APPENDIX B

FINANCIAL REQUIREMENTS

A. Financial Standards

1. Equity Requirements and Solvency Protection

The CHC-MCO must meet the Equity and solvency protection requirements set forth below and with all financial requirements included in this Agreement, in addition to those of the PID.

The CHC-MCO must maintain a 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:

- Twenty Million Dollars ($20.00 million);

- Seven percent (7.000%) of revenue earned by the CHC-MCO during the most recent four (4) calendar quarters; or

- Seven percent (7.000%) of revenue earned by the CHC-MCO 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 CHC-MCO with PID to determine Equity amounts.

The CHC-MCO must provide the Department with reports as specified in Section VIII.E and F. Financial Reports and Equity.

If the CHC-MCO operates its plan through another legal entity or entities, and if that other entity or those other entities receive(s) from the CHC-MCO a total amount that is at least seventy five percent (75%) of the revenue paid by the Department to the CHC-MCO, then the CHC-MCO may request the following equity requirement as an alternative to the Three (3) Part Test set forth above, subject to the approval of the Department:

1. The CHC-MCO RBC ratio must be at least three (3.0);

2. The CHC-MCO must maintain a SAP-basis Equity no less than an amount that is the higher of:

    a. Five and one-half percent (5.5%) of revenue earned by the CHC-MCO during the most recent four (4) calendar quarters; or

    b. Five and one-half percent (5.5%) of revenue earned by the CHC-MCO during the then-current calendar quarter multiplied by 3; and

3. The other entity or other entities that operate(s) the CHC-MCO's plan in a particular zone must maintain (individually, in the case of multiple entities) Equity no less than an amount that is the higher of:

    a. Eight and three-tenths percent (8.3%) of revenue earned by the entity during the most recent four (4) calendar quarters; or

    b. Eight and three-tenths percent (8.3%) of revenue earned by the entity during the then-current calendar quarter multiplied by three (3).

Revenue, for the purpose of this alternative equity requirement, would be premiums as noted on the most-recent audited statements.

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

2. Risk Based Capital

The RBC ratio is defined as:

- The Total Adjusted Capital figure in Column One from the page titled Five Year Historical Data in the Annual Statement for the most recent year filed most recently with the PID, divided by the Authorized Control Level Risk-based Capital figure.

The CHC-MCO must maintain a RBC ratio of two (2.0).

3. Prior Approval of Payments to Affiliates

With the exception of payment of a Claim for a medical product or service that was provided to a Participant, and that is paid in accordance with a written Provider Agreement, the CHC-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 CHC-MCO's RBC ratio was less than two (2.0) as of December 31 of

the most recent year for which the due date for filing the annual unaudited PID financial report has passed;

b. The CHC-MCO was not in compliance with the Agreement Equity and solvency protection requirement as of the last day of the most recent quarter for which the due date for filing PID financial reports has passed;

c. After the proposed transaction took place, the CHC-MCO would not be in compliance with the Agreement Equity and solvency protection requirement; or

d. Subsequent adjustments are made to the CHC-MCO's financial statement as the result of an audit, or otherwise modified, such that after the transaction took place, a final determination is made that the CHC-MCO was not in compliance with the Agreement's 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.

4. Change in Independent Actuary or Independent Auditor

The CHC-MCO must notify the Department within ten (10) days when its contract with an independent auditor or actuary has ended. The CHC-MCO must include in the notification, 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 CHC-MCO must disclose the nature of the disagreement or dispute.

5. Modified Current Ratio

The CHC-MCO must maintain current assets, plus long-term investments that can be converted to cash within five (5) business days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

- If a penalty for conversion of long-term investments is applicable, only the value net of the penalty may be counted for the purpose of compliance with this requirement.
- The definitions of current assets and current liabilities are included in the Financial Reporting Requirements.
- Restricted assets may be included only with authorization from the Department.
- The following types of long-term investments may be counted, consistent with above requirements, so long as they are not issued by or include an interest in an Affiliate:

- Certificates of Deposit
- United States Treasury Notes and Bonds
- United States Treasury Bills
- Federal Farm Credit Funding Corporation Notes and Bonds
- Federal Home Loan Bank Bonds
- Federal National Mortgage Association Bonds
- Government National Mortgage Association Bonds
- Municipal Bonds
- Corporate Bonds
- Stocks
- Mutual Funds

6. Sanctions

In addition to the Department's general sanction authority specified in Section VIII.I, Sanctions, if the CHC-MCO fails to comply with the requirements of Section VII.A, Financial Requirements, the Department may take any or all of the following actions, in accordance with 42 C.F.R. §§ 438.700; 438.702; and 438.704:

- Discuss fiscal plans with the CHC-MCO's management;
- Suspend payments or a portion of payments for Participants enrolled after the effective date of the sanction and until the Department is satisfied that the reason for the imposition of the sanction no longer exists and is not likely to recur;
- Require the CHC-MCO to submit and implement a corrective action plan;
- Suspend all new and default Enrollment of Participants into the CHC-MCO, including auto-assignments, after notification by the Federal or State government;
- Terminate this Agreement upon forty-five (45) days written notice, in accordance with Section X of this Agreement, Termination and Default.

In addition, the Department may impose sanctions described above when a CHC-MCO, either directly or through a Subcontractor, acts or fails to act as follows:

- Fails substantially to arrange for Medically Necessary services that the CHC-MCO is required to provide to a Participant under law or under its Agreement.
- Imposes on Participants premiums or charges that are in excess of the premiums or charges permitted under the MA program.
- Acts to discriminate among Participants on the basis of their health status or need for healthcare services.
- Misrepresents or falsifies information that it furnishes to CMS, the Department, Participants, Potential Participants, or Healthcare Providers.
- Fails to comply with requirements for PIPs as set forth in 42 C.F.R. §§

422.208 and 422.210.

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

7. Payment for Disproportionate Share Hospitals and Graduate Medical Education

The Department will make direct Disproportionate Share Hospital and Graduate Medical Education Payments to hospitals.

8. Participant Liability

In accordance with 42 C.F.R. § 438.106, the CHC-MCO must provide that its Participants are not held liable for the following:

a. Debts of the CHC-MCO in the event of the CHC-MCO's insolvency.

b. Services provided to the Participant in the event that the CHC-MCO fails to receive payment from the Department for such services.

c. Services provided to the Participant in the event of a Provider with a contractual, referral or other arrangement with the CHC-MCO failing to receive payment from the Department or the CHC-MCO for such services.

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

e. Balance billing for Covered Services.

If a Participant's eligibility for MA LTSS is terminated retroactively because the Participant was determined functionally ineligible as a result of the CHC-MCO failure to conduct the Participant's annual Reassessment, the CHC-MCO must continue to provide coverage for services to the Participant until the Participant's functional eligibility determination is made. The CHC-MCO may not recover payments to providers for services provided to the Participant or seek to hold the Participant financially responsible for such services.

9. Restitution for Fees Owed to the Department

The Department may require the CHC-MCO to offset against any payment amount due to a Provider from the CHC-MCO any amounts that are due to the

Department from the Provider and that have not been paid by the Provider.

- The Department will notify the CHC-MCO and the Provider in writing of the amount due to the Department.
- If the Network Provider fails to make payment of the amount within 30 days of the written notice, then the Department will notify the CHC-MCO that it must offset the amount due to the Department from the CHC-MCO's payments to the Network Provider and pay the Department until the amount due to the Department has been collected in full.
- The Department reserves the right to deduct any unpaid amounts due from Network Provider from future payments to the CHC-MCO after ninety (90) days from the mailing date of the written notice.

B. Department Capitation Payments

1. Payments for Covered Services

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

2. Capitation Payments

i. The CHC-MCO shall receive capitated payments for the previous month for Covered Services as defined in Section VII.B.1, Payments for Covered Services, and in Appendix 3a, Explanation of Capitation Payments.

ii. The Department will compute Capitation payments using daily per diem rates. The Department will make a monthly payment to the CHC-MCO for each Participant enrolled in the CHC-MCO, for the first (1st) day in the month the Participant is enrolled in the CHC-MCO and for each subsequent day, through and including the last day of the month.

iii. The Department will not make a Capitation payment for a Participant Month if the Department notifies the CHC-MCO before the first (1st) of the month that the individual's MA eligibility or CHC-MCO Enrollment ends prior to the first (1st) of the month.

iv. The Department will make payments by wire transfer or electronic funds transfer unless the CHC-MCO is unable or unwilling to receive payment through wire or electronic funds transfer. If such arrangements are not in place, the Department will provide payments through the U.S. Mail.

v. Upon notice to the CHC-MCO, and for those months specified by the

Department, by the fifteenth (15^{th}) of each month, the Department will make a Capitation payment, referenced in Section VII.B.1, for each Participant for all dates of Enrollment indicated on the Department's eCIS through the last day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the CHC-MCO.

vi. This paragraph vi. is applicable unless it is superseded by paragraph v. immediately above. By the fifteenth (15^{th}) of each month, the Department will make a Capitation payment, referenced in Section VII.B.1, for each Participant for all dates of Enrollment indicated on the Department's eCIS prior to the first day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the CHC-MCO.

vii. The Department will recover Capitation payments made for Participants who were later determined to be ineligible for managed care for up to twelve (12) months after the service month for which payment was made. The Department will recover Capitation payments made for deceased Participants for up to twenty-one (21) months after the service month in which the date of death occurred. See Exhibit K, CHC-MCO Participant Coverage Document.

viii. The CHC-MCO must report to the Department within sixty (60) calendar days when it has identified capitation payments or other payments in excess of amounts specified in the Agreement.

ix. Upon written notification to the CHC-MCO, the Department may delay the capitation payments made in May and/or June of each calendar year that would have otherwise been made under Section VII.B.2.v above, to payment dates in July of the same calendar year. The Department will include in the written notification the applicable payment dates for the delayed capitation payments.

3. Program Changes

Amendments, revisions, or additions to the Medicaid State Plan, the CHC 1915(b) and 1915(c) Waivers, or to Federal or State statutes and regulations, guidelines, or policies shall, insofar as they affect the scope or nature of benefits available to Participants, amend the CHC-MCO's obligations as specified herein, unless the Department notifies the CHC-MCO otherwise. The Department will inform the CHC-MCO of any changes, amendments, revisions, or additions to the Medicaid State Plan or 1915(b) and 1915(c) Waivers or changes in the Department's regulations, guidelines, or policies in a timely manner.

If the scope of Eligible Individuals or services, inclusive of limitations on those services that are the responsibility of the CHC-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 the Department makes such determination in the affirmative, 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 will consider input from the CHC-MCO when making this determination. At a minimum, the Department will adjust the rates as necessary to maintain actuarial soundness. If the Department makes a change, the Department will provide the analysis used to determine the rate adjustment. If the scope of services or Eligible Individuals that are the responsibility of the CHC-MCO is changed, upon request by the CHC-MCO, the Department will provide written information on whether the rates will be adjusted and how, along with an explanation for the Department's decision.

The Department will appropriately adjust the rates provided by Appendix 3c, Capitation Rates, to reflect changes in an Assessment, Premium Tax, or other similar tax.

The rates in Appendix 3c, Capitation Rates, will remain in effect until an 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 this Agreement, the CHC-MCO has reviewed the rates set forth in Appendix 3c, Capitation Rates, and accepts the rates for the relevant Agreement period.

D. Claims Processing Standards, Monthly Report and Sanctions

These requirements and assessments are applied separately by zone.

1. Timeliness Standards

The CHC-MCO must adjudicate Provider Claims consistent with the requirements below. These requirements apply to Claims processed both by the CHC-MCO and by any subcontractor the CHC-MCO may have contracted with to receive and process claims for it. Subcapitation payments and claims adjustments are excluded from these requirements.

The adjudication timeliness standards follow for each of four (4) 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. Nursing Facility (NF) 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. Home and Community Based Services (HCBS) 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.

d. Other Claims (Not Inpatient, NF, HCBS or Pharmacy):

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, Waste or Abuse from the date of service to the date of adjudication of the Claims. The CHC-MCO, however, must provide immediate notification to the Department of providers under investigation by the CHC-MCO.

The CHC-MCO must adjudicate every Claim entered into its MIS that is not a Rejected Claim. The CHC-MCO must maintain an electronic file of Rejected Claims, including a reason or reason code for rejection. The CHC-MCO will deny a claim for services provided to an individual who was not a CHC-MCO Participant as of the date of service and notify the Provider of the denial.

The amount of time required to adjudicate a paid Claim is computed by comparing the date the Claim was received with the check date or the CHC-MCO bank notification date for electronic payment. The check date is the date printed on the check. The amount of time required to adjudicate a Denied Claim is computed by comparing the date the Claim was received with the date the denial notice was created or the transmission date of an electronic denial notice. The CHC-MCO must mail checks no later than three (3) business days from the check date. Electronic payments must also occur within three (3) business days of the bank notification date.

The CHC-MCO must record, on every Claim processed, the date the Claim was received. A date of receipt embedded in a Claim reference number is acceptable. The CHC-MCO must have this date carried on Claims records in the Claims processing computer system. Each hardcopy Claim received by the CHC-MCO, or the electronic image thereof, must be date-stamped with the date of receipt no later than the first (1^{st}) business day after the date of receipt. The CHC-MCO must add a date of receipt to each Claim received in the form of an electronic record or file within one (1) business day of receipt.

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

2. Sanctions

The Department will utilize the monthly report that is due on the fifth (5^{th}) calendar day of the fifth (5^{th}) subsequent month after the Claim is received to determine compliance with Claims processing standards. For example, the Department shall utilize the monthly report that is due January 5th, to determine Claims processing compliance for Claims received in the previous August.

The Department will consider all Claims received during the month for which compliance is being determined and that remain non-adjudicated at the time compliance is being determined to be Clean Claims.

If a Commonwealth audit, or an audit done on the Commonwealth's behalf, determines Claims processing timeliness data that are different than data submitted by the CHC-MCO, or if the CHC-MCO has not submitted required

Claims processing data, the Department will use the audit results to determine compliance.

If the Department determines that a CHC-MCO has not complied with the Claims Processing timeliness standards, the Department may separately impose sanctions to the following claims types:

a) Inpatient Claims.
b) NF Claims
c) HCBS Claims
d) Other Claims (Not Inpatient, NF, HCBS or Pharmacy)

The sanctions provided by this Section apply to all Claims, including Claims processed by any subcontractor.

The CHC-MCO will be considered in compliance with the requirement for adjudication of one hundred percent (100.0%) of all Inpatient, NF, and HCBS Claims if ninety-nine-and-one-half percent (99.5%) of all Inpatient, NF and HCBS Claims are adjudicated within ninety (90) days of receipt. The CHC-MCO will be considered in compliance with the requirement of adjudication of one hundred percent (100.0%) of all Other Claims (not Inpatient, NF, HCBS or Pharmacy) if ninety-nine-and-one-half percent (99.5%) of all Other Claims (not Inpatient, NF, HCBS or Pharmacy) are adjudicated within ninety (90) days of receipt.

The Department will reduce the sanctions below by one-third (1/3) if the CHC-MCO has fifty thousand (50,000) to one hundred thousand (100,000) Participants and by two-thirds (2/3) if the CHC-MCO has less than fifty thousand (50,000) Participants.

CLAIMS ADJUDICATION MONTHLY SANCTIONS CHART

The Department will compute sanctions for failure to adjudicate Inpatient, NF, HCBS and Other Claims (not Inpatient, NF, HCBS, or Pharmacy) as shown in the following tables.

Percentage of Clean Claims Adjudicated within Thirty (30) Days	Sanctions
88.0 – 89.9	$2,000
80.0 – 87.9	$6,000
70.0 – 79.9	$10,000
60.0 – 69.9	$16,000
50.0 – 59.9	$20,000
Less than 50.0	$30,000

Percentage of Clean Claims Adjudicated within Forty-five (45) Days	Sanctions
98.0 – 99.5	$2,000
90.0 – 97.9	$6,000
80.0 – 89.9	$10,000
70.0 – 79.9	$16,000
60.0 – 69.9	$20,000
Less than 60.0	$30,000
Percentage of All Claims Adjudicated within Ninety (90) Days	Sanctions
98.0 – 99.5	$2,000
90.0 – 97.9	$6,000
80.0 – 89.9	$10,000
70.0 – 79.9	$16,000
60.0 – 69.9	$20,000
Less than 60.0	$30,000

E. Other Financial Requirements

1. Physician Incentive Arrangements

a. CHC-MCOs must comply with the PIP requirements included under 42 C.F.R. §§ 422.208 and 422.210, which apply to MA managed care under 42 C.F.R. § 438.3(i).

b. The CHC-MCO may operate PIPs if 1) no specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to a Participant; and 2) the disclosure, computation of Substantial Financial Risk, Stop-Loss Protection, and Participant survey requirements of this section are met.

c. The CHC-MCO must provide information specified in the regulations to the Department and CMS, upon request. In addition, the CHC-MCO must provide the information on its PIPs to any Participant, upon request. CHC-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 require that the physician or physician group has adequate Stop-Loss Protection. CHC-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 Participants and disenrollees addressing their satisfaction with the quality of services and their degree

of access to the services.

d. CHC-MCOs must provide the following information concerning their PIPs to the Department:

- 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 patients are pooled, pooling method used to determine if Substantial Financial Risk exists, and
- Evidence that the physician or physician group has adequate Stop-Loss Protection and the type of coverage, if this requirement applies.

Where Participant/disenrollee survey requirements exist, the CHC-MCO must provide the survey results.

e. The CHC-MCO must provide the disclosure information specified in 1.d. immediately above to the Department annually, unless the Department has notified the CHC-MCO of the suspension of this requirement.

2. Retroactive Eligibility Period

The CHC-MCO shall not be responsible for any payments owed to Providers for services that were rendered prior to the Participants' Start Date.

3. In-Network Services

The CHC-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 Provider Agreement;

c. Services were Prior Authorized or did not require Prior Authorization;

d. The CHC-MCO denied Prior Authorization of services but the Department determined, after a hearing, that the services should have been authorized.

4. Payments for Out-of-Network Providers

The CHC-MCO must coordinate with Out-of-Network Providers to make timely payments for Medically Necessary Covered Services as otherwise provided for in this Agreement, including, but not limited to, when:

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

b. Services were Prior Authorized;

c. Services were not available in Network;

d. The CHC-MCO denied Prior Authorization of services but the Department determined, after a hearing, that the services should have been authorized.

The CHC-MCO may not impose any cost on the Participant for using an Out-of-Network Provider that is greater than the cost would have been if a Network Provider furnished the services.

The CHC-MCO must allow a Participant, who is an Indian as defined in 42 CFR § 438.14(a), to obtain Covered Services from Out-of-Network I/T/U HCPs from which that Participant is otherwise eligible to receive services.

The CHC-MCO is not financially liable for:

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

b. Prescriptions presented at Out-of-Network Pharmacies that were written by Non-Participating or non-network prescribers unless:

- the Non-Participating Provider or non-network Provider arrangements were approved in advance by the CHC-MCO and any Prior Authorization requirements (if applicable) were met; or
- the Non-Participating or non-network prescriber and the pharmacy are the Participant's Medicare Providers; or
- the Participant is covered by a third party carrier and the Non-Participating or non-network prescriber and the pharmacy are the Participant's third party Providers.

The CHC-MCO is responsible, in accordance with applicable law, for emergency

services and urgently needed services as defined in 42 C.F.R. § 417.401 that are obtained by its Participants from Providers and suppliers outside the Network even in the absence of the CHC-MCO's prior approval.

5. Payments to FQHCs and Rural Health Centers (RHCs)

The CHC-MCO must pay all FQHCs and RHCs rates that are not less than FFS Prospective Payment System (PPS) rates, as determined by the Department. The CHC-MCO must also include in its Network every FQHC and RHC that is willing to accept FFS Prospective Payment System rates as payment in full and are located within the CHC zone.

If a FQHC/RHC has opted-out of receiving the PPS rate from the CHC-MCOs, upon notification from the Department of the date that the FQHC/RHC has opted-out, the CHC-MCO is no longer required to make payment at the FFS PPS rate, as noted above. Effective with the FQHC/RHC opt-out, the CHC-MCO must negotiate and pay the opted-out FQHC/RHC at rates that are no less than what the CHC-MCO pays to other providers who provide comparable services within the CHC-MCO's Provider Network.

The CHC-MCO may require that an FQHC and RHC comply with Service Coordination procedures that apply to other entities that provide similar benefits or services.

6. Payments to Nursing Facilities

The CHC-MCO shall pay all NFs at a payment rate that is not less than the facility-specific minimum payment rate established by the Department and shared with the CHC-MCO. The Department will notify the MCO of the facility-specific payment rate. Nothing in this provision should be construed to prohibit the CHC-MCO and the NF to agree to a higher payment rate or to a VBP Payment Arrangement in accordance with Section VII.E.16 that provides an alternative payment for services that is at a payment rate equal to or greater than the facility-specific minimum payment rate. An incentive payment earned under the Nursing Facility Quality Incentive Program described in Exhibit DD(2) shall be in addition to the facility-specific minimum payment rate required under this subsection.

7. Coverage for Participants in an IMD

The Department will make Capitation payments for a Participant aged twenty-one through sixty-four (21 – 64) residing in a freestanding Institution for Mental Diseases (IMD) and the Participant's condition is not related to Substance Use Disorder (SUD) based on the following criteria:

- If the stay is no more than fifteen (15) cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in a freestanding IMD meets the requirements for in lieu of services in 42 C.F.R. 438.3 (e) (2)(i) through (iv), payment will be full capitation in which a Participant is enrolled in the CHC-MCO.

- If the stay is at least sixteen (16) cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in a freestanding IMD meets the requirements for in lieu of services in 42 C.F.R. 438.3 (e) (2)(i) through (iv), the payment will be based as follows: per diem rate identified in Section VII.B.1 multiplied by the number of days the Participant is both enrolled in the CHC-MCO and not residing in a freestanding IMD.

8. Liability during an Active Grievance or Appeal

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

9. Financial Responsibility for Dual Eligible Participants

The CHC-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for Dual Eligible Participants not to exceed the contracted CHC-MCO rate. The CHC-MCO will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions.

If no contracted CHC-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the CHC-MCO must pay deductibles and coinsurance up to the applicable MA fee schedule rate for the service.

For Medicare services that are not covered by MA or the CHC-MCO, the CHC-MCO must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the CHC-MCO do not exceed eighty percent (80%) of the Medicare-approved amount.

The CHC-MCO, its subcontractors and Providers are prohibited from balance billing Participants for Medicare deductibles or coinsurance. Participants who are dually eligible for Medicare and Medicaid are allowed to continue using their Medicare PCP even if the PCP is not MA enrolled. The CHC-MCO must provide a Dual Eligible Participant access to Medicare products and services from the Medicare Provider of his or her choice. The CHC-MCO is responsible to pay any Medicare coinsurance and deductible amount, whether or not the

Medicare Provider is included in the CHC-MCO's Provider Network, is a participating provider in Medicaid, and whether or not the Medicare Provider has complied with the Prior Authorization requirements of the CHC-MCO.

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

10. Confidentiality

The Department may elect from time to time to share with the CHC-MCO an internal Business Requirements Document or an internal Business Design Document, FFS inpatient hospital rates, cost-to-charge ratio information, and other LTSS rates. The CHC-MCO shall not use this information for any purpose other than to support the CHC-MCO's performance of its responsibilities under this Agreement and related responsibilities provided by law. The CHC-MCO may share a Business Requirements Document, a Business Design Document, or the FFS inpatient hospital rates, cost-to-charge ratio, and relative value information provided by the Department with another party, provided that the other party does not use the information for any purpose other than to support the CHC-MCO's performance of its responsibilities of this Agreement and any other related responsibilities provided by law.

11. Audits

The CHC-MCO must comply with audit requirements as specified in Exhibit O, CHC Audit Clause.

12 Restitution for Overpayments

The CHC-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 CHC-MCO after such overpayment is discovered by the CHC-MCO, the Department, or third party.

13 Penalty Periods

The CHC-MCO must, in coordination with the Department, monitor the completion of all NF and HCBS related processes, including the maintenance of a Penalty Period, if applicable.

14 Prohibited Payments

The CHC-MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital), that is furnished:

a. by, or at the medical direction or prescription of, any individual or entity during any period that the individual or entity is excluded from participation in Medicare, Medicaid, the federal Maternal and Child Health Services Block Grant program or the federal Social Services Block Grant program; or

b. by any individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the Department determines in accordance with then-applicable federal regulations there is good cause not to suspend such payments.

The CHC-MCO must not pay any amount for which funds may not be used under the federal Assisted Suicide Funding Restriction Act of 1997, including payments for items or services furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia or mercy killing.

The CHC-MCO must not pay for any item or service for road bridges, stadiums, or any other item or service not provided for under this Agreement.

15 Payment for Personal Assistance Services

The Department requires CHC-MCOs to pay for Personal Assistance Services at no less than the FFS rate. Nothing in this provision should be construed to prohibit the CHC-MCO and the provider to agree to a higher payment rate.

16 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, PH-MCOs, and CHIP-MCOs can form integrated VBP models. MCOs should work towards integrating VBP models, because addressing all service and supports needs will improve health outcomes.

a. VBP Payment Strategies

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

Each arrangement must include quality benchmarks, financial incentives, penalties or both, without which the Department will reject the arrangement as counting towards the required VBP medical or LTSS 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 Participant sub-population or the total Participant 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 Participant sub-population or the total Participant population served by a Network Provider. The cost benchmark should be developed prospectively, based at least in part on historical claims, and risk adjusted if needed. The payment is a percentage of the net savings generated by the Network Provider. These arrangements also include shared losses with Network Providers if costs are higher relative to a benchmark.

iv. Bundled payments (medium-risk strategy): Bundled payments include all payments for services rendered to treat a Participant 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 Participant. ACO models may include shared savings, shared risk, or global payments.

ii. Patient Centered Medical Home (PCMH): MCOs may include PCMH models as defined by NCQA, current existing Medicare PCMH programs, current D-SNP PCMH programs, and the HealthChoices PCMH program to have the arrangement qualify as a PCMH. Note that payments to PCMHs must be categorized as one of the VBP payment arrangements listed in Section A, and still include quality benchmarks, with incentives or penalties or both based upon meeting these benchmarks, without which the payments will not count towards the required VBP medical spend percentage.

iii. Performance-based Contracting (PBC): Fee-for-Service (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.

iv. Shared Savings: Supplemental payments to Network Providers if they can reduce health care spending relative to an annual cost benchmark, either for a defined Participant sub-population or the total Participant 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.

v. Shared Risk: Supplemental payments to Network Providers if they are able to reduce health care spending relative to a cost benchmark, either for a defined Participant sub-population or the total Participant 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.

vi. Bundled Payments: Bundled payments include all payments for services rendered to treat a Participant for an identified condition during a specific time period. The payments may either be made in bulk or be paid over regular predetermined intervals. The Department of Human Services (DHS) may specify certain services that must be paid through bundled payments.

vii. Global Payment: Population-based payments that cover all services rendered by a Network Provider, hospital or health system by the participating MCO.

1) An annual global budget is developed prospectively. These payments can either be made in bulk, delivered over regular predetermined intervals or based on FFS payments with retrospective reconciliation to the global budget. If these payments are retrospective, at least a portion of the payment must be prospective to allow Network Providers to make

upfront investments in population health infrastructure.

2) 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.
3) Network Providers who are paid via global payments are excluded from participating in bundled payment arrangements, because this would make the Network Provider doubly liable for the services rendered. MCOs should consider reduction of prior authorization requirements for Network Providers who are paid via global payments.

Required Models:

MCOs must participate in required VBP payment models if specified by the Department and work with the Department on the development of new models.

c. Financial Goals

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

i. Calendar year 2023 – 15% of the medical portion of the capitation must be expended through VBP. The 15% may be from any combination of strategies 8.a.i through 8.a.v., and 7.5% of LTSS payments through a value-based payment arrangement.

d. Reporting

The Department will measure compliance through required reports that have been developed by the Department. By October 1st of each calendar year, the CHC-MCO must submit its proposed VBP plan to the Department in the format required by 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 CHC-MCO. By the last work day of every quarter, the CHC-MCO must submit a progress report.

By June 30 of the subsequent calendar year, the CHC-MCO must submit a report as directed by the Department 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 and LTSS 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 Participants attributed to the provider's panel during the calendar year.

ii. The CHC-MCOs will use the Nursing Facility Quality Measurement Program to evaluate nursing homes and develop a valued based incentive arrangement as detailed in Exhibit DD(2) Pay for Performance Nursing Facility Quality Measurement Program.

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

iv. Shared risk – dollar value of any performance (bonus) payments and penalty payments, direct payments made to the provider total medical costs incurred by the CHC-MCO for Participants of the provider's panel during the time period of the calendar year the Participant was attributed to the provider's panel.

v. Bundled payments– dollar value of bundled payments made to providers. The Department may add additional reporting requirements depending on the services being bundled.

vi. Global payments – dollar value of any performance (bonus) payments, direct payments made to the provider

and total medical costs incurred by the CHC-MCO for Participants of the provider's panel inclusive of any previous (bonus) payments during the time period of the calendar year the Participant was attributed to the provider's panel.

e. New Agreements

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

f. Assessment

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

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

If the CHC-MCO fails to provide a timely and adequate report on VBP accomplishments, the Department may determine that the CHC-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 .5 percent (.5%) of the capitation it paid to the CHC-MCO for December of the prior calendar year.

g. Data Sharing

The CHC-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, nursing facilities, HCBS services and prescriptions,

iv. Care management information such as initial assessments and care plans, reassessments and updated care plans, as well as transition of care information from nursing home to the community.

F. Third Party Liability

The CHC-MCO must comply with the TPL procedures implemented by the Department. Under this Agreement, the TPL responsibilities of the Department will be allocated between the Department and the CHC-MCO.

1. Cost-Avoidance Activities

a. The CHC-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 ii, the CHC-MCO must attempt to avoid initial payment of Claims, whenever possible, where federal or private health insurance-type resources are available. The CHC-MCO must report all funds that are cost-avoided by the CHC-MCO to the Department via Encounter Data submissions. The number of claims cost avoided by the CHC-MCO's claims system should be reported in Financial Report #8A, “Claims Cost Avoided.” The use of the appropriate HIPAA 837 Loop(s) for Medicare and Other Insurance Paid shall indicate that TPL has been pursued and the amount which has been cost-avoided. The CHC-MCO shall not be held responsible for any TPL errors in EVS or the Department's TPL file. The CHC-MCO must sign a Coordination of Benefits Agreement and participate in the automated claims crossover process administered by Medicare.

b. The CHC-MCO may not deny or delay approval of otherwise covered treatment or services based upon TPL considerations. The CHC-MCO may neither unreasonably delay payment nor deny payment of Claims

unless the probable 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 CHC-MCO assigns to the Department the CHC-MCO's subrogation rights to collect the Other Resources covered by this provision. The CHC-MCO must immediately forward to the Division of TPL any correspondence or Inquiry received by the CHC-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 Participant and the services which were provided. The CHC-MCO may neither unreasonably delay payment nor deny payment of Claims because they involve an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by the Department under the scope of these "Other Resources" shall be retained by the Department.

With respect to any third party payment received by the CHC-MCO from a Provider, the CHC-MCO shall return all casualty funds to the Department. CHC-MCOs will not instruct Providers to send funds directly to the Department. The CHC-MCO may not hold these third party payments more than thirty (30) days. If the casualty funds received by the Department must be returned to the CHC-MCO for any reason, for example, an outdated check or the amount of the check does not match supporting documentation, the CHC-MCO shall have ninety (90) days to return all casualty funds to the Department using the established format.

c. The CHC-MCO is responsible for pursuing, collecting, and retaining recoveries of a claim involving Workers' Compensation.

d. Due to potential time constraints involving casualty cases subject to litigation as well as estate cases, 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 for a

casualty case or a final accounting has been approved for an estate. Should the Department fail to identify and establish a claim prior to settlement due to the CHC-MCO's untimely submission of notice of legal involvement where the CHC-MCO has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the CHC-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. If the Department fails to identify and establish a casualty or estate claim prior to settlement due to the CHC-MCO's untimely submitting of notice of legal involvement where the CHC-MCO has received such notice, the Department's actual loss of recovery shall be assessed against the CHC-MCO. The Department's assessment will not include the attorney's fees or other costs that the Department would not have retained from the recovery.

e. The CHC-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 CHC-MCO must indicate its intent to recover on health-related insurance by providing to the Department an electronic file of those cases it will pursue. The cases must be identified, and a file provided to the Department by the CHC-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 permitted by the Department. The Department's Division of TPL may pursue, collect and retain recoveries of all health-related insurance cases which are not identified by the CHC-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 CHC-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 CHC-MCO has identified the cases to be pursued, the CHC-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 CHC-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 CHC-MCO is responsible for notifying 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 because the Claims cannot be adjusted in the Department's automated processing system.

With respect to any third party payment received by the CHC-MCO from

a Provider, the CHC-MCO shall ensure that the funds are within their right of recovery. If the funds are outside the allowable recovery window, the funds shall be returned to the Department. These third party payments shall not be held by the MCO for more than thirty (30) calendar days. If the provider funds received by the Department from the CHC-MCO must be returned to the CHC-MCO for any reason, for example, an outdated check or the amount of the check does not match supporting documentation, then the CHC-MCO shall have sixty (60) calendar days to return all provider funds to the Department using the established format.

f. 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 filing 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 CHC-MCO. The same will apply in any situation where the Department loses recovery rights on an estate due to the CHC-MCO's failure to timely supply the data necessary to perfect the Department's claim and meet the forty-five (45) day regulatory mandate.

g. Encounter Data that is not submitted to the Department in accordance with the data requirements and/or timeframes identified in this Agreement can possibly result in a loss of revenue to the Department. Strict compliance with these requirements and timeframes shall therefore be enforced by the Department and could result in the assessment of sanctions against the CHC-MCO.

h. Health Insurance Premium Payment (HIPP) Program. The HIPP Program pays for employment-related health insurance for Participants when it is determined to be cost effective.

3. Requests for Additional Data

The CHC-MCO must provide, at the Department's request, such information not included in the Encounter Data submissions that may be necessary for the administration of TPL activity, specifically casualty and estate recoveries. The CHC-MCO must provide casualty information within fifteen (15) calendar days of the Department's request. The CHC-MCO must provide information for urgent requests involving casualty and Encounter data for estate cases within forty-eight (48) hours. Such information may include, but is not limited to, individual medical records for the express purpose of determining TPL for the services rendered. Confidentiality of the information must be maintained as required by Federal and State regulations

4. Accessibility to TPL Data

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

5. Third Party Resource Identification

The CHC-MCO must supply the Department with TPL information identified by the CHC-MCO or its subcontractors, which does not appear on the Department's TPL database, as well as 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. 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 (2) weeks of its receipt by the CHC-MCO. A web-based referral is only to be submitted in the following instances: the CHC-MCO is no longer the Participant's CHC-MCO; the Contract /Policy ID number is longer than 12 digits; or the referral is from the Pennsylvania Health Insurance Premium Payment Program. For web-based referrals, the CHC-MCO must use an exact replica of the TPL resource referral form supplied by the Department. For electronic submissions, the CHC-MCO must follow the required report format, data elements, and specifications supplied by the Department.

The Department will contact the CHC-MCO when the validity of a resource is in question. The CHC-MCO shall verify inconclusive resource information within two (2) business days of notification by the Department that the resource information is in dispute. However, if the verification notification is requested on the last business day of the week, the CHC-MCO must respond by the close of business that day to avoid a potential access to care issue for its Participant.

The CHC-MCO must use EVS and secured services on the Internet (previously known as POSNet) to identify insurance information the Participants have on file. If there is additional or different insurance information, the CHC-MCO or its subcontractors need to communicate the information as listed above.

6. Estate Recovery

The Department is required to recover MA costs paid on behalf of certain deceased individuals age fifty-five (55) and older who were receiving MA benefits for any of the following services:

a. Public or private NF services;

b. Residential care for home and community-based services;

c. Any hospital care and prescription drug services provided while receiving NF services or residential care for home and community-based services.

The Department's Division of TPL is solely responsible for administering the Estate Recovery Program. The CHC-MCO must supply all requested Encounter data timely to permit the Department’s timely filing of a claim.