to private insurance.)

13) **Home Health Care**- Home health care is care provided in an Enrollee's home and includes skilled nursing services; help with activities of daily living such as bathing, dressing, and eating; and physical, speech, and occupational therapy.

14) **Hospice Services**- Home and inpatient care that provides treatment for terminally ill Enrollees to manage pain and physical symptoms and provide supportive care to Enrollees and their families.

15) **Hospitalization-** Care in a hospital that requires admission as an inpatient.

16) **Hospital Outpatient Care**- Care provided by a hospital or hospital-based clinic that does not require admission to the hospital.

17) **Medically Necessary**- A service, item, or medicine that does one of the following:

- Will, or is reasonably expected to, prevent an illness, condition, or disability;
- Will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;
- Will help an enrollee] get or keep the ability to perform daily tasks, taking into consideration both the Enrollee's abilities and the abilities of someone of the same age.

18) **Network**- Contracted providers, facilities, and suppliers that provide covered services to MCO Enrollee.

19) **Network Provider**- A provider, facility, or supplier that has a contract with an MCO to provide services to an enrollee

20) **Non-Participating Provider**- When referring to a provider that is not in the network, MCOs should use the term "Out-of-Network Provider."

21) **Out-of-Network Provider**- A provider that does not have a contract with an MCO to provide services to enrollees.

22) **Physician Services**- Health care services provided or directed by a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

23) **Plan**- A health care organization that provides or pays for the cost of services or supplies.
24) **Preauthorization or Prior Authorization**- Approval of a service or item before an enrollee receives the service or item.

25) **Participating Provider**- When referring to a provider that is in the network, MCOs should use “Network Provider.”

26) **Premium**- The amount an Enrollee pays for health care coverage.

25) **Prescription Drug Coverage** - A benefit that pays for prescribed drugs or medications.

26) **Prescription Drugs**- Drugs or medications that require a prescription for coverage.

27) **Primary Care Physician**- A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

28) **Primary Care Provider**- A doctor, doctors’ group, or certified registered nurse practitioner who provides and works with an Enrollee’s other health care providers to make sure the Enrollee gets the health care services the Enrollee needs.

29) **Provider**- An individual or entity that delivers health care services or supplies.

30) **Rehabilitative Services and Devices**- Term should not be used by MCO. MCO should define specific service.

31) **Skilled Nursing Care**- Services provided by a licensed nurse.

32) **Specialist**- A doctor, a doctor’s group, or a certified registered nurse practitioner who focuses his or her practice on treating one disease or medical condition or a specific part of the body.

33) **Urgent Care**- Care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition.

EXHIBIT Q

CHIP-MCO Model Enrollee HANDBOOK

A. The CHIP-MCO must ensure that the Enrollee handbook contains written information regarding Enrollee rights and protections and is written at no higher than a sixth grade reading level. The CHIP-MCO must provide an Enrollee handbook in the appropriate prevalent language, or alternate format, to all members within five (5) business days of being notified of an Enrollee's enrollment, but no sooner than five (5) business days before the enrollee's effective date of enrollment. The CHIP-MCO may provide the Member handbook in formats other than hard copy. If this option is exercised, the CHIP-MCO must inform Enrollees what formats are available and how to access each. Upon request, the CHIP-MCO must provide a hard copy version of the Enrollee handbook to the Enrollee.

B. In compliance with 42 CFR § 457.127 referencing § 438.10(g), the content of the Enrollee handbook must include information that enables the member to understand how to effectively use the managed care program. At a minimum, the Enrollee handbook shall include:

1. Benefits provided by the CHIP-MCO.

2. How and where to access benefits provided by the Department, including any cost sharing.

    a. In the case of a counseling or referral service that the CHIP-MCO does not cover because of moral or religious objections, the CHIP-MCO must inform Enrollees that the service is not covered by the CHIP-MCO and provide information to Enrollees about how to access the services

3. The amount, duration, and scope of benefits available in sufficient detail to ensure that Enrollees 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 Enrollee'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 Enrollee has a right to use any hospital or other setting

for emergency care.

6. Any restrictions on the Enrollees freedom of choice among network providers.

7. The extent to which, and how, Enrollees may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the CHIP-MCO cannot require an Enrollee 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 CFR § 457.1220 referencing §438.100.

10. The process of selecting and changing the Enrollee's PCP.

11. Grievance, appeal, external review and fair hearing procedures and timeframes, consistent with 42 CFR §§ §§ 457.1120 – 457.1180 and 457.1260, in a DHS-developed or DHS-approved description. Such information must include:

    a. The right to file complaints, grievances and appeals.

    b. The requirements and timeframes for filing a complaint, grievance or appeal.

    c. The availability of assistance in the filing process.

    d. The right to request an External Review or DHS fair hearing after the CHIP-MCO has made a determination on an Enrollee's appeal which is adverse to the Enrollee.

    e. The fact that, when requested by the Enrollee, eligibility that the CHIP-MCO seeks to terminate for failure to pay, or seeks to increase premiums payments, will continue if the Enrollee files an appeal or a request for a DHS fair hearing within the timeframes specified for filing, and that the Enrollee may, consistent with DHS policy, be required to pay the premium costs accrued while the appeal of DHS fair hearing is pending if the final decision is adverse to the Enrollee. The Enrollee may choose to disenroll from the CHIP-MCO back to the original termination date if the outcome of the DHS Fair Hearing is adverse to the Enrollee. The Enrollee would then be responsible for payments to providers for services rendered during the disenrollment period.

12. How to access auxiliary aids and services, including additional information in alternative formats or languages.

13. The toll-free telephone number for member services, medical management, and any other unit providing services directly to Members.

14. Information on how to report suspected fraud or abuse.

15. Any other content required by DHS.

C. Information required by this exhibit to be provided by the CHIP-MCO will be considered to be provided if the CHIP-MCO:

1. Mails a printed copy of the information to the Enrollee's mailing address;

2. Provides the information by email after obtaining the Enrollee's agreement to receive the information by email;

3. Posts the information on the Web site of the CHIP-MCO and advises the Enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that Enrollees 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 Enrollee receiving that information.

D. In compliance with 42 CFR § 457.1207 referencing 438.10(c)(4)(ii), the CHIP-MCO is required to use the Enrollee handbook template provided within this exhibit. The CHIP-MCO must make modifications in the language contained in the Enrollee Handbook if ordered by the Department so as to comply with the requirements described in Section V.Q and Exhibit Q of this Agreement.

CHIP 2023 Model Enrollee Handbook

[MCO – add cover sheet and taglines page]

Table of Contents

Topic **Page [MCO to Complete]**

Section 3 – Health Services

Section 4 – Out-of-Network and Out-of-Plan Services

Section 5 – Special Needs and [Case/Care/Disease] Management

Section 6 – Complaints, Grievances, and External Review

Section – 1

Welcome

Introduction

What is CHIP?

CHIP is a state and federally funded program that provides comprehensive health insurance to children up to 19 years of age. Our enrollees have a wide range of benefits available to them through the CHIP program.

Welcome to [MCO Name]

Thank you for enrolling your child in the Children's Health Insurance Program (CHIP) brought to you by ***[MCO Name].*** **[MCO to provide a brief description of plan.] [MCO Name]** has a network of contracted providers, facilities, and suppliers to provide covered health services to enrollees. **[MCO to provide explanation of the need/importance to get services from network providers.]**

Enrollee Services

Staff at Enrollee Services can help you with:

[MCO to provide list and description of things that Enrollee Services can help with and services offered.]

[MCO Name]'s Enrollee Services are available:

[MCO to provide hours of operation]

And can be reached at **[MCO Enrollee Services Phone Number and TTY].**

Enrollee Services can also be contacted in writing at:

[MCO address]

And

[MCO to provide any additional means of contact (email, website, etc.)]

Enrollee Identification Cards

[MCO to provide description of enrollee 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 enrollee is receiving will continue and all services will continue to be available while the enrollee waits for a new card to be delivered.]

Until you get your new or replacement **[MCO Name]** ID card, **[MCO to explain how to continue to receive services in the case of card loss.]**

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 Enrollee Services for help: **[MCO Enrollee Services Phone Number and TTY]**.

Emergencies

Please see Section 3, Covered Services, beginning on page **[xx],** for more information about emergency services. If you have an emergency, you can get help by calling the nearest emergency department, calling 911, or contacting 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		
Office of CHIP	1-800-986-KIDS (5437) www.chipcoverspakids.com	Unresolved issues
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 CHIP 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 enrollee or provider fraud or abuse in the CHIP program. See page **[page]** of this handbook for more information.
Other Important Phone Numbers		
[MCO Name Nurse Hotline or MCO equivalent]	**[MCO Name Nurse Hotline or MCO Equivalent 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.

Insurance Department; Bureau of Consumer Services	1-877-881-6388	Ask for a complaint form, file a complaint, or talk with a consumer services representative.
[MCO's Behavioral Health subcontractor/unit]	**[MCO's Behavioral Health subcontractor/unit Phone Number or other contact information]**	**[MCO explain why/when to contact]**
[MCO's Vision subcontractor/unit]	**[MCO's Vision subcontractor/unit Phone Number or other contact information]**	**[MCO explain why/when to contact]**
[MCO's Dental Subcontractor/unit]	**[MCO's Dental Subcontractor/unit Phone Number or contact information]**	**[MCO explain why/when to contact]**
[MCO to add other important contact information, for example, case management, as appropriate]		

Other Phone Numbers

[MCO to provide list of relevant phone numbers in counties of operation here or refer 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
Crisis Intervention Services	**[MCO to provide]**
Legal Aid	**[MCO to provide]**
Mental Health/Intellectual Disability Services	**[MCO to provide]**
National Suicide Prevention Lifeline	1-800-273-8255
Women, Infants, and Children Program (WIC)	1-800-942-9467
Domestic Violence Hotline	**[MCO to provide]**

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 necessary, at no cost to you. Please contact Enrollee Services at **[MCO Enrollee Services Phone Number and**

TTY] to ask for any help you need. Depending on the information you need, it may take up to five (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 Enrollee Services at **[MCO Enrollee Services Phone Number]** and Enrollee 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 Enrollee 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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]** if you need an interpreter for an appointment.

Enrollment

In order to qualify for health insurance coverage under the CHIP program, your child must be:

- Under 19 years of age
- A resident of Pennsylvania
- A U.S. citizen, U.S. national, or lawfully present immigrant
- Uninsured (not covered by any other health insurance coverage)
- Not eligible for Medical Assistance (Medicaid)

You must meet the guidelines based on household size and income **(provide link to income/family size information).** Most families can receive CHIP coverage for free. Others can get the same benefits at a low cost, depending on household size and income. You will receive CHIP coverage for a twelve (12) month enrollment period unless one of the situations under the “loss of benefit” section occur.

[MCO to add enrollment information as necessary.]

Renewal

CHIP coverage must be renewed at the end of the twelve (12) month period of enrollment. A child’s coverage maybe renewed, if eligible, every twelve (12) months until the child reaches the age of 19.

A renewal is just a review of the family situation. You will only be requested to verify the household income unless other household factors have changed and require verification.

At one hundred-twenty (120) calendar days before the end of the twelve (12) month enrolment period, a reminder notice will be sent to you. This notice will explain that **[MCO Name]** will try to perform the renewal with electronic verification sources, as well as notifying you that you should report any relevant changes to **[MCO Name]**.

If **[MCO Name]** is unable to perform the renewal with electronic verification sources, notices well be sent to you at ninety (90) and sixty (60) calendar days prior to the end of the twelve (12) month enrollment period. These notices will include pre-populated renewal forms as well as a postage-paid envelope. You must provide the renewal form and verifications prior to the end of the twelve (12) month enrollment period.

It is important you follow instructions so that your CHIP coverage does not end. If you have questions about any paperwork you get or are unsure whether your eligibility for CHIP is up-to-date, call **[MCO Name]** Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]** or the office of CHIP at 1-800-986-KIDS (5437).

Changing Your CHIP MCO

You may change your CHIP plan at any time, for any reason. To change your CHIP plan, call **[MCO]** at **[MCO's phone number]**. They will tell you when the change to your new CHIP plan will start, and you will stay in **[MCO Name]** until then. It can take up to six (6) weeks for a change to your CHIP plan to take effect. Use your **[MCO Name]** ID card at your appointments until your new plan starts.

Changes in the Household

Call **[MCO Name]** Enrollee Services at **[MCO Enrollee 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 CHIP plan for the first thirty-one (31) days. There will then be a review for Medical Assistance.

What Should I Do if I Move?

If you move out of your county, you may need to choose a new CHIP plan. Contact **[MCO]** 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, **[MCO Name]** will help you transfer to a new MCO for your new county.

If you move out-of-state, you will no longer be eligible to receive services through Pennsylvania CHIP. Contact **[MCO Name]** if you move out of the state. **[MCO Name]**

will end your benefits in Pennsylvania. You will need to apply for benefits in your new state.

Loss of Benefits

If your CHIP coverage ends for any reason, but you become eligible again within six (6) months, you will be re-enrolled in the same insurance company. You may choose a different MCO at any time.

There are a few reasons why you may lose your benefits, even during the twelve (12) month enrollment period.

They include:

- You become eligible for certain other credible medical insurance coverage (including Medical Assistance, certain employer insurances, etc.).
- You are not paying your premium (if you are required to pay a premium).
- You do not complete a renewal.
- You obtain other credible medical insurance coverage.
- You enter a nursing home outside of Pennsylvania.
- You commit CHIP fraud and exhaust all appeals.
- You go to prison.
- Your child is placed in a Youth Development Center.
- You terminate your coverage voluntarily.
- Your child reaches 19 years of age.
- Your child is deceased.
- Your child moves out-of-state.
- Your child moves out of the county.
- Your child is a prison inmate or a patient in a public institution for behavioral diseases.
- Misinformation was provided at the time of application or renewal that would have resulted in a determination of ineligibility.
- There is misuse of your child(ren)'s ID card(s).
- Your mail has been returned.

Provider Directory Information

[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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]** to ask that a copy of the provider directory be sent to you or to request information about a doctor's medical school or residency program. You may also call to get help finding a provider. The provider directory includes the following information about network providers:

- Name, address, website address, email address, and telephone number.

- Whether or not the provider is accepting new patients.
- Days and hours of operation.
- Credentials and board certifications of the provider.
- Specialty of 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 Enrollee 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 the specialists you need and keeps track of the care you receive by all of your providers.

A PCP may be a family doctor, a general practice doctor, a pediatrician, 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.

All enrolled children must have a PCP. You have ten (10) days from the receipt of your notice of enrollment letter to select a PCP. If you do not select a PCP, **[MCO Name]** will assign a PCP for your child.
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 special medical 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.

[MCO to provide any additional PCP information needed]

Changing Your PCP

If you want to change your PCP for any reason, call Enrollee Services at **[MCO Enrollee 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 Enrollee Services to send you a printed provider directory.

[MCO add this paragraph only if your cards do include PCP name and phone number] [MCO Name] will send you a new ID card with the new PCP's name and phone number on it. The Enrollee 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 Family Practice services at any time.

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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]**.

If you do not have your **[MCO Name]** ID card by the time of your appointment, you should also tell your PCP that you selected **[MCO Name]** as your CHIP plan.

Appointment Standards

[MCO Name]'s providers must meet the following appointment standards:

- Your PCP should see you within ten (10) business days of when you call for a routine appointment.
- You should not have to wait in the waiting room longer than thirty (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 ten (10) business days of **[MCO Name]** learning you are pregnant.
    - In your second trimester, your provider must see you within five (5) business days of **[MCO Name]** learning you are pregnant.
    - In your third trimester, your provider must see you within four (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 doctors' group) or a CRNP who focuses their practice on treating one disease, medical condition, or 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]** only has one or two specialists in your area, and you do not want to see either specialist, **[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 Enrollee 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 services. You must use a **[MCO Name]** network provider unless **[MCO Name]** approves an out-of-network provider.

Services that do not need a referral include:

- Prenatal visits.
- Routine obstetric (OB) care.
- Routine gynecological (GYN) care.
- Routine family planning services (may see out-of-network provider).
- Routine dental services.
- Routine eye exams.
- Emergency services.
- Specialist services.
- Surgical consultation.
- **[MCO to add additional services as appropriate.]**

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 3 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 **[MCO Nurse Hotline or MCO equivalent name]** at **[MCO Nurse Hotline or MCO equivalent 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.

Enrollee Engagement

Suggesting Changes to Policies and Services

[MCO Name] would like to hear from you about ways to make your experience with CHIP better. If you have suggestions for how to make the program better or how to deliver services differently, please contact **[MCO Contact].**

[MCO Name] Quality Improvement Program

[MCO to provide description of their quality improvement program including any necessary contact information.]

Section – 2

Rights and Responsibilities

Enrollee Rights and Responsibilities

[MCO Name] and its network of providers do not discriminate against enrollees based on race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, CHIP status, income status, program participation, health status, disease or pre-existing condition, anticipated need for healthcare, or physical or mental disability, except where medically indicated.

As a **[MCO Name]** enrollee, you have the following rights and responsibilities.

Enrollee Rights

You have the right to:

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 you can easily understand and receive help when you need it.
3. To get information 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 you want to treat you.
5. To receive emergency services when you need them from any provider without **[MCO Name]**'s approval.
6. To get information you can easily understand and talk to your providers about your treatment options, risks of treatment, alternative therapies, and consultation or tests that may be self-administered without any interference from **[MCO Name]** regardless of cost or benefit coverage.
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 medical 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 External Review.
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 receive information about services that **[MCO Name]** or a provider does not cover because of moral or religious objections and about how to obtain those services.
16. To exercise your rights without it negatively affecting the way DHS, **[MCO Name]**, and network providers treat you.

17. To make recommendations about the rights and responsibilities of **[MCO name]'s** enrollees.

Enrollee Responsibilities

Enrollees are asked to work with their health care service providers. **[MCO Name]** needs your help so that you get the services and supports you need.

You have the responsibility to:

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. You may have to pay if you do not use in-network providers.
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]**.

Your Costs for Covered Services

Premiums

Premiums are the regularly scheduled monthly payments you pay to **[MCO Name]** for CHIP coverage. **There are no premiums for enrollees with Free CHIP coverage.** If your child is enrolled in Low-cost or Full-cost CHIP, each month you will receive a bill for the following month's premium. You will receive notice from **[MCO Name]** of any change in your monthly premium payment thirty (30) days before the change takes place.

If your child is terminated due to non-payment of premiums, you may opt to have the

child re-enrolled within ninety (90) days. Any unpaid premiums must be paid before your child can be re-enrolled. If you wait longer than 90 days, you will need to complete a new application.

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 receive 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.

Enrollees in the free program do not have to pay co-payments.

The following services do not require a co-payment:

- Well-child PCP visit.
- Outpatient medical therapy.
- Inpatient facility stays.
- Inpatient/outpatient behavioral health visit for mental health or substance abuse.
- Routine dental care.
- Routine vision care.
- Emergency services.
- Laboratory services.
- Family planning services, including supplies.
- Hospice services.
- Home health 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 you believe you should not have had to pay, you can file a complaint with **[MCO Name]**. Please see Section 6, Complaints, Grievances, and External Review for information on how to file a Complaint, Grievance, or External Review or call Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]**.

Dental Costs

Except in the case of an emergency, for a dental benefit to be completely covered by CHIP, dental care must be provided by a dentist who is an in-network **(MCO or MCO Dental Subcontractor)** provider. Covered dental benefits provided by a network provider and approved by **(MCO or MCO Dental Subcontractor)** will have no out of pocket costs.

Some out-of-network dental providers will expect payment in full for services at the time of the visit. In this case, it will be your responsibility to pay the bill and then submit the bill to **(MCO or MCO Dental Subcontractor)** to request reimbursement. You will be sent a check for the allowed amount of the covered services your child received. This check may be less than the amount you paid the out-of-network dentist.

In a case involving a covered service in which the dentist, the enrollee, or the enrollee's parent selects a more expensive course of treatment than is customarily provided for the dental condition, payment under this benefit will be based on the charge allowance for the lesser procedure. In this case, the parent is responsible to pay the difference between the charge of the actual service rendered and the amount received from **(MCO or MCO Dental Subcontractor).**

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]**, 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]**, the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- Your child received a service from a provider who is not enrolled with the Commonwealth.
- Your child goes over a benefit limit on a service.
- Your child receives a medical service that is not a covered benefit.

Out-of-network providers are not allowed to bill enrollees for services above and beyond **[MCO Name]**'s agreed upon reimbursement rate. This means that, other than in the above circumstances, you should not receive a bill from an out-of-network provider. If you do receive a bill from an out-of-network provider, call Enrollee Services at **[Enrollee Services' Phone Number]** immediately so the situation can be resolved as soon as possible.

Providers in **[MCO Name]**'s network may not bill you for 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.

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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]**.

[MCO may add additional steps it would like enrollees 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

CHIP Enrollees are not allowed to have any other creditable medical insurance coverage in addition to CHIP, but occasionally there are times when some of your child's healthcare bills may be covered by a different policy other than CHIP. An example of when this might happen is when an enrollee is involved in a motor vehicle accident, and some of the cost of his or her medical care is covered by the automobile insurance policy. This is called subrogation. If your child is injured or ill as a result of an accident and another insurance policy is involved, call **[MCO name]** and inform them of the situation.

Reporting Fraud or Abuse

How Do I Report Enrollee Fraud or Abuse?

If you think that someone is using your or another enrollee's **[MCO Name]** card to obtain services, equipment, or medicines, is forging or changing their prescriptions, or is getting services they do not need, you should 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 receive 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 –

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, 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.

[MCO to complete table, including additional services that MCO covers]

Service		Free	Subsidized	Full
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			

Service		Free	Subsidized	Full
	Prior Authorization / Referral			
Hospice Care	Limit			
	Co-payment			
	Prior Authorization / Referral			
Dental Care Services	Limit			
	Co-payment			
	Prior Authorization / Referral			
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			

Service		Free	Subsidized	Full
	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			
Nursing Facility Services	Limit			
	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			

Service		Free	Subsidized	Full
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			

[MCO to add any additional information as necessary]

Services That Are Not Covered

Listed below are the 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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]**.

- Experimental medical procedures, medicines, and equipment
- Non-medically necessary services
- **[MCO to provide list of other services not covered.]**

This is not an all-inclusive list.

Second Opinions

You have the right to ask for a second opinion if you are unsure 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 of 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 Enrollee Services at **[MCO**

Enrollee Services Phone Number and TTY].

[MCO to add additional 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 Enrollee Services at **[MCO Enrollee 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 or your provider is unsure about whether a service, item, or medicine requires prior authorization, call Enrollee Services at **[MCO Enrollee 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 two (2) business days of the date **[MCO Name]** received the request as long as **[MCO Name]** has been given 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 forty-eight (48) hours of receiving the request that we need more information to decide the request and allow fourteen (14) days for the provider to give us more information. **[MCO Name]** will tell you of our decision within two (2) business

days after **[MCO Name]** receives the additional information.

You and your provider will receive a written notice telling you if the request was approved or denied and, if it was denied, the reason it was denied.

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 receive a written notice telling you if the request was 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 may cause harm to 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 are issued a denial notice from **[MCO Name]** ten (10) days before your prescription ends telling you 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 Complaint or a Grievance. 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 unless the pharmacist thinks the medicine will harm you. See Section 6, Complaints, Grievances, and External Review, starting on page **[xx]** 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 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 request a PE, **[MCO to add information on how to request a PE]**

[MCO to add additional information as necessary]

Service Descriptions

Service descriptions listed in the Handbook are taken from the Pennsylvania State Plan. The Pennsylvania State Plan lists all the services available to CHIP enrollees and is subject to change. For more information about services covered by CHIP, please contact your MCO.

Autism Related Services: Covers medically necessary services included on an autism treatment plan developed by a physician or licensed psychologist. Coverage includes evaluations and tests performed to diagnose autism disorder, services of a psychologist/psychiatrist, rehabilitative care including applied behavioral analysis, speech/language, occupational, and physical therapy, and prescription and over-the-counter drug coverage. Enrollees are eligible to use the expedited appeals process defined in Act 62 for autism related complaints and grievances. To provide your child with the best possible autism related services, you should contact [MCO Name] Enrollee Services at _and ask to speak with a Case Manager. You may also visit the Department of Human Services Autism website at www.PAautism.org for more information about autism and Act 62.

Behavioral Health: includes mental health and substance use disorder services treatment. Further information is on page **[XX]**.

Chiropractic Services: Includes spinal manipulations or of other body parts as treatment of diagnosed musculoskeletal conditions. Consultations and x-rays are included.

Preauthorization may be required. Limit to 20 visits per year.

Diabetic Treatment, Equipment, and Supplies: See Disposable Medical Supplies.

Dental Care (Emergency, Preventive, and Routine): Services include diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral and maxillary surgery, orthodontic, and adjunctive dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions as mandated by law. Cosmetic related services are not covered. Covered services are listed in the CHIP Dental Benefits Plan.

Further information for the dental coverage will be on page **[xx].**

Disposable Medical Supplies: Includes ostomy supplies and urological supplies deemed medically necessary. No limits apply.

Diabetic treatment, equipment and supplies includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, and outpatient management training and education. Physicians order required.

Medical foods include medical foods and prescribed nutritional formulas used to treat Phenylketonuria (PKU) and related disorders given orally or by tube feeding. No limits apply.

Some of these items need prior authorization, and your PCP or other provider must order them. No limits apply.

Durable Medical Equipment (DME): Equipment designed to serve a medical purpose for a medical condition, is intended for repeated use, and is not disposable, and is appropriate for home or school use. May require prior authorization.

Emergency Transportation: Transportation by land, air, or water ambulance rendered in response to an emergency. Emergency transportation must be medically necessary.

Emergency services: Services provided for a sudden onset of a medical condition that is accompanied by a rapidly progressing symptoms such that enrollee would suffer serious impairment or loss of function of a body part or organ, or whose life or life of an unborn child would be in danger.

Family Planning Services: These services include Included, but is not limited to, birth control pills, injectables, transdermal (patches) and insertion and implantation of contraceptive devices approved by the FDA, voluntary sterilization and counseling. Abortifacient drugs are not covered.

Gender Transition: These services include coverage related to gender affirming services that otherwise fall within the beneficiary's scope of covered services including physician services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies, and behavioral health care. Medical necessity is to be determined utilizing the World Professional Association for Transgender Health (WPATH) guidelines and any successor to WPATH guidelines.

Services provided for a sudden onset of a medical condition that is accompanied by rapidly progressing symptoms such that the member would suffer serious impairment or loss of function of a body part or organ, or whose life or life of an unborn child would be in in danger. No limits apply.

Hearing care: Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary. Payment limited to one routine hearing examination and one audiometric examination per calendar year.

Includes the cost of examinations and one hearing aid or device per ear every two calendar years.

Home and Community-based Health Care services: Covered for homebound patients, including nursing care, home health aide services, oxygen, medical and surgical supplies and home infusion therapy. Home infusion therapy does not include

blood or blood products. Private duty nursing and custodial services are not covered. No copays apply. No visit limitations.

Hospice Care: Care for a member who is suffering from a terminal illness. Respite care is also included. Requires a certification by a physician stating that the member has a terminal illness. There are no day limits. Members receiving hospice care may still receive care for other illnesses and conditions.

Immunizations: Coverage will be provided for pediatric immunizations (except those required for employment or travel), including immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Pediatric and adult immunization schedules may be found by accessing the following link: http://www.cdc.gov/vaccines/rec/schedules/default.htm.

Influenza vaccines can be administered by a participation pharmacy for enrollees starting at the age of nine years old, with parental consent, according to PA Act 8 of 2015. No copays.

Injections and Medications: Includes all injections and medications provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital, or freestanding ambulatory service center. Includes immunizations as described in this benefits package and anesthesia services when performed in conjunction with covered services, including emergency services. Must be medically necessary.

Inpatient Mental Health Services: Includes services furnished in a state-operated mental hospital, residential facility, or other 24-hour therapeutically structured services. Covers medical care including psychiatric visits and consultations, nursing care, group and individual counseling, and therapeutic services, and concurrent care and services normally provided relating to inpatient hospitalization. Members may self-refer. No day limits apply.

Inpatient Hospitalization: Includes pre-admission testing, semi-private room unless private room is medically necessary, board, general nursing care, intensive or special care facilities, or and related facilities, anesthesia, oxygen, therapy services, and any other services normally provided with inpatient care. Covered services include inpatient therapy up to 45 visits per calendar year for treatment of CVA, head injury, spinal cord injury, or as a result of a post-operative brain surgery. No day limits apply. Preauthorization required for non-emergency services.

Inpatient rehabilitation stays are covered when an enrollee requires skilled rehabilitation daily. Requires a physician's prescription. No day limits apply.

Inpatient Substance Use Disorder Services: Services provided in a hospital or an inpatient non- hospital facility that meets the requirements established by the

Department of Health and is licensed as an alcohol/drug addiction treatment program. Covers detoxification stays, services of physicians, psychologists, psychiatrists, counselors, trained staff, laboratory and psychological/psychiatric testing, individual and family therapy and interventions and medication management and services normally provided to inpatients. No day limits apply. Treatment for tobacco use cessation is not included.

Maternity care: 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. Further information can be found on page **[XX]**.

Maternity home care visit: Included at least one (1) visit provided at their home when the CHIP member is released prior to 48 hours of inpatient care following a vaginal delivery or 96 hours following a Cesarean delivery, or in the case of a newborn, in consultation with the mother or the newborn's representative.

Medical Foods: See Disposable Medical Supplies.

Newborn Care: Includes the provision of benefits for a newborn child of an enrollee for a period of thirty-one (31) days following birth. Includes routine nursery care, prematurity services, preventive/ well-child health care services, newborn hearing screens, and coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Organ Transplants: Includes transplants that are medically necessary and not considered to be experimental or investigative for a recipient who is an enrollee and services related to inpatient care related to the transplant. This benefit also includes immunosuppressants.

Orthotic Devices: Includes the purchase, fitting, necessary adjustment, repairs, and replacement of a rigid or semi-rigid device designed to support, align, or correct bone and muscle injuries or deformities. Replacements are covered only when the replacement is deemed medically necessary and appropriate and due to the normal growth of the child.

Osteoporosis Screening: Coverage is provided for bone mineral density testing using a U.S. FDA approved method. Requires a prescription from a legally licensed provider.

Outpatient Mental Health Services: Includes partial hospitalization and intensive outpatient mental health services, psychological testing, visits with outpatient mental health providers, individual, group, and family counseling, targeted mental health case management and medication management. No day limits apply.

Outpatient Habilitation Services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and

occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of outpatient settings. Covered services are limited to 30 visits per calendar years for physical therapy, 60 visits per calendar year for occupational therapy, and 60 visits per calendar year for speech therapy, for a combined visit limit of 180 days per calendar year.

Outpatient Hospital Services: Includes medical services, nursing, counseling or therapeutic treatment, or supplies received from an approved health care facility while not an inpatient. Outpatient physical health services related to ambulatory surgery, outpatient hospitalization, specialist office visits, follow up visits or sick visits with a PCP are included.

Outpatient Medical Services: Includes chemotherapy, dialysis, radiation treatments, and respiratory therapy when the enrollee has a documented diagnosis which necessitates the prescribed therapy. There is no limit on number of visits.

Outpatient Rehabilitative Therapy Services: Speech, occupational, and physical therapy to regain lost skills. Enrollees must have a documented diagnosis that indicates the prescribed therapy is medically necessary. Limited to 60 visits per for each type of therapy per calendar year.

Outpatient Substance Use Disorder Services: Services provided in a facility licensed by the Department of Health as an alcohol/drug addiction treatment program. Covers services of physicians, psychologists, psychiatrists, counselors, trained staff, laboratory and psychological/psychiatric testing, individual and family therapy. No limit on number of visits. Treatment for tobacco use cessation is not covered.

Physician Office Services: Includes visits for the examination, diagnosis and treatment of an illness or injury at the enrollee's PCP's office, during and after regular office hours, emergency visits, house-calls in the physician's service area, and telehealth services. Coverage includes medical care at a Retail Health Clinic staffed by a Certified Registered Nurse Practitioner (CRNP) supported by a local physician who is on-call during clinic hours or at an Urgent Care Center.

Remember that you may contact your child's PCP 24 hours a day, 7 days a week, if your child becomes ill and you need a doctor's advice. Your child's PCP can provide many of the healthcare services your child needs including:

- Preventive and well-child visits and services including immunizations
- Physical examinations and routine diagnostic tests
- Oral health risk assessment and fluoride varnish for children ages five (5) months to five (5) years old
- Blood lead testing
- Sick and urgent care office visits including those that occur after normal office hours when medically necessary
- Follow up care after emergency services

- Woman's health services and family planning services (see benefit description for details)
- House-calls in the physician's service area
- Telehealth services

Prescription Medicines: Medications/medicine that is are prescribed by a doctor. Further information about prescription medicines can be found on **page [XX]**.

Prosthetics Devices: Includes the purchase of prosthetic devices and supplies required as a result of injury or illness to replace all or part of an absent body part or to restore function to permanently malfunctioning body organs. The benefit extends to the purchase, fitting, and necessary adjustment of prosthetic devices. Replacements are covered only when the replacement is deemed medically necessary and appropriate due to the normal growth of the child.

Qualifying Clinical Trials: Clinical trial conducted in relation to prevention, detection and treatment of cancer of other life- threatening disease or condition. Covers items and services consistent with what the plan normally covers. Notification of participation in the trial must be given before enrolling in the trial.

Skilled Nursing Services: Medically necessary skilled nursing and related services are covered on an inpatient basis in semi-private accommodations for patients requiring skilled nursing services, but not requiring confinement in a hospital. No day limits apply.

Specialist Physician Services: Includes medical care in any generally accepted medical specialty or subspecialty. Covers office visits, diagnostic testing, and treatment if medically necessary and the enrollee has an illness or condition outside the scope of practice of the enrollee's PCP. Services must be within the scope of practice of the specialist. PCP referral is not required to see a specialist. However, some services may require preauthorization.

Surgical Services: Includes services provided for treatment of disease or injury. Surgery performed for treatment of diseased is covered on an inpatient or outpatient basis. Cosmetic surgery intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes (excluding surgery resulting from an accident) is not covered. Includes anesthesia administered by or under the supervision of a specialist other than the surgeon, assistant surgeon, or other attending specialist. Includes general anesthesia and hospitalization and other expenses normally incurred with administration of general anesthesia. Consultations for a second opinion consultations to determine the medical necessity of elective surgery or when an enrollee's family desires another opinion about medical treatment. No referral is needed for consultation. Surgical services may require prior authorization.

Mastectomy and breast reconstruction benefits are provided for a mastectomy performed on an inpatient or outpatient basis. Benefits include all stages of reconstruction on the

breast on which the mastectomy has been performed, surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to, augmentation, mammoplasty, reduction mammoplasty, mastopexy, and surgery on the other breast to produce a symmetrical appearance. Covers surgery for initial and subsequent insertion or removal prosthetic devices to replace a removed breast or portions of the breast, and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is also provided for one Home Health Care visit, as determined by the member's physician, received within forty-eight (48) hours after discharge.

Oral surgery may be performed at an inpatient or outpatient facility depending on the nature of the surgery and medical necessity. Examples of covered services include: removal of partially or fully impacted third molars (wisdom teeth), non-dental treatments of the mouth relating to medically diagnosed congenital defects, birth abnormalities, surgical removal of tumors, cysts and infections, surgical correction of dislocated or completely degenerated temporomandibular joints, incision and drainage of abscesses, and baby bottle syndrome. Preauthorization is required. Must be medically necessary.

Reconstructive surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease or in relation to gender transition surgery deemed medically necessary in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the e of 18; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a mastectomy. Preauthorization required. Must be medically necessary.

Vision Care: Includes vision exams, corrective lenses, frames, or contacts in lieu of glasses or when medically necessary. Limited to one exam every 12 months unless an additional exam is medically necessary. Includes dilation if professionally indicated. Covers one pair of prescription eyeglass lenses and one frame, unless a second frame is medically necessary, or contacts every calendar year. Eyeglass lenses may be plastic or glass, single vision, bifocal or trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, or polycarbonate prescription lenses with scratch resistant coating. There may be copayments for optional lens types and treatments. Further information may be found on page **[XX]**.

Urgent Care Services: **[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 or equivalent]** at **[MCO Nurse Hotline or equivalent's phone number]** first. Your PCP or the **[MCO Name Nurse Hotline or equivalent]** 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.

In-Depth Service Descriptions

Behavioral Health Care

Behavioral health services include both mental health services and substance use disorder services. These services are provided through your MCO. Contact your MCO at **[MCO phone number appropriate for behavioral health services]**.

You can call your 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; an enrollee (14 years of age or older) or a parent or guardian may self-refer.

Behavioral Health or Substance Use Disorder Emergency

A behavioral health emergency is the sudden onset of a potentially life-threatening condition where you believe that your child is at risk of injury to himself/herself or others if immediate medical attention is not given.

A substance use crisis is where your child is considered in imminent, potentially life-threatening physical danger with a need for immediate detoxification for chemical dependency.

If you believe your child is in a behavioral health or substance use crisis or emergency, call the **[MCO Name]** Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]**. You will be connected with a behavioral health professional who will help you assess the seriousness of the situation.

If it is an emergency, the behavioral health professional will assist you in obtaining the treatment your child needs as quickly as possible.

If the condition is not a life-threatening one that requires immediate inpatient admission, **[MCO Name]** will schedule your child for an urgent care appointment.

Admission to a non-hospital residential treatment facility for rehabilitation treatment is never considered a part of emergency treatment.

The **initial** treatment for a behavioral health emergency is covered even when provided by out-of-network behavioral health providers or rendered at an out-of-network facility if the symptoms are severe enough to need immediate attention.

The following services are covered:

- Behavioral Health Rehabilitation Services (BHRS) (Child/Adolescent)
- Clozapine (Clozaril) Support Services
- Drug and Alcohol Inpatient Hospital-Based Detoxification Services

- Drug and Alcohol Inpatient Hospital-Based Rehabilitation Services
- Drug and Alcohol Outpatient Services
- Drug and Alcohol Methadone Maintenance Services
- Family Based Mental Health Services
- Laboratory Services (when related to a behavioral health diagnosis and prescribed by a behavioral health practitioner under the practitioner's scope of practice)
- Mental Health Crisis Intervention Services
- Mental Health Inpatient Hospitalization
- Mental Health Outpatient Services
- Mental Health Partial Hospitalization Services
- Peer Support Services
- Residential Treatment Facilities (Child/Adolescent), if not court-ordered
- Targeted Case Management Services

Dental

[MCO provide the DBM]

Dental Benefit Limit Exception

Some dental services are only covered with a Benefit Limit Exception (BLE). You or your dentist can ask for a BLE if you believe 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.
- You have a serious or chronic illness or health condition, and, without the additional service, your health would get much worse.
- You would require more expensive treatment if you do not receive the requested service.
- It would be against federal law for **[MCO Name]** to deny the exception.

To ask for a BLE before you receive the service, you or your dentist can call **[MCO/DBM Name]** Enrollee Services at **[MCO/DBM Enrollee 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 receive 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 have already received the service, **[MCO Name]** will let you know whether or not the BLE request is approved within thirty (30) days of the date **[MCO Name]** receives 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 6 of this Handbook, "Complaints, Grievances, and External Review" on page **[MCO to insert page number]**.

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 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 may use any hospital or other emergency care setting.

Below are some examples of emergency medical conditions and non-emergency medical conditions:

<u>Emergency medical conditions</u>

- Heart Attack
- Chest Pain
- Severe Bleeding
- Intense Pain
- Unconsciousness
  Poisoning

<u>Non-emergency medical conditions</u>

- 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]

Hospital Services

[MCO Name] covers inpatient and outpatient hospital services. If you need to be admitted inpatient to a hospital, and it is not an emergency, your PCP or specialist will arrange for you to go 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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]** or check the provider directory on **[MCO Name]**'s website at **[website link to provider directory]**. If you have any other questions about hospital services, please call Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]**.

If you have an emergency and are admitted to the hospital, you, a family member, or a 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 does not accept **[MCO Name]**, you may be transferred to a **[MCO Name]** participating hospital. You will not be moved until you are strong enough to be transferred.

It is very important to make an appointment to see your PCP within seven (7) days after you are discharged from the hospital. Seeing your PCP soon after your hospital stay will help you follow any instructions you got while you were in the hospital and prevent you from requiring readmission to the hospital.

Sometimes you may need to see a physician specialist or receive treatment at a hospital without being admitted overnight. These services are referred to as Outpatient Hospital Services. **[MCO to add any additional information as necessary including whether prior authorization or referral from a PCP is required, or information about Hospital clinic, radiology, laboratory services etc.]**

[MCO to include further details and specifics as necessary]

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 nurse-midwife. Early and regular prenatal care is very important for your 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 Enrollee Services at **[MCO Enrollee 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 within:

- Ten (10) business days of **[MCO Name]** learning you are pregnant when in your first trimester.
- Five (5) business days of **[MCO Name]** learning you are pregnant when in your second trimester.
- Four (4) business days of **[MCO Name]** learning you are pregnant when in your third trimester.
- 24 hours of **[MCO Name]** learning you are pregnant when you have a high-risk pregnancy.

In an emergency, call **911** or go to the nearest emergency room.

It is important you stay with the same maternity care provider throughout your pregnancy and postpartum care (sixty [60] days 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 CHIP 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 CHIP Program and must call **[MCO Name]** for approval to treat you.

[MCO to add any additional information 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 doctor requests to see you sooner.

Your baby should have an appointment with the baby's PCP when they are 3 to 5 days old, unless the doctor requests 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 Enrollee Services at **[MCO Enrollee 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].

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. **[MCO Name]** will pay for any medicine listed on **[MCO Name]**'s drug 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 one 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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]**.

[MCO to add additional information as necessary]

Drug Formulary

A formulary, also called a preferred drug list (PDL), is a list of medicines that **[MCO Name]** covers. This is what your PCP or other doctor should use when deciding what medicine, you should take. The formulary has 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 **[MCO Name]**'s formulary needs prior authorization. The 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 drug formulary, call Enrollee Services at **[MCO Enrollee 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 as necessary]

Reimbursement for Medication

[MCO to provide description of any potential reimbursement for medication]

Specialty Medicines

The drug formulary includes medicines that are called specialty medicines. A prescription for these medicines needs prior authorization **[MCO may remove sentence if prior authorization is not applicable]**. To see the drug formulary and a complete list of specialty medicines, call Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO to insert link to formulary on website]**.

You will need to obtain these medicines from a specialty pharmacy. A specialty pharmacy can mail your medicines directly to your home at no cost to you for the mailing and will contact you before sending them. You may have a co-payment for 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 Enrollee Services at **[MCO Enrollee 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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]**.

Over-the-Counter Medicines

[MCO Name] covers some over-the-counter medicines when drug is part of the formulary. You must have a prescription from your provider for these medicines for **[MCO Name]** to pay for them and a documented medical condition that indicates that the drug is medically necessary. 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 Enrollee Services at **[Enrollee Services phone number and TTY]**.

Vision Care Services

[MCO to provide information on Vision Benefit Manager if applicable]

[MCO Name] covers all medically necessary vison services. 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]

Expanded Services

[MCO to provide list and description of any enhanced benefits offered to all enrollees, including requirements for coverage and how to access. Delete this section if there is none provided]

Bright Futures

Bright Futures services are available for children under the age of 19. 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 a Bright Futures 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 19 will need just one visit per year.

Recommended Screening Schedule			
3-5 Days	By 1 Month	2 Months	4 Months
6 Months	9 Months	12 Months	15 Months
18 Months	24 Months	30 Months	
Children ages 3-19 should be screened yearly			

What Will the Provider Do during the Bright Futures 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
- Immunization
- Vision test
- Hearing test
- Autism screening
- Tuberculosis screening
- Dyslipidemia
- Sexually transmitted infections
- HIV
- Anemia
- Oral health examination
- Blood pressure check
- Health and safety education
- Check of the child's body mass index (BMI)
- Measurements
- Newborn Blood
- Screen and/or counsel for tobacco, alcohol, 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 Bright Futures 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 enrollees. 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 two (2) providers in your area, **[MCO Name]** will cover the medically necessary treatment by the 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 receive 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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]** who will help you to get the most appropriate care.

[MCO Name] will not pay for non-emergency 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 Enrollee Services at **[MCO Enrollee 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 coercive behavior where one person tries to gain power and control over another person in a family or intimate relationship.

There are many types of domestic violence. Some examples include:

- Emotional Abuse.
- Physical Violence.
- Stalking.
- Sexual Violence.
- Financial Abuse.
- Verbal Abuse.

There are many words 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)
1-800-537-2238 (national)

Sexual Assault and Rape Crisis

Sexual Assault is a term which includes any type of unwanted sexual contact. A person may use force, threats, manipulation, or persuasion to commit sexual violence. Sexual violence can include words and actions of a sexual nature including, but not limited to:

- 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.
- Sexual or 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 can have physical, mental, and/or emotional reactions to sexual violence. While every survivor is different, many feel alone, scared, ashamed, and afraid that no one will believe them. Healing can take years with advances and setbacks, but healing can happen.

Where to get help:

Pennsylvania Coalition Against Rape (www.pcar.org/)

Pennsylvania rape crisis centers serve all adults and children. Services include:

- Free and confidential crisis counseling twenty-four (24) hours a day.
- Services for the 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 above to reach your local rape crisis center.

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 from birth to the age of five (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 five (5). In addition, CONNECT can help parents with contacting their county Early Intervention Program or local preschool Early Intervention Program.

Section 5 –

Special Medical Needs and Care/Disease Management

Special Needs

[MCO Name] wants to make sure all our enrollees get the care they need. We have trained case managers that help our enrollees with special needs have access to the care they need. The case managers help enrollees 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. **[MCO Name]** can 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 as necessary]

If you think you or someone in your family has a special need and would like **[MCO Name]** to help you, please contact them by calling **[MCO Hotline #].** Staff are available **[days and hours of operation]**. If you need assistance when staff are not available, you may call **[alternate MCO contact]**.

Coordination of Care

[MCO Name] will help you coordinate care for you and your family who are covered under **[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 **[MCO Name]** for assistance.

[MCO Name] will also assist enrollees in transitioning care from services received in a hospital or temporary medical setting to care received at home. We want our enrollees to be able to move back home as soon as possible. Please contact **[MCO Name]** for assistance in receiving care in your home.

[Case/Disease/Care] Management

[MCO to add language specific to any Care 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 **[case/care/disease]** 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] [case/disease/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 Enrollee Services at **[MCO Enrollee Services Phone Number and TTY]**.

Section 6 –

Complaints, Grievances, and External Reviews

Complaints, Grievances, and External Reviews

If a provider or **[MCO Name]** does something you are unhappy about or disagree with, you can tell **[MCO Name]** or the Department of Human Services 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 received 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 **[Enrollee Services Phone Number and TTY]** and tell **[MCO Name]** your Complaint.
- Write down your Complaint and send it to **[MCO Name]** by mail or fax.
- 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 **sixty (60) days of receiving a notice** telling you that:

- **[MCO Name]** has decided that you cannot receive 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 received.
- **[MCO Name]** did not tell you it's 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 must pay your provider.

You must file a Complaint **within sixty (60) days of the date you should have received a service or item** if you did not receive a service or item in a timely manner.

New enrollee appointment for your first examination…	**We will make an appointment for you…**
Enrollees with HIV/AIDS	with PCP or specialist no later than seven (7) days after you become an enrollee in **[MCO Name]** unless you are already being treated by a PCP or specialist.
Enrollees for a Bright Futures exam	with PCP no later than forty-five (45) days after you become an enrollee in **[MCO Name],** unless you are already being treated by a PCP or specialist.
All other enrollees	with PCP no later than three (3) weeks after you become an enrollee in **[MCO Name]**.
Enrollees who are pregnant:	**We will make an appointment for you…**
Pregnant women in their first trimester	with OB/GYN provider within ten (10) business days of **[MCO Name]** learning you are pregnant.
Pregnant women in their second trimester	with OB/GYN provider within five (5) business days of **[MCO Name]** learning you are pregnant.
Pregnant women in their third trimester	with OB/GYN provider within four (4) business days of **[MCO Name]** learning you are pregnant.
Pregnant women with high-risk pregnancies	with OB/GYN provider within twenty-four (24) hours of **[MCO Name]** learning you are pregnant.
Appointment with…	**An appointment must be scheduled...**
PCP Urgent medical condition	within twenty-four (24) hours.
Routine appointment	within ten (10) business days.

Health assessment/general physical examination	within three (3) weeks
Specialists (when referred by PCP) Urgent medical condition	 within twenty-four (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 fifteen (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 seven (7) 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 one 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 receiving services:

If you have been receiving 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 ten (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 review of your Complaint if the Complaint is about one of the following:

- **[MCO Name]**'s decision that you cannot receive 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 received.
- **[MCO Name]**'s failure to decide a Complaint you told **[MCO Name]** about within **30** days from when **[MCO Name]** received your Complaint or Grievance.
- Not receiving 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 review within **fifteen (15) days of the date you got the First Level Complaint decision notice**.

For all other Complaints, you may file a Second Level Complaint within **forty-five (45) days of the date you got the Complaint decision notice**.

For information about external complaint reviews, 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 numbers]**.

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 **[Enrollee 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 fifteen (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 three (3) or more people, including at least one person who does not work for **[MCO Name]**, and were not involved in any previous level of review or decision-making, 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 by either the Department of Health or the Insurance Department.

You must ask for an external review **within fifteen (15) days of the date you received the Second Level Complaint decision notice.**

External Review of a Complaint

How Do I Ask for an External Review of a Complaint?

You must send your request for an external review of your Complaint in writing to either:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, PA 17120-0701
Telephone Number: 1-888-466-2787

or

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120

Telephone Number: 1-877-881-6388

If you ask, the Department of Health will help you put your Complaint in writing.

The Department of Health handles Complaints that involve the way a provider gives care or services. The Insurance Department reviews Complaints that involve **[MCO Name]**'s policies and procedures. If you send your request for an external review to the wrong Department, it will be sent to the correct Department.

What Happens after I Ask for an External Review of my Complaint?

The Department of Health or the Insurance Department will obtain 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 receiving services:

If you have been receiving the services or items that are being reduced, changed, or denied, and your request for an external review is postmarked or hand-delivered within ten (10) days of the date on the notice telling you **[MCO Name]**'s First Level Complaint decision that you cannot receive 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.

GRIEVANCES

What is a Grievance?

When **[MCO Name]** denies or decreases a service or item you requested because it is not medically necessary or approves a service or item different than the service or item you requested, you will receive 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 **[Enrollee 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 received 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 **sixty (60) days from the date you receive 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 receive 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 fifteen (15) 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 three (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. **[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 receiving services:

If you have been receiving 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 ten (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. 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 **fifteen (15) days of the date you received the Grievance decision notice**.

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 Review of a Grievance

How Do I Ask for External Review?

To ask for an external review for a Grievance:

- Call **[MCO Name]** at **[Enrollee 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 Department of Health.

What Happens after I Ask for an External Review of my Grievance?

The Department of Health 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 fifteen (15) days of filing the request for an external Grievance review.

You will receive a decision letter within sixty (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 receiving services:

If you have been receiving 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 ten (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.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting 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 **[Enrollee Services Phone Number and TTY]**, faxing a letter or the Complaint/Grievance Request Form to **[MCO fax number],** or sending an email to **[CHIP-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 the standard amount of time 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 days from when **[MCO Name]** first received your Complaint or Grievance.

Expedited Complaint and Expedited External Review of your Complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor. Enrollees of 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.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person if possible 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]** receives your doctor 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]** receives 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 fourteen (14) more days to decide your Complaint. You will also receive 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 review of your Complaint from the Department of Health within **two (2) business days from the date you receive the expedited decision notice**. To ask for expedited external review of a Complaint:

- Call **[MCO Name]** at **[Enrollee Services Phone Number and TTY]** and tell **[MCO Name]** your Complaint.
- Send an email to **[MCO Name]** at **[MCO email address]**.
- 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 Review of your Grievance

A committee of three (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 if possible 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]** received your doctor 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]** receives 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 fourteen (14) more days to decide your Grievance. You will also receive 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 review of your Grievance.

You must ask for expedited external review of your Grievance by the Department of Health within **two (2) business days from the date you receive the expedited Grievance decision notice**. To ask for expedited external review of a Grievance:

- Call **[MCO Name]** at **[Enrollee 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 Department of Health within 24 hours after receiving it.

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 be 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, inform **[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 **[Enrollee 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.
- Providing someone to help copy and present information.

EXHIBIT R

PCP, DENTISTS, SPECIALISTS AND PROVIDERS OF ANCILLARY SERVICES DIRECTORIES

A. PCP and Dentist Directories

The CHIP-MCO must provide its Enrollees with PCP and Dentist directories upon request, which include, at a minimum, the following information:

- The names, addresses, and telephone numbers of participating PCPs.
- The hospital affiliations of the PCP.
- Identification of whether the PCP is a Doctor of Medicine or Osteopathy, and whether the PCP is a Pediatrician.
- Identification of whether PCPs are Board-certified and, if so, in what area(s).
- Identification of PCP Teams which include physicians, Certified Registered Nurse Practitioners (CRNPs), Certified Nurse Midwives and physicians' assistants.
- Indication of whether dentist is DDS or DMD, and whether dentist is a periodontist.
- Identification of whether dentists possess anesthesia certificates.
- Identification of languages spoken by Health Care Providers at the primary care and dental sites.
- Identification of sites which are wheelchair accessible.
- Identification of the days of operation and the hours when the PCP or dentist office is available to Enrollees.

The CHIP-MCO, at the request of the PCP or dentist, may include the PCP's or dentist's experience or expertise in serving individuals with particular conditions.

B. Specialist and Providers of Ancillary Services Directories

The specialist and providers of ancillary services directories shall include, at a minimum, the following information:

- The names addresses and telephone numbers of specialists and their hospital affiliations.
- Identification of the specialty area of each specialist's practice.
- Identification of whether the specialist is Board-certified and, if so, in what area(s).
- Experience or expertise in serving individuals with particular conditions.

EXHIBIT S

COMPLAINT, GRIEVANCE, AND EXTERNAL REVIEW PROCESSES

A. General Requirements

1. The CHIP-MCO must obtain the Department's prior written approval of its Complaint, Grievance, External Review and Fair Hearing policies and procedures.

2. The CHIP-MCO must follow the Complaint, Grievance, and External Review processes in federal regulations 42 CFR §457.1260 and 40 P.S. §§991.2101-991.2194.

3. The CHIP-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances as they relate to the CHIP population and must make these policies and procedures available to Enrollees upon request.

4. The CHIP-MCO policies and procedures resolving Complaints and Grievances as they relate to the CHIP population should outline expectations that providers secure and submit all documentation available at the time of request for service or item.

5. The CHIP-MCO must determine if the Complaint or Grievance includes an Adverse Benefit Determination.

6. The CHIP-MCO must maintain an accurate written record of each Complaint and Grievance and the actions taken by the CHIP-MCO to resolve each Complaint and Grievance. The record must include at least the following:

    a. The name of the Enrollee 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.

    g. Documentation the member was asked if they were in need of an interpreter and that one was provided for them.

The CHIP-MCO must provide the record of each Complaint and Grievance and

the actions taken by the CHIP-MCO to resolve each Complaint and Grievance to the Department and CMS upon request.

7. The CHIP-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 G, Quality Management and Utilization Management Program Requirements.

8. The CHIP-MCO must have a data system to process, track, and trend all Complaints and Grievances. This system must be updated and maintained to assure accurate accountability.

9. The CHIP-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 Enrollee Complaints and Grievances in accordance with the requirements specified in this Exhibit. To ensure a seamless transference of information, the CHIP-MCO will notify and update all changes to correspondence upon receipt of change by email and phone call.

10. CHIP-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.

11. The CHIP-MCO must provide information about the Complaint and Grievance process to all Providers and Subcontractors when the CHIP-MCO enters into a contract or agreement with the Provider or Subcontractor. The CHIP-MCO is held accountable for the actions and outcomes from their Providers and Subcontractors. Accountability measures must be submitted to these partners in writing annually and will be reviewed and validated upon request by the Complaints, Grievances, External Review and Fair Hearings supervisor or designee.

12. The CHIP-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 an Enrollee from receiving Medically Necessary care in a timely manner.

13. The CHIP-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.

14. The CHIP-MCO may not charge Enrollees a fee for filing a Complaint or a Grievance.

15. The CHIP-MCO must allow the Enrollee and the Enrollee's representative to have access to all relevant documentation, available in alternative formats if requested, 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.

16. The CHIP-MCO must maintain the following information in the Enrollee's case file:

    a. Medical records;

    b. Any documents or records relied upon or generated by the CHIP-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 CHIP-MCO in connection with the Complaint or Grievance.

17. The CHIP-MCO must provide language interpreter services at no cost when requested by an Enrollee.

18. The CHIP-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 Enrollee who are deaf or hearing impaired; Braille; tape; computer disk; and other commonly accepted alternative forms of communication. The CHIP-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitations of Enrollees with disabilities or language barriers, so they treat these individuals with patience, understanding, and respect.

19. The CHIP-MCO must provide Enrollees with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Enrollee. This includes but is not limited to:

    a. Providing qualified sign language interpreters for Enrollees who are deaf or hearing impaired;

    b. Providing information submitted on behalf of the CHIP-MCO at the Complaint or Grievance review in an alternative format accessible to the Enrollee or Enrollee's representative, filing the Complaint or Grievance. The alternative format version must be supplied to the Enrollee at or before the review, so the Enrollee can discuss and/or refute the content during the review; and

    c. Providing personal assistance to an Enrollee filing the Complaint or Grievance who has other physical limitations in copying and presenting documents and other evidence.

20. The CHIP-MCO must offer Enrollees the assistance of a CHIP-MCO staff member trained and updated in the Complaints and Grievances process throughout the Complaint and Grievance processes at no cost to the Enrollee.

21. The CHIP-MCO must provide Enrollees with a toll-free number to file a Complaint or Grievance, request information about the Complaint or Grievance process, and ask any questions the Enrollee may have about the status of a Complaint or Grievance.

22. The CHIP-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances at one location within each of its Managed Care Program Zones of operation. If a Enrollee requests an in-person review, the CHIP-MCO must notify the Enrollee of the location of the review and who will be present at the review, using the template specified by the Department.

23. The CHIP-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.

24. The CHIP-MCO must notify the Enrollee when the CHIP-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 CHIP-MCO must mail this notice to the Enrollee one (1) day following the date the decision was to be made not to exceed 30 calendar days.

25. The CHIP-MCO must notify the Enrollee 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 CHIP, using the template specified by the Department. The CHIP-MCO must mail this notice to the Enrollee on the day the decision is made to deny payment.

26. The CHIP-MCO must notify the Enrollee 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 Enrollee, using the template specified by the Department. The CHIP-MCO must mail this notice to the Enrollee on the day the decision is made to deny payment.

27. The CHIP-MCO must notify the Enrollee when it denies payment after a service or item has been delivered because the CHIP-MCO determined that the service or item was not Medically Necessary, using the template specified by the Department. The CHIP-MCO must mail this notice to the Enrollee on the day the decision is made to deny payment.

28. The CHIP-MCO must notify the Enrollee when it denies the Enrollee'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 CHIP-MCO must mail this notice to the Enrollee on the day the decision is made to deny payment.

29. The CHIP-MCO must use all templates specified by the Department, which are available in Docushare.

B. Complaint Requirements

Complaint: A dispute or objection regarding:

- a denial because the requested service or item is not a covered service;

this does not include BLE.

- the failure of the CHIP-MCO to provide a service or item in a timely manner, as defined by the Department;

- the failure of the CHIP-MCO to decide a Complaint within the specified time frames;

- a denial of payment by the CHIP-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 or CHIP;

- a denial of payment by the CHIP-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Enrollee; or

- a denial of a Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

These types of complaints must be filed within sixty (60) calendar days from the date of the incident complained of or the date the Enrollees receives written notice of a decision.

A Complaint without an adverse benefit determination is an expression of dissatisfaction about any matter other than an adverse benefit determination. Complaints may include, but are not limited to, the quality of care of services provided, and aspect of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's right regardless of whether remedial actions is requested. Complaint includes an Enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision. These types of complaints do not have a filing timeframe.

The term does not include a Grievance.

1. First Level Complaint Process

A CHIP-MCO must permit an Enrollee or Enrollee's representative, which may include the Enrollee's Provider, with proof of the Enrollee's written authorization for the representative to be involved and/or act on the Enrollee's behalf, to file a first level Complaint either in writing or verbally. The CHIP-MCO must commit oral requests to writing if not confirmed in writing by the Enrollee and should provide the written Complaint to the Enrollee or Enrollee's representative for signature.

i. If the requestor is the Enrollee's representative, the signature may be obtained at any point in the process, and failure to obtain a signed consent may not delay the Complaint process.

ii. If the requestor is the Enrollee's Provider, the written consent must be obtained prior to the onset of this process. If written consent from the Enrollee or Enrollee's representative has not been obtained by the Provider, the Provider should proceed using the Provider Appeal Process.

b. If the first level Complaint disputes one of the following, the Enrollee must file a Complaint within sixty (60) calendar days from the date of the incident complained of or the date the Enrollee receives written notice of a decision:

i. a denial because the service or item is not a covered service;

ii. the failure of the CHIP-MCO to provide a service or item in a timely manner, as defined by the Department;

iii. the failure of the CHIP-MCO to decide a Complaint 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 or CHIP;

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 Enrollee; or

vi. a denial of an Enrollee'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 Enrollee 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, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.

d. Upon receipt of the Complaint, the CHIP-MCO must send the Enrollee and Enrollee's representative, if the Enrollee has designated one in writing, a first level Complaint acknowledgment letter by the next business day, using the template specified by the Department.

e. The first level Complaint review for all complaints must be conducted by a first level Complaint review committee, which must include one or more employees of the CHIP-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. For a first level complaint with an adverse benefit determination involving a clinical issue, a licensed physician or dentist, in the same or similar specialty must participate on the committee panel.

f. 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.

g. The CHIP-MCO must afford the Enrollee or Enrollee's representative, a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

h. The CHIP-MCO must give the Enrollee at least ten (10) calendar days advance written notice of the first level Complaint review date, using the template specified by the Department. The CHIP-MCO must be flexible when scheduling the review to facilitate the Enrollee's attendance. If the Enrollee cannot appear in person at the review, the CHIP-MCO must provide an opportunity for the Enrollee to communicate with the first level Complaint review committee by telephone or videoconference.

i. The Enrollee may elect not to attend the first level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Enrollee was present.

j. If an Enrollee 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.

k. The decision of the first level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Enrollee or the Enrollee's representative without regard to whether such information was submitted or considered in the initial determination of the issue.

l. The testimony taken by the Complaint review committee (including the Enrollee's comments) must be tape-recorded, transcribed verbatim and maintained as part of the Complaint record.

m. The first level Complaint review committee must complete its review of the Complaint as expeditiously as the Enrollee's health condition requires.

n. 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.

o. The CHIP-MCO must send a written notice of the first level Complaint decision, using the template specified by the Department, to the Enrollee, Enrollee's representative, if the Enrollee has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) calendar days from the date the CHIP-MCO received the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) calendar days at the request of the Enrollee.

p. If the Complaint disputes one of the following, the Enrollee may file a request for an external review:

i. a denial because the service or item is not a covered service;

ii. the failure of the CHIP-MCO to provide a service or item in a timely manner, as defined by the Department;

iii. the failure of the CHIP-MCO to decide the Complaint or Grievance within the specified time frames;

iv. a denial of payment by the CHIP-MCO after the service or item has been delivered because the service or item was provided by a Provider not enrolled in the MA Program or CHIP;

v. a denial of payment by the CHIP-MCO after the service or item has been delivered because the service or item provided is not a covered service for the Enrollee; or

vi. a denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

The Enrollee or Enrollee's representative, which may include the Enrollee's Provider, with proof of the Enrollee's written authorization for the representative to be involved and/or act on the Enrollee's behalf, may file a request for an external review in writing with either PID within fifteen (15) calendar days from the date the Enrollee receives written notice of the CHIP-MCO's first level Complaint decision.

For all other Complaints, the Enrollee or Enrollee's representative, which may include the Enrollee's Provider, with proof of the Enrollee's written authorization for the representative to be involved and/or act on the Enrollee's behalf, may file a second level Complaint either in writing or verbally within forty-five (45) calendar days from the date the Enrollee receives written notice of the CHIP-MCO's first level Complaint decision.

2. Second Level Complaint Process

a. A CHIP-MCO must permit an Enrollee or Enrollee's representative, which

may include the Enrollee's Provider, with proof of the Enrollee's written authorization for the representative to be involved and/or act on the Enrollee's behalf, to file a second level Complaint either in writing or verbally for any Complaint unless it is one of the following as they are eligible for an external review with the Department of Insurance.

i. a denial because the service or item is not a covered service;

ii. the failure of the CHIP-MCO to provide a service or item in a timely manner, as defined by the Department;

iii. the failure of the CHIP-MCO to decide the Complaint within the specified time frames;

iv. a denial of payment by the CHIP-MCO after the service or item has been delivered because the service or item was provided by a Provider not enrolled in the MA Program or CHIP;

v. a denial of payment by the CHIP-MCO after the service or item has been delivered because the service or item provided is not a covered service for the Enrollee; or

vi. a denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

b. Upon receipt of the second level Complaint, the CHIP-MCO must send the Enrollee and Enrollee's representative, if the Enrollee has designated one in writing, a second level Complaint acknowledgment letter by the next business day, using the template specified by the Department.

c. The second level Complaint review 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. At least one-third of the second level Complaint review committee members may not be employees of the CHIP-MCO or a related subsidiary or Affiliate.

e. 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.

f. The CHIP-MCO must afford the Enrollee a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

g. The CHIP-MCO must give the Enrollee at least fifteen (15) calendar days advance written notice of the second level Complaint review date, using the template specified by the Department. The CHIP-MCO must be flexible when scheduling the review to facilitate the Enrollee's attendance. If the Enrollee cannot appear in person at the review, the CHIP-MCO must provide an opportunity for the Enrollee to communicate with the second level Complaint review committee by telephone or videoconference.

h. The Enrollee may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Enrollee was present.

i. If an Enrollee 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.

j. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Enrollee or the Enrollee'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.

k. The testimony taken by the second level Complaint review committee (including the Enrollee's comments) must be tape-recorded, transcribed verbatim and maintained as part of the Complaint record. The Complaint review committee must prepare a verbatim written transcription of the issues presented and decisions made, which must be maintained as part of the Complaint record.

l. The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Enrollee's health condition requires.

m. The CHIP-MCO must send a written notice of the second level Complaint decision, using the template specified by the Department, to the Enrollee, Enrollee's representative, if the Enrollee has designated one in writing, service Provider, and prescribing Provider, if applicable, within forty-five (45) calendar days from the date the CHIP-MCO received the second level Complaint.

n. The Enrollee or the Enrollee's representative, which may include the Enrollee's Provider, with proof of the Enrollee's written authorization of the representative to be involved and/or act of the Enrollee's behalf, may file in writing a request for an external review of the second level Complaint

decision with either PID within (15) calendar days from the date the Enrollee receives the written notice of the CHIP-MCO's second level Complaint decision.

3. External Complaint Process

a. If an Enrollee files a request directly with PID for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service or item that the Enrollee has been receiving on the basis that the service or item is not a covered service, the Enrollee must continue to receive the disputed service or item at the previously authorized level pending resolution of the external review.

b. Upon the request of PID, the CHIP-MCO must transmit all records from the CHIP-MCO's Complaint review to the requesting department within thirty (30) calendar days from the request in the manner prescribed by that department. The Enrollee, the Provider, or the CHIP-MCO may submit additional materials related to the Complaint.

4. Expedited Complaint Process

a. The CHIP-MCO must conduct expedited review of a Complaint if the CHIP-MCO determines that the Enrollee'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 an Enrollee or Enrollee's representative, with proof of the Enrollee's written authorization for the representative to be involved and/or act on the Enrollee's behalf, provides the CHIP-MCO with a certification from the Enrollee's Provider that the Enrollee'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 is only required if the CHIP-MCO cannot make a determination based on the information provided and must include the Provider's signature.

b. A request for an expedited review of a Complaint may be filed in writing, by fax, verbally, or by email.

c. Upon receipt of an oral or written request for expedited review, the CHIP-MCO must inform the Enrollee 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 CHIP-MCO cannot determine based on the information provided that the Enrollee'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 CHIP-MCO must inform the Enrollee that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHIP-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 Enrollee's request for expedited review, the CHIP-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) calendar days at the request of the Enrollee. If the CHIP-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the CHIP-MCO must make a reasonable effort to give the Enrollee 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. An Enrollee 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 Enrollee 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.

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. 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. The testimony taken by the expedited Complaint review committee (including the Enrollee's comments) must be tape-recorded, transcribed verbatim and maintained as part of the expedited Complaint record.

h. The CHIP-MCO must issue the decision resulting from the expedited review in person or by phone to the Enrollee, the Enrollee's representative, if the Enrollee 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 Enrollee'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) calendar days at the request of the Enrollee. In addition, the CHIP-MCO must mail written notice of the decision to the Enrollee, the Enrollee's representative, if the Enrollee 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 Enrollee, or the Enrollee's representative, which may include the Enrollee's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Enrollee's behalf, may file a

request for an expedited external Complaint review with the CHIP-MCO. An Enrollee who files a request for an expedited Complaint review that disputes a decision to discontinue, reduce, or change a service or item that the Enrollee 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.

j. A request for an expedited external Complaint review may be filed in writing, by fax, verbally, or by email.

k. The CHIP-MCO must follow PID guidelines relating to submission of requests for expedited external Complaint reviews.

l. The CHIP-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Enrollee's request for expedited review of a Complaint.

C. Grievance Requirements

Grievance: A request to have a CHIP-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 CHIP-MCO's decision to:

- Deny, in whole or in part, payment for a service or item;
- 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;
- Reduce, suspend, or terminate a previously authorized service or item;
- Deny the requested service or item but approve an alternative service or item;
- Deny a request for a BLE; and
- Decide a Grievance within the specified time frames.

The term does not include a Complaint.

1. Grievance Process

a. A CHIP-MCO must permit an Enrollee or Enrollee's representative, which may include the Enrollee's Provider, with proof of the Enrollee's written authorization for the representative to be involved and/or act on the Enrollee's behalf, to file a Grievance either in writing or verbally. The CHIP-MCO must commit oral requests to writing if not confirmed in writing by the Enrollee and should provide the written Grievance to the Enrollee or the Enrollee's representative for signature.

i. If the requestor is the Enrollee's representative, the signature may be obtained at any point in the process, and the failure to obtain a signed consent may not delay the Grievance process.

ii. If the requestor is the Enrollee's Provider, the written consent must be

obtained prior to the onset of this process. If written consent from the member or Enrollee's representative has not been obtained by the Provider, the Provider should proceed using the Provider Appeal Process.

b. An Enrollee must file a Grievance within sixty (60) calendar days from the date the Enrollee receives written notice of decision.

c. An Enrollee who files a Grievance that disputes a decision to discontinue, reduce, or change a service or item that the Enrollee has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance.

d. Upon receipt of the Grievance, the CHIP-MCO must send the Enrollee and Enrollee's representative, if the Enrollee has designated one in writing, a Grievance acknowledgment letter by the next business day, using the template specified by the Department.

e. An Enrollee who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Enrollee may rescind consent throughout the process upon written notice to the CHIP-MCO and the Provider.

f. In order for the Provider to represent the Enrollee in the conduct of a Grievance, the Provider must obtain the written consent of the Enrollee and submit the written consent with the Grievance. A Provider may obtain the Enrollee's written permission at the time of treatment. The CHIP-MCO must assure that a Provider does NOT require an Enrollee 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 Enrollee, the Enrollee's date of birth and identification number;

ii. If the Enrollee is a minor, or is legally incompetent, the name, address, and relationship to the Enrollee of the person who signed the consent;

iii. The name, address, and CHIP-MCO identification number of the Provider to whom the Member is providing consent;

iv. The name and address of the CHIP-MCO to which the Grievance will be submitted;

v. An explanation of the specific service or item which was provided or denied to the Enrollee to which the consent will apply;

vi. The following statement: "The Enrollee or the Enrollee's representative may not submit a Grievance concerning the service or item listed in this consent form unless the Enrollee or the Enrollee's representative rescinds consent in writing. The Enrollee or the Enrollee's representative has the right to rescind consent at any time during the Grievance process;

vii. The following statement: “The consent of the Enrollee or the Enrollee’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 Enrollee or the Enrollee’s representative, if the Enrollee 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 Enrollee or the Enrollee’s representative understands the information in the Enrollee’s consent form.” and

ix. The dated signature of the Enrollee, or the Enrollee’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 CHIP-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. 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 CHIP-MCO must afford the Enrollee’s or Enrollee’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 CHIP-MCO must give the Enrollee at least fifteen (15) calendar days advance written notice of the review date, using the template specified by the Department. The CHIP-MCO must be flexible when scheduling the review to facilitate the Enrollee’s attendance. If the Enrollee cannot appear in person at the review, the CHIP-MCO must provide an opportunity for the Enrollee to communicate with the Grievance review committee by telephone or videoconference.

m. The Enrollee may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Enrollee was present.

n. If an Enrollee 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 Enrollee or the Enrollee'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. The testimony taken by the Grievance review committee (including the Enrollee's comments) must be tape-recorded, transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record.

q. The Grievance review committee must complete its review of the Grievance as expeditiously as the Enrollee's health condition requires.

r. The CHIP-MCO must send a written notice of the Grievance decision, using the template specified by the Department, to the Enrollee, Enrollee's representative, if the Enrollee has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) calendar days from the date the CHIP-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) calendar days at the request of the Enrollee.

s. The Member a request for an external review,.

The Enrollee or Enrollee's representative, which may include the Enrollee's Provider, with proof of the Enrollee's written authorization for a representative to be involved and/or act on the Enrollee's behalf, may file a request with the CHIP-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed by PID. The request must be filed in writing or verbally within fifteen (15) calendar days from the date the Member receives the written notice of the CHIP-MCO's Grievance decision.

2. **External Grievance Process:**

a. The CHIP-MCO must process all requests for external Grievance review. The CHIP-MCO must follow the protocols established by PID in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Enrollee, Enrollee's representative, if the Enrollee has designated one in writing, service Provider, and prescribing Provider.

b. An Enrollee who files a request for an external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Enrollee has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the external Grievance review.

c. Within five (5) business days of receipt of the request for an external Grievance review, the CHIP-MCO must notify the Enrollee, the Enrollee's representative, if the Enrollee has designated one in writing, the Provider if the Provider filed the request for the external Grievance review, and PID 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 CHIP-MCO.

e. Within two (2) business days from receipt of the request for an external Grievance review, PID will randomly assign a CRE to conduct the review and notify the CHIP-MCO and assigned CRE of the assignment.

f. If PID fails to select a CRE within two (2) business days from receipt of a request for an external Grievance review, the CHIP-MCO may designate a CRE to conduct a review from the list of CREs approved by PID. The CHIP- MCO may not select a CRE that has a current contract or is negotiating a contract with the CHIP-MCO or its Affiliates or is otherwise affiliated with the CHIP-MCO or its Affiliates.

g. The CHIP-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 CHIP-MCO must transmit this information within fifteen (15) calendar days from receipt of the Member's request for an external Grievance review.

h. Within fifteen (15) calendar days from receipt of the request for an external Grievance review by the CHIP-MCO, the Enrollee or the Enrollee's representative, or the Enrollee'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 CHIP-MCO so that the CHIP-MCO has an opportunity to consider the additional information.

i. Within sixty (60) calendar 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 CHIP-MCO, the Enrollee, the Enrollee's representative, and the Provider (if the Provider filed the Grievance with the Enrollee'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.

j. The external Grievance decision may be appealed by the Enrollee, the Enrollee's representative, or the Provider to a court of competent jurisdiction (Commonwealth Court) within sixty (60) calendar days from the date the Member receives notice of the external Grievance decision.

3. **Expedited Grievance Process**

a. The CHIP-MCO must conduct expedited review of a Grievance if the CHIP-MCO determines that the Enrollee'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 an Enrollee or Enrollee's representative, with proof of the Enrollee's written authorization for a representative to be involved and/or act on the Enrollee's behalf, provides the CHIP-MCO with a certification from the Enrollee's Provider that the Enrollee'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 is only required if the CHIP-MCO cannot make a determination based on the information provided and must include the Provider's signature.

b. A request for expedited review of a Grievance may be filed in writing, by fax, by email, or verbally.

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 CHIP-MCO must inform the Enrollee 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 CHIP-MCO cannot determine based on the information provided that the Enrollee'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 CHIP-MCO must inform the Enrollee that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHIP-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 Enrollee's request for expedited review, the CHIP-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) calendar days at the request of the Enrollee. If the CHIP-MCO decides that expedited consideration with the initial or extended time frame is not warranted, the CHIP-MCO must make a reasonable effort to give the Enrollee 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. An Enrollee 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 Enrollee 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) calendar 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 CHIP-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. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.

j. The testimony taken by the expedited Grievance review committee (including the Enrollee's comments) must be tape-recorded, transcribed verbatim and maintained as part of the expedited Grievance record.

(14) The CHIP-MCO must issue the decision resulting from the expedited review in person or by phone to the Enrollee, the Enrollee's representative, if the Enrollee 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 Enrollee'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) calendar days at the request of the Enrollee. In addition, the CHIP-MCO must mail written notice of the decision to the Enrollee, the Enrollee's representative, if the Enrollee 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.

k. The Enrollee, or Enrollee's representative, which may include the Enrollee's Provider, with proof of the Enrollee's written authorization for the representative to be involved and/or act on the Enrollee's behalf, may file a request for an expedited external Grievance review with the CHIP-MCO within two (2) business days from the date the Enrollee receives the CHIP-

MCO's expedited Grievance decision. An Enrollee 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 Enrollee 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.

l. A request for an expedited external Grievance review may be filed in writing, by fax, orally, or by email.

m. The CHIP-MCO must follow DOH guidelines relating to submission of requests for expedited external Grievance reviews.

n. The CHIP-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports an Enrollee'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 to determine if eligibility is accurate.

1. Eligibility Review Process

i. An Enrollee or Enrollee's representative, with proof of the Enrollee's written authorization for the representative to be involved and/or act on the Enrollee's behalf, must file a Complaint or Grievance with the CHIP-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the CHIP-MCO fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, the Enrollee is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

b. The Enrollee or the Enrollee's representative may request a Fair Hearing in writing, signed by the member or Enrollee's representative, with proof of the Enrollee's written authorization for the representative to be involved and/or act on the Enrollee's behalf, within one hundred and twenty (120) calendar days from the mail date on the written notice of the CHIP-MCO's decision regarding an adverse determination as listed in paragraph (c) of this section.

c. The Enrollee or the Enrollee's representative may request a Fair Hearing for the following adverse determinations: eligibility for CHIP tier was inaccurate; or termination from CHIP program for failure to pay premium. All other actions are process through the complaint, grievance and external review processes.

d. 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 CHIP-MCO failed to provide written notice of the Complaint or Grievance decision within the

time frames specified in this Exhibit. A Fair Hearing may be requested as follows:

Fax: 1-717-772-6328
Mail: Department of Human Services
OMAP – Children's Health Insurance Program Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

e. An Enrollee who files a request for a Fair Hearing may continue receiving CHIP coverage through the resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered, faxed, or post-marked within ten (10) calendar 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 Enrollee and the CHIP-MCO will receive notification of the hearing date by letter at least ten (10) calendar days before the hearing date, or a shorter time if requested by the Enrollee. 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 CHIP-MCO is a party to the hearing and must be present. The CHIP-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 CHIP-MCO from the hearing will not be reason to postpone the hearing.

h. The CHIP-MCO must provide Enrollees, 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) calendar days of the date the Enrollee filed the first level Complaint or the Grievance involving a qualifying adverse decision with the CHIP-MCO, not including the number of days before the Enrollee requested the Fair Hearing.

j. BHA's adjudication is binding on the CHIP-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) calendar days from the date of the adjudication. Only the Enrollee may appeal to Commonwealth Court within thirty (30) calendar 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 CHIP-MCO.

2. **Expedited Fair Hearing Process**

a. An Enrollee or the Enrollee's representative may file a request for an expedited Fair Hearing with the Department either in writing or orally.

b. An Enrollee 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 an Enrollee or a Enrollee'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 Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function in jeopardy.

d. An Enrollee who files a request for a Fair Hearing may continue receiving CHIP coverage through the resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered, faxed, or post-marked within ten (10) calendar 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 CHIP-MCO is a party to the hearing and must be present. The CHIP-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The absence of the CHIP-MCO from the hearing will not be reason to postpone the hearing.

g. The CHIP-MCO must provide the Enrollee, 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 Enrollee's oral or written request for an expedited review.

i. BHA's adjudication is binding on the CHIP-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) calendar days from the date of the adjudication. Only the Enrollee may appeal to Commonwealth Court within thirty (30) calendar 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 CHIP-MCO.

E. Provision of and Payment for Service or Item Following Decision

1. If the CHIP-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 CHIP-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 CHIP-MCO requests

reconsideration, the CHIP-MCO must authorize or provide the disputed service or item pending reconsideration unless the CHIP-MCO requests a stay of the BHA decision and the stay is granted.

2. If the CHIP-MCO, BHA, or the Secretary reverses an eligibility decision which moves the Enrollee to another coverage tier, the CHIP-MCO will retroactively enroll the child into the correct CHIP coverage tier to the date in which the original decision was effective.

3. If the CHIP-MCO, BHA, or the Secretary reverses a decision regarding failure to pay premiums, the CHIP MCO will credit premiums back to the date in which premiums were determined as paid.

4. If the CHIP-MCO, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Enrollee received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, the CHIP-MCO must pay for the service or item that the Enrollee received.

EXHIBIT T

REQUIRED CONTRACT TERMS FOR ADMINISTRATIVE SUBCONTRACTORS

All subcontracts must be in writing and must include, at a minimum, the following provisions:

- The specific activities and report responsibilities delegated to the subcontractor;
- A provision for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
- All subcontractors shall comply with all applicable requirements of the Agreement between the CHIP-MCO and the Department concerning the CHIP;
- Include nondiscrimination provisions;
- Include the provisions of the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq);
- Contain a provision in all subcontracts with any individual firm, corporation or any other entity which provides medical services and receives reimbursement from the CHIP-MCO either directly or indirectly through capitation, that data for all services provided will be reported timely to the CHIP-MCO. Penalties and sanctions will be imposed for failure to comply. The data is to be included in the utilization and encounter data provided to the Department in the format required;
- Contain a provision in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to CHIP Enrollees, that the subcontractor will report all new third party resources to the CHIP-MCO identified through the provision of medical services, which previously did not appear on the Department's recipient information files provided to the CHIP-MCO;
- Contain a hold harmless clause that stipulates that the CHIP-MCO subcontractor agrees to hold harmless the Commonwealth, all Commonwealth officers and employees and all CHIP-MCO Enrollees in the event of nonpayment by the CHIP-MCO to the subcontractor. The subcontractor shall further indemnify and hold harmless the Commonwealth and their agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Commonwealth or their agents, officers or employees, through the intentional conduct, negligence or omission of the subcontractor, its agents, officers, employees or the CHIP-MCO;
- Contain a provision in all subcontracts that the subcontractor agrees to comply with all applicable CHIP, federal and state laws and regulations; including sub-regulatory guidance;

- Contain provisions in all subcontracts with any individual firm, corporation or any other entity which provides medical services to CHIP Enrollees, that prohibits gag clauses which limit the subcontractor from disclosure of medical necessary or appropriate health care information or alternate therapies to Enrollees, other health care professionals or the Department;

- Contain provisions in all employee contracts prohibiting gag clauses which limit said employees from the disclosure of information pertaining to the CHIP; and

- Contain provisions in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to CHIP Enrollees, that limits incentives to those permissible under the applicable Federal regulation.

The CHIP-MCO shall require as a written provision in all subcontracts that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to CHIP Enrollees.

The CHIP-MCO and its subcontractor(s) must agree to maintain books and records relating to the CHIP services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records and prescription files.

The CHIP-MCO and its subcontractor(s) also must agree to comply with all standards for practice and medical records keeping specified by the Commonwealth.

The CHIP-MCO and its subcontractor(s) and the subcontractor's contractor(s) shall, at their own expense, make all books, records, contracts, computers, or other electronic systems available for audit, review, evaluation or inspection by the Commonwealth, its designated representatives, CMS, the HHS Inspector General, the Comptroller General or their designees. Access must be granted either on-site, electronically or through the mail at the discretion of the reviewing entity. The right to audit exists for ten (10) years from the final date of the contract period; or from the date of completion of any audit, whichever is longer. The CHIP-MCO must fully cooperate with any and all reviews and/or audits by state or federal agencies or their agents, such as the Independent Assessment Contractor, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

If the Commonwealth, CMS, or the HHS Inspector General or their designees determine that there is a reasonable possibility of fraud or similar risk, the Commonwealth, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

The CHIP-MCO and its subcontractor(s) shall maintain books, records, documents and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this contract as well as to all required programmatic activity and data pursuant to this contract. 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 contract period and ten (10) 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.

The CHIP-MCO and its subcontractor(s) must agree to retain the source records for its data reports for a minimum of ten (10) years and must have written policies and procedures for storing this information.

The CHIP-MCO shall require, as a written provision in all subcontracts that the subcontractor recognize that payments made to the subcontractor are derived from federal and state funds. Additionally, the CHIP-MCO shall require, as a written provision in all contracts for services rendered to Recipient, that the subcontractor shall be held civilly and/or criminally liable to both the CHIP-MCO and the Department, in the event of nonperformance, misrepresentation, fraud, or abuse. The CHIP-MCO shall notify its PCPs and all subcontractors of the prohibition and sanctions for the submission of false claims and statements.

The CHIP-MCO shall require, as a written provision in all subcontracts that the subcontractor cooperate with Quality Management/Utilization Management Program requirements.

The CHIP-MCO shall monitor the subcontractor's performance on an on-going basis and subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State laws and regulations. If the CHIP-MCO identifies deficiencies or areas needing improvement, the CHIP-MCO and the subcontractor must take corrective action.

EXHIBIT U

REPORTING SUSPECTED FRAUD AND ABUSE TO THE DEPARTMENT

The following requirements are adapted from, Provider Prohibited Acts, which are directly adapted from the 62 PS §1407, (also referred to as Act 105 of 1980, Fraud and Abuse Control Act) and Federal Regulations 42 CFR §457.1285 referencing §438.608(a)(7-8) and 42 CFR 457.935 referencing §455.23(a).

Reporting Requirements:

CHIP-MCOs are required to report to the Department any act by Providers/ Enrollees/Caregivers/Employees that may affect the integrity of CHIP. Specifically, if the CHIP-MCO suspects that either Fraud, Waste or Abuse (as discussed in Section V.3 of the Agreement (may have occurred the CHIP-MCO must report the issue to the Department's Bureau of Program Integrity. In addition to referrals to the Department, the CHIP-MCO is required to simultaneously submit fraud referrals to the Pennsylvania Office of Attorney General Medicaid Fraud Control Section in accordance with 42 CFR §457.1285 referencing §438.608(a)(7). The referrals shall be submitted using the Department's CHIP-MCO Referral Form. Fraud referrals submitted to the Department using the CHIP-MCO Referral Form will be automatically sent to the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section. The CHIP-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.

In addition to referrals to the Department, the CHIP-MCO is required to simultaneously submit fraud referrals directly to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section as provided in 42 CFR 457.1285 referencing CFR §438.608(a)(7). Fraud referrals to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section may be submitted by using the Department's CHIP-MCO Referral Form. Fraud referrals submitted to the Department using the CHIP-MCO Referral Form will be automatically forwarded by the Department to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section. After the referral form is submitted, the CHIP-MCO is required to upload the supporting documentation to the Department using DocuShare. The CHIP-MCO is also required to upload the same supporting documentation to the Office of Attorney General, Medicaid Fraud Control Section through ShareFile.

The CHIP-MCO must also notify the Department if it recovers overpayments or improper payments related to Fraud, Waste or Abuse of CHIP 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 Enrollees or services of a PCP.

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

All Fraud, Abuse, Waste or quality referrals must be made within thirty (30) days of the identification of the problem/issue. The CHIP-MCO must conduct a preliminary investigation to the level of an indication of indicia of fraud. The CHIP-MCO may informally consult with other state agencies or law enforcement to reach this determination. The CHIP-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 Enrollee or significant financial loss to the Department or its agent) must be referred immediately to BPI for further investigation.

Failure to comply with the requirements of Exhibit V will result in sanctions and or corrective action as stated in the CHIP Agreement. The Department must suspend all CHIP payments to a provider after a determination that there is a credible allegation of fraud for which an investigation is pending against an individual or entity unless the Department has good cause not to suspend payments or to suspend payments in part. (42 CFR §457.935 referencing §455.23 (a)). Upon notification from the Department of the imposition of a payment suspension, the CHIP-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 CHIP-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 CHIP-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 CHIP-MCO Referral Form,
- A copy of the confirmation page which will appear after the “Submit” button is clicked, submitting the CHIP-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 CHIP-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

In the event enrollee fraud is suspected but the criteria for restriction is not met, the CHIP-MCO should forward all supporting documentation, including a narrative description of the alleged fraud, to the Department.

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, Enrollee 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 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 V

GUIDELINES FOR SANCTIONS REGARDING FRAUD, WASTE AND ABUSE

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

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

FRAUD, WASTE AND ABUSE ISSUES WHICH MAY RESULT IN SANCTIONS

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

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

B. Failure to cooperate with reviews by oversight agencies or their designees, including the Department, Pennsylvania Office of Attorney General Medicaid Fraud Control Unit , Office of Inspector General of the U.S. DHHS, and other state or federal agencies and auditors under contract to CMS or the Department 42 CFR § 457.1201 referencing 438.3(h).

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

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

E. If a CHIP-MCO fails to provide the relevant operating agency, upon its written request, encounter data, claims data and information, payment methodology, policies and/or other data required to document the services and items delivered by or through the CHIP-MCO to Enrollees 42 CFR § 457.1285 referencing CFR §438.604.

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

under its agreement.

G. If a CHIP-MCO or associate fails to furnish services or to provide members a health benefit, service or item that the organization is required to provide under its Agreement in accordance with 42 CFR § 457.1270 cross-referencing 438.700(b)(1).

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

I. Discriminating against Enrollees or prospective Enrollees on any basis including without limitation, age, gender, ethnic origin or health status 42 CFR § 457.1201 referencing §438.3(d)(3-4).

J. The CHIP-MCO must conduct a preliminary investigation and may consult with other state agencies or law enforcement to determine credible allegations of fraud for which an investigation is pending under the Medicaid program against an individual, a provider, or other entity (42 CFR §457.935 referencing §455.23(a)). Allegations are to be considered credible when there is indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case by case basis (42 CFR §457.935 referencing §455.2).

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

RANGE OF SANCTIONS

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

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

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

EXHIBIT W

PROVIDER MANUALS

The CHIP-MCO shall develop, distribute prior to implementation and maintain a Provider manual. In addition, the CHIP-MCO and/or CHIP-MCO Subcontractors will be expected to distribute copies of all manuals and subsequent policy clarifications and procedural changes to participating Providers following advance written approval of the documents by the Department. Provider manuals must be updated to reflect any program or policy change(s) made by the Department via CHIP Transmittal or Policy Clarification within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the CHIP Transmittal or Policy Clarification, whichever is later, when such change(s) affect(s) information that the CHIP-MCO is required to include in its provider manual, as set forth in this Exhibit. The Provider manual must include, at a minimum, the following information:

A. A description of the case management system and protocols;

B. A description of the role of a PCP as described in Section II, Definitions, and of the Agreement and the CHIP State Plan.

C. Information on how Enrollees may access specialists, including standing referrals and specialists as PCPs;

D. A summary of the guidelines and requirements of Title VI of the Civil Rights Act of 1964 and its guidelines, and how Providers can obtain qualified interpreters familiar with medical terminology;

E. Contact information to access the CHIP-MCO, DHS, advocates, other related organizations, etc;

F. A copy of the CHIP-MCO's Formulary, Prior Authorization, and Program Exception process;

G. Contact follow-up responsibilities for missed appointments;

H. Description of drug and alcohol treatment available and how to make referrals;

I. Complaint, Grievance, External Review and DHS Fair Hearing information;

J. Information on Provider Disputes;

K. CHIP-MCO policies, procedures, available services, and sample forms applicable to the Provider type;

L. A full description of covered services,;

M. Billing instructions;

N. Information on self-referred services and services;

O. Provider performance expectations, including disclosure of Quality Management and Utilization Management criteria and processes;

P. Information on procedures for sterilizations, hysterectomies and abortions (if applicable);

Q. Information about Bright Futures screening requirements and information on the dental referral process);

R. Information on ADA and Section 504 of the Rehabilitation Act of 1973, other applicable laws, and available resources related to the same;

S. A definition of "Medically Necessary" consistent with the language in the Agreement;

T. Information on Enrollee confidentiality requirements;

U. Information regarding school-based/school-linked services in this Managed Care Program Zone; and

V. The Department's Provider Compliance Hotline (formerly the Fraud and Abuse Hotline) number and explanatory statement.

AA. Information regarding written translation and oral interpretation services for Enrollee's with LEP and alternate methods of communication for those requesting communication in alternate formats.

BB. List and scope of services for referral and Prior Authorization.

CC. Information about the Pennsylvania MA Provider Self Audit Protocol which allows Providers to voluntarily disclose overpayments or improper payments of MA funds.

The CHIP-MCO is required to provide documented training to its Providers and their staffs and to Subcontractors, regarding the contents and requirements of the Provider manuals.

EXHIBIT X

AUDIT CLAUSE

AUDITS

Annual Agreement Audits

The CHIP-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 CHIP-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 CHIP-MCO is responsible to provide CHIP benefits to CHIP Enrollees shall be submitted to the Commonwealth within 180 days after the Agreement termination date or the last date the CHIP-MCO is responsible to provide CHIP benefits.

The CHIP-MCO shall ensure that audit working papers and audit reports are retained by the CHIP-MCO's auditor for a minimum of ten (10) years from the date of final payment under the Agreement, unless the CHIP-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 CHIP-MCO's auditor.

Annual Entity-Wide Financial Audits

The CHIP-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 CHIP-MCO, its subcontractors or Providers. Any such additional audit work will rely on work already performed by the CHIP-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 CHIP-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 CHIP-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 CHIP-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 CHIP-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 CHIP-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 CHIP-MCO shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site, during normal business hours, or through the mail. During the Agreement and record retention period, these records shall be available at the CHIP-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 CHIP-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 CHIP-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 CHIP-MCO shall include in all risk sharing CHIP-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 CHIP-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 Y

ENCOUNTER DATA SUBMISSION REQUIREMENTS AND PENALTY APPLICATIONS

The submission of timely and accurate Encounter Data is critical to the Department's ability to establish and maintain cost effective and quality managed care programs. Consequently, the requirements for submission and metrics for measuring the value of the data for achieving these goals are crucial.

- **CERTIFICATION REQUIREMENTS**

  All CHIP-MCOs must be certified through the Department's MMIS prior to the submission of live Encounter Data. The certification process is detailed on the Pennsylvania HealthChoices Extranet.

- **SUBMISSION REQUIREMENTS**

  - Timeliness:

    With the exception of NCPDP Encounters, all CHIP-MCO approved Encounters and those specified CHIP-MCO-denied Encounters must be approved in the Department's MMIS by the last day of the third month following the month of initial CHIP-MCO adjudication. NCPDP Encounters must be submitted and approved in the Department's MMIS within thirty (30) days following the CHIP-MCO adjudication.

    - Metric:

      During the six months following the month of the initial MMIS adjudication, Encounters will be analyzed for timely submission.

      - Failure to achieve the Department's MMIS approved/paid status for 98% of all CHIP-MCO paid/approved and specified CHIP-MCO denied Encounters by the last day of the third month following initial CHIP-MCO adjudication may result in a penalty.

      - Any Encounter Data corrected or initially submitted after the last day of the third month following initial CHIP-MCO adjudication may be subject to a penalty.

  Accuracy and Completeness:

  Accuracy and completeness are based on consistency between Encounter Data submitted to the Department's MMIS and information for the same service maintained by the CHIP-MCO in their Claims/service history database.

  - Metric:

Accuracy and completeness will be determined through a series of analyses of CHIP-MCO Claims history data and Encounters received and processed through the Department's MMIS. This analysis will be done at least yearly but no more than twice a year and will consist of making comparisons between encounter samples and what is found in the CHIP-MCO's claims history. Samples may also be drawn from the CHIP-MCO's service history and compared with Encounters processed through the Department's MMIS.

Samples will be drawn proportionally based on the CHIP-MCO financial expenditures for each transaction type submitted during the review period. Each annual or semi-annual analysis will be based on a statistically valid sample of no less than 200 records.

- **PENALTY PROVISION**

Timeliness:

Failure to comply with timeliness requirements will result in a sanction of up to $10,000 for each program month.

Completeness and Accuracy:

Errors in accuracy or completeness that are identified by the Department in an annual or semi-annual analysis will result in sanctions as follows. An error in accuracy or completeness or both, in one sample record, counts as one error.

Percentage of the sample that includes an error	Sanction
Less than 1.0 percent	None
1.0 – 1.4 percent	$4,000
1.5 – 2.0 percent	$10,000
2.1 - 3.0 percent	$16,000
3.1 – 4.0 percent	$22,000
4.1 – 5.0 percent	$28,000
5.1 – 6.0 percent	$34,000
6.1 – 7.0 percent	$40,000
7.1 – 8.0 percent	$46,000
8.1 – 9.0 percent	$52,000
9.1 – 10.0 percent	$58,000
10.1 percent and higher	$100,000

EXHIBIT Z

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

The CHIP-MCO must consider the following in establishing and maintaining its Provider Network per 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(a):

- The anticipated CHIP enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHIP populations represented in the CHIP-MCO;
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted CHIP services;
- The number of Network Providers who are not accepting new CHIP patients, and
- The geographic location of Providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities.
- Ability of providers to communicate with enrollees with Limited English Proficiency (LEP) in their preferred language;
- Ability of providers to ensure physical access, reasonable accommodations, culturally competent communication, and accessible equipment to enrollees with physical or mental disabilities; and
- Availability of triage lines or screening systems, telemedicine and e-visits, or other evolving and innovative technological solutions, or both.

The CHIP-MCO must adhere to CMS network adequacy standards as outlined in 42 CFR §§457.1218 and 457.1230 referencing 42 CFR §438.68(b)(1)(viii), 438.68(b)(3), and 438.206. The CHIP-MCO must ensure that its Provider Network is adequate to provide its Enrollees in this Managed Care Program Zone with access to quality Enrollee care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the CHIP-MCO must supply geographic access maps using Enrollee 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 Enrollees. The Department may require additional numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The CHIP-MCO must also have a process in place which ensures that the CHIP-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The CHIP-MCO must make all reasonable efforts to honor an Enrollees choice

of Providers who are credentialed in the Network. If the CHIP-MCO is unable to ensure an Enrollee's access to provider or specialty provider services within the CHIP-MCO's network, within the travel times set forth in this Exhibit, the CHIP-MCO must make all reasonable efforts to ensure the Enrollee's access to these services within the travel times herein through out-of-network providers. In locations where the CHIP-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 an Enrollee's access to these services within the travel times set forth in this Exhibit, the CHIP-MCO must work with Enrollees to offer reasonable provider alternatives. Additionally, the CHIP-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire Managed Care Program Zone in which the CHIP-MCO operates if providers exist:

a. PCPs

Make available to every Enrollee 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. Enrollees 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 Enrollees who want a pediatrician as a PCP to have a choice of two (2) within the travel time limits (30 minutes Urban, 60 minutes Rural).

c. Specialists

i. For the following provider types, the CHIP-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	Cardiology
Obstetrics & Gynecology	Pharmacy
Oncology	Orthopedic Surgery
Physical Therapy	General Dentistry
Radiology	Pediatric Dentistry

CHIP-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	Cardiology
Obstetrics & Gynecology	Pharmacy
Orthopedic Surgery	Pediatric Dentistry
General Dentistry	

ii. For the following provider types, the CHIP-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 Managed Care Program Zone:

Oral Surgery	Urology
Nursing Facility	Neurology
Dermatology	Otolaryngology

The CHIP-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 Managed Care Program Zone:

Oral Surgery	Urology
Nursing Facility	Neurology
Dermatology	Otolaryngology
Oncology	Radiology
Physical Therapy	

iii. For all other specialists and subspecialists, the CHIP-MCO must have a choice of two (2) providers who are accepting new patients within the Managed Care Program 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 Managed Care Program 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 CHIP-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the enrollees, then the CHIP-MCO must allow Enrollees to pick an Out-of-Network Provider if not satisfied with the Network Provider. The CHIP-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for

informing the Enrollee of how to request this authorization for Out-of-Plan Services.

f. Anesthesia for Dental Care

For Enrollees needing anesthesia for dental care, the CHIP-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 Managed Care Program Zone.

h. CNMs / CRNPs, Other Health Care Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. In accordance with RX for PA Principles, the CHIP-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

i. Qualified Providers

The CHIP-MCO must limit its PCP Network to appropriately qualified Providers. The CHIP-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.

j. Members Freedom of Choice

The CHIP-MCO must demonstrate its ability to offer its Enrollees freedom of choice in selecting a PCP. At a minimum, the CHIP-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 Enrollees assigned to a PCP may be decreased by the CHIP-MCO if necessary to maintain the appointment availability standards.

k. FQHCs / RHCs

The CHIP-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 CHIP-MCO has an agreement. If the CHIP-MCO's primary care Network includes FQHCs and RHCs, these sites may be designated as PCP sites.

l. Medically Necessary Emergency Services

The CHIP-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.

m. ADA Accessibility Guidelines

The CHIP-MCO must inspect the office of any PCP or dentist who seeks to participate in the CHIP-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 CHIP-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 CHIP-MCO's Provider Network provided that the PCP or dentist: 1) requests and is determined by the CHIP-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 CHIP-MCO identified the barrier.

The CHIP-MCO must document its efforts to determine architectural accessibility. The CHIP-MCO must submit this documentation to the Department upon request.

n. Laboratory Testing Sites

The CHIP-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.

o. CHIP-MCO Discrimination

The CHIP-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 CHIP-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 CHIP-MCO.

p. Declined Providers

If the CHIP-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.

q. Second Opinions

The CHIP-MCO must provide for a second opinion from a qualified

Health Care Provider within the Network, at no cost to the Enrollee. If a qualified Health Care Provider is not available within the Network, the CHIP-MCO must assist the Enrollee in obtaining a second opinion from a qualified Health Care Provider outside the Network, at no cost to the Enrollee, unless co-payments apply.

r. American Indians and Indian Healthcare Providers

Consistent with 42 CFR §457.1209 referencing 438.14(b)(1-3), The CHIP-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 CHIP managed care services provided to Indian Enrollees who are eligible to receive services from such providers either at a rate negotiated between the CHIP-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 CFR §457.1209 referencing §438.14(b)(5-6), the CHIP-MCO must permit American Indian Enrollees to access out of state IHCPs; or permit an out- of-network IHCP to refer an American Indian Enrollee to a network provider.

When an IHCP is enrolled in CHIP as an FQHC, but not a participating provider of the CHIP-MCO, the IHCP must be paid an amount equal to the amount the CHIP-MCO would have paid to a network FQHC. When the IHCP is not enrolled in CHIP as an FQHC, the CHIP-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 CHIP-MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever an Enrollee 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 Enrollee. 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 CHIP-MCO must provide the Department with its protocol for ensuring that an Enrollee'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 Enrollee must be informed of scheduling time frames through educational outreach efforts.

vi. The CHIP-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room visits.

b. Persons with HIV/AIDS

The CHIP-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 CHIP-MCO to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the Enrollee is already in active

care with a PCP or specialist.

c. Specialty Referrals

For specialty referrals, the CHIP-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.

d. Pregnant Women

Should the EAP contractor or Enrollee notify the CHIP-MCO that a new Enrollee is pregnant or there is a pregnancy indication on the files transmitted to the CHIP-MCO by the Department, the CHIP-MCO must contact the Enrollee 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 CHIP-MCO must arrange initial prenatal care appointments for enrolled pregnant Members as follows:

i. First trimester — within ten (10) Business Days of the Enrollee

being identified as being pregnant.

ii. Second trimester — within five (5) Business Days of the Enrollee being identified as being pregnant.

iii. Third trimester — within four (4) Business Days of the Enrollee being identified as being pregnant.

iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the CHIP-MCO or maternity care Provider, or immediately if an emergency exists.

3. Policies and Procedures for Appointment Standards

The CHIP-MCO will comply with the program standards regarding service accessibility standards that are set forth in this Exhibit and in Section V.BB.1 of the Agreement, Provider Agreements.

The CHIP-MCO must have written policies and procedures for disseminating its appointment standards to all Enrollees through its Enrollee handbook and through other means. In addition, the CHIP-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The CHIP-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 CFR §457.1218, cross-referencing 42 CFR 438.68 CFR(b)(1)(viii), the CHIP-MCO must adhere to any time and distance access standards established by CMS. The CHIP-MCO must comply with the access standards in accordance with this Exhibit and Section V.BB.1 of the Agreement, Provider Agreements. If the CHIP-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 CHIP-MCO must make reasonable efforts to honor an Enrollee's choice of Providers among Network Providers as long as:

i. The CHIP-MCO's agreement with the Network Provider covers the services required by the Enrollee; and

ii. The CHIP-MCO has determined that the Enrollee's choice is clinically appropriate.

The CHIP-MCO must provide the Department adequate assurances that the CHIP-MCO, with respect to each Managed Care Program Zone of operation, has the capacity to serve the expected Enrollment in each Managed Care Program Zone of operation. The CHIP-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 CHIP-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.BB.1 of the Agreement, Provider Agreements.

c. CHIP-MCO's Corrective Action

The CHIP-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 CHIP-MCO will be given the opportunity to institute a corrective action plan. The CHIP-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 CHIP-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the CHIP-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the CHIP-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the CHIP-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 CHIP-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 AA

OUTPATIENT DRUG SERVICES

1. General Requirements

a. All requirements in this Exhibit apply to all outpatient drugs regardless of the setting in which the drug is dispensed or administered, the billing provider type, or how the CHIP-MCO makes payment for the drug (pharmacy benefit and/or medical benefit).
b. All outpatient drugs must be dispensed through CHIP-MCO Network Providers.

c. Outpatient drugs include brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers enrolled in CHIP.

d. The CHIP-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.

e. Under no circumstances will the CHIP-MCO permit the therapeutic substitution of an outpatient drug by a pharmacist without explicit authorization from the licensed prescriber.

f. All proposed outpatient 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, outcomes-based contracting, 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.

g. The CHIP-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for outpatient drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will:

    i. Apply, regardless of whether the outpatient drug is provided as an outpatient drug benefit or as a “medical benefit” incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).

    ii. Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-

reviewed medical literature.

h. The CHIP-MCO must submit for review and approval a policy for each section of this Exhibit that includes the requirements in the respective section and the CHIP-MCO's procedures to demonstrate compliance.

i. The CHIP-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 CHIP-MCO policy and procedures for continuity of care for outpatient drugs, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the CHIP-MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to outpatient drugs that the Member was prescribed before enrolling in the CHIP-MCO.

j. The CHIP-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) either by addition to the MCO Formulary, or through prior authorization, within ten (10) days from their availability in the marketplace.

k. The CHIP-MCO must comply with Section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).

2. Coverage Exclusions

a. The CHIP-MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.
b. The CHIP-MCO must not provide coverage for drugs distributed by a manufacturer that has not entered into a Federal Drug Rebate Program agreement with the Centers for Medicare and Medicaid Services (CMS).
c. The CHIP-MCO must exclude coverage of non-compensable drugs in accordance with 55 PA Code §1121.54.

3. Formularies and Preferred Drug Lists (PDLs)

a. The Formulary or PDL must be developed and reviewed annually by an appropriate Pharmacy and Therapeutics (P&T) Committee.

b. The Formulary or PDL must meet the clinical needs of the CHIP population. The Formulary or PDL must include a range of drugs in each therapeutic drug class represented. The Department reserves the right to determine if the Formulary or PDL meets the clinical needs of the CHIP population.

c. The Formulary or PDL must be clinically based. Only those drugs that do not have a significant, clinically meaningful therapeutic advantage, in terms of safety, effectiveness, or clinical outcomes, over the drugs included in the Formulary or

PDL, may be designated as non-formulary or non-preferred.

d. The CHIP-MCO must make a satisfactory written explanation of the reason(s) for designating a drug as non-formulary or non-preferred available to the Department upon request.

e. The CHIP-MCO must allow access to all non-formulary or non-preferred drugs when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy).

f. The CHIP-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, 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. CHIP-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 CHIP-MCO must submit all Formulary or PDL deletions to the Department for review and written approval prior to implementation.

h. The CHIP-MCO must submit written notification of any Formulary or PDL additions to the Department within fifteen (15) days of implementation.

i. The CHIP-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 Outpatient Drugs

a. For outpatient drugs that require Prior Authorization (including step therapy) as a condition of coverage or payment:

i. The CHIP-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 an urgent request, and within 2 business days but no more than 72 hours for non-urgent requests and

ii. If an Enrollee's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the CHIP-MCO must instruct the pharmacist to dispense:

- A seventy-two (72) hour supply of the medication.

b. For drugs not able to be divided and dispensed into individual doses, the CHIP-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 Enrollee 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 Enrollee may be taking, would jeopardize the health or safety of the Enrollee.

d. In such an event, the CHIP-MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber.

e. If the CHIP-MCO denies the request for prior authorization, the CHIP-MCO must issue a written denial notice, within twenty-four (24) hours of receiving the request for an urgent prior authorization and within 2 business days but no more than 72 hours for non-urgent prior authorization requests.

f. If the Enrollee files a Grievance request from a denial of an Ongoing Medication, the CHIP-MCO must authorize the medication until the Grievance or External Review request is resolved.

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

h. In addition, 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 Enrollee'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 minimum of three reasonable attempts to contact the prescriber prior to issuing a denial for the requested service. The reasonable attempts to contact the prescriber must be documented in writing.

i. When medication is authorized due to the CHIP-MCO's obligation to continue services while a Enrollee's Grievance or External Review is pending, and the final binding decision is in favor of the CHIP-MCO, a request for subsequent refill of the prescribed medication does not constitute an Ongoing Medication.

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

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

5. Provider and Enrollee Notification

The CHIP-MCO must have policies and procedures for notification to Providers and enrollees of changes to the MCO Formulary, Prior Authorization requirements and other requirements for outpatient 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 Enrollees at least thirty (30) days prior to the effective date of the change.

b. The CHIP-MCO must provide all other Providers and Enrollees written notification of changes to the requirements upon request.

c. The CHIP-MCO also must generally notify providers and enrollees of changes through enrollee and provider newsletters, its website, or other regularly published media of general distribution.

d. Enrollee notices must be submitted to the Department for review and approval prior to mailing.

6. CHIP-MCO Pharmacy & Therapeutics (P&T) Committee

The P&T Committee membership must include at a minimum: physicians, including behavioral health physicians pharmacists, other appropriate clinicians, and CHIP program consumers.

a. The CHIP-MCO must submit a P&T Committee membership list for Department review and approval upon request.

b. 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.

c. The minutes from each CHIP-MCO P&T Committee meeting must be posted for public view on the CHIP-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 CHIP-MCO or Subcontractor must contract on an equal basis with any pharmacy qualified to participate in the CHIP Program that is willing to comply with the CHIP-MCO's payment rates and terms and to adhere to quality standards established by the CHIP-MCO as required by 62 P.S 449.

i. The provisions for any willing pharmacy apply if the CHIP-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. CHIP-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 CHIP-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 CHIP-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 CHIP-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 CHIP-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 CHIP-MCO or subcontractor must submit to the Department for review and approval all changes to the payment methodology prior to implementation.

d. The CHIP-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 CHIP-MCO.

f. The CHIP-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. Outpatient Drug Encounters

a. The CHIP-MCO shall submit all outpatient 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. For all outpatient drug encounter data including pharmacy point-of-sale (NCPDP), physician- administered drugs (837P), outpatient hospital drugs (837I), and drugs dispensed by 340B covered entities and contract pharmacies, the following data elements are required:

i. Valid NDC for the drug dispensed.

- The CHIP-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 CHIP-MCO shall also include the diagnosis codes associated with the NDC for all 837P and 837I encounters where payment was made by the CHIP-MCO based on the HCPCS code and HCPCS code units.

ii. Valid NDC units for the drug dispensed.

- The CHIP-MCO shall also include the HCPCS units associated with the NDC for all 837P and 837I encounters where payment was made by the CHIP-MCO based on the HCPCS code and HCPCS code units.

iii. Actual paid amount by the CHIP-MCO, or the CHIP-MCO's PBM, to the provider for the drug dispensed.

iv. Actual TPL amount paid by the Enrollee's primary pharmacy coverage to the provider for the drug dispensed.

v. Actual copayment paid by the Enrollee to the provider for the drug dispensed.

vi. Actual dispensing fee paid by the CHIP-MCO, or the CHIP-MCO's PBM, to the provider for the drug dispensed.

vii. The billing provider's:

- NPI and/or CHIP or MA PROMISe Identification Number
- Full address and phone number associated with the NPI

viii. The prescribing provider's:

- NPI and/or CHIP or MA PROMISe 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 CHIP-MCO, or the CHIP-MCO's PBM, to the provider for the drug.

xi. Any other data elements identified by the Department.

c. The CHIP-MCO will edit and validate claim transaction submissions and outpatient drug encounter data for completeness and accuracy in accordance with claim standards such as NCPDP. The actual paid amount by the CHIP-MCO, or the CHIP-MCO's PBM, to the dispensing provider must be accurately submitted on each outpatient drug encounter to the Department.

d. The CHIP-MCO shall ensure that the NDC on all outpatient drug encounters is appropriate for the HCPCS code based on the NDC and units billed. The NDC must represent a drug that was available to the prescriber in an outpatient setting for administration.

e. The CHIP-MCO shall meet outpatient drug encounter data accuracy requirements by submitting CHIP-MCO paid outpatient drug encounters with no more than a

3% error rate, calculated for a month's worth of encounter submissions. The Department will monitor the CHIP-MCO's corrections to denied encounters by random sampling performed quarterly and over the term of this Agreement. The CHIP-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.

f. If the CHIP-MCO fails to submit outpatient drug encounter data within timeframes specified, the Department shall assess civil monetary penalties upon the CHIP-MCO. These penalties shall be $2,000 for each calendar day that the outpatient drug encounter data is not submitted. The Department may waive these sanctions if it is determined that the CHIP-MCO was not at fault for the late submission of the data.

9. Prospective Drug Utilization Review (Pro-DUR)

a. The CHIP-MCO must provide for a review of drug therapy before each prescription is filled or delivered to an Enrollee 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 CHIP-MCO must provide for counseling of Enrollees receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

10. Retrospective Drug Utilization Review (Retro-DUR)

a. The CHIP-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 Enrollees.

b. The CHIP-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 CHIP-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.

11. Pharmacy Benefit Manager (PBM)

The CHIP-MCO may use a PBM to process prescription Claims only if the CHIP-MCO has received advance written approval by the Department. The CHIP-MCO must indicate the intent to use a PBM, and identify the proposed PBM Subcontract, the CHIP-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 outpatient drugs, and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly, in part, or by the same parent company as a CHIP-MCO, retail pharmacy Provider, chain drug store or pharmaceutical manufacturer, the CHIP-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.

EXHIBIT BB

CHIP MCO PROVIDER AGREEMENTS

The CHIP-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Enrollee access to all Medically Necessary services covered by CHIP. The CHIP-MCO is also required to ensure that its participating providers are enrolled in CHIP, and to require that their information is kept up to date in the DHS PROMISe™ system.

The CHIP-MCO's Provider Agreements must include the following provisions:

a. A requirement that the CHIP-MCO must not exclude or terminate a Provider from participation in the CHIP-MCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

b. A requirement that the CHIP-MCO must not exclude a Provider from the CHIP-MCO's Provider Network because the Provider advocated on behalf of and Enrollee for Medically Necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable Health Care Provider practicing according to the applicable legal standard of care.

c. Notification of the prohibition and sanctions for submission of false Claims and statements.

d. The definition of Medically Necessary as defined in Section II of this Agreement, Definitions.

e. A requirement that the CHIP-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of an Enrollee including: information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

f. A requirement that the CHIP-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from providing information the Enrollee needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or nontreatment.

g. A requirement that the CHIP-MCO cannot terminate a contract or employment with a Health Care Provider for filing a Grievance on an Enrollee's behalf.

h. A clause which specifies that the agreement will not be construed as requiring the CHIP-MCO to provide, reimburse for, or provide coverage of, a counseling or referral service if the Provider objects to the provision of such services on

moral or religious grounds.

i. A requirement securing cooperation with the QM/UM Program standards outlined in Exhibit G of this Agreement, Quality Management and Utilization Management Program Requirements.

j. A requirement for cooperation for the submission of Encounter Data for all services provided within the time frames required in Section VIII of this Agreement, Reporting Requirements, no matter whether reimbursement for these services is made by the CHIP-MCO either directly or indirectly through capitation.

k. A continuation of benefits provision which states that the Provider agrees that in the event of the CHIP-MCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the CHIP-MCO's Enrollees, including Enrollees in an inpatient setting, through the period for which the Capitation has been paid.

l. A requirement that the PCPs who serve Enrollees are responsible for conducting all Bright Futures screens for individuals on their panel. Should the PCP be unable to conduct the necessary Bright Futures screens, the PCP is responsible for arranging to have the necessary Bright Futures screens conducted by another Network Provider and ensure that all relevant medical information, including the results of the Bright Futures screens, are incorporated into the Enrollee's PCP medical record. For details on access requirements, see Exhibit Z of this Agreement, Provider Network Composition/Service Access, as applicable.

m. A requirement that PCPs report Encounter Data associated with Bright Futures screens, using a format approved by the Department, to the CHIP-MCO within ninety (90) days from the date of service.

(1) A requirement that PCPs contact new Enrollees identified in the quarterly Encounter lists who have not had an Encounter during the first six (6) months of Enrollment, or who have not complied with the scheduling requirements outlined in the RFA and this Agreement. The CHIP-MCO must require the PCP to contact Enrollees identified in the quarterly Encounter lists as not complying with the Bright Futures periodicity and immunization schedules for children. The PCP must be required to identify to the CHIP-MCO any such Enrollees who have not come into compliance with the Bright Futures periodicity and immunization schedules within one (1) month of such notification to the site by the CHIP-MCO. The PCP must also be required to document the reasons for noncompliance, where possible, and to document its efforts to bring the Enrollee's care into compliance with the standards. PCPs shall be required to contact all Enrollees who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in Exhibit Z of this Agreement, Provider Network/ Service Access, as applicable, to arrange appointments.

n. A requirement that the CHIP-MCO include in all capitated Provider Agreements

a clause which requires that should the Provider terminate its agreement with the CHIP-MCO, for any reason, that the Provider provide services to the Enrollees assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.

o. A requirement that ensures each physician providing services to Members eligible for Medical Assistance under the State Plan to have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act.

p. Language which requires the Provider to disclose annually any Physician Incentive Plan or risk arrangements it may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no Substantial Financial Risk between the CHIP-MCO and the physician or physician group.

q. A provision that the CHIP-MCO's Utilization Management (UM) Departments are mandated by the Department to monitor the progress of an Enrollee's inpatient hospital stay. This must be accomplished by the CHIP-MCO's UM department receiving appropriate clinical information from the hospital that details the member's admission information, progress to date, and any pertinent data within two (2) business days from the time of admission. The CHIP-MCOs providers must agree to the CHIP-MCO's UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the CHIP-MCO's Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the CHIP-MCO must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

r. Requirements regarding Behavioral Health (BH) Providers Agreements:

(1) Comply with all applicable laws and regulations pertaining to the confidentiality of Enrollee medical records, including obtaining any required written member consents to disclose confidential medical records.

(2) Make referrals for social, vocational, education or human services when a need for such service is identified through assessment.

(3) Provide health records if requested by the BH Provider.

(4) Notify BH Provider of all prescriptions, and when deemed advisable, check with BH Provider before prescribing medication. Make certain BH clinicians have complete, up-to-date record of medications.

(5) Be available to the BH Provider on a timely basis for consultations.

s. The CHIP-MCO must require that participating ER staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for the county.

t. The CHIP-MCO must require that each provider furnishing services to Enrollees maintains and shares, as appropriate, an Enrollee health record in accordance with professional standards.

The CHIP-MCO may not enter into a Provider Agreement that prohibits the Provider from contracting with another CHIP-MCO or that prohibits or penalizes the CHIP-MCO for contracting with other Providers.

The CHIP-MCO must make all necessary revisions to its Provider Agreements to be in compliance with the requirements set forth in this section. Revisions may be completed as Provider Agreements become due for renewal provided that all Provider Agreements are amended within one (1) year of the effective date of this Agreement with the exception of the Encounter Data requirements which must be amended immediately, if necessary, to ensure that all Providers are submitting Encounter Data to the CHIP-MCO within the time frames specified in Section VIII.A.1 of this Agreement, Encounter Data Reporting.

Exhibit CC

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 CHIP-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 CHIP-MCOs, and report annually on the clinical and financial outcomes of their PCMH program.

A. The CHIP-MCO will educate Enrollees what the PCMH model is and inform Enrollees of the resources available through the PCMH.

B. The CHIP-MCO will ensure the PCMH provider meets the following requirements:

1. Will be a high-volume CHIP practice already participating in the CHIP-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,

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 CHIP-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 CHIP-MCO provider 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 CHIP-MCO,

7. Will measure patient satisfaction using a validated low literacy appropriate tool to assess individual and family 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,

10. Will participate in a PCMH learning network,

11. Will complete a Social Determinants of Health (SDOH) 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 CHIP-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 CHIP-MCO and Department a report of the SDOH assessment outcomes as may be requested, and

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 Enrollee who reports having a special need to the Enrollee’s CHIP-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 CHIP-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 CHIP-MCO's PCMH network will include high volume pediatric providers that serve the percentage of total Enrollees and percentage of Enrollees that fall within the top 5th percentile of medical costs.

- Calendar year 2025 – 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 CHIP-MCO will collect key quality metrics from the PCMHs and report those results annually to the Department.

F. The CHIP-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 CHIP-MCO will develop a quarterly regional learning network that includes all PCMHs, patient advocates or family team members, and CHIP-MCOs in a Geographical Service Area. At least one of the PCMH Learning Collaboratives needs to be face-to-face.

H. The CHIP-MCO will report annually on the clinical and financial outcomes of their PCMH program. The report will address key quality, utilization, and financial outcomes as well as a return on investment calculation. The report will also describe the number of PCMHs that have gain share arrangements, risk arrangements, payments made for quality, and payments made for gain share or risk arrangements. The report will also list the total medical costs of the patients attributed to the PCMHs.

I. Data Sharing

The CHIP-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.