



# **CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)**

## **PROCEDURES HANDBOOK**

## Introduction

Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, allowed for the creation of the Children's Health Insurance Program (CHIP). Pennsylvania's CHIP was started as a one of a kind program established to provide health coverage to uninsured children that reside in households with income exceeding the current levels for Medical Assistance. Pennsylvania's CHIP program was later used as a model for the federal government's State Children's Health Insurance Program (SCHIP).

The CHIP Procedures Handbook serves to provide Managed Care Organizations (MCOs) with a comprehensive guide that ensures proper implementation of statutory requirements, including Title XXI of the Social Security Act, the Children's Health Care Act, Pub. L. No. 106-113, § 113. Stat. 1501. (1999), and the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

The CHIP Procedures Handbook is divided into four parts:

**Part 1:** Application Processing Procedures

**Part 2:** Quality Management

**Part 3:** Marketing and Outreach

**Part 4:** Administrative Requirements

## TABLE OF CONTENTS

<b>Introduction .....</b>	<b>2</b>
<b>Definitions.....</b>	<b>5</b>
<b>Part 1: Application Processing Procedures.....</b>	<b>22</b>
Chapter 1: Application Submission .....	22
Chapter 2: Central Eligibility Unit Verification Processes .....	35
Chapter 3: Income and Tax Deduction Verification .....	41
Chapter 4: Determining Financial Eligibility .....	71
Chapter 5: Enrollment Procedure.....	77
Chapter 6: Enrollee Services.....	79
Chapter 7: Complaint, Grievance and External Review .....	84
Chapter 8: Notices.....	103
Chapter 9: Changes Affecting Eligibility During Intake or Renewal .....	106
Chapter 10: Eligibility Review Process.....	108
Chapter 11: Changes during the Enrollment Period.....	114
Chapter 12: Reassessment.....	129
Chapter 13: Renewal Procedures .....	132
Chapter 14: Termination Procedures for Ineligible Child.....	140
<b>Part 2: Quality Management.....</b>	<b>144</b>
Chapter 15: Division of Quality Assurance.....	144
Chapter 16: Quality Management Routine Reports.....	149
Chapter 17: Quality Management Intermittent Reports .....	155
Chapter 18: Internal and External Audits.....	158
Chapter 19: Data Warehouse.....	176
Chapter 20: Fraud, Waste, and Abuse .....	185
Chapter 21: Managed Care Organizations Quality Requirements .....	194

<b>Part 3: Marketing and Outreach .....</b>	<b>253</b>
Chapter 22: Marketing and Outreach .....	253
Chapter 23: MCO Report on Company or Programmatic Changes .....	258
<b>Part 4: Administration Requirements .....</b>	<b>263</b>
Chapter 24: Administrative Requirements.....	263
<b>Acronyms.....</b>	<b>272</b>

## DEFINITIONS

For the purpose of this CHIP Procedure Handbook, the following definitions shall apply:

**Abuse-** Any practice that is inconsistent with sound fiscal, business or medical practices, and results in unnecessary costs to the CHIP Program, or any reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or agreement obligations. Agreement obligations include those found in the Request for Proposal, Agreement, or the requirements of state 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 MCO, subcontractor to the MCO including providers, state employee, or an enrollee, among others. Abuse also includes enrollee practices that result in unnecessary costs to any of the following:

1. CHIP;
2. the MCO;
3. MCO's subcontractor; or
4. the MCO's provider.

**Actuarially Sound Principles-** generally accepted actuarial principles and practices that are

1. applied to determine aggregate utilization pattern;
2. are appropriate for the population and services to be covered; and
3. have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board.

**Adult-** custodial parent or legal guardian of a child.

**Adjudicated Claim-** A claim that has been processed to payment or denial.

**Affiliate-** Any entity that controls, is controlled by or under common control of the MCO or its parent(s), whether such control be direct or indirect, all persons, holding five (5) percent or more of the outstanding ownership interests of the MCO or its parent(s), directors or subsidiaries of MCO are Affiliates. For purposes of this definition, "control" means the possession of the power to direct or cause the direction of the management or policies.

**Amended Claim-** A provider request to adjust the payment of a previously adjudicated claim. A provider appeal is not an amended claim.

**Appeal-** To file a complaint, grievance, or request an external review.

**Applicant-** a child who has filed an application or who has an application filed on their behalf.

**Authorization-** Approval for a service.

**Business Days-** Monday through Friday except for those days recognized as federal holidays or Pennsylvania state holidays.

**Calendar Year-** A one-year period that begins on January 1 and ends on December 31.

**Capitation-** A fee the Department pays monthly to an MCO for each enrollee enrolled in its managed care plan to provide coverage of medical services, whether or not the enrollee receives the services during the period covered by the fee.

**Case Management Services-** Services that assist individuals with chronic and complex conditions in gaining access to necessary medical, behavioral health, educational and other services.

**Certificate of Authority-** A document issued jointly by the Pennsylvania Department of Health (PADOH) and Pennsylvania Insurance Department (PID) authorizing a corporation to establish, maintain and operate a Managed Care Organization (MCO) 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-** An individual licensed under the laws within the scope of Chapter 6 of Professions & Occupations, 63 P.S. §§218.2.

**Central Eligibility Unit (CEU)-** The name of the unit within CHIP that verifies citizenship and identity, reviews data exchanges and verifies CHIP eligibility.

**Child-** A person under nineteen (19) years of age.

**Children's Health Insurance Program (CHIP)-** The Pennsylvania program that provides free, low-Cost or full-cost health care services to children in accordance with 40 P.S. §§ 991.2301-A – 991.2309-A.

**CHIP Application Processing System (CAPS)-** Automated system used by CHIP to capture application information and process eligibility determinations.

**Claim-** A bill from a provider of a medical service or product that is assigned a claim reference number. A Claim does not include an encounter for which no payment is made or only a nominal payment is made.

**Claim reference number-** a unique identifier assigned to a provider of a medical service or product by the CHIP program.

**Client Information System (CIS)-** The Department's mainframe database that contains historical information for the Temporary Assistance for Needy Families (TANF), Medicaid and Supplemental Nutrition Assistance Program (SNAP) programs.

**Citizen-** An applicant or enrollee who is a citizen of United States.

**Commonwealth of Pennsylvania Application for Social Services (COMPASS)-** Pennsylvania's online portal for applying for and renewing health and human services benefits.

**Community Provider-** A private or public service organization that is not part of the MCO's Provider Network with which the MCO coordinates Out-of-Plan Services for their members.

**Complaint-** A dispute or objection regarding a participating provider or the coverage, operations, or management policies of an MCO, which has been filed with the MCO or with the PADOH or the PID. The term does not include a Grievance. Complaints include, but are not limited to the following:

1. Denial because the requested service or item is not a covered benefit;
2. Failure of the MCO to meet the required timeframes for providing a service or item;
3. Failure of the MCO to decide a Complaint or Grievance within the specified time frames;
4. Denial of payment by the 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 CHIP;
5. Denial of payment by the MCO after a service or item has been delivered because the service or item is not a covered service or item for the enrollee.

**Concurrent Review-** A review conducted by the MCO during a course of treatment to determine whether the amount, duration and scope of the prescribed services continues to be medically necessary or whether any service, a different service or lesser level of service is medically necessary.

**Copayment-** A fixed amount paid by enrollee to the provider for a covered health care service usually when the enrollee receives the service. The amount can vary by the type of covered health care service.

**Cost Sharing-** The premium contributions and copayments that the enrollee's household is responsible to pay as their share of health insurance coverage.

**County Assistance Office (CAO)-** The county offices of the Department that administer all benefit programs on the local level. Department staff in these offices perform necessary functions such as determining and maintaining recipient eligibility for MA.

**Coverage Area-** The geographic area for which an MCO is contracted by CHIP to provide health insurance.

**Covered Outpatient Drug-** A brand name drug, a generic drug, or an over-the-counter drug which is:

1. Approved by the Federal Food and Drug Administration;
2. Distributed by a manufacturer that entered into a Federal Drug Rebate Program agreement with the Centers for Medicare and Medicaid Services (CMS);
3. Prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice; and
4. Dispensed or administered in an outpatient setting.

The term includes biological products and insulin. The drug may be dispensed only upon prescription through the CHIP Program.

**Covered Service-** A service or supply for which benefits are provided.

**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.

**Data Exchanges (DX)-** The collection of information from various external agencies such as the Pennsylvania Department of Labor and Industry (PADLI), Social Security Administration (SSA), PADOH, Administration of Children and Families, Public Assistance Reporting Information System (PARIS), and other exchanges used for the purpose of verifying eligibility.

**Deliverables-** Documents, records and reports required to be furnished to the Department for review, approval, or both. Deliverables include, but are not limited to operational policies and procedures, required materials, letters of agreement, provider reimbursement methodology, coordination agreements, reports, tracking systems, required files, Quality Management (QM) and Quality Utilization (UM) documents, and referral systems.

**Demographics-** Social statistics about applicants and enrollees, their parents, guardians, or custodians that includes race, date of birth, household income, ethnicity, gender, county of residence, marital status, and occupation.

**Department-** Pennsylvania Department of Human Services.

**Developmental Disability-** A severe, chronic disability of an individual that is:

1. Attributable to a mental or physical impairment or combination of mental or physical impairments;
2. Manifests before the individual attains age twenty-two (22);
3. Likely to continue indefinitely;
4. Reflects of the individual's need for special, interdisciplinary or generic services, supports or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided; and
5. Manifested in substantial functional limitations in three or more of the following areas of life activity:
  - a. Self-care;
  - b. Receptive and expressive language;
  - c. Learning;
  - d. Mobility;
  - e. Capacity for independent living; and
  - f. Economic self-sufficiency.

**Disease Management-** An integrated treatment approach that:

1. Includes the collaboration and coordination of patient care delivery systems;
2. 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
3. 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 MCO is terminated. An enrollee may disenroll from CHIP at any time.

**Effective Date-** The date an enrollee's coverage begins as shown on the records of the MCO.

**Electronic Client Information System (eCIS)-** The Department's online database that contains information needed to authorize TANF, Medicaid and SNAP programs.

**Eligibility Period-** A period of time during which an enrollee is eligible to receive CHIP benefits. An eligibility period is indicated by the eligibility start and end dates on CAPS.

**Eligible Child-** A child who has been determined as meeting all of the eligibility requirements for CHIP.

**Emergency Medical Condition-** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention will result in: placing the health of the individual or for a pregnant woman, the health of the woman or the unborn baby in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily function.

**Emergency Services-** Covered inpatient and outpatient services that are furnished by a provider qualified to provide the services and are needed to evaluate or stabilize an Emergency Medical Condition.

**Encounter-** Any covered health care service provided to an enrollee regardless of whether it has an associated claim.

**Encounter data-** A record of any encounter, including encounters reimbursed through capitation, Fee-for-Service (FFS), or other methods of compensation regardless of whether payment is due or made.

**Enrollment-** The process by which an enrollee's coverage by an MCO is initiated.

**Enrollee-** A child who has been determined to be eligible for CHIP and is enrolled with an insurance MCO.

**Enrollment Period-** A period of eligibility for CHIP which consists of twelve (12) consecutive calendar months beginning with the first month that an eligible child is enrolled.

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

**External Complaint or Grievance-** An review conducted by either PADOH or PID that occurs after the exhaustion of the CHIP MCO internal Complaint or Grievance process.

**External Quality Review-** The analysis and evaluation of aggregated information on the quality, timeliness, and access to the health care services that are furnished to CHIP beneficiaries by an organization that qualifies as an External Quality Review Organization under 42 C.F.R. § 457.10.

**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.

**Federal Data Services Hub (FDSH)** – a system that allows limited access to payroll information through its TALX interface, typically called “the work number” and is provided by Equifax.

**Federal Poverty Level (FPL)**- A scale to judge whether a family's income meets the financial needs for the basic necessities of life. New guidelines are issued every year in late January or early February to account for fiscal changes such as higher utility costs, inflation, and minimum wage levels. The FPL is determined by the United States Department of Health and Human Services (HHS).

**Federally-Facilitated Marketplace (FFM)**- Developed by CMS to operate in states that have chosen not to build their own Marketplace.

**Federally Qualified Health Center (FQHC)**- 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.

**Formulary**- A listing of preferred prescription drugs and supplies approved by the Department and covered by the MCO.

**Fraud**- Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The Fraud can be committed by many entities, including the MCO, a subcontractor of an MCO, a provider, a state employee, or an enrollee, among others.

**Free CHIP**- Medical coverage provided to an eligible child whose family income is less than or equal to 208% of the FPL.

**Full-Cost CHIP**- Medical coverage provided to an eligible child whose family income is greater than 314% of the FPL. The enrollee, or the enrollee’s parent or legal guardian, is responsible for full-cost of the premium.

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

**Grievance-** A request to have an MCO or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. The term does not include a Complaint. A Grievance may be filed regarding a MCO's decision to:

1. deny, in whole or in part, payment for a service or item;
2. deny or issue a limited authorization of a requested service or item including the type or level of service or item;
3. reduce, suspend, or terminate a previously authorized service or item;
4. deny the requested service or item but approve an alternative service or item; and
5. deny a request for a Benefit Limit Exemption (BLE).

This term does not include a complaint.

**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.

**HealthCare Handshake (HCHS)-** The process where a complete application is electronically transferred from the CAO to a CHIP MCO, or from a CHIP MCO to a CAO. All information on the application is considered verified.

**Health Insurance Portability and Accountability Act (HIPAA)-** The Federal standards for privacy and security of individual identifiable health information in Title II of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. §1320d et seq.) and its regulations (45 C.F.R. Parts 160 and 164 Subparts A and E).

**Health Maintenance Organization (HMO)-** A Pennsylvania licensed risk-bearing entity that combines delivery and financing of health care and which provides basic health services to enrollees for a fixed, prepaid fee.

**Health Management System (HMS)-** This system is used in the eligibility determination process to determine if an enrollee is covered under Medical Assistance and other health insurances.

**Home Health Care-** care provided in a person's home including: skilled nursing services; help with activities of daily living such as bathing, dressing and eating; and physical, speech, and occupational therapy.

**Hospitalization-** care in a hospital that requires admission as an inpatient at a licensed hospital.

**In-Plan Services-** Services which are the payment responsibility of the MCO under the CHIP Program.

**Inquiry-** An enrollee's request for administrative service, information or to express an opinion.

**Insurer-** A health insurance entity licensed in Pennsylvania to issue any individual or group health, sickness or accident policy or subscriber contract or certificate that provides medical or health care coverage by a health care facility or licensed provider that is offered or governed under 40 P.S. §§ 991.2301-A – 991.2309-A or any of the following:

1. 40 P.S. §§1551-1567 known as the "Health Maintenance Organization Act";
2. The Act of May 18, 1976 (P.L. 123, No. 54), known as the "Individual Accident and Sickness Insurance Minimum Standards Act";
3. 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or Ch. 63 (relating to professional health services plan corporations); or
4. 40 P.S. §§ 1101-1114 Article XXIV of the Insurance Company Law of 1921.

**Interagency Team-** A multi-system planning team comprised of the enrollee, when appropriate, at least one accountable family member, a representative of the County Mental Health and/or Drug and Alcohol Program, the case manager, the prescribing physician or psychologist, and as applicable, the County Children and Youth, Juvenile Probation, Developmental Disability, and Drug and Alcohol agencies, a representative of the school district, MCO, PCP, other agencies that are providing services to the child, and other community resource persons identified by the family.

**Lawfully Residing-** A child that is legally present in the United States and is living in the state with the intent to reside in the state, including those without a fixed address or a member of a child's household who has entered the state with a job commitment or seeking employment (whether or not that individual is currently employed).

**Legal Guardian-** A person who has the legal authority and the corresponding duty to assume care, control of, and financial responsibility for another person.

**Limited English proficiency (LEP)-** individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English. LEP individuals may be eligible to receive language assistance for a service, benefit, or encounter.

**Low-Cost CHIP-** Medical coverage provided to an eligible child whose family income is greater than 208% and less than or equal to 314% of the FPL, and for which the family must pay a cost sharing premium established by the Department.

**Managed Care Organization (MCO)**- A risk bearing entity which manages the purchase and provision of physical and behavioral health services under the CHIP Program.

**Master Client Index (MCI)**- Applicant identifier that is assigned across multiple Commonwealth systems.

**Master Provider Index (MPI)**- A component of PROMISe™ which is a central repository of provider profiles and demographic information that registers and identifies providers uniquely within the Department.

**Medicaid**- Federal medical assistance program established under Title XIX of the Social Security Act.

**Medical Assistance (MA)** - The state program established under the Act of June 13, 1967, known as the “Human Services Code”.

**Medical Loss Ratio (MLR)**- A basic financial measurement of the percentage of premium dollars that a health plan spends on medical claims and quality improvements, versus administrative costs.

**Medically Necessary**- a service, item, or medicine does one of the following:

1. It will, or is reasonably expected to, prevent an illness, condition, or disability;
2. It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability;
3. It will help a child get or keep the ability to perform daily tasks, taking into consideration both the child’s abilities and the abilities of someone of the same age.

**Medicare**- A federally-financed health insurance program administered by the CMS pursuant to 42 U.S.C. §§1395 et seq., covering almost all Americans sixty-five (65) years of age and older and certain individuals under sixty-five years (65) of age who are disabled or have chronic kidney disease.

**Member Month**- One enrollee covered by the CHIP Program for one calendar month.

**Minimum Essential Coverage (MEC)**- Coverage required to meet the individual responsibility requirement under the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

**Modified Adjusted Gross Income (MAGI)** – Calculated as total adjusted gross income plus tax-exempt interest income, foreign earned income excluded from taxes, and tax-exempt social security benefits. Determined as point-in-time, projected for twelve (12) months, including predictable increases or decreases in household income.

**Newborn-** An infant from birth to one (1) month of age.

**Network-** The providers, facilities, and suppliers contracted with the MCO to provide covered services to enrollees.

**Network Provider-** A CHIP enrolled provider, facility, or supplier who has a written provider agreement with and is credentialed by an MCO and who participates in the MCO's provider network to serve enrollees.

**Non-participating Provider-** A provider facility, or supplier who is not enrolled with Pennsylvania to provide services to CHIP enrollees.

**Nursing Facility-** A general, county or hospital-based nursing facility, which is licensed by the DOH, enrolled in the MCO Network and certified for Medicare participation. The provider types and specialty codes are as follows:

1. General
2. County
3. Hospital-based
4. Certified Rehab Agency

**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 medically 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.

**Out-of-Area Covered Services-** Medical services provided to enrollees under one (1) or more of the following circumstances:

1. An Emergency Medical Condition that occurs while outside the MCO coverage area;
2. The health of the enrollee would be endangered if the enrollee returned to his or her MCO coverage area for needed services;
3. The provider is located outside the enrollee's MCO coverage area, but regularly provides medical services to enrollees at the request of the MCO; or
4. The needed medical services are not available in the MCO coverage area.

**Out-of-Network Provider** - A provider, facility, or supplier who has not been credentialed by or does not have a signed provider agreement with an MCO.

**Out-of-Plan Services-** Services which are non-plan, non-capitated, and are not the responsibility of the MCO under the CHIP Program comprehensive benefit package.

**Out-of-Pocket Expenses-** Includes premiums and point-of-service co-payments paid by the household to MCOs or providers on behalf of the child enrolled in a Low- or Full-Cost category of CHIP for CHIP covered benefits and services only.

**Parent-** A natural parent, stepparent, adoptive parent, legal guardian or legal custodian of a child, unless otherwise noted in this handbook.

**Participating provider-** A provider, facility, or supplier who is enrolled with the Department.

**Personal Property-** A privately owned possession which is not real property, such as cash on hand, motor vehicles, and life insurance.

**Physical Health Services-** Those medical and other related services, provided to enrollees, for which the MCO has assumed coverage responsibility under the Agreement.

**Physician Incentive Plan -** Any compensation arrangement between an MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to an enrollee who is enrolled in the MCO that complies with 42 C.F.R. § 438.3(i), as incorporating 42 CFR §§ 422.208 and 422.210.

**Physician Services-** Health care services provided or directed by a licensed medical doctor (MD) or Doctor of Osteopathic Medicine (DO).

**Pennsylvania Department of Health (PADOH)-** The department which monitors healthcare quality within Pennsylvania.

**Pennsylvania Insurance Department (PID)-** The department which enforces insurance regulations within Pennsylvania.

**Post-stabilization Services-** Covered services, related to an Emergency Medical Condition, that are provided after an enrollee is stabilized to maintain the stabilized condition, or under the circumstances described in the Contract, as amended and this Handbook, to improve or resolve the enrollee's condition..

**Pre-existing Condition-** A condition (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or has been received prior to the effective date of coverage.

**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

MCO enrollees by the MCO's Pharmacy and Therapeutics Committee.

**Premium-** The amount a family pays to their health insurance company every month for health insurance coverage for low-cost or full-cost CHIP.

**Premium Lock-out Period-** A period up to ninety (90) days in which a family must pay overdue premiums in order to have the child reinstated back to the termination date without having to reapply for coverage.

**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.

**Primary Care Provider (PCP)-** The doctor or doctor's group who provides and works with a child's other health care providers to make sure the child gets the health care services the child needs.

**Prior Authorization-** A determination made by the 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-** In-Plan Services, determined to be medically necessary, the utilization of which the MCO manages in accordance with Department-approved prior authorization policies and procedures.

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

**Provider-** An individual or entity that delivers health care services or supplies.

**Provider Agreement-** A Department-approved written agreement between the MCO and a provider to provide medical or professional services to enrollees.

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

1. Provider credentialing denial by the MCO;
2. Claims denied by the MCO for providers participating in the MCO's Network. (This includes payment denied for services already rendered by the Provider to the enrollee); and
3. Provider agreement termination by the MCO.

**Provider Dispute-** A written communication to an MCO, made by a provider, expressing dissatisfaction with an 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 claims processing and management system that supports the FFS and MA Managed Care delivery programs.

**Qualified Alien-** An applicant that meets the definition of Qualified Alien as defined by Section 431 of the Personal Responsibility and Work Reconciliation Act of 1996, P.L. 104-193 (PRWORA).

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

**Real Property-** Real property includes any land and related outbuildings needed to operate the home.

**Reasonably Compatible-** For purposes of this policy, the insurer must consider information through electronic data sources, other information provided by the applicant, or other information in the records of the insurer to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the eligibility of the applicant.

**Reassessment-** The process of changing a child's eligibility status during the enrollment period, at the request of the parent or legal guardian because of a reported change in family size and/or household income.

**Rehabilitative Services-** health care services that help to maintain, regain, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient or outpatient settings.

**Reinstatement-** The act of restoring a child's CHIP benefit without a lapse in coverage pending payment of any past due premiums, if applicable.

**Renewal-** The outcome of a review of eligibility that results in an eligible child receiving another twelve (12) month enrollment period of CHIP coverage.

**Renewal Due Date (RDD)-** Date renewal of coverage must be completed to remain enrolled in CHIP.

**Resident-** An individual who is living and intends to reside in Pennsylvania, with or without a fixed or permanent address.

**Resource-** Real or personal property.

**Retrospective Review-** A review conducted by the MCO to determine whether services were delivered as prescribed and consistent with the MCO's payment policies and procedures.

**Revenue-** The total gross direct business premiums, for all Pennsylvania lines of business, reported in Schedule T, "Premiums and other Considerations," of the PID report. In this handbook, revenue is used for the purposes of the equity requirement calculation.

**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.

**Seasonal Worker-** An individual whose ability to work directly relates to the weather or to the season. For example, individuals who work in landscaping, construction, grounds maintenance or individuals that pick fruit at an orchard work as the weather or season permits. Many of these jobs are performed for only a part of a year. The other part of the year the employee is unemployed or laid off.

**Secretary-** Secretary of the Pennsylvania Department of Human Services.

**Skilled Nursing Services-** Services provided by licensed nurses.

**Social Determinates of Health (SDOH)-** SDOH are the conditions in which people are born, grow, live, work, and age. They are the factors mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between different geographic locations. There are five major determinant areas:

1. Economic stability (poverty, employment, food security, housing stability, transportation);
2. Education (high school graduation, enrollment in higher education, language and literacy);
3. Social and community context (social cohesion, discrimination, incarceration);
4. Health and health care (accessibility and health literacy) and
5. Neighborhood and built environment (quality of housing, safety).

**Special Needs Unit-** A special dedicated unit within the MCO's organizational structure established to deal with issues related to enrollees with special needs.

**Specialist-** A doctor, a doctor's group, or a CRNP who focuses his or her practice on treating on disease or medical condition or a specific part of the body.

**Start Date-** The first date on which the 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 costlier therapies determined to be medically necessary.

**Subcontract-** A contract between the MCO and an individual, business, university, governmental entity, or nonprofit organization to perform part or all the MCO's responsibilities. Exempt from this definition are salaried employees, utility agreements and provider agreements, which are not considered subcontracts for the purpose of this handbook, and, unless otherwise specified herein, are not subject to the provisions governing subcontracts.

**Supplemental Security Income (SSI)-** Monthly cash payments made to the aged, blind, or disabled under the authority of Title XVI of the Social Security Act, as amended, Section 1616 (A) of the Social Security Act, or Section 212 (A) of Pub. L. 93-66.

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

**Systematic Alien Verification for Entitlements (SAVE)-** The program maintained by the United States Citizenship and Immigration Services that verifies immigration status for non-U.S. citizens.

**Tax household-** The group of persons and their income used to determine a child's CHIP eligibility based upon the MAGI rules.

**TALX** – an interface that allows limited access to payroll information; a system that allows limited access to payroll information through its TALX interface, typically called “the work number” and is provided by Equifax. See also: Federal Data Services Hub (FDSH).

**Termination-** Discontinuance of CHIP coverage for a child who had been previously enrolled and has ended his or her relationship with an approved CHIP MCO for one of the reasons enumerated in this handbook.

**Third Party Liability (TPL)-** An individual entity or program (e.g. Medicare, private insurance) other than the MCO financial responsibility for all or part of an individual's health care expenses.

**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 an Emergency Medical Condition. The term also includes services that are necessary to avoid a delay in hospital discharge or hospitalization.

**Utilization Management (UM)-** An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide medically necessary, timely and quality health care services in the most cost-effective manner.

**Utilization Review Criteria-** Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but not limited to, level of care, place of service, scope of service, and duration of service.

**Value-Based Purchasing (VBP)-** A model which aligns more directly to the quality and efficiency of care provided, by rewarding providers for their measured performance across the dimensions of quality. VBP strategies for the CHIP Program may include, but are not limited to gain sharing contracts, risk contracts, episodes of care payments, bundled payments, and contracting with Centers of Excellence and Accountable Care Organizations.

**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.

## **Part 1: APPLICATION PROCESSING PROCEDURES**

### **CHAPTER 1: APPLICATION SUBMISSION**

#### **1.1. GENERAL REQUIREMENTS**

Title XXI of the Social Security Act requires that a child be placed in the health care coverage program for which the child is financially eligible. The two programs for which eligibility must be determined are SCHIP and Medicaid (MA).

CHIP and MA have mutually adopted a practice called “Any Form is a Good Form,” the purpose of which is to facilitate the application process for an applicant applying for health care coverage for a child - either for CHIP or for MA.

If an applicant applies for CHIP and the determination of eligibility reveals that annual family income is below the limit for CHIP, a determination of eligibility for MA must be made.

If an applicant applies for MA and the determination of eligibility reveals that annual family income is above the income limit for MA for the child’s age group, a determination of eligibility for CHIP must be made.

If a family applies for insurance through the federally-facilitated marketplace (FFM) and is determined eligible for Advanced Premium Tax Credits (APTC), a child cannot be enrolled in the APTC coverage unless it is determined that the child is not eligible for MA and CHIP first. The family can still enroll in a Qualified Health Plan through the FFM as a family if they are not asking for a premium subsidy.

With the implementation of the ACA, eligibility is not determined for APTC. CHIP and MA pass applications back and forth with the FFM.

#### **1.2. SUBMISSION OF APPLICATION**

##### **1.2.1. GENERAL SUBMISSION OF ANY APPLICATION**

The CHIP application process begins when a parent or adult in care and control of a child applies for health care on behalf of a child. Applications may be submitted electronically through COMPASS ([www.compass.pa.us](http://www.compass.pa.us)), via a telephone call, or submitted in paper form to any of the MCOs. Applications may also be sent to an MCO as referrals from the County Assistance Office (CAO) or from the FFM. The MCO must process any application received and “Submit” it in CAPS within fifteen (15) calendar days of the receipt of the application. If the 15th

calendar day falls on a non-working day, the MCO is allowed until the close of business on the next working day to submit the application.

If the application indicates that there is only earned income, or citizenship of an applicant needs to be verified, or both, the application is electronically submitted to the CHIP Central Eligibility Unit (CEU). If the CEU can verify income, citizenship, or both, the application is electronically returned to the MCO as “complete”. Once the MCO receives a complete application from the CEU, processing is completed.

If the CEU cannot verify income, citizenship, or both, the application is determined “incomplete”. The incomplete application is returned to the MCO. The CHIP Application Processing System (CAPS) generates a letter outlining the required documentation. The MCO then mails the letter requesting further information to the family.

The application received date is the date CAPS received the application from any good source.

### **1.2.2. ELECTRONIC APPLICATIONS: REAL-TIME ELIGIBILITY**

Real-time eligibility determinations are available for applications submitted through COMPASS that meet set criteria. The following instructions outline how real-time eligibility is determined:

1. Applicant creates a “My COMPASS Account” and submits an COMPASS application.
2. An MCI clearance is performed, and MCI numbers assigned if necessary.
3. A complete remote identity proofing is preformed through Experian via the Federal Data Services Hub (FDSH).
4. COMPASS connects to the FDSH via the electronic data exchange to gather additional verification details.
5. COMPASS connects the existing system for eligibility services and receives an eligibility determination.

If eligible, COMPASS routes the application to CAPS for enrollment into CHIP.

If unable to pass all required steps or if the applicant is determined ineligible, the application is routed to CAPS for manual processing.

### **1.2.2.1. MCO SELECTION**

Applicants may submit their application directly to the MCO they choose.

An electronic application submitted through COMPASS allows the applicant to select one CHIP MCO providing service in his or her county. If an MCO is not chosen by the applicant, COMPASS assigns an MCO. If electronic verifications are incomplete, COMPASS provides instructions for submitting additional information and the selected MCO's address for the applicant to submit the required information.

#### **1.2.2.1.1.1. AUTOMATIC ASSIGNMENT**

Any applicant who does not select an MCO at application and is enrolled into the CHIP is subject to the auto-assignment process as described below. The auto-assignment process does not negate the enrollee's option to change enrollment at any time.

#### **1.2.2.1.1.2. AUTOMATIC ASSIGNMENT PROCESS**

Enrollees in a family unit will be assigned together to one MCO.

An eligible applicant who has not made an MCO selection and who has a case that also includes another active enrollee in the case is assigned to that same MCO.

All remaining eligible enrollees, who have not voluntarily selected an MCO, are equally auto-assigned to the active MCOs in their county. For example, if there are five (5) MCOs in the county, each MCO receives 20% of applicants.

Once an applicant is open for benefits with an MCO, he or she is an enrollee. The enrollee may transfer to a different active MCO in the enrollee's county of residence at any time. The transfer becomes effective the first day of the following month, based on MCO dating rules.

When enrollees move from one county to another, they remain in the MCO in which they were enrolled prior to their move only if the MCO is operational in the county to which they move. If the enrollee moves to a county where the MCO is not active, the losing MCO outreaches to the enrollee to assist in choosing an MCO in the new county of residence.

#### **1.2.2.1.2. E-SIGNATURES**

Applications submitted via COMPASS may be electronically signed by using the last four digits of the applicant's social security number. If an applicant chooses to submit an e-signed COMPASS application, the applicant is not required to submit a signed signature page to the MCO. During the applicant's review of the CAPS Detail Screen, the applicant will notice in Section VII that the signature flag field will be automatically populated with a "yes" for e-signed applications. Additionally, the signature date is populated with the date the e-signature was completed. If the applicant chooses not to provide an electronic signature, the application is incomplete. The MCO sends a signature page along with the incomplete letter for the head of household's signature.

#### **1.2.3. TELEPHONE APPLICATIONS**

The applicant for a child may submit an application via telephone. The application received date is the date of the call in which the application was completed. If the application is submitted through the Department's call center, the signature must follow telephone signature procedures.

##### **1.2.3.1. TELEPHONE APPLICATION SIGNATURE PROCEDURES**

All applications must be signed (under penalty of perjury) in order to complete an eligibility determination. In the case of telephonic applications, MCOs must have a process in place to assist applicants in applying by phone and be able to accept telephonically recorded signatures at the time of application submission. MCOs maintain their applicable best practices of audio recording and accepting voice signatures as required to prove the identity of the applicant.

#### **1.2.4. PAPER APPLICATIONS**

Paper applications may be obtained from a variety of sources, such as an MCO, a County Assistance Office (CAO), hospitals, and community agencies. A postage-paid envelope in which to return the application must be supplied with the application.

The head of household submits the signed paper application to a chosen MCO. The timeframe for processing an application begins on the date the application is received by the CHIP.

The MCO is responsible for date stamping the application promptly with the date on which it is received.

### **1.3. COMPLETE APPLICATIONS**

The CHIP application is considered to be “complete” when all of the following criteria have been met:

1. All questions are answered, and all information requested on the application form is provided;
2. The application is signed and dated (or e-signed in COMPASS) by the head of household (faxed signatures are acceptable);
3. Verification of all family income is received through the FDSH and is provided by the family or verified by the CEU using Data Exchanges (DX) matches;
4. Verification of citizenship is received through VLP (Verified Lawful Presence); and
5. Verification of other eligibility factors is provided as requested by the MCO.

**NOTE:** An application is not incomplete due to the lack of citizenship and identity verification (if all SSNs are provided). (See section 2.3 Conditional Enrollment pending citizenship verification).

**NOTE:** MCOs must not delay processing of applications while waiting for receipt of verification documents.

### **1.4. INCOMPLETE APPLICATION**

The applicant must be given the opportunity to submit any missing information or verification. As a general rule, a minimum of 30 calendar days is given for this submission. The MCO must inform the applicant in writing (e.g., by letter, fax, or secure e-mail) of additional information or verification required, and the date by which the information must be received to complete the application.

Case comments of any oral communication with the family are immediately recorded in the Comments Tab in CAPS. In the case of written communication, the MCO must maintain a copy of the notification in either hard copy or electronic file.

When the pending information is received, a determination of eligibility or ineligibility must be made by the MCO within fifteen (15) calendar days. If the 15th calendar day falls on a non-working day, then the determination must be completed by close of business on the next working day.

The MCO makes a determination of ineligibility if the applicant fails to provide the information by the date requested.

A notice of eligibility or ineligibility with an appropriate explanation for denial must be sent to the head of household. (See Chapter 8 – Notices)

## **1.5. DATA ENTRY OF APPLICATION**

When an MCO receives a CHIP application, renewal, or receives notification along with documentation that a change has occurred, the MCO enters information that appears on the application, renewal, or notification of change into CAPS promptly.

If mandatory data elements are missing, the MCO must attempt to obtain the missing information and enter the data into CAPS. Failure to enter mandatory data elements into CAPS will result in applications and electronic referrals being delayed or denied.

## **1.6. MANDATORY DATA ELEMENTS OF AN APPLICATION**

Mandatory data elements that are needed for all household enrollees are:

1. Last Name;
2. First Name;
3. Date of Birth;
4. Gender;
5. Citizenship.

### **1.6.1. EMPLOYER NAME**

If an applicant's household member has wages, and the wages are verified, the name of the employer is a mandatory data field in CAPS. MCOs will be unable to proceed without the data entry of an employer's name.

**NOTE:** MCOs should enter the Federal Employer Identification Number (FEIN) when available and exact name of the employer to prevent duplicate income entries from TALX (FDSH).

## **1.7. AUTOMATED REFERRALS (E-REFERRALS) FROM A CAO**

Federal and state law require that if an applicant submits a CHIP application, but may be eligible for MA, the application for benefits must be transmitted to the appropriate CAO for an MA eligibility determination.

Correspondingly, if an applicant applies for MA and the determination of eligibility reveals that annual family income is above the income limit for MA, a determination of eligibility for CHIP must be made.

When an application for health care coverage is filed with the CAO using an MA application form or through COMPASS, and the child is determined to be ineligible for MA, the CAO forwards the information electronically via the HealthCare Handshake (HCHS) process. This process creates an electronic referral to an MCO that operates in that county.

### **1.7.1. MA FAILURE REASONS THAT DO NOT RESULT IN A HCHS TO CHIP**

The CAO only refers children over four years of age who are not eligible for MA and when the household income is over the MA eligibility limit.

Beginning March 2018, MA began continuous eligibility for newborns and children up to age four (4) when a reported change in income was over the MA limit but reported before the 12-month enrollment period was complete. At the MA renewal, the child's eligibility is evaluated, and the child is placed in the correct program based on income at renewal.

The CAO does not refer a child if the family did not provide all information to the CAO for a full eligibility determination, if the child is enrolled in the PH-95 category of MA or if the child has private insurance.

### **1.7.2. CAO REFERRAL REPORT**

Referrals from the CAO come into "Received via CAO" or the "Awaiting Fax from CAO" sections of the "Application Entry" tab in CAPS.

MCOs may receive referrals from the CAO before the MA record is actually closed.

The MA close date is displayed on the “CAO Referral Report”. There should be no lapse in coverage.

If the MA close date on the CAO referral report is blank, then the referral is from a denied MA application. Normally, no retroactivity is authorized.

All electronic CHIP referrals from MA are marked as signed in CAPS.

### **1.7.3. PROCESSING A CAO REFERRAL**

MCOs are able to process all referrals as complete, except for instances when income is not processed in CAPS.

If income screens are processed in CAPS, the income verification code from CAPS is displayed. The referral is directed to the “Received via CAO” section of “Application Entry” tab in CAPS. The MCO can process the application immediately.

If the income screens are not processed in CAPS, the income is not considered verified and the resulting referral may be directed to the “Awaiting Fax from CAO” section of “Application Entry” tab in CAPS.

CAO’s are not required to fax notification (See Appendix 1-B for the Fax: e-Referral form) documenting the income the CAO collected; however, if this notification is received, the MCO must match this income documentation to the application

When an eReferral lands on the “Received via CAO” or “Awaiting Fax from CAO” section of the “Application Entry” tab and it has no income listed or has \$0 income verified, the MCO must contact the CAO within two (2) business days to obtain the income or determine if it is an incorrect eReferral. The CAO has two (2) business days to respond.

If it is a correct eReferral and the income was verified by the CAO within the past sixty (60) days, the MCO enters the income into CAPS and process the application.

If the CAO states it is an incorrect eReferral (family failed to provide documentation, failed to renew, intercounty transfer, foster/adoption assistance ended, or the child aged out of the program, etc.) or the child is reopened in MA, the eReferral is deleted.

If the MCO is not able to obtain income from the CAO, the MCO must enter “Dummy Income” in the Employer Name and submit the application so the application is routed to the CEU.

NOTE: An MA end date present in the referral has no bearing on this process.

The MCO will not request additional information from the family or individual unless the application is incomplete for additional verification documents or the family disagrees with the eligibility determination. (See Appendix 1-A for CAO Contact Information)

#### **1.7.4. ELIGIBILITY REVIEW PROCESS**

If the CHIP applicant disagrees with the eligibility decision made, based on information provided by the CAO, the applicant may request an Eligibility Review. (See Chapter 10 - Eligibility Review Process)

##### **EXAMPLE 1A: CHILD NOT ELIGIBLE FOR MA ENROLLMENT**

Sammy was referred to CHIP from the CAO on August 4. The CAO completes an electronic referral to CHIP. The referral shows the family income is within the CHIP guidelines. Sammy meets all the eligibility factors and is enrolled in CHIP effective September 1.

##### **EXAMPLE 1B: CHILD’S ELIGIBILITY FOR MA TERMINATED (HEALTH CHOICES)**

Susie is enrolled in MA. The family’s income has increased, and MA eligibility will be terminated April 15. However, the MA MCO coverage is paid on a monthly basis and will continue through April 30. The CAO referral is received showing the new family income. Susie is enrolled in CHIP effective May 1.

**EXAMPLE 1C: CHILD’S ELIGIBILITY FOR MA TERMINATED (FEE-FOR-SERVICE)**

Jimmy is enrolled in MA fee-for-service. The family’s income has increased, and the MA coverage will be terminated effective July 15. The CAO completes an electronic referral to CHIP showing the new family income. Jimmy is enrolled in CHIP effective July 1.

**EXAMPLE 1D: REFERRAL FROM CAO--CHILD ELIGIBLE FOR LOW-COST OR FULL-COST CHIP**

Alex was referred to CHIP from the CAO on August 4. The CAO completes an electronic referral to CHIP showing the family income. Alex potentially meets all the eligibility factors. A request for premium is sent to the family. Alex is enrolled in Low-Cost CHIP effective with the next enrollment date after the premium is received by the MCO. If the premium is not received within thirty (30) days, the child is denied enrollment in CHIP.

**EXAMPLE 1E: CHILD’S ELIGIBILITY FOR MA TERMINATED (HEALTH CHOICES) AND CHILD ELIGIBLE FOR LOW-COST OR FULL-COST CHIP**

Richard is enrolled in MA. The family’s income has increased, and MA eligibility will be terminated April 15, but health care coverage will continue until April 30. An electronic referral from the CAO is received on April 8 that shows the new family income to be within the Low-Cost CHIP guidelines. The eligibility determination will be for the month of May. Richard is placed in Awaiting Contractor Response (ACR) status in Low-Cost CHIP and a request for the May premium is sent to the family for enrollment in Low-Cost CHIP. If the premium is not received within thirty (30) days, the child is denied enrollment in CHIP.

**EXAMPLE 1F: CHILD’S ELIGIBILITY FOR MA TERMINATED (FEE-FOR-SERVICE) - CHILD ELIGIBLE FOR LOW-COST OR FULL-COST CHIP**

Jeffrey is enrolled in MA fee-for-service. The family’s income has increased, and the MA coverage will be terminated effective July 23. An electronic referral from the CAO is received showing the new family income to be within the Low-Cost CHIP guidelines. Contact is made with the family, preferably by phone, to explain that Jeffrey is eligible for Low-Cost CHIP. The parent is given a choice of a retroactive enrollment to July 1 to avoid a gap in health care coverage or enrollment on the next enrollment date of August 1. Once the parent chooses an enrollment date, Jeffrey is placed in ACR status in Low-

Cost CHIP and a request for premium is sent to the family for enrollment in Low-Cost CHIP. If the premium payment is not received within thirty (30) days, the child's CHIP coverage is denied.

#### **EXAMPLE 1G: CHILD ELIGIBLE FOR FULL-COST CHIP**

Alice is referred to CHIP from the CAO on August 3. The CAO referral shows the family income is over 314% of the FPL. Alice meets all eligibility factors, thus a request for premium is sent to the family. Alice is enrolled in the Full-Cost program effective with the next enrollment date after the premium is received by the MCO. If the premium is not received within thirty (30) days, the child is denied enrollment in CHIP.

#### **EXAMPLE 1H: MCO RECEIVES A CHIP REFERRAL FROM THE CAO BUT INCOME HAS NOT BEEN VERIFIED**

Brian is terminated from MA due to high income with an effective date of April 15. The MCO receives an electronic referral from the CAO, but the income has not been documented. After seven (7) business days, the MCO still has not received income documentation from the CAO. The MCO contacts the CAO to inquire about the missing income documentation. The MCO receives the CAO e-Referral Fax Sheet showing income documentation the next day. Brian is determined to be eligible for Free CHIP and enrolled with an effective date of April 1 or May 1 depending upon the MA coverage type (Health Choices or Fee-for-Service).

### **1.8. AUTOMATED REFERRALS TO THE CAO**

When an application for health care coverage is filed with the CHIP MCO, CAPS runs an income eligibility test and screens for MA eligibility using MA eligibility rules for monthly income calculation and household size. If the child is determined to be ineligible for CHIP due to income being too low, or the child reaches age 19, CAPS forwards the information electronically to the appropriate CAO via the HCHS.

Manual referrals will not be acceptable, unless specific situations are identified where an electronic referral was not able to be sent to the CAO.

### **1.8.1. INCOME**

The MCO must verify all income, including changes that are reported. When the CAO receives a referral from an MCO, the referral is treated as though the income has been verified by the MCO.

**NOTE:** A referral initially sent by a CAO should not be sent back to the CAO due to low-income. Eligibility workers should contact the caseworker to discuss differences in eligibility determinations.

### **1.9. TRANSFERS TO ANOTHER MCO**

The MCO may receive an application for a child from another CHIP MCO. The MCO is prohibited from restricting its enrollees from changing MCOs for any reason. The CHIP enrollee has the right to initiate a change of MCOs at any time.

The MCO must transfer a CHIP application to another MCO upon request from the applicant's family or if the applicant's address changes to one that is outside the current MCO's service area. MCOs should work together to expedite the enrollment of a child in the plan that serves the applicant's place of residence or the plan of the family's choosing.

When an address change is entered in CAPS that is outside the current MCO's coverage area, an application transfer is initiated by the system via an automated alert, which terminates the child in the existing case and generate a new case for the receiving MCO.

The information entered in CAPS by the original MCO, including the tax household's income and size is electronically forwarded to the appropriate or requested MCO within 24 hours of the request.

The transferring MCO is responsible for verification of all information on the application. The receiving MCO is responsible for verifying information at renewal.

An effective enrollment date should be indicated to the receiving MCO with this transfer to avoid any lapse or delay in coverage. The original application in hard copy form and all supporting documentation must be retained by the transferring MCO.

The receiving MCO takes action on the transfer within 48 hours of receiving the transfer.

Once the transfer is complete the receiving MCO conducts the following activities:

1. Send a notice informing the applicant of their eligibility;
2. Request Primary Care Physician (PCP) selection, if appropriate;
3. Apply continuity of care standards if applicable; and
4. Request payment for coverage if applicable.

Coverage is denied or terminated if the payment is not received within 30 days.

#### **1.10. TRANSFERS FROM THE FFM**

When a family applies for health insurance through the FFM as well as for the advance premium tax credits (APTC), the FFM forwards those applications to CHIP when the FFM determines that the child may qualify for CHIP.

Transfers from the FFM come into “Received via FFM” section in the “Application Entry” tab of CAPS.

MCOs review the FFM application to ensure that all information on the application is verified. If no additional verification is required, the MCO must still run clearance on citizenship and income before submitting the application. If there is missing or unverified information, the application is incomplete, and the applicable verifications must be requested.

## CHAPTER 2: CENTRAL ELIGIBILITY UNIT VERIFICATION PROCESSES

### 2.1 CENTRAL ELIGIBILITY UNIT (CEU)

The CHIP Office's Central Eligibility Unit (CEU) is responsible for:

1. Assisting the MCO in obtaining citizenship and identity verification for children whose citizenship and identity cannot be initially verified;
2. Verifying income through data matches with the DX and FDSH;
3. Data entering income information received electronically from FDSH onto an application and submitting;
4. Determining eligibility for new applications except for CAO referrals with verified income and COMPASS applications that meet real time eligibility criteria; and
5. Processing retroactivity requests from insurers when the retroactive period exceeds 3 months.

### 2.2 ELECTRONIC VERIFICATION OF CITIZENSHIP AND IDENTITY

Once an application successfully passes the clearance process, a request is sent to the Social Security Administration (SSA) to electronically confirm citizenship and identity of all applicants.

**Note:** If a Social Security Number (SSN) is not provided by the family, an attempt is made to obtain an SSN electronically from SSA. If the SSN is obtained from SSA, another request is generated to the SSA to validate citizenship and identity. If an SSN is not acquired from the SSA, the CEU attempts to obtain the SSN from the family. If unsuccessful, the application is incomplete until a SSN is provided.

Once an SSN is obtained, the child's information is again sent to SSA to validate citizenship and identity of the child. If SSA confirms citizenship and identity for a CHIP child, the verification code is updated in CAPS automatically. The MCO is not required to take further action.

An alert is created in CAPS to identify a child whose citizenship and identity cannot be verified electronically. The CEU worker acts on this alert.

## **2.3      CONDITIONAL ENROLLMENT PENDING CITIZENSHIP VERIFICATION**

The MCO or CEU enters a child into a conditional enrollment period of ninety (90) calendar days if an inconsistency exists between information in CAPS and information on file with the SSA, making electronic verification of citizenship and identity not possible.

The family receives letters at ninety (90) and sixty (60) calendar days prior to the end of the conditional enrollment period. The letters advise the enrollee that CHIP coverage will terminate if the inconsistency between data in CAPS and data in SSA files cannot be corrected, or proof of citizenship and identity is not provided. A U.S. Citizenship and Identity Guide is included with each letter.

An enrollee will only be given one 90-day period of conditional eligibility.

After the 90-day period has expired the enrollee receives a 30-day disenrollment period.

If another application is received after the 90-day conditional enrollment period, the application is determined incomplete until and unless citizenship and identity are verified.

An alert is generated in CAPS for the CEU for any child whose citizenship and identity cannot be electronically verified.

**NOTE:** An explanation of “90-day conditional eligibility” is displayed on the Eligibility Detail Screen in CAPS.

## **2.4      CEU REVIEW OF CAPS REGARDING CITIZENSHIP VERIFICATION**

The CEU worker attempts to contact the family by telephone to correct any information in CAPS or obtain any missing verification needed to complete the eligibility process.

If the CEU worker is able to contact the family the CEU worker will review all information in CAPS to determine if there is an error in CAPS.

If there is an error in CAPS, the CEU corrects CAPS.

Any change in CAPS demographics (name, SSN, date of birth, and gender) initiates another citizenship and identity match with SSA.

If, after contacting the family, the CEU worker determines the information in CAPS is correct, the CEU worker advises the family to provide the MCO with citizenship and identity documentation. The CEU worker also suggests the family contact their local SSA office to update the information SSA has on file for the child.

The CEU worker also assists applicants in acquiring birth certificates, if needed. The CEU worker directs individuals to the following web sites, or, if the individuals do not have access to the internet, advises them where to send a request and what must be included with that request.

The sites include instructions on how an individual can request a copy of a birth certificate by mail:

For individuals born in PA needing to obtain a birth certificate: [www.health.pa.gov](http://www.health.pa.gov). Individuals click on the "Birth Certificates" link for detailed instructions.

For individuals needing to obtain an out of state birth certificate: [www.cdc.gov/nchs/w2w.htm](http://www.cdc.gov/nchs/w2w.htm) operated by the National Center for Health Statistics. This site provides detailed instructions by choosing the appropriate state.

If the CEU worker is unable to contact the family, the child remains conditionally enrolled in CHIP for ninety (90) days pending the receipt of citizenship and identity documentation by the MCO.

Both MCO and the CEU workers enter case comments for all actions taken.

## **2.5 CITIZENSHIP AND IDENTITY DOCUMENTATION RECEIVED BY THE MCO**

If citizenship and identity cannot be verified electronically, the family is instructed to provide their citizenship and identity documentation directly to their MCO.

### **2.5.1 ACCEPTABLE CITIZENSHIP AND IDENTITY DOCUMENTATION**

Once the MCO receives acceptable citizenship and identity documentation, the MCO verifies all demographic information in CAPS and updates the appropriate verification fields to “Document in Record” (D). If changes are made to the demographics, CAPS initiates another match with the SSA.

The MCO is required to maintain documentation of citizenship and identity as a permanent part of the case record.

### **2.5.2 VERIFICATION OF UNDOCUMENTED IMMIGRANTS**

If the MCO or the CEU receives verified information that the applicant does not meet the citizenship requirements, the applicant is retro-terminated to the original enrollment date (See Eligibility Handbook Chapter 9, Section 9.3).

Both the MCO and the CEU worker enter case comments for all actions taken.

## **2.6 TERMINATION FOR FAILURE TO PROVIDE CITIZENSHIP AND IDENTITY DOCUMENTATION**

If the CEU worker cannot resolve any discrepancy, or the enrollee does not provide the verification documentation to the MCO within the ninety (90) day verification period, a thirty (30) day advance notice to close is issued.

In the event the applicant provides the required information to the MCO during this thirty (30) day period, the benefits continue.

## **2.7 DATA EXCHANGES (DX)**

The CEU worker uses the DX in an effort to acquire income verification for an applicant, enrollee and household members on an ongoing basis.

The DX details can only be accessed by authorized Commonwealth employees.

Details from the DX are updated in CAPS by the CEU worker.

The CEU worker enters case comments for all actions taken as a result of DX matches or not taken because the DX caused the application to register as incomplete. For example:

**EXAMPLE 2A:** If the CEU worker determines that there is a discrepancy relating to wages, Unemployment Compensation or Social Security benefits, but there is no change in eligibility or the enrollment level (information provided is reasonably compatible), the CEU worker continues the eligibility process.

**EXAMPLE 2B:** If the CEU worker determines there is a discrepancy that would change eligibility or the enrollment level, relating to wage data, new hire, Unemployment Compensation or Social Security Benefits, the application is considered to be incomplete.

A system generated letter is issued advising the applicant that additional income verification is needed. The letter advises the applicant to provide this additional income verification to the MCO.

If the CEU worker discovers a deceased person's match, the CEU worker contacts the MCO to request that they contact the family to validate information before initiating a closure.

If the CEU worker discovers benefits are being received in another state, the CEU worker contacts the MCO to request that the MCO attempt to contact the family to validate the information before initiating a closure.

## **2.8 VERIFICATION OF LAWFUL PRESENCE (VLP)**

VLP replaces the Systematic Alien Verification for Entitlements (SAVE) process the CEU used in the past to verify the immigration status of non-citizen applicants. The CEU is able to access the VLP service through CAPS from the Citizenship screen. The process is as follows:

1. The CEU worker enters information provided by the applicant into CAPS:
  - a. Alien Number,
  - b. Date of Entry into the U.S,
  - c. Document Type,
  - d. I-94 Number, or
  - e. Passport Number.

2. The CEU worker checks the “Verify Lawful Presence Box” on the Citizenship Screen;
3. A call is electronically initiated to the VLP service.
4. The VLP service then sends back a “VLP Response” which identifies the individual’s immigration status:
  - a. Verified; or
  - b. Not verified.
5. If the status comes back as verified, the CEU worker enters “Document in Record” under the “Citizenship Verification” field and no further documentation is required.
6. If the status comes back as not verified, the CEU leaves the “Citizenship Verification” field as “Client Statement” and the application is “Incomplete”. A letter is sent requesting that the family provide verification documents to the MCO.

NOTE: While SAVE is obsolete, it can still be used. The VLP, is more efficient. The process to use SAVE is as follows:

- a. The CEU submits a SAVE request on all lawfully residing aliens. The following information is required to submit a SAVE request:
  - i. Name
  - ii. DOB
  - iii. Alien registration number (A#)
  - iv. Card Number is required for certain types of documents
  - v. Documentation to verify the status of a lawfully residing alien is only required if the individual fails the 1<sup>st</sup> step in the SAVE verification process. If an individual fails the 1<sup>st</sup> step, a legible front and back copy of their immigration documentation is required.

## **2.9 COMMENTS in CAPS**

The COMMENTS Tab in CAPS is updated for all actions taken by either the MCO or the CEU regarding citizenship and identity and DX.

## CHAPTER 3: INCOME AND TAX DEDUCTION VERIFICATION

### 3.1. GENERAL REQUIREMENTS

When a CHIP application or renewal form is submitted, the annual gross income must be determined.

The household's annual gross income includes all taxable income and nontaxable interest, foreign earned income and Social Security benefits minus all losses which would appear on Form 1040 Lines 7 through 21 or Form 1040A Lines 7 through 14b, reduced by the tax deductions which would appear on Form 1040 Lines 23 through 35 or Form 1040A Lines 16 through 19.

Please note that for MAGI methodology, the income of all persons (i.e. tax filer and tax dependents required to file a tax return) expected to be claimed on the tax filer's next year's tax return must be reviewed for inclusion in the eligibility determination. This means that income is counted for siblings who are over 19 years of age, in-laws, grandparents, and other relatives or nonrelatives for whom the tax filer is claiming as a tax dependent. It also means that the individual who receives Supplemental Security Income (SSI) is included in the household size. The SSI income of this individual, however, is not counted.

When income and deduction verification is received, and it is insufficient to determine the household's annual gross income, the MCO must make every reasonable effort to contact the family prior to denial or termination to allow the family an opportunity to clarify the verification or submit more complete information before eligibility is determined.

Income must be attached to the individual for whom the income is intended.

**EXAMPLE 3A:** Jane, the parent, receives child support and SSD benefits for Johnny. Jane, the head of household, also receives alimony. The SSD and child support are entered in CAPS under Johnny, not Jane. The alimony is entered under Jane.

### 3.2. INCOME THAT IS COUNTED INCLUDES, BUT IS NOT LIMITED TO:

- 3.2.1. Salaries, wages, compensation as an officer in an S Corporation, overtime, shift differentials, allowances, commissions, incentives, bonuses, etc.;
- 3.2.2. Interest (both Lines 8a and 8b on the Form 1040 or 1040A);
- 3.2.3. Dividends (only Line 9a on Form 1040 or 1040A);

- 3.2.4. Taxable refunds, credits or offsets of state and local income taxes (Line 10 on Form 1040);
- 3.2.5. Alimony, court ordered (Line 11 on Form 1040);
- 3.2.6. Net profit/loss from a sole proprietorship (Line 31 from each Schedule C);
- 3.2.7. Capital Gain/Loss (Line 13 on Form 1040 or Line 10 on Form 1040A);
- 3.2.8. Other Gain/Loss (Line 14 on Form 1040);
- 3.2.9. IRA Distributions (gross amount or Line 15b on Form 1040 or Line 11b on Form 1040A);
- 3.2.10. Pensions and annuities (gross amount or Line 16b on Form 1040 or Line 12b on Form 1040A);
- 3.2.11. Net profit/net loss from rental property, royalty, partnership, the tax liability of an S Corporation, trust, estate and REMIC (Schedule E);
- 3.2.12. Farm income/loss (Schedule F, line 34);
- 3.2.13. Unemployment Compensation (UC) (see note in this subsection);
- 3.2.14. Social Security (OASDI – old age (retirement), survivors & disability insurance) (Gross amount);
- 3.2.15. Parent's income is always counted;
- 3.2.16. The child/tax dependent's income (not counting the Social Security benefit) which would require the child/tax dependent to file a tax return;
- 3.2.17. The child/tax dependent's income if the child is in a household without a parent (biological, adoptive, or step parent);
- 3.2.18. Other income/loss (Line 21 on Form 1040);
- 3.2.19. Workers' Compensation (WC) IF the person receiving it also receives a Social Security Disability benefit;
- 3.2.20. Housing allowances if included on Schedule C or in wages;
- 3.2.21. Foreign Earned Income;
- 3.2.22. Stipends used for living expenses;
- 3.2.23. Scholarships, grants and loans used for living expenses; or
- 3.2.24. TAA benefits (Trade or NAFTA Transitional Adjustment Assistance).

**NOTE:** If the UC income is verified by the CAO, there is no need to update the UC income unless the family contacts the MCO to request a reassessment based on the submittal of the current UC award letter in situations where a job is lost. This is not applicable to seasonal UC.

**NOTE:** CAO verified UC income that caused a Low-Cost or Full-Cost CHIP determination may be updated by the MCO to move the applicant into a lower Low-Cost or free category of CHIP. However, the MCO may not subsequently refer the enrollee back to the CAO as a result of the UC income update. The MCO must contact the CAO if there is any question regarding the income used to determine eligibility.

**3.3. INCOME THAT IS NOT COUNTED INCLUDES BUT IS NOT LIMITED TO:**

- 3.3.1. Child support and arrears;
- 3.3.2. WC if the person is not receiving SSD;
- 3.3.3. Social Security benefits of a child or tax dependent if the child or tax dependent lives in a household with a parent and the child or tax dependent is not required to file a tax return;
- 3.3.4. SSI;
- 3.3.5. Alaska Native Claims payments;
- 3.3.6. German Reparation payments; and
- 3.3.7. Earnings of a child or tax dependent that is not required to file a tax return.

**3.4. DEDUCTIONS ARE LIMITED TO THE FOLLOWING:**

Tax Deductions	2016 Form 1040, Line:	2016 Form 1040A, Line:
Educator expenses	23	16
Certain business expenses of reservists, performing artists, and fee-basis government officials	24	
Health savings account deduction	25	
Moving expenses	26	
Deductible part of self-employment tax	27	
Self-employed SEP, Savings Incentive Match Plan for Employees of Small Employers (SIMPLE) and qualified plans	28	
Self-employed health insurance deduction	29	
Penalty on early withdrawal of savings	30	
Alimony paid	31a	
IRA deduction	32	17
Student loan interest deduction	33	18
Tuition and fees	34	19
Domestic production activities deduction	35	

**3.5. VERIFICATION REQUIREMENTS**

Income and deductions must be verified prior to enrollment and prior to renewal with the exception noted below. Income verification should reflect the household's reasonably expected income over the 12-month enrollment period.

Deduction verifications should reflect the household's reasonably expected deductions on next year's federal individual tax return. At time of application, the

CEU determines if deduction verification is needed. A comparison is performed between no deductions being taken and the deductions a family expects to take on next year's tax return. If the deductions do not change the eligibility determination, verification is not required. Only in cases where the expected deductions would result in a different eligibility determination will verification be required.

**NOTE:** If verification of income deductions is the only reason for an application or renewal to go incomplete resulting in the denial or termination of a child's CHIP coverage, the MCO can ignore the deductions and process the application as if the deductions were not claimed. If the deductions do not change the eligibility determination, verification is not required. This allows eligibility to be run and an outcome to be determined.

Verification of changes to the household income and deductions are not required during the 12-month enrollment period. Household income and deductions do not need to be reviewed until the next renewal period unless the family requests a reassessment (See Chapter 12 Reassessment) of verified income or deductions and provides current supporting documentation.

At the time of application or renewal that an eligibility determination has been completed and the family then reports a change of income, deductions or tax filing household size prior to the beginning of the 12-month enrollment period, these changes must be used in the eligibility determination. This means eligibility must be re-determined and, if necessary, the child's coverage will have to be managed to the appropriate category of CHIP for which the child now qualifies by using the reported changes.

**EXCEPTION:** For a tax household enrolled in CHIP with unverified income in excess of 314% of the Federal Poverty Level that requests a reassessment, tax household income must be verified prior to reassessing.

### **3.6. ACCEPTABLE INCOME VERIFICATION DOCUMENTATION**

Electronic means are utilized to verify income where possible. Several electronic sources are available to verify household income. The SSA Composite system provides current Social Security Benefit (SSB) amounts. The Federal Data Services Hub (FDSH) allows limited access to payroll information through its TALX interface. In cases where no electronic means are available or when electronic means do not support the income being reported, paper documentation will be

required. Additionally, income reported as verified by an CAO is considered acceptable verification.

### **3.6.1. SALARIES, WAGES, COMMISSIONS, BONUSES**

#### **3.6.1.1. Electronic Sources of Income (Preferred)**

TALX data can be requested by clicking the “Retrieve FDSH – Equifax Data” button on the Income screen in CAPS. If any matches are found in TALX, the income is returned at the bottom of the Income screen in CAPS with the employer name, FEIN, income frequency, hire date, termination date and detailed wages.

#### **3.6.1.2. Paystubs (alternative to electronic source)**

The most recent paystub should be submitted. If an individual’s income fluctuates, they must submit multiple paystubs received within the previous sixty (60) days. Paystubs must include enough identifying information to show that it is earned income for that individual (i.e. name, SSN, employee number, etc.), and the employer name. If an employer’s FEIN is shown on the paystub, it should be entered into CAPS.

When the MCO reviews the paystub for the gross pay amount, the MCO reviews the number of hours worked for that pay period and all items listed under the paystub’s earnings/wage column and year-to-date (YTD) column for other types of income being earned in prior pay periods. The number of hours worked listed on the application/renewal should reflect the number of hours on the paystub. If not, the hours listed on the application are likely not representative of tax household’s income. Additional paystubs may be requested, however, the MCO may use the one paystub submitted to calculate the average gross pay using the YTD earnings. This aids in more efficient processing of the application or renewal rather than waiting for additional paystubs to be submitted.

To calculate the YTD average gross pay, divide the total gross YTD figure listed on the most recent paystub by the number of pays received by the actual Pay Date on the most recent paystub. The MCO must not use the number of pay periods worked as of the pay date. This serves as a comparison to the gross wage for the individual pay period. This is a double check to determine if other income occurs. Be sure to count only the number

of pays received during the employment period within the calendar year and not the number of pay dates from the beginning of the calendar year.

**EXAMPLE 3B:** If an individual's start date was 4/10/18, and the MCO is averaging a paystub dated 9/23/18, the MCO would only count the number of pay dates received during that timeframe.

If the YTD average calculation is the same or higher than the gross earnings shown on the most recent paystub received, then all income listed on the paystub is included. The higher amount is to be used in the eligibility determination. If the person disagrees with the determination caused by using the higher amount, they may request an eligibility review as described in CHIP (See Chapter 10– Eligibility Review Process).

If the YTD average is lower than the gross pay on the most recent paystub, the MCO may use this amount as long as the MCO is confident that there is no error in the YTD calculation, i.e. the correct YTD gross earnings and number of pays received were used or that the individual was not earning income from that employer at some point during the year, i.e. on leave without pay or hired after the 1<sup>st</sup> day of the current year.

There may be times where income such as overtime, commissions, shift differentials, allowances, bonuses, etc. are a sporadic occurrence. The MCO may request the applicant or enrollee to submit their most recent paystubs. The MCO must ensure a comparison of YTD gross average versus the average of the gross pay amounts for the paystubs received. If the additional paystubs received show that all types of income are being received, the most appropriate way to determine eligibility would be to use the gross YTD average.

On most paystubs, all of the different types of income (regular earnings, overtime, shift differentials, allowances, commissions, bonuses, etc.) are totaled individually. For individuals that receive quarterly or annual bonuses, individual calculations may be performed and added to the eligibility determination.

**NOTE:** As long as paystubs are dated within sixty (60) days of the date of the signature on the application or renewal, the paystubs can continue to be accepted, and updated verification is not required regardless of when eligibility is determined.

### **3.6.1.3. Letter from the Employer (Alternative to paystubs)**

In the event that paystubs are not available, a letter on employer stationery that details the number of hours worked per pay, hourly rate, and length of pay period (i.e. weekly, bi-weekly) is acceptable documentation. This letter is to include the employee's YTD gross earnings that includes all types of earnings as of the most recent pay period.

If an applicant states that additional pay (i.e. overtime) is seasonal, then the employer is to provide the YTD earnings as stated in the preceding paragraph. The letter is to further state the dates through which the additional pay is worked, such as through the winter only, and provide the gross amount of the additional pay that is included in the overall YTD earnings.

The letter should be signed and dated by the employer and include a contact number in the event the MCO has any questions.

### **3.6.1.4. Business Records (Alternative to Letter from the Employer)**

In the event that a letter from the employer is not available, business records from the employer are acceptable. Examples of a business record are employee time cards or computerized payroll records. The business records should include the employer's name, employee's name, and employer contact number in the event the MCO has any questions. Questions regarding earnings may need to be asked of the employer in the case of time cards that show only hours worked.

### **3.6.1.5. Form W-2, Form 1099-MISC, or Tax Return**

These documents are an acceptable alternative if paystubs, a letter from the employer, or business records cannot be obtained. MCOs should ensure that the tax household member is still either employed with the employer listed on the Form W-2 or 1099-MISC Form or in the same line of work for which the 1099-MISC was issued and, that the tax document is reflective of employment beginning January 1 through December 31 of the respective calendar year. An example when this type of documentation

could be accepted is for subcontractors, college professors, consultants, etc.

**NOTE:** Specific to Form W-2, boxes 1, 3, 5, 16, and 18 contain the wage, tip, and other determination. One full year of income is then used in the determination of eligibility instead of 48 weeks.

### **3.6.2. BUSINESS INCOME**

The most current federal individual income tax return and related schedules are to be submitted for the eligibility determination. The net profit/net loss is used in the eligibility determination. For an individual with multiple sources of self-employment income, the cumulative losses reduce the cumulative profits. In short, counting self-employment income would be equivalent to counting the amount of profit/loss appearing on the Form 1040 Lines 12, 17, or both. However, when entering these types of income in CAPS, the net profit/net loss should be entered for each business or source of income.

**EXAMPLE 3C:** If an individual has two (2) partnerships, three (3) 'S' Corporations, one (1) sole proprietorship and fifteen (15) rental properties, then eight (8) entries should be made in CAPS; one (1) entry for each of the six (6) businesses and two (2) for the rental properties. Specific to the two (2) separate entries for rental properties, the employer name in CAPS should contain the number of rental properties having net profits and net losses.

#### **3.6.2.1. Acceptable Tax Returns**

The latest filed yearly tax return is acceptable as proof of income. When a new calendar year starts, a tax return from the previous year may not have been completed at the time of application or renewal.

**EXAMPLE 3D:** When 2018 begins, the tax returns for 2017 may not be finalized and filed. If this is the case, the following should be done:

January 1 – Tax deadline day mid-April:

For example, in 2018 a yearly tax return from 2016 or a copy of the last quarterly tax filing from 2017 will be accepted until mid-April, if

the 2017 tax return has not been finalized. If a quarterly return is used, the net profit shown must be annualized.

An YTD profit & loss statement may be accepted for the current year for each source of business income. The profit & loss statement should list the business name, type of business entity (sole proprietor, partnership, S Corporation), the time period covered by the profit and loss statement, gross income earned in that period, a line item list of expenses for the period, and a net profit/loss figure for the period.

**NOTE:** In reviewing the profit & loss statements, if the individual receives profit, the wages must be added to the eligibility determination.

Mid-April – End of Year:

A tax return for the last calendar year is accepted. In 2018, the accepted form would be for tax year 2016. In addition, a copy of the last quarterly tax return for 2017 would be acceptable. The quarterly net profit must be annualized.

If the business has extended the filing of its taxes for the past calendar year, then an YTD profit and loss statement may be accepted for the current year for each source of business income. The profit and loss statement should list the business name, type of business entity (sole proprietor, partnership, S Corporation), the time period covered by the profit & loss statement, gross income earned in that period, a line item list of expenses for the period, and a net profit/loss figure for the period.

**NOTE:** When reviewing the profit & loss statements, if the individual receives wages from the business, it appears as a business expense and reduces the net profit. The wages must be added to the eligibility determination.

### **3.6.2.2. Types of Business Income**

#### **3.6.2.2.1. Self-Employment (Royalties, Rental Properties, Sole Proprietors, and Partnerships) and S Corporations.**

For self-employment sole proprietor income, all income generated by the business is the individual's personal income. The income earned minus the business expenses is considered the gross income, i.e. the net profit/loss of the individual.

An individual might state that he or she takes a draw on wages from the business; however, this money comes directly out of the net profit. It is highly unlikely the sole proprietor pays him/herself a wage as an employee and receives a Form W2 for wages.

The amount appearing on Schedule C, line 31 (or Schedule C-EZ line 3) is used in the eligibility determination. Check line 12 of Form 1040 and line 31 of Schedule C to ensure all Schedule C income is accounted for. If the two related lines do not match, then the MCO must contact the applicant or enrollee to obtain the missing Schedule C. If there is more than one related Schedule C, the amount appearing on line 31 of each schedule will be used as the business income. If there is a loss on a Schedule C, the actual amount of the loss is used in the eligibility determination

If an YTD profit and loss is used and "wages" were deducted as a business expense, the MCO contacts the enrollee or applicant to inquire as to whom the wages were paid. Sole proprietors may have employees on their payroll. The MCO must confirm that the "wage" business expense does not include wages for the sole proprietor. If the response is that the sole proprietor received the "wages", the MCO adds this amount back into the net profit.

#### **3.6.2.2.2. Self-employment Royalties and Rental Properties**

Use Schedule E, Part 1, line 21 for each source of royalty or rental property net profit/loss.

A separate entry should be made in CAPS for each source of royalty. For multiple rental properties, two (2) separate entries should be made in CAPS: one (1) for the cumulative net profit and one (1) for the cumulative net loss. The employer name in CAPS should contain the number of rental properties having net profits and net losses.

**EXAMPLE 3E:** If someone has seventeen (17) rental units and fifteen (15) had profits and two (2) had losses, an entry should be made for "15 rental

profits” and the amount of the cumulative profits and an entry should be made for “2 rental losses” and the amount of cumulative losses. There should only be one (1) entry in CAPS if all properties had a profit, or all properties had a loss.

#### **3.6.2.2.3. Self-employment partnerships**

The income earned by the partnership after all business expenses have been deducted (net profit of partnership) is considered the gross income of the partnership. The different partners share any income or loss in a partnership. The individual partners include their share of the net profit or net loss on their individual federal tax return (line 17) and related Schedule E, Supplemental Income and Loss, Part II.

Partnerships may have Section 179 expense deductions (column i) of Line 28 and/or “unreimbursed partner expenses” identified on Line 28. Specific only to partnerships, these amounts should be deducted from the individual respective net profit. For instance, if Line 28 has the information listed:

Line 28 A – non-passive income \$30,000, Section 179 expense \$2,300;

Line 28B – non-passive income \$5,000;

Line 28C – non-passive income \$17,500, unreimbursed partner expense \$150, Section 179 expense of \$1,800;

The amount for purposes of determining eligibility would be as follows:

Line 28A - \$27,700 (\$30,000 - \$2,300);

Line 28B - \$5,000; or

Line 28C - \$15,550 (\$17,500 - \$150 - \$1,800).

A separate entry should be made in CAPS for each partnership. The employer name in CAPS should identify “partnership” after the name of the business. For instance, if the business is called A1 Construction, the employer name should be “A1 Construction Partnership. If character space is limited, abbreviate partnership as “pship”.

#### **3.6.2.2.4. S Corporations**

An S Corporation is a regular corporation that has between one (1) and one hundred (100) shareholders.

There are two (2) types of shareholders:

1. Shareholder-employee(s), such as owners, officers and employees, and;
2. Shareholder-non-employee(s).

**NOTE:** The Internal Revenue Service (IRS) requires a shareholder-employee to be paid a reasonable salary from the S Corporation; however, not all S Corporations follow this requirement.

The S Corporation passes through net income and losses to the shareholders via special tax status with the IRS. Therefore, the S Corporation is not considered a separate taxable entity. The S Corporation can retain its net profits as operating capital. All profits are considered as if they were distributed to shareholders. Thus, a shareholder might be taxed on income they never received because the shareholder is liable for paying tax (tax liability) on his or her shares of the S Corporation's aggregate income whether or not income was actually received by the shareholder.

The shareholder's tax liability is combined with actual income being reported on the individual's Form 1040.

Specific only to S Corporations, the listed amount on Schedule E, line 28, identified as "S" represents tax liability and under the new rules of MAGI methodology, is counted in the eligibility determination. Section 179 expense deductions or unreimbursed expenses, or both, are of relevance and should be removed from the tax liability just as explained above in Section 3.6.2.2.3 (relating to Self-Employment Partnerships).

Compensation as an officer (i.e., wages for which the shareholder-employee receives a Form W2 and that is reported on Form 1040 line 7) is counted.

Property distributions (Schedule K 1 (Form 1120S) box 16 marked with a letter "d" or "D") are no longer counted in the eligibility determination.

A separate entry should be made in CAPS for each 'S' Corporation. The Employer Name in CAPS should identify "S Corp" after the name of the business. For instance, if the business is called Creative Consultants, the Employer Name should be "Creative Consultants S Corp".

### **3.6.3. UNEMPLOYMENT COMPENSATION (UC)**

#### **3.6.3.1. Award Letters (Preferred)**

Award letters are an acceptable form of documentation. The award letter lists all the necessary information.

#### **3.6.3.2. Electronic Records (Alternative to Award Letters)**

A print out from the Internet that shows the gross payment is an acceptable form of documentation. Please keep in mind that federal income tax that is deducted from the gross payment must be included as part of the income used in the eligibility determination.

A print out from the Internet of the Claim Status and Additional Benefit Payment History screens may be submitted. The Claim Status shows the UC begin date, the number of weeks awarded and the balance remaining on the claim.

**Note:** Only the number of remaining weeks that UC income will be received is used in situations where a job is lost.

For seasonal workers, the annual amount of UC is to be counted in the eligibility determination.

For situations where the worker is collecting partial unemployment due to reduced hours for a time period and then collects full unemployment for a time period, the pay should be averaged and counted for the eligibility determination.

### **3.6.4. SEASONAL WORKERS**

When an applicant or enrollee indicates seasonal employment, MCOs should ask additional questions of the applicant or enrollee. For renewals where an enrollee was a seasonal employee during the last renewal process, CAPS

history should be searched to ascertain a pattern for the enrollee. The MCO should ask the following questions regarding seasonal work:

1. What are the dates that the tax household member worked i.e., to determine the number of weeks worked?
2. If UC was collected by the individual last year, will it be collected this year?
3. Does the individual have a UC award letter that shows the benefit amount?
4. Has the individual been given a date that they should expect to return to work, i.e., to determine the number of weeks of UC to be used in income calculations?
5. Can the individual provide copies of the latest UC award letter or a copy of their federal tax return that shows the amount of UC paid to them last year?

Many times, an applicant or enrollee may not know the amount of their new UC benefit. In these instances, the award letter from last year or 1099-MISC form from last year may be accepted to determine a clear picture of an individual's income.

### **3.6.5. WORKERS' COMPENSATION (WC) PAYMENTS**

Workers' Compensation is excluded income under MAGI unless the individual receives both WC and Social Security Disability payments. If the person receives Social Security Disability benefits, the gross benefit amount indicated on the SSA award letter or obtained through the SSA electronic verification includes the WC portion of the benefit. For example, the gross award on the SSA letter is \$2,000 monthly and it shows reductions for Medicare Part B of \$104.90 and a WC offset of \$500. The SSA letter \$2,000 amount which is provided through the SSA electronic verification and listed on the SSA award letter is utilized for determining benefits. One entry appears in CAPS for the Social Security benefit which would encompass both the SS benefit and the WC benefit.

#### **3.6.5.1. Electronic Verification (Preferred)**

At initial application, the CEU should be able to electronically verify the award amount. At renewal, the amount should be prepopulated from the data hub.

#### **3.6.5.2. Award Letters (Alternate)**

Social Security award letters are an acceptable form of documentation. The award letter lists all the needed information. Refer to the Social Security Benefits section below for additional information regarding the award letters.

### **3.6.6. SOCIAL SECURITY BENEFITS**

If the individual receives Workers' Compensation benefits, the gross benefit amount indicated on the SSA award letter, Form 1099-SSA or obtained through the SSA electronic verification includes the WC portion of the benefit. For example, the gross award on the SSA letter is \$2,000 monthly and it shows reductions for Medicare Part B of \$104.90 and WC offset of \$500. The SSA letter \$2,000 amount which is provided through the SSA electronic verification and listed on the SSA award letter is utilized for determining benefits.

If the SSA award letter or the SSA electronic verification is used in the determination, there is only one (1) entry in CAPS for the Social Security benefit.

#### **3.6.6.1. Electronic Verification (Preferred)**

At initial application, the CEU should be able to electronically verify the award amount. At renewal, the amount should be prepopulated from the data hub.

#### **3.6.6.2. AWARD LETTERS (ALTERNATE)**

Award letters are an acceptable form of documentation. The award letter lists all the needed information. The MCO counts the gross monthly income. Some recipients have Medicare deductions, or a WC offset removed from their payments.

Award letters for the upcoming calendar year are mailed to the recipient in October/November of the current calendar year.

**EXAMPLE 3F:** If an applicant is applying in January 2018, the 2017 award letter is preferred. The applicant should have received that letter in October or November 2017. If the applicant states they do not have the 2017 award letter, the applicant needs to request a copy.

If an applicant does not have a copy of their proof of income letter, instructions to receive a copy are available online

<https://secure.ssa.gov/apps6z/BEVE/main.html>. Each enrollee must request his or her own letter. According to the website, a letter may take four to six weeks, so it is suggested that an applicant print it electronically for immediate verification.

#### **3.6.2.2. SSA-1099 Form or Form 1040 or 1040A (Alternate to Award Letter)**

An SSA-1099 Form or Forms 1040 or 1040A are acceptable forms of income documentation if 12 months of income is represented. If the form represents less than 12 months of income, the most recent year's award letter must be obtained.

Additionally, the annual amount must be increased to account for any Cost of Living Adjustment. For example, if a 2017 SSA-1099 is submitted, it is possible there was no Cost of Living Adjustment (COLA) for 2018. However, future years must be reviewed for the COLA amount.

### **3.7. MONTHLY RETIREMENT BENEFITS**

#### **3.7.1. Award Letters (Preferred)**

Award letters are an acceptable form of documentation. The award letter lists all the needed information.

#### **3.7.2. IRS Form 1099-R (Alternative to Award Letter)**

A 1099-R that shows distribution from Pensions, Annuities, Retirement Plans, IRAs, Structured Settlements or Insurance Contracts is acceptable.

#### **3.7.3. Bank Statement – Alternative to IRS Form 1099-R**

Bank statements from the account where the Social Security deposit are made or the "Direct Express" card statements are acceptable, as a last resort, for income documentation. If a bank statement is used, the MCO must reach out to the applicant or enrollee to ensure that the amount deposited is the gross amount and that any deductions have been included. The outreach effort and results should become a permanent part of the enrollee's file and comments should be included in CAPS.

### **3.8. ALIMONY PAYMENTS**

Alimony refers to a court order for monetary support from one spouse to the other for a specified length of time. Alimony is considered taxable income to the recipient and a tax deduction to the payer. Alimony is to be included in the eligibility determination whether the tax household member is using it as income or as a tax deduction, as appropriate.

### **3.8.1. Decree of Divorce, Separation Maintenance or a written instrument to that decree (Preferred)**

A Decree of Divorce, Separation Maintenance or a written instrument to that decree is a written separation agreement or a decree of any type of court order requiring a spouse to make payments for the support or maintenance of the other spouse. This includes a temporary decree, a 'not final' decree, and a decree of alimony pendente lite.

The court ordered amount for alimony is to be used in the eligibility determination.

The amount being paid according to the court order must be an accurate reflection of what the parent states is currently being paid. If a parent claims they are not receiving the amount appearing on the court order, the parent should then submit a twelve (12) month payment history print out or a court order modification showing the alimony termination date. A letter from the paying parent is NOT acceptable in this case since the alimony was ordered by a court of law.

### **3.8.2. 12-month Electronic Payment History (Alternate)**

In Pennsylvania, court ordered alimony payments are handled through the Pennsylvania State Collection and Disbursement Unit. Both the recipient and payer have online access to the payment history through the PA Child Support Enforcement System. An applicant or enrollee may find the PA information at [www.childsupport.pa.gov](http://www.childsupport.pa.gov) and clicking on "Receiving Support" then "View Payment Information" link.

Payment history for the past twelve (12) months must be requested. The history shows the amount and frequency of payments. In many cases, payments may be inconsistent such as the payer might pay ahead several months of alimony or might make infrequent payments. This needs to be taken into account when determining income eligibility. The recipient may

not get alimony payments every month but that may be due to the fact that the payer paid ahead or only pays occasionally. If payments are sporadic, annualize the past twelve (12) month history figure to obtain a monthly average and use this in the eligibility calculation.

**EXAMPLE 3G:** Wife's court ordered monthly support is \$350. This means \$350 is to be received every month and is to be used in the eligibility determination.

On 4/15/18, mom contacts the CHIP MCO and states alimony has not been received in 4 months. Because CHIP policy states that income is not to be removed without documentation to support it, mom is asked to submit a twelve (12) month payment history to support her claim. The 12-month payment history for time 5/1/17 to 4/16/18 shows the following payments were received:

5/2/17 - \$350	-	9/2/15 - \$350
6/2/17 - \$350	-	10/2/15 - \$350
7/2/17 - \$350	-	11/2/15 - \$350
8/2/17 - \$350	-	12/2/15 - \$1,750

This shows that \$350 a month was received for the first 7 of the last 12 months and nothing was received for the 4 most recent months, as she claimed. However, the payment received in the 8<sup>th</sup> month was for \$1,750 (\$350 x 5 months). This confirms that all of the court ordered alimony currently due was received. For purposes of prospectively determining what annual alimony income is reasonably expected, the MCO should assume that the court ordered amount will be received even though a payment for each of the 4 most recent months was not paid monthly because it was paid in one payment.

An MCO should not look solely at the most recent payments occurring within the past sixty (60) days without reviewing the past payment history to determine what income is to be reasonably expected during the upcoming twelve (12) month enrollment period. In the above example, had the MCO only reviewed the actual income received within the past sixty (60) days, the MCO would have incorrectly calculated the alimony income to be zero for the upcoming 12-month enrollment period.

**EXAMPLE 3H:** Dad's court ordered monthly alimony is \$1,100. This means \$1,100 is to be received every month and is to be used in the eligibility determination.

On 3/30/18, Dad contacts the CHIP MCO and states he hasn't received an alimony payment since 1/13/17. He further states that he cannot count on the alimony and believes the mother will not pay any future alimony. Because CHIP policy states that income is not to be removed without documentation to support it, Dad is asked to submit a twelve (12) month payment history to support his claim. The payment history is received. It is dated 3/2/18 and shows transactions from 1/1/17 to 3/2/18. It shows the total arrears currently owed are \$37,456.07 and that the following payments have been applied to Dad's account:

2/2/17	-	\$6,092
9/13/17	-	\$4,953
10/5/17	-	\$273.73
10/12/17	-	\$4,953.35
11/12/17	-	\$4,953.35
12/13/17	-	\$4,953.35
1/13/18	-	\$4,953.35

The payment history shows that Dad has been receiving payments. Although he has not received a payment within the past sixty (60) days, this does not mean that the income is to be disregarded (see Note below). In this case, the MCO should annualize the income. The payment received on 2/2/17 can be ignored because it was received prior to the past twelve (12) months.  $\$25,040.48$  total alimony payments received divided by twelve (12) months =  $\$2,086.71$  average monthly alimony received. This amount should be used in the eligibility determination.

**NOTE:** This could be disregarded if Dad supplies a signed court order modification showing the alimony termination date. A letter from Mom stating she is no longer paying alimony is not acceptable in this situation because this alimony order was issued by a court of law.

### **3.9.INTEREST and DIVIDENDS**

The following forms are acceptable proof of income from interest and dividends.

#### **3.9.1. Interest**

Form 1099-INT – use each amount appearing in boxes 1 and 8; or,

The most recent federal income tax return – use the amount appearing on Lines 8a and 8b.

#### **3.9.2. Dividend**

Form 1099-DIV – use the amount appearing in box 1a; or,

The most recent federal income tax return – use the amount appearing on Line 9a. Line 9b should not be counted because it is already included in Line 9a.

#### **3.9.3. Statement from Financial Institution**

A statement from the financial institution stating the amount of interest or dividends paid to the applicant or enrollee is acceptable. Any payments listed on the statement that are for a period less than one year, e.g., quarterly, needs to be annualized.

### **3.10.CAPITAL GAINS/LOSSES and OTHER GAINS/LOSSES**

The following forms are acceptable proof of income from capital gains/losses and other gains/losses.

#### **3.10.1. Capital Gains/Losses**

The most recent individual federal income tax return.

Form 1040a – use Line 10

Form 1040 – use Line 13.

Specific to an individual who “flips” houses, because house “flipping” is a source of self-employment, the capital gain/loss is counted. For an

individual who sold a home not as a source of generating income (i.e. a family that sold its home and bought a new one) the capital gain/loss attributable to that sale is excluded.

For someone who sells stocks or mutual fund investments every year, the capital gain/loss is counted. If an individual reports that this income should not be counted, they should be asked if the selling of investments is something they do each year regardless of consistency or routine. If so, it is counted. If they state they fell on hard times and needed money to pay bills, then it can be treated as a one-time event lump sum as long as the MCO does not have information to the contrary.

**EXAMPLE 3I:** If on a family's 2017 and 2018 tax returns, the family had capital gains and in 2019 they report that the selling of stocks or funds is an unusual occurrence for them. In this particular case, the income should be counted because the MCO has documentation showing the family continues to sell. Only if the family reports that they have no other stocks/funds to sell would this income be removed in this example.

### **3.11.TAA (Trade or NAFTA Transitional Adjustment Assistance) BENEFITS**

#### **3.11.1. Award Letters (Preferred)**

Award letters are an acceptable form of documentation. The award letter lists all the needed information.

#### **3.11.2. Form 1099-G – Alternative to Award Letters**

A 1099-G, Certain Government Payments form, is acceptable.

#### **3.11.3. Check Stubs – Alternative to Form 1099-G**

A check stub that shows the gross payment is an acceptable form of documentation. Please keep in mind that the federal income tax shown as deducted from the payment should be included as part of the gross income, i.e., added to the payment received figure.

### 3.12. OTHER SOURCES OF INCOME

Any taxable income that is received by a family member e.g., sale of stocks, IRA distributions, lottery winnings taken as an annuity, severance packages paid in installments, etc. is considered an income source for the family and should be included in the eligibility determination.

One-time event lump sum payments, e.g., life insurance payouts, inheritance, lottery winnings, or estate settlement payments, are not considered as part of a tax household's income unless the money is received in the month in which the eligibility determination is completed.

This is different from Other Income appearing on Line 21 of the Form 1040, which is counted in the eligibility determination.

### 3.13. ACCEPTABLE DEDUCTION VERIFICATION DOCUMENTATION

For tax deductions appearing under this section, the most recent tax return may be used for all deductions with the exception of moving expenses.

The moving expense deduction is deductible if the employee incurs the job-related expense for which the employer will not provide reimbursement and it meets the federal tax law criteria to be claimed on the employee's tax return. The expense must be incurred in the same year for which eligibility is being determined.

**EXAMPLE 3J:** An application is received February 2018 indicating a moving expense will be claimed as a tax deduction on next year's tax return. If the expense was incurred on January 1, 2018, up to the date eligibility is determined, the deduction will be allowed. If the expense incurred prior to January 1, 2018, it will not be allowed. If an applicant indicates on the February 2018 application an expected moving expense later in the year, the deduction is not allowed. Once the deduction is incurred, the applicant may submit the applicable IRS document to verify the deduction and may request a reassessment.

For an applicant who does not have a recent tax return or for those who expect their tax deduction on next year's tax return to be higher or lower than the most recent tax return, they may complete the necessary IRS

federal income tax schedule/form/worksheet specific to the deduction \* with any necessary modification.

**Note:** All deductions listed here are for reference only in determining CHIP eligibility and ultimately limited based on all applicable IRS Guidelines.

<b>Tax Deductions</b>	<b>2015 Form 1040, Line:</b>	<b>2015 Form 1040A, Line:</b>	<b>Applicable IRS Document</b>	<b>IRS Limit</b>
Educator expenses.	23	16	N/A	\$250 per educator.
Certain business expenses of reservists, performing artists, and fee-basis government officials.	24		Form 2106, line 10 or 2106EZ, line 6, but only the portion which will carry over to the Form 1040.	None. Maximum limit is determined by IRS calculation.
Health savings account deduction.	25		Form 8889, line 13.	None.
Moving expenses (job related only).	26		Form 3903, line 5.	None.
Deductible part of self-employment tax.	27		Schedule SE, line 6.	None.
Self-employed SEP, SIMPLE and qualified plans.	28		Publication 560, Worksheet for Self Employed, Step 21 but only the amount which will carry over to the Form1040.	None. Maximum limit is determined by IRS calculation.

Tax Deductions	2015 Form 1040, Line:	2015 Form 1040A, Line:	Applicable IRS Document	IRS Limit
Self-employed health insurance deduction.	29		Form 1040 Instructions, Line 29, Self-employed Health Insurance Deduction Worksheet, line 3 or Publication 535, Self Employed Health Insurance Worksheet-6A, line 14.	None.
Penalty on early withdrawal of savings.	30		Form 1099-INT, Box 2 or Form 1099-OID, Box 3 or end of year statement from financial institution	None.
Alimony paid.	31a		A fully executed copy of Decree of Divorce or Separation Maintenance or a written instrument incident to that decree; a written separation agreement, or a decree of any type of court order requiring a spouse to make payments for the support or	None.

Tax Deductions	2015 Form 1040, Line:	2015 Form 1040A, Line:	Applicable IRS Document	IRS Limit
			maintenance of the other spouse. This includes a temporary decree, a 'not final' decree and a decree of alimony pendente lite.	
IRA deduction.	32	17	Form 1040 Instruction Booklet, Line 32, IRA Deduction Worksheet, lines 12a and 12b (or 1040A Booklet, Line 17, IRA Deduction Worksheet, lines 10a and 10b).	\$5,500 if under age 50 at end of tax year; \$6,500 if age 50 or older but under 70 1/2 at end of tax year, per tax filer.
Student loan interest deduction.	33	18	Form 1040 Instruction Booklet, Line 33, (or 1040A, Line 18) Student Loan Interest Deduction Worksheet, line 9 or if the individual files Form 2555, 2555EZ or 4563 or excludes income from Puerto Rico, use Publication	\$2,500 per annual tax filing.

Tax Deductions	2015 Form 1040, Line:	2015 Form 1040A, Line:	Applicable IRS Document	IRS Limit
			970, Worksheet 4-1, line 16.	
Tuition and fees.	34	19	Form 8917, line 6 This will be either \$2,000 or \$4,000.	\$4,000 per annual tax filing.
Domestic production activities deduction.	35		Form 8903, line 25.	None.

**NOTE:** Under MAGI methodology, income from self-employment as a sole proprietor, a partnership, limited liability company, general partnership, 'S' Corporation, etc. is all treated the same. Net losses are countable and reduce positive income. As a result, net losses reduce all positive income and, in some cases, might reduce the overall household income used in the eligibility determination to a negative amount.

As always, the tax return and schedules provided with the application or renewal should be reviewed to make sure all income is accounted for. If it appears that a schedule may be missing, the family should be contacted for the missing schedules.

### **EXAMPLE 3K: SELF-EMPLOYMENT OF A SOLE PROPRIETOR**

A federal income tax return with one Schedule C for the past calendar year is provided. Schedule C, line 31 shows John Smith Painting had a net profit of \$19,000. Form 1040 Line 12 shows a business loss of (\$1,000). The two lines do not match. This indicates all income from sole proprietorships is not all accounted for. The MCO reaches out to the family to obtain all missing Schedule Cs to complete the tax return. The missing Schedule C is received. It shows self-employment sole proprietor income for John Smith Computer Services with a net loss of (\$20,000). Now Lines 31 from both Schedule Cs match with Form 1040,

Line 12. John's income is his net profit from John Smith's Painting, \$19,000 + the net loss from John Smith's Computer Services (\$20,000) = an overall net loss (\$1,000) to be used in the eligibility determination.

### **EXAMPLE 3L: SELF EMPLOYMENT PARTNERSHIP 'S' CORPORATION**

A federal income tax return and Schedule E for the past calendar year is provided for Jane's income. Schedule E, Part 1, line 21 shows \$73,000 rental net profit and Part II, line 28 A for Looking Good Beauty Salon shows a partnership non-passive income of \$17,025 and Line 28 B for Fitness Fanatics of (\$890) non-passive loss. Schedule E, line 41, shows the total supplemental income/loss is \$89,135, which matches Form 1040, line 17. This indicates all line 17 income is accounted for. Jane's income is the net profit \$17,025 + the net loss (\$890) + rental net profit of \$73,000 = \$89,135 to be used in the eligibility determination.

### **EXAMPLE 3M: OTHER NET LOSS**

A federal income tax return and Schedule E for the past calendar year is provided. Form 1040, line 17 shows \$7,490 and line 21 shows a net operating loss carryover of (\$3,000). Schedule E, Part II, line 28A shows an 'S' Corporation, Clean Gutters, LLC, \$7,490 tax liability and line 28B shows a partnership, Gutter Clean, \$0. All amounts on the schedules match Form 1040 which means all schedules are accounted for. The income to be used in the eligibility determination is the net loss of (\$3,000), the 'S' Corporation's tax liability of \$7,490 and the partnership's breakeven of \$0 which results in an overall income of \$4,490.

**NOTE:** The business type (Self-employment) and business name should be entered on the CAPS Income screen.

**NOTE:** Remember that any wages paid to a partner or 'S' Corporation officer are to be counted in the eligibility determination. Wage verification should be obtained.

## **3.14. TAX DEDUCTIONS**

Tax deductions appearing on the Form1040, lines 23 through 35 or Form 1040A, lines 16 through 19 are countable in the eligibility determination and reduce positive income. As a result, tax deductions reduce all positive income and, in some cases, might reduce the overall household income used in the eligibility determination to a negative amount.

Tax deductions should be entered in CAPS for the exact amount appearing on the tax form. Be sure to enter the amount correctly in CAPS.

**NOTE:** MCOs must heed the limitations allowed for tax deductions. Refer to the Tax Deduction Verification chart in this chapter. Be sure when entering the amount in CAPS that it is entered only for the applicable person. CAPS does not prevent an MCO from entering the tax deduction for more than one person. Caution should be exercised to ensure the correct amount is entered, not to exceed the limitation, if applicable.

**EXAMPLE 3N:** A family completes an application indicating the expected tax deductions on next year's tax return are:

Educator expenses	\$500
Student loan interest	\$3,000
Tuition and fees	\$6,250
IRA deduction	\$12,000
SEP Simple Plan	\$10,000

The family is asked to provide the most recently filed tax return as verification of the tax deductions. The family does provide last year's Form 1040 which shows the following:

Educator expenses	\$250
Student loan interest	\$2,000
Tuition and fees	\$4,000
IRA deduction	\$5,100
SEP Simple Plan	\$8,200

When entering the information in CAPS, the amounts on the most recent tax return should be used. When comparing these tax deductions to the chart, you will notice that some are per tax filer and some are per tax filing.

Educator Expenses            \$250 - per tax **filer**

The application indicates only one (1) parent is receiving wages from a school (university, college, preschool, etc.). Because only one (1) parent is receiving school wages and the deduction is per tax filer, the amount entered in CAPS is limited to \$250 for the person receiving the school wages.

Student Loan Interest      \$2,500 – per tax filing

The application indicates the tax dependent daughter pays student loan interest of \$2,250, mom \$350 and dad \$400. The total interest paid is \$3,000; however, the limit per tax filing (i.e. per return) is \$2,500 regardless of how many people are paying interest. Because this deduction is per tax filing, the deduction should be entered under the tax filer's name for the amount appearing on the tax return but not to exceed the limit appearing in the Tax Deduction Verification chart. In this case, \$2,500 should be entered under the tax filer.

Tuition and Fees              \$4,000 – per tax filing

The application indicates the tax dependent daughter pays tuition of \$4,100 and mom of \$3,250. The total tuition is \$7,350; however, the limit per tax filing (i.e. per return) is \$2,000 or \$4,000 depending on the income limit used under federal tax rules for Form 8917 regardless of how many people are paying tuition. Because last year's tax return shows \$4,000, the deduction should be entered under the tax filer's name for the amount appearing on the tax return but not to exceed the limit appearing in the Tax Deduction Verification chart.

IRA Deduction                  \$5,500 – per tax filer with age limits

The application indicates the tax filer expects to claim a \$12,000 deduction because the one tax filer contributes \$1,000 monthly to an IRA. The other tax filer does not. Because the last year's federal income tax return shows \$5,500, the deduction should be entered under the tax filer's name for the amount appearing on the tax return. Should the tax household member contact the MCO and state that the IRA deduction on last year's return represents a smaller contributed monthly amount or does not represent 12 months of contributions, the MCO asks the tax filer to submit the applicable IRS document listed in the Tax Deductions Verification table in this chapter.

SEP (Simplified Employee Pension) Simple Plan \$12,500 – per tax filing.

The application indicates the tax filer expects to claim a \$10,000 deduction because the one (1) tax filer contributes \$833 monthly to his retirement plan through his business. Because the last year's federal income tax return shows \$8,200, the deduction should be entered under the tax filer's name for the amount appearing on the tax return. Should the tax filer contact the MCO and state that the SEP deduction on last year's return represents a smaller contributed monthly amount or does not represent twelve (12)

months of contributions, the MCO asks the tax filer to submit the applicable IRS document listed in the Tax Deductions Verification table below.

**NOTE:** If both tax filers are self-employed and both contribute to their own SEP, the limit that can be taken is for the tax filing itself, not per tax filer.

## CHAPTER 4: DETERMINING FINANCIAL ELIGIBILITY

### 4.1. GENERAL REQUIREMENTS

Financial eligibility is prospectively determined on the basis of the tax household's reasonably expected income, including a net loss, to be received during the twelve (12) month enrollment period based upon current documentation and the tax deductions the tax filer expects to take on next year's federal individual income tax return. The household's income and the household's size is reviewed to determine in which category the applicants are eligible. The eligibility chart is at Appendix 4-A. Examples of the determination are at appendix 4-B

If an enrollee reports a change in income including a loss of income such as lost wages, Social Security Survivor's or Disability or alimony, documentation must be submitted to verify the loss of income prior to removing it from the eligibility determination.

An MCO may not remove income without verification of the change.

**EXAMPLE A:** If Mrs. X reports that her husband lost his job, she should be asked if there is replacement income, such as unemployment or starting a new job. The MCO removes income if Mrs. X reports replacement income and provides the documentation to support this claim, such as a copy of the Notice of Financial Determination provided by the Department of Labor and Industry or a letter of employment for the new job. The income could be removed if the family had proof that the parent was no longer working. If no documentation is received, the income must not be updated.

This also applies to removing income that appears in CAPS but is not listed on the application or renewal form. The MCO contacts the applicant to verify if this "missing" income is still being received, if there is replacement income, and to obtain the appropriate documentation.

If an applicant or enrollee reports that a spouse or parent is now deceased and there is no indication of a survivor or death benefit being received by the surviving spouse or child, the MCO contacts the applicant to verify if any survivor or death benefit is being received and obtain the appropriate documentation.

### 4.2. Annual Income Calculations

Annual income is calculated based on:

1. Forty-eight (48) pays, if paid weekly;
2. Twenty-four (24) pays, if paid biweekly or bimonthly if not an employee of a school district using the exception below:
  - 2.1. Twenty-two (22) pays for employees of school districts who only receive earned income during the ten (10) month school year (September to June). If the employee is a teacher who has elected to receive the ten (10) month salary during the full calendar year, then twenty-four (24) biweekly pays would apply; or
3. Twelve (12) pays, if paid monthly.

When annual income is being calculated, consideration is given to fluctuations in the period of time or the amount of income that is expected to be received during the twelve (12) month enrollment period. The following income categories should be particularly noted:

1. Unemployment Compensation;
2. Alimony;
3. Income received intermittently throughout the twelve (12) month period, e.g., seasonal employment or an “as-needed” basis; and
4. Income that fluctuates in amount (i.e. a person who works continually but for a different number of hours each week).

The calculation reflects the tax household’s prospective financial circumstances by taking into account income or losses that are reasonably expected to be received during the enrollment period. If income is received for a predetermined period of time, the calculation should only include the income that is predicted to be received. If the amount of income is expected to fluctuate, the calculation is based on an average that takes into account the amount of income or loss that is predicted to be received throughout the enrollment period.

#### **4.3. PAYSTUB REVIEW AND AVERAGING**

Income can be determined by averaging income. The examples provided underscore various scenarios that may occur when reviewing paystubs and provide the MCO with insight on what to look for to determine if and when YTD average should be used. The MCO is expected to use the method that is best able to determine the reasonably representative income of a tax household member over the upcoming twelve (12) month enrollment period, based on valid supporting

documentation regardless of what category of CHIP results from the use of this method.

#### **4.3.1.1. How to recognize fluctuating income and when to use a YTD average**

##### **EXAMPLE 4B: One Paystub Received**

**Scenario:** Mr. B submits one (1) biweekly paystub containing earning types of Hourly Regular Rate, Overtime, Holiday Pay, and Vacation Hourly Rate. His biweekly paystub for Pay Date 6/3 is \$1,165.28 and the YTD gross earnings are \$11,862.52. The YTD Overtime is \$2,898.12 and Vacation is \$160. The number of hours worked this pay period is 102.27.

##### **Comparison:**

YTD Average: The most recent paystub dated 6/3 (his 11<sup>th</sup> pay of the year) shows the total YTD gross income is \$11,862.52.  $\$11,862.52 / 13 \text{ pays received} = \$1,078.41$  average biweekly pay.

Individual Paystub: The individual paystub he submitted shows his gross biweekly pay is \$1,165.28.

**Conclusion:** Because his paystub confirms that he receives other types of income which indicates his pay does fluctuate (regardless of what was stated on the application) averaging the YTD earnings would best represent the income reasonably expected to be received over the 12-month enrollment period. Therefore, in this example, \$1,078.41 would be used as his average biweekly pay in the eligibility determination.

##### **EXAMPLE 4C: One Paystub Received**

**Scenario:** A father completes the application or renewal form stating that his gross pay is \$1,600 bimonthly and that it does not fluctuate. He provides his current paystub for Pay Date 8/15 showing the gross pay amount of \$1,600 and the YTD gross earnings are \$24,000. There are no other earning types appearing on the paystub.

##### **Comparison:**

YTD Average: The most recent paystub dated 8/15 (his 15<sup>th</sup> pay of the year) shows a total YTD gross income of \$24,000.  $\$24,000 / 15 \text{ pays received} = \$1,600$  average biweekly pay.

Individual Paystub: The individual paystub he submitted shows his gross biweekly pay is \$1,600.  $\$1,600 \times 15 \text{ pays} = \$24,000$ .

**Conclusion:** Because the paystub supports the parent's claim of earning \$1,600 bimonthly and there are no other types of earnings listed on the paystub, the MCO can use the \$1,600 bimonthly gross pay in the eligibility determination.

#### **EXAMPLE 4D: One Paystub Received**

**Scenario:** A father reports he receives a biweekly gross pay of \$1,600 and that his Income does not fluctuate.

He submits one (1) biweekly paystub containing earning types of Regular Pay, OT Pay, and Bonus. The paystub for Pay Date 6/11 shows \$1,730 and YTD gross pay of \$22,814. The earnings for the 6/11 pay are comprised of \$1,600 of Regular Pay (80 Regular Hours x \$20 hourly rate) and a \$130 Bonus. The YTD gross earnings from OT and Bonuses are not totaled separately. It is all combined into one YTD Gross Pay.

#### **Comparison:**

YTD Average: The paystub dated 6/11 (his 12<sup>th</sup> pay of the year) shows the total YTD gross income is \$22,814.  $\$22,814 / 12 \text{ pays received} = \$1,901.17$  average biweekly pay.

Individual Paystub: The individual paystub he submitted shows his gross biweekly pay is \$1,730.

**Conclusion:** Because his paystub confirms that he receives other types of income which indicates his pay does fluctuate (regardless of what was stated on the application) averaging the YTD earnings would best represent the income reasonably expected to be received over the twelve (12) month enrollment period. Therefore, in this example, \$1,901.17 would be used in the eligibility determination.

#### **EXAMPLE 4E: One Paystub Received**

**Scenario:** A mother submits one (1) paystub for pay period ending 5/31, Pay Date 5/31 showing her rate of \$2,253.34. The paystub also shows her current gross earnings this period of \$1,525.34 and a YTD gross of \$10,161.70. Her paystub does not provide a pay period begin date to determine if this is a monthly pay as she indicated on the renewal form nor is the gross amount of the pay the same as she indicated.

**Comparison:**

CAPS Income History screen shows no prior employer by this name for the 2017 renewal. There is no correlating flat voluntary deduction or flat tax from her earnings to determine how many pays she has received as of the Pay Date 5/31/18.

**Conclusion:** The MCO may contact mom and request that she submit the 6/30 paystub as soon as she receives it. Alternatively, because the YTD amount shows a different monthly average than the 5/31 pay amount, the MCO may use the information mom provided on the renewal form of a \$2,253.34 gross pay rate as a monthly pay rate.

**EXAMPLE 4F: Multiple Paystubs Received**

**Scenario:** A mother completes the application or renewal form stating that she is working 32 hours per week with a slight fluctuation in income. The mother submits her last four weekly pay subs, which show gross pay amounts of \$260, \$240, \$300, and \$280. The YTD gross earning on her most recent paystub (the 23<sup>rd</sup> pay received) is \$6,235.

**Comparison:**

YTD Average: The gross annual income based on averaging the gross YTD income of \$6,235 / 23 pays received = \$271.09 average gross weekly.

Multiple Paystub Average: The weekly gross pay amounts of \$260 + 240 + 300 + 280 = \$1,080. \$1,080 ÷ 4 pays = \$270 average weekly gross pay.

**Conclusion:** Because the paystubs confirm that the income does fluctuate (regardless of what was stated on the application) averaging the YTD earnings would best represent the income reasonably expected to be received over the

twelve (12) month enrollment period. In this example, the YTD average amount of \$271.09 would be used in the eligibility determination.

#### **EXAMPLE 4G: Multiple Paystubs Received with Overtime**

**Scenario:** A father completes the application attesting that he works 80 hours per biweekly pay and that his income does not fluctuate. The father submits 4 biweekly paystubs containing earning types of Hourly Regular Rate, Overtime, Holiday Pay and Vacation Hourly Rate for the following Pay Dates: 5/6, \$1,192.62 with a YTD gross \$9,550.41; 5/20, \$1,146.83 with a YTD gross \$10,697.24; 6/3, \$1,165.28 with a YTD gross \$11,862.52 and 6/17, \$892.71 with a YTD gross \$12,755.23. Of the four (4) paystubs, only the most recent pay date has no overtime or vacation pay. The YTD overtime on the most recent pay is \$2,898.12 and Vacation is \$160. The number of hours worked on each biweekly pay varies from 107 hours to 87 hours.

#### **Comparison:**

YTD Average: On the most recent paystub (Pay Date 6/17 which is his 12<sup>th</sup> pay of the year), the total YTD gross income is \$12,755.23.  $\$12,755.23/12$  pays received = \$1,062.94 average gross biweekly pay.

Multiple Paystub Average: The individual gross pays amounts of  $\$1,192.62 + \$1,146.83 + \$1,165.28 + \$892.71 = \$4,397.44/4$  pays = \$1,099.36 average gross biweekly pay.

**Conclusion:** Because his paystubs confirm that his income does fluctuate (regardless of what was stated on the application) averaging the YTD earnings would best represent the income reasonably expected to be received over the twelve (12) month enrollment period. In this example, \$1,062.94 would be used in the eligibility determination.

## **CHAPTER 5: ENROLLMENT PROCEDURE**

### **5.1. GENERAL REQUIREMENTS**

The MCO enters the application into CAPS within fifteen (15) calendar days of the date stamp so that an eligibility determination can be made timely. If the 15th calendar day falls on a non-working day, the determination must be completed by close of business on the next working day. A notice of eligibility or ineligibility (with an appropriate explanation and reason code for denial) must be sent to the parent or guardian.

Once an application moves to the “Pending CEU Review” process, the MCO is unable to hold the application for additional information (e.g. income). There is a strong possibility that the CEU is able to verify income or complete other portions of the application without waiting for paper verification from the applicant. Therefore, the MCO enter all available information into CAPS and submit the application.

### **5.2. COMPLETE APPLICATION – ELIGIBLE FOR FREE CHIP**

Once all the information is entered into the CAPS, eligibility is determined. If all of the eligibility requirements have been met and the applicant is eligible for Free CHIP, an electronic cross check with MA is performed automatically to ensure that the applicant is not enrolled in MA. The child is also checked through the Health Management System (HMS) to see if they are covered under any private health insurance that is Minimal Essential Coverage (MEC). If no coverage is found, the child is enrolled in Free CHIP on the appropriate effective date of coverage.

#### **EXAMPLE 5A:**

Determination of Eligibility made April 15  
Effective Date of Coverage – Optimum May 1  
Effective Date of Coverage – Alternate June 1

### **5.3. COMPLETE APPLICATION - ELIGIBLE FOR LOW-COST OR FULL-COST CHIP**

Once all the information is entered into CAPS, eligibility is determined. If all of the eligibility requirements have been met and the child is Low-Cost or Full-Cost eligible, the child is placed in a pending status check for the enrollment date currently being processed.

An electronic cross check with MA is performed automatically to ensure that the applicant is not enrolled in MA. An additional check is made with a third-party liability (TPL) vendor to verify if there is private health insurance.

**EXAMPLE 5B:**

Determination of Eligibility made April 15

Effective Date of Coverage – Optimum May 1, premium request sent April 16, premium received April 30, and child is enrolled May 1, if possible

Effective Date of Coverage – Optimum May 1, premium request sent April 16, premium received May 5, child is enrolled June 1

Effective Date of Coverage – Alternate June 1, premium request sent April 16, premium received before May 17, child is enrolled June 1.

**NOTE:** It is acceptable to work with the parent to start coverage the first of the month following eligibility determination even if the payment is received after the first of the next month. An example would be if the eligibility determination was made on April 15, the notice was sent on April 16, and on May 5 the head of household requests a May 1 start date and arranges for payment of premiums for May and June (and July for those MCOs that require a month in advance). The effective date may be managed to May 1.

**5.4. COMPLETE APPLICATION - LOW INCOME REFERRAL TO THE CAO**

Once all the information is entered into CAPS, eligibility is determined. When the income is below the CHIP income eligibility guidelines; an electronic referral to MA is forwarded to the appropriate CAO for a determination of eligibility for MA. (Refer to Section 1.8 relating to Automated Referrals to the CAO).

## **CHAPTER 6: ENROLLEE SERVICES**

### **6.1. Services for New Enrollees**

The MCO must make available the full scope of benefits to which an enrollee is entitled from the effective enrollment date provided by the Department.

### **6.2. New Enrollee Orientation**

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

- a. An enrollee handbook for new enrollees outlining their benefits and the basic features of managed care;
- b. Information on cost sharing;
- c. A Provider Directory and formulary information;
- d. A physician incentive plan upon request;
- e. Educational and preventative care programs that include an emphasis on health promotion, wellness and healthy lifestyles and practices;
- f. The proper use of the MCO identification card;
- g. The role of the PCP;
- h. What to do in an emergency or urgent medical situation;
- i. How to utilize services in other circumstances;
- j. How to request information from the MCO, and
- k. How to register a complaint, file a grievance or request an external review.

### **6.3. MCO Policy and Procedure Materials**

The MCO must obtain the Department's advance written approval of the following policies and procedures.

**6.3.1.1.** The MCO must comply with information requirements 42 CFR 438.10 as required.

**6.3.1.2.** The MCO must provide an enrollee handbook, or other written materials, at a minimum with information outlined in 42 C.F.R. §

438.10(g)(2), including information on enrollee rights and protections and how to access services.

- 6.3.1.3.** Materials must be in the appropriate language or alternate format to enrollees within five (5) Business Days of an enrollee's effective date of coverage.
- 6.3.1.4.** The CHIP MCO will provide the enrollee handbook by mailing a printed copy to the enrollee's mailing address; by emailing the information after obtaining the enrollee's consent; by posting the information on the CHIP MCO's website and advising enrollees of the availability of the information through the Internet, the applicable Internet address and the availability of auxiliary aids and services upon request and at no cost to enrollees with disabilities; or by providing the information in a manner that is reasonably expected to result in enrollee's receipt of the information.
- 6.3.1.5.** The 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.
- 6.3.1.6.** The MCO must notify all enrollees of all changes defined significant by the Department at least thirty calendar days prior to the effective date of the change and on an annual basis of any other changes made, and the formats and methods available to access the handbook.
- 6.3.1.7.** Upon request, the MCO must provide a hard copy version of the enrollee handbook to the enrollee.
- 6.3.1.8.** The enrollee handbook contains standard non-discrimination information and is available in alternate languages and formats.
- 6.3.1.9.** The CHIP MCO must adopt practice guidelines that: (i) Are based on valid and reliable clinical evidence or a consensus of providers in a particular field; (ii) Consider the needs of the CHIP MCO's enrollees; (iii) Are adopted in consultation with contracting health care professionals; (iv) Are periodically reviewed and updated, as appropriate. The CHIP MCO will disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. The CHIP MCO will make decisions relating to utilization management, enrollee education, coverage of services and other areas to which the guidelines apply in a manner consistent with the guidelines.

### **6.3.2. Enrollee Handbook Requirements**

The MCO must ensure that the enrollee handbook is written at no higher than a sixth-grade reading level and includes, at a minimum, the information included in the model enrollee handbook issued by the Department.

### **6.3.3. Department Approval of Enrollee Handbook**

The enrollee handbook must be in the format specified by the Department. The MCO must submit the enrollee handbook to the Department for advance written approval prior to distribution to enrollees. The MCO must make modifications in the language contained in the enrollee handbook if required for Department approval.

#### **6.3.4. MCO Identification Cards**

The MCO must issue identification cards to enrollees.

#### **6.3.5. Provider Directories**

- 6.3.5.1.** The MCO must make available directories for all types of network providers, including, but not limited to: PCPs, hospitals, specialists, behavioral health providers, pharmacies, providers of ancillary services, rehabilitation facilities, etc.
- 6.3.5.2.** The provider directories must be made available on the MCO's website in a machine-readable document format.
- 6.3.5.3.** The MCO must utilize a web-based Provider directory for its enrollees and must make it available in paper form upon request.
- 6.3.5.4.** The MCO must establish a process to verify the accuracy of electronically posted content, including a method to monitor and update changes in Provider information.
- 6.3.5.5.** The MCO must perform monthly reviews of the web-based Provider directory, subject to random monitoring by the Department to verify complete and accurate entries.
- 6.3.5.6.** The MCO must update paper provider directories at least monthly and electronic versions no later than thirty (30) calendar days after the MCO receives updated provider information.
- 6.3.5.7.** This includes information regarding terminations, additions, PCPs and specialists not accepting new assignments, and other information determined by the Department to be necessary.
- 6.3.5.8.** The MCO must utilize the file layout and format specified by the Department that includes all Providers in the MCO's Network. The format must include, but not be limited to the following:
  - 6.3.5.8.1.** Provider name as well as group affiliation (if any);
  - 6.3.5.8.2.** Correct MIS Provider ID;
  - 6.3.5.8.3.** Provider's street address or location, or both, where the Provider sees enrollees, as well as whether the provider has hours in the evening, on weekends, or both;
  - 6.3.5.8.4.** Provider's telephone number;
  - 6.3.5.8.5.** Provider's website URL (as appropriate);
  - 6.3.5.8.6.** Provider's specialty (as appropriate);
  - 6.3.5.8.7.** Provider's site accommodations for people with physical disabilities including but not limited to

wheelchair accessibility;

**6.3.5.8.8.** Provider's cultural and linguistic capabilities and whether the provider has completed cultural competence training;

**6.3.5.8.9.** Language indicators including a list of current providers in the enrollee's service area who speak languages other than English; and

**6.3.5.8.10.** The Provider's panel status and whether new patients are accepted.

**6.3.5.9.** An MCO will not be certified as "ready" without the completion of the electronic provider directory component as determined and provided by the Department.

**6.3.5.10.** The MCO must notify its enrollees annually of their right to request and obtain provider directories.

**6.3.5.11.** Upon request, the MCO must provide its enrollees with directories for PCPs, dentists, specialists, hospitals, and Providers of ancillary services.

### **6.3.6. Formulary List**

The MCO must make available to its enrollees in electronic or paper form formulary information that includes the medications which are covered (generic and brand name) and medication tiers. Formulary drug lists must be made available on the MCO's website in a machine-readable file and format. Upon request from the enrollee, the MCO may print the most recent electronic version from their Provider file and mail it to the enrollee.

### **6.3.7. Ancillary Service Directory**

The 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 MCO also must make modifications to its Provider directories if ordered by the Department.

### **6.3.8. Enrollee Rights.**

The MCO must develop, maintain and enforce written policies and procedures recognizing and protecting an enrollee's rights as specified in 42 CFR § 438.100, including the right to:

- Receive required information;
- Be treated with respect and due consideration for his or her dignity and privacy;
- Receive information on available treatment options and alternatives in a manner appropriate to the enrollee's condition and ability to understand;

- Participate in decisions regarding the health care, including the right to refuse treatment;
- Be free from restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations;
- If the privacy rules, as set forth in 45 CFR Parts 160 and 164 subparts A and E, apply, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 C.F.R §§ 164.524 and 164.526;
- Be furnished with covered health care services as required by 42 C.F.R. § 438.206 – 438.210;
- Have privacy rights protected as provided by 42 C.F.R. § 457.1110, including compliance with applicable federal and state law relating to the confidentiality of information, safeguarding information about applicants and beneficiaries of services as provided by 42 C.F.R. Part 431, Subpart F, maintaining records and information in a timely and accurate manner and specifying to whom and the purpose of disclosure of information outside the Department; and
- Upon an enrollee's request and except as otherwise provided by law, provide a copy of an enrollee's records or information in a timely manner and permit the enrollee to request that the information or records be supplemented or corrected.

The MCO must comply with applicable federal and state laws relating to enrollee rights and must require that its employees and providers observe and protect enrollee rights. An enrollee's exercise of his or her enrollee rights may not adversely affect manner in which the enrollee is treated by the MCO or its providers.

## **CHAPTER 7: COMPLAINT, GRIEVANCE, AND EXTERNAL REVIEW**

### **7.1. General Requirements**

- 7.1.1.** The MCO must obtain the Department's prior written approval of its Complaint, Grievance, and External Review policies and procedures.
- 7.1.2.** The 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.
- 7.1.3.** The MCO must maintain an accurate written record of each Complaint and Grievance and the actions taken by the MCO to resolve each Complaint and Grievance. The record must include at least the following:
  - 7.1.3.1.** The name of the enrollee on whose behalf the Complaint or Grievance was filed;
  - 7.1.3.2.** The date the Complaint or Grievance was received;
  - 7.1.3.3.** A description of the reason for the Complaint or Grievance;
  - 7.1.3.4.** The date of each review or review meeting;
  - 7.1.3.5.** The date of resolution of the Complaint or Grievance and how the Complaint or Grievance was resolved; and
  - 7.1.3.6.** A copy of any documents or records reviewed.
- 7.1.4.** The MCO must provide the record of each Complaint and Grievance and the actions taken by the MCO to resolve each Complaint and Grievance to the Department and CMS upon request.
- 7.1.5.** The 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.
- 7.1.6.** The MCO must have a data system to process, track, and trend all Complaints and Grievances.
- 7.1.7.** The MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements specified in this chapter.
- 7.1.8.** MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training, and experience to make an informed and impartial determination regarding issues assigned to them.

- 7.1.9.** The MCO must provide information about the Complaint and Grievance process to all providers and subcontractors when the MCO enters into a contract or agreement with the provider or subcontractor.
- 7.1.10.** The 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.
- 7.1.11.** The 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.
- 7.1.12.** The MCO may not charge Members a fee for filing a Complaint or a Grievance.
- 7.1.13.** The MCO must allow the enrollee and the enrollee's representative to have access to all relevant documentation pertaining to the subject of the Complaint or Grievance free of charge and sufficiently in advance of the time frame for resolution of the Complaint or Grievance outlined in this chapter.
- 7.1.14.** The MCO must maintain the following information in the Member's case file:
  - 7.1.14.1.** Medical records;
  - 7.1.14.2.** Any documents or records relied upon or generated by the 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
  - 7.1.14.3.** Any new or additional evidence considered, relied upon, or generated by the MCO in connection with the Complaint or Grievance.
- 7.1.15.** The MCO must provide language interpreter services at no cost when requested by an enrollee.
- 7.1.16.** The MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including:
  - 7.1.16.1.** TTY/TDD for telephone inquiries and Complaints and Grievances from enrollees who are deaf or hearing impaired;
  - 7.1.16.2.** Braille;
  - 7.1.16.3.** tape;
  - 7.1.16.4.** computer disk; and

- 7.1.16.5.** other commonly accepted alternative forms of communication.
- 7.1.17.** The MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitations of enrollees with disabilities, so they treat these individuals with patience, understanding, and respect.
- 7.1.18.** The 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:
- 7.1.18.1.** Providing qualified sign language interpreters for enrollees who are deaf or hearing impaired;
  - 7.1.18.2.** Providing information submitted on behalf of the MCO at the Complaint or Grievance review in an alternative format accessible to the enrollee 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
  - 7.1.18.3.** Providing personal assistance to an enrollee filing the Complaint or Grievance who has other physical limitations in copying and presenting documents and other evidence.
- 7.1.19.** The MCO must offer enrollees the assistance of a MCO staff member throughout the Complaint and Grievance processes at no cost to the enrollee.
- 7.1.20.** The 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.
- 7.1.21.** The MCO must, at a minimum, hold in-person reviews of Complaints and Grievances at one location within each of its zones of operation. If an enrollee requests an in-person review, the 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.
- 7.1.22.** The MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.
- 7.1.23.** The MCO must notify the Member when the MCO fails to decide a first level Complaint or a Grievance within the time frames specified in this chapter, using the template specified by the Department. The MCO must mail this notice to the enrollee one (1) day following the date the decision was to be made (day 31).

- 7.1.24.** The 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 CHIP, using the template specified by the Department. The MCO must mail this notice to the enrollee on the day the decision is made to deny payment.
- 7.1.25.** The 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 MCO must mail this notice to the enrollee on the day the decision is made to deny payment.
- 7.1.26.** The MCO must notify the enrollee when it denies payment after a service or item has been delivered because the MCO determined that the service or item was not medically necessary, using the template specified by the Department. The MCO must mail this notice to the enrollee on the day the decision is made to deny payment.
- 7.1.27.** The 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 MCO must mail this notice to the enrollee on the day the decision is made to deny payment.
- 7.1.28.** The MCO must use all templates specified by the Department.

## **7.2. Complaint Requirements**

### **7.2.1. First Level Complaint Process**

- 7.2.1.1.** A 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 orally. The MCO must commit oral requests to writing if not confirmed in writing by the enrollee and must provide the written Complaint to the enrollee or enrollee's representative for signature. The signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process.
- 7.2.1.2.** 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:

- 7.2.1.2.1.** a denial because the service or item is not a covered service;
  - 7.2.1.2.2.** the failure of the MCO to provide a service or item in a timely manner, as defined by the Department;
  - 7.2.1.2.3.** the failure of the MCO to decide a Complaint or Grievance within the specified time frames;
  - 7.2.1.2.4.** 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 CHIP;
  - 7.2.1.2.5.** 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
  - 7.2.1.2.6.** a denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities,
- 7.2.1.3.** For all other Complaints, there is no time limit for filing a first level Complaint.
- 7.2.1.4.** Upon receipt of the Complaint, the MCO must send the enrollee and enrollee's representative, if the Member has designated one in writing, a first level Complaint acknowledgment letter, using the template specified by the Department.
- 7.2.1.5.** The first level Complaint review for Complaints not involving a clinical issue must be conducted by a first level Complaint review committee, which must include one or more employees of the 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.
- 7.2.1.6.** The first level Complaint review for Complaints involving a clinical issue must be conducted by a first level Complaint review committee, which must include one or more employees of the MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The first level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on

the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the first level Complaint.

- 7.2.1.7.** 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 member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.
- 7.2.1.8.** The 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.
- 7.2.1.9.** The MCO must give the enrollee at least seven (7) calendar days advance written notice of the first level Complaint review date, using the template specified by the Department. The 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 MCO must provide an opportunity for the enrollee to communicate with the first level Complaint review committee by telephone or videoconference.
- 7.2.1.10.** 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.
- 7.2.1.11.** 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.
- 7.2.1.12.** 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.
- 7.2.1.13.** The first level Complaint review committee must complete its review of the Complaint as expeditiously as the enrollee's health condition requires.

- 7.2.1.14.** 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.
- 7.2.1.15.** The 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 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.
- 7.2.1.16.** If the Complaint disputes one of the following, the enrollee may file a request for an external review:
- 7.2.1.16.1.** a denial because the service or item is not a covered service;
  - 7.2.1.16.2.** the failure of the MCO to provide a service or item in a timely manner, as defined by the Department;
  - 7.2.1.16.3.** the failure of the MCO to decide the Complaint or Grievance within the specified time frames;
  - 7.2.1.16.4.** a denial of payment by the MCO after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in CHIP;
  - 7.2.1.16.5.** a denial of payment by the MCO after the service or item has been delivered because the service or item provided is not a covered service for the enrollee; or
  - 7.2.1.16.6.** a denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
- 7.2.1.17.** The enrollee or enrollee's representative may file a request for an external review within fifteen (15) calendar days from the mail date on the written notice of the MCO's first level Complaint decision in connection with section 7.2.1.16.
- 7.2.1.18.** 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 Member's behalf, may file a second level Complaint either in writing or orally within forty-five (45)

calendar days from the date the enrollee receives written notice of the MCO's first level Complaint decision.

## **7.2.2. Second Level Complaint Process**

- 7.2.2.1.** A 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 orally for any Complaint for which an external review is not available.
- 7.2.2.2.** Upon receipt of the second level Complaint, the MCO must send the enrollee and enrollee's representative, if the enrollee has designated one in writing, a second level Complaint acknowledgment letter, using the template specified by the Department.
- 7.2.2.3.** The second level Complaint review for Complaints not involving a clinical issue must be performed 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.
- 7.2.2.4.** The second level Complaint review for Complaints involving a clinical issue must be conducted by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The second level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the second level Complaint.
- 7.2.2.5.** At least one-third of the second level Complaint review committee members may not be employees of the MCO or a related subsidiary or Affiliate.
- 7.2.2.6.** 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 member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

- 7.2.2.7.** The 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.
- 7.2.2.8.** The 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 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 MCO must provide an opportunity for the Member to communicate with the second level Complaint review committee by telephone or videoconference.
- 7.2.2.9.** 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.
- 7.2.2.10.** 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.
- 7.2.2.11.** 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.
- 7.2.2.12.** The testimony taken by the second level Complaint review committee (including the enrollee's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.
- 7.2.2.13.** The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Member's health condition requires.
- 7.2.2.14.** The MCO must send a written notice of the second level Complaint decision, using the template specified by the Department, to the Member, Member's representative, if the enrollee has designated one in writing, service Provider, and prescribing provider, if

applicable, within forty-five (45) calendar days from the date the MCO received the second level Complaint.

- 7.2.2.15.** 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 Complaint decision with either DOH or PID within fifteen (15) calendar days from the date the enrollee receives the written notice of the MCO's second level Complaint decision.

### **7.2.3. External Complaint Process**

- 7.2.3.1.** Upon the request of either DOH or PID, the MCO must transmit all records from the MCO's Complaint review to the requesting department within thirty (30) days from the request in the manner prescribed by that department. The enrollee, the provider, or the MCO may submit additional materials related to the Complaint.

- 7.2.3.2.** DOH and PID will determine the appropriate agency for the review.

### **7.2.4. Expedited Complaint Process**

- 7.2.4.1.** The MCO must conduct expedited review of a Complaint if the 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 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 must include the provider's signature.

- 7.2.4.2.** A request for an expedited review of a Complaint may be filed in writing, by fax, orally, or by email.

- 7.2.4.3.** Upon receipt of an oral or written request for expedited review, the 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.

- 7.2.4.4.** If the provider certification is not included with the request for an expedited review and the 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 MCO must inform the enrollee that the provider must submit a certification as to the reasons why the expedited review is needed. The 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 MCO must decide the Complaint within the standard time frames as set forth in this chapter, 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 MCO decides that expedited consideration within the initial or extended time frame is not warranted, the 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.

- 7.2.4.5.** Expedited review of a Complaint must be conducted by a Complaint review committee that includes a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the 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.
- 7.2.4.6.** The MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.
- 7.2.4.7.** The MCO must issue the decision resulting from the expedited review in person or by phone to the enrollee, the enrollee's representative, if the Member has designated one in writing, service provider and prescribing provider, if applicable, within either forty-eight (48) hours of receiving the provider certification or seventy-two (72) hours of receiving the 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) days at the request of the enrollee. In addition, the 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.

- 7.2.4.8.** The enrollee or the enrollee's representative may file a request for an expedited external review within fifteen (15) calendar days from the mail date on the written notice of the MCO's expedited Complaint decision.
- 7.2.4.9.** A request for an expedited external Complaint review may be filed in writing, by fax, orally, or by email.
- 7.2.4.10.** The MCO must follow DOH guidelines relating to submission of requests for expedited external Complaint reviews.
- 7.2.4.11.** The MCO may not take punitive action against a provider who requests expedited resolution of a Complaint or supports an enrollee's request for expedited review of a Complaint.

### **7.3. Grievance Requirements**

#### **7.3.1. Grievance Process**

- 7.3.1.1.** A 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 orally. The MCO must commit oral requests to writing if not confirmed in writing by the enrollee and must provide the written Grievance to the enrollee or the enrollee's representative for signature. The signature may be obtained at any point in the process, and the failure to obtain a signed Grievance may not delay the Grievance process.
- 7.3.1.2.** An enrollee must file a Grievance within sixty (60) calendar days from the date the enrollee receives written notice of decision.
- 7.3.1.3.** Upon receipt of the Grievance, the MCO must send the enrollee and enrollee's representative, if the enrollee has designated one in writing, a Grievance acknowledgment letter, using the template specified by the Department.
- 7.3.1.4.** 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 MCO and the provider.
- 7.3.1.5.** 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 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:

- 7.3.1.5.1.** The name and address of the enrollee, the enrollee's date of birth and identification number;
- 7.3.1.5.2.** 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;
- 7.3.1.5.3.** The name, address, and MCO identification number of the provider to whom the enrollee is providing consent;
- 7.3.1.5.4.** The name and address of the MCO to which the Grievance will be submitted;
- 7.3.1.5.5.** An explanation of the specific service or item which was provided or denied to the enrollee to which the consent will apply;
- 7.3.1.5.6.** 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.";
- 7.3.1.5.7.** 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.";
- 7.3.1.5.8.** 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
- 7.3.1.5.9.** The dated signature of the enrollee, or the enrollee's representative, and the dated signature of a witness.

- 7.3.1.6.** 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.
- 7.3.1.7.** At least one-third of the Grievance review committee may not be employees of the MCO or a related subsidiary or affiliate.
- 7.3.1.8.** The Grievance review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the Grievance.
- 7.3.1.9.** A committee member who does not personally attend the Grievance review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.
- 7.3.1.10.** The 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.
- 7.3.1.11.** The 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 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 MCO must provide an opportunity for the enrollee to communicate with the Grievance review committee by telephone or videoconference.
- 7.3.1.12.** 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.
- 7.3.1.13.** 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.
- 7.3.1.14.** 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.

- 7.3.1.15.** The testimony taken by the Grievance review committee (including the enrollee's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Grievance record.
  - 7.3.1.16.** The Grievance review committee must complete its review of the Grievance as expeditiously as the enrollee's health condition requires.
  - 7.3.1.17.** The 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 Member has designated one in writing, service provider and prescribing provider, if applicable, within thirty (30) calendar days from the date the 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.
  - 7.3.1.18.** The enrollee may file a request for an external review.
  - 7.3.1.19.** The enrollee or enrollee's representative may file a request for an external review within fifteen (15) calendar days from the mail date on the written notice of the MCO's Grievance decision.
- 7.3.2. External Grievance Process:**
- 7.3.2.1.** The MCO must process all requests for external Grievance review. The MCO must follow the protocols established by DOH for external reviews 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.
  - 7.3.2.2.** Within five (5) business days of receipt of the request for an external Grievance review, the 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 DOH, if appropriate, that the request for external Grievance review has been filed.

- 7.3.2.3.** The external Grievance review must be conducted by a certified review entity (“CRE”) not affiliated with the MCO.
- 7.3.2.4.** Within two (2) business days from receipt of the request for an external Grievance review, DOH will randomly assign a CRE to conduct the review and notify the MCO and assigned CRE of the assignment.
- 7.3.2.5.** If DOH fails to select a CRE within two (2) business days from receipt of a request for an external Grievance review, the MCO may designate a CRE to conduct a review from the list of CREs approved by DOH. The MCO may not select a CRE that has a current contract or is negotiating a contract with the MCO or its Affiliates or is otherwise affiliated with the MCO or its Affiliates.
- 7.3.2.6.** The 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 MCO must transmit this information within fifteen (15) calendar days from receipt of the enrollee’s request for an external Grievance review.
- 7.3.2.7.** Within fifteen (15) calendar days from receipt of the request for an external Grievance review by the 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 MCO so that the MCO has an opportunity to consider the additional information.
- 7.3.2.8.** 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 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 handbook.
- 7.3.3.** The external Grievance decision may be appealed by the enrollee, the enrollee’s representative, or the provider to a court of competent jurisdiction within sixty (60) calendar days from the date the enrollee receives notice of the external Grievance decision.
- 7.3.4.** Expedited Grievance Process

- 7.3.4.1.** The MCO must conduct expedited review of a Grievance if the 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 a 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 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 must include the provider's signature.
- 7.3.4.2.** A request for expedited review of a Grievance may be filed in writing, by fax by email, or orally.
- 7.3.4.3.** 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.
- 7.3.4.4.** Upon receipt of an oral or written request for expedited review, the 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.
- 7.3.4.5.** If the provider certification is not included within the request for an expedited review and the 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 MCO must inform the Member that the provider must submit a certification as to the reasons why the expedited review is needed. The 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 MCO must decide the Grievance within the standard time frames as set forth in this chapter, 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 MCO decides that expedited consideration with the initial or extended time frame is not warranted, the 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.

- 7.3.4.6.** 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.
- 7.3.4.7.** At least one-third of the expedited Grievance review committee may not be employees of the MCO or a related subsidiary or affiliate.
- 7.3.4.8.** The expedited Grievance review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the Grievance.
- 7.3.4.9.** The MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Grievance record.
- 7.3.4.10.** The MCO must issue the decision resulting from the expedited review in person or by phone to the enrollee, the enrollee's representative, if the Member has designated one in writing, service provider, and prescribing provider, if applicable, within either forty-eight (48) hours of receiving the provider certification or seventy-two (72) hours of receiving the 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 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.
- 7.3.4.11.** The enrollee or the enrollee's representative may file a request for an expedited external Grievance review within fifteen (15) calendar days from the mail date on the written notice of the MCO's expedited Grievance decision.
- 7.3.4.12.** A request for an expedited external Grievance review may be filed in writing, by fax, orally, or by email.
- 7.3.4.13.** The MCO must follow DOH guidelines relating to submission of requests for expedited external Grievance reviews.

**7.3.4.14.** The MCO may not take punitive action against a provider who requests expedited resolution of a Grievance or supports a enrollee's request for expedited review of a Grievance.

**7.4. Provision of and Payment for Service or Item Following Decision**

- 7.4.1.** If the MCO, or the External Review reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or External Review process, the MCO must authorize or provide the disputed service or item as expeditiously as the enrollee's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed.
  
- 7.4.2.** If the MCO, or External Review 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 External Review process, the MCO must pay for the service or item that the enrollee received.

## CHAPTER 8: NOTICES

### 8.1. GENERAL REQUIREMENTS

The applicant receives standardized notification of enrollment or conditional enrollment in Free, Low-Cost or Full-Cost CHIP, premium notification for Low-Cost or Full-Cost CHIP, potential eligibility for MA and ineligibility for CHIP.

The MCO uses the standardized notices developed by the Department. If the MCO wishes to deviate from the standardized notice provided by the Department, it must submit a draft of its amended notice to the Department, per the standard approval procedure known as programmatic change form, for review and approval prior to use.

### 8.2. NOTICES TO APPLICANT FAMILY ELIGIBLE FOR FREE CHIP

The applicant must receive standardized notification of CHIP enrollment. A copy of the dated notice must be retained by the MCO. The following information must be contained in the notice:

1. The child is eligible;
2. The period of eligibility (begin date and renewal due date (RDD));
3. The additional information that will be sent under separate cover (e.g., I.D. card);
4. Notice regarding availability of enrollee handbook (i.e. whether it will be sent under separate cover, or directions on where to find it on the website and how to obtain it if the family does not have internet access);
5. The telephone number to be used if the applicant has any questions; and
6. The name of the PCP, if selected upon application.

**Note:** If a PCP is not designated by the family, the notification letter must inform the applicant of the necessity to select a PCP within ten (10) days or a PCP is automatically selected. In making an assignment, the MCO considers such factors as the age of the child, any special health condition (if known), travel time and distance.

### **8.3. NOTICE TO APPLICANT FAMILY OF ELIGIBILITY FOR LOW- COST OR FULL-COST CHIP**

The applicant receives notification of enrollment in Low-Cost or Full-Cost CHIP. A copy of the dated notice must be retained by the MCO. The following information must be contained in the notice:

1. The child is eligible;
2. Tax household size and income upon which the eligibility decision was based;
3. Maximum out-of-pocket expenses;
4. Premium required;
5. The effective date of CHIP coverage, provided a premium payment is received;
6. 90-day premium lock out period if premiums are not paid;
7. The period of eligibility;
8. The additional information that will be sent under separate cover (e.g., I.D. card, premium requests);
9. Notice regarding availability of enrollee handbook (i.e. whether it will be sent under separate cover, or directions on where to find it on the website and how to obtain it if the family does not have internet access);
10. The telephone number to be used if the applicant has any questions;
11. The name of the PCP if selected upon application; and
12. Eligibility Review Process (ERP) language.

**Note:** If a PCP is not designated by the family, the notification letter must inform the applicant of the necessity to select a PCP within 10 days or one will automatically be selected. In making an assignment, the MCO considers such factors as the age of the child, any special health condition(s) (if known), travel time and distance.

### **8.4. PREMIUM REQUEST NOTIFICATION**

The applicant receives premium request notification of enrollment in Low-Cost or Full-Cost CHIP. A copy of the dated notice must be retained by the MCO. The following information must be contained in the notice:

1. The child is eligible;
2. Income the eligibility decision was based on;

3. Amount of monthly premium required;
4. Premium bill and due date;
5. 90-day premium lock out period if premiums are not paid;
6. The telephone number to be used if the applicant has any questions;
7. ERP language; and
8. Information that the MCO can accept premium payment including initial payment by Electronic Fund Transfer (EFT).

#### **8.5. NOTICE TO APPLICANT FAMILY OF POTENTIAL ELIGIBILITY FOR MA**

The applicant receives notification that the applicant is ineligible for CHIP and was referred to the local CAO for further processing. A copy of the signed and dated notice must be retained by the MCO. The following information must be contained in the notice:

1. The child is potentially eligible for MA;
2. The reasons why the child may be potentially eligible for MA and why the child is not eligible for CHIP (tax household size and income upon which the eligibility decision was based);
3. The CAO address and phone number for the tax household's address; and
4. Instructions to call the appropriate CAO if the CAO does not contact the family within 30 days.

#### **8.6. NOTICE TO APPLICANT FAMILY OF INELIGIBILITY FOR CHIP**

The applicant receives notification that the applicant is ineligible for CHIP. A copy of the dated notice must be retained by the MCO. The following information must be contained in the notice:

1. The child is ineligible for CHIP;
2. The complete list of all reasons that the child is ineligible (e.g. failure to provide specific information such as income verification, private insurance, citizenship/alien status issues, or Full-Cost eligibility factors not met);
3. The applicant may reapply if the circumstances change;
4. The telephone number to be used if the applicant has any questions; and
5. ERP language.

## **CHAPTER 9: CHANGES AFFECTING ELIGIBILITY DURING INTAKE OR RENEWAL**

### **9.1. GENERAL REQUIREMENTS**

The MCO differentiates between changes made during the time that eligibility was determined (i.e., prior to enrollment period) from changes during the enrollment period. Any change affecting the eligibility determination or process must be handled through the eligibility review process (See Chapter 10). Any change occurring after eligibility has been determined is handled through reassessment (See Chapter 11).

Should the Department or its MCOs, or both, discover through employers, financial sources or other third party's information that was not provided or that differs from information on the application, eligibility may be re-determined.

### **9.2. CHANGES MADE OR FOUND IMPACTING THE ELIGIBILITY DETERMINATION**

**9.2.1.** If the change impacts the eligibility determination, the twelve (12) month continuous enrollment period defined in the definitions and discussed throughout this manual becomes null and void. Any changes affecting intake must be handled through the eligibility review process and not through reassessment.

#### **EXAMPLE 9A: Change occurs prior to start of enrollment period.**

Mary is determined eligible for Free CHIP effective March 1 based on her application completed January 27. On February 15, Dad ends unemployment and starts a job paying \$32,000 per year. Added to the income previously reported, Mary is now eligible for Low-Cost CHIP. Eligibility must be re-determined and Mary must be enrolled in the proper CHIP program because the change occurred prior to the start of the enrollment period (March 1). If there is an appeal, it must be handled through the eligibility review process

#### **EXAMPLE 9B: Change occurs prior to start of enrollment period.**

Misinformation was provided at application or renewal that would have resulted in a different eligibility decision had accurate or complete information been provided. John is enrolled in Free CHIP effective July 1. On September 4, it is reported and verified that John's mother had a part time job since before July 1 that was not included on the original application. Eligibility is re-

determined. If John is found eligible for low-cost CHIP, the change is made back to July 1 and the family is required to make any back-premium payments or be retroactively terminated.

**EXAMPLE 9C: CHANGE OCCURS PRIOR TO START OF ENROLLMENT PERIOD.**

Misinformation was provided at application or renewal that would have resulted in a different eligibility decision had accurate or complete information been provided. Mary is enrolled in Free CHIP with an effective date of July 1. It is discovered on November 3 that she has had private insurance through her father's employer since before July 1. Mary's CHIP coverage must be retroactively terminated to July 1.

**EXAMPLE 9D: CHANGE IN INCOME BETWEEN RENEWAL DATE AND RENEWAL DUE DATE.**

The renewal due date is April 1. The renewal application is received and processed on February 25. Based on reported income, the child is found eligible for low-cost CHIP. On March 15, the father loses his job and files for unemployment. The family appeals the CHIP eligibility decision. The MCOS reviews during the eligibility review process.

## **CHAPTER 10: ELIGIBILITY REVIEW PROCESS**

### **10.1. GENERAL REQUIREMENTS**

- 10.1.1.** An applicant or enrollee may request an impartial eligibility review when a determination made at application or renewal results in any of the following:
1. An applicant is denied coverage;
  2. An enrollee's coverage will be terminated;
  3. An enrollee's coverage will change from Free CHIP to Low-Cost or Full-Cost CHIP;
  4. An enrollee's cost changes – goes from low cost to higher cost or decreases, but the enrollee disagrees with the amount (may think it should be even lower);
  5. An applicant with income over 314% of the FPL disagrees with the determination of availability or affordability of private insurance; or
  6. The MCO fails to make a timely determination of eligibility.
- 10.1.2.** At application and renewal, the applicant or enrollee is provided with information concerning the impartial eligibility review process. If an applicant requests help in filing a request for a review, assistance should be provided promptly.
- 10.1.3.** The applicant or enrollee may submit a written request for a review within 30 days of the date of the notice for which the review is being requested.
- 10.1.4.** A request for a review must be sent by the applicant directly to the appropriate MCO to resolve any disputes related to eligibility.

### **10.2. NOTICE OF INELIGIBILITY TO APPLICANTS AND ENROLLEES**

The MCO is required to send a notice of denial to applicants or a notice of termination to enrollees in accordance with this handbook. The notice must inform the applicant of the reason for ineligibility, the right to request an impartial review of the decision of ineligibility and how to file a request for an impartial review.

### **10.3. FILING A REQUEST FOR AN IMPARTIAL REVIEW**

A request for an impartial review must be filed in written or printed form (e.g., letter, e-mail, or fax) and be postmarked or received by the MCO within thirty (30) calendar days of the date of the notice of ineligibility or termination. The request contains the reason for the request and be signed by the applicant.

The Department has provided a sample format that may be used by the applicant to file a request for review. See Appendix 10 - A for the sample format that may be used in filing a request for review. The use of this format is not required but is recommended. If a different format is used, it contains all of the information, and be at least as easy to understand, as the sample format. If the applicant requests assistance in filing a written request, the MCO, or Department assists as requested.

If an applicant files a verbal request for review (e.g., by telephone or in person), the applicant must be informed by the MCO or the Department that the request must be in written form. The MCO or Department makes a record of the verbal request and enters the request into the CAPS comments. The request is data entered into CAPS at the time it is made. The date of the oral communication is considered the date of filing for the purpose of determining that the request is or is not filed in a timely fashion. However, if no written request is received, the review interview is not held.

### **10.4. REQUEST FOR AN IMPARTIAL REVIEW RECEIVED BY THE MCO**

When a request for an impartial review is received, the MCO must:

1. Log in the request for review and note its receipt, being sure to update the MCO's monthly ERP log sheet;
2. Inform the applicant that the request for review was received;
3. Determine the need for expedited review (i.e., the applicant has indicated that the child has an immediate need for medical attention);
4. Inform the Department's Review Officer that a request for review has been received, if the MCO cannot resolve the issue within 2 business days;
5. Continue coverage or reinstate the enrollee, if appropriate (excludes terminations due to MA, private insurance, state employees and late renewals), until the review process has been concluded;

6. Offer coverage for an applicant if a decision is made in favor of the applicant.

Coverage will be after the review process is concluded and if the applicant is found eligible.

#### **10.5. CONTINUATION OF COVERAGE FOR ENROLLEES IN FREE CHIP**

Coverage of a child enrolled in Free CHIP continues uninterrupted pending the outcome of the eligibility review. In the event that an MCO has terminated an enrollee's coverage prior to the timely receipt of a request for a review, coverage is reinstated to the date of termination.

#### **10.6. CONTINUATION OF COVERAGE FOR ENROLLEES IN LOW-COST OR FULL-COST CHIP COVERAGE**

Coverage of a child enrolled in Low-Cost or Full-Cost CHIP continues uninterrupted pending the outcome of the eligibility review if the enrollee elects to continue paying the monthly premium until the review process is completed.

When a request for review is received from an enrollee in Low-Cost or Full-Cost CHIP, the parent is offered the option of paying the premium for coverage to continue pending the outcome of the review.

If the enrollee elects to continue paying the premium, coverage continues.

If the enrollee elects not to pay the premium, coverage will not continue.

#### **10.7. MANAGEMENT REVIEW BY THE MCO**

The purpose of the management review is to assure that the decision made regarding eligibility was appropriate.

The MCO must conduct a management review of the decision of eligibility within two (2) working days of the receipt of the appeal request. If the management review results in a determination that the eligibility decision was appropriate, the MCO must:

1. Prepare a written record of the management review;
2. Forward the results of the management review along with the complete eligibility file to the Department's Review Officer;

3. Inform the applicant in writing of:
  - a. The right to review records maintained by the MCO regarding the eligibility determination;
  - b. The right to receive a copy of the relevant portions of the CHIP Procedures Handbook and State or Federal law upon which the decision of ineligibility was based;
  - c. The right to have a representative during the interview; and
  - d. The opportunity for continuation of coverage for an enrolled provided that premium payments are made (as appropriate); and,
4. Update the monthly ERP log sheet.

If the management review results in a determination that the eligibility decision was not appropriate, the MCO must:

1. Inform the applicant and review officer in writing that an error occurred, and the child is eligible;
2. Enroll the applicant child retroactively to the date that the child should have been enrolled;
3. Reinstate an enrollee who has been terminated retroactively to the date the enrollee was terminated; and
4. Update the monthly ERP log sheet.

#### **10.8. REQUEST FOR REVIEW WITHDRAWN**

An applicant may withdraw a request for a review for any reason, at any time during the process.

#### **10.9. CONDUCTING THE ELIGIBILITY REVIEW**

If the management review results in a determination that the decision was appropriate, the Department's review officer conducts an interview with the applicant and the MCO's representative.

The Department designates a review officer to conduct the eligibility review. The review is an informal process. The primary objectives of the review are to facilitate resolution of the matter at issue and, when appropriate, to enroll the child.

The review officer reviews the application and verification documents and the letter of request prior to the conference call in order to become familiar with the case circumstances.

The review officer:

1. Schedules a review interview (to be held by telephone unless a face-to-face review is requested due to special circumstances);
2. Informs the applicant in writing of:
  - a. The date, time and location of the interview;
  - b. The right to have appropriate interpretative service available during the interview if needed; and,
3. Informs the MCO of the date, time, and location of the interview.

The actual interview is recorded for reference purposes. The MCO provides the review officer information as follows:

- a. Income documentation used in determination;
- b. Calculation;
- c. Deductions applied;
- d. Family size; and
- e. Additional documents that may have an impact on the decision.

The review officer may ask either or both parties for additional documentation, as needed.

The review officer considers the eligibility factors, the documents provided and the relevant eligibility requirements.

A detailed written decision in the form of a letter is prepared and sent to the applicant, the representative (if appropriate) and the MCO.

The MCO implements the decision of the review officer upon receipt of the letter.

#### **10.10. RECONSIDERATION**

An applicant or the applicant's representative may request reconsideration of the decision of the review officer if they are dissatisfied with the outcome of the review. The letter from the review officer containing the decision

includes information describing how an applicant may request reconsideration.

An applicant or the representative must submit a written request for reconsideration with the Secretary of the DHS, postmarked within fifteen (15) calendar days from the date of the review officer's decision. The request for reconsideration must describe the reasons the request is being made. Requests for reconsideration will stay the action proposed in the decision of the review officer (e.g., that coverage should be terminated).

The Secretary may affirm, amend, or reverse the decision of the review officer. The Secretary of DHS decision will be provided in writing. A copy of the reconsideration decision is sent to: the applicant, the representative (if applicable), and to the MCO.

#### **10.11. APPEALS TO COMMONWEALTH COURT**

An applicant or the representative may appeal the decision of the department within thirty (30) days from the date that the Secretary of Human Services issues the reconsideration decision.

## **CHAPTER 11: CHANGES DURING THE ENROLLMENT PERIOD**

### **11.1. GENERAL REQUIREMENTS**

The enrollee is required to report changes in the family's circumstances during the twelve (12) month enrollment period. When a change is reported, the information is recorded in the child's record. If the enrollee wants their income reassessed, the enrollee must request the reassessment. Comments relevant to the reported change are recorded in CAPS.

Reported changes do not extend the enrollment period or affect the renewal due date.

Should the Office of CHIP or its MCOs, or both, discover through employers, financial sources, or other third parties, information that was not provided or that differs from information on the application that would have impacted eligibility, eligibility must be re-determined (See Chapter 10 Eligibility Review Process).

Except for the situations listed in this chapter, no change in eligibility status during the enrollment period is required.

### **11.2. CHANGES THAT REQUIRE TERMINATION**

A child is no longer eligible for CHIP when any of the following circumstances occur:

1. The child moves out of state;
2. The child becomes 19 years of age (At age 19, the child is screened for potential MA eligibility and if potential MA eligibility exists, then the child is electronically referred to the appropriate CAO for final eligibility determination);
3. Private health insurance is obtained, or the child becomes eligible for or is enrolled in MA. See Chapter 14 - Termination Procedures for an Ineligible Child, Section 14.3 - Private Insurance, Retroactive Termination;
4. The child becomes an inmate of a juvenile delinquency facility or related public facility;
5. The child is a resident in a public hospital or similar facility for treating behavioral or mental health issues;
6. Notification is received that the child is deceased;

7. A voluntary request for termination is received;
8. Information was omitted, or misinformation was provided at the time of the application or renewal that would have resulted in a different eligibility determination had the correct information been provided;
9. A special needs child is referred to MA, but the family or physician does not provide required information for an eligibility determination;
10. The child is eligible for coverage through a state health benefit plan based on a family member's employment with a state/ public agency;  
or
11. Nonpayment of the required monthly premium payment for Low-Cost and Full-Cost CHIP.

### **11.3. ENROLLING A CHILD WHEN ANOTHER CHILD IS ALREADY ENROLLED**

If a child is enrolled in CHIP, an enrollee's parent, legal guardian, or legal custodian may request that another child in the household be added for coverage.

An abbreviated application developed by the MCO may be used to acquire information regarding the child to be added for coverage. At a minimum, the MCO must obtain the child's:

1. Full name;
2. Date of birth;
3. Gender;
4. Citizenship;
5. Social security number (if the child is older than 90 days); and
6. Existing health insurance and date of termination.

The child being added must be screened for MA. If the children being added is potentially eligible for MA, an auto-referral is generated to the appropriate CAO.

The child being added must have his or her renewal due date aligned with the existing enrollee. Under the added child system logic, the new enrollee is automatically aligned with the existing enrollee unless the existing enrollee is "Managed" to the existing file. In each case, the MCO must double-check to ensure RDDs match to the existing child to ensure that all children in the household are able to renew at the same time.

**EXAMPLE 11A:** An applicant calls on January 15 to report the recent adoption of a child. The adoption was finalized on January 3. The MCO gathers the information

required above and adds the child to the current application. When eligibility is run, it is determined that by adding the child, the tax household is now eligible for Free CHIP. The MCO should reassess the other child, and the adopted child can be enrolled with an effective date of January 1 based on newborn rules (reported within thirty (30) days of birth or adoption) if the child cannot be covered under the tax filer's insurance for the first thirty (30) days. Otherwise the child along with the other children are enrolled in Free CHIP effective February 1.

**EXAMPLE 11B:** The MCO receives an e-referral from the county assistance office that would add a child to an existing household; however, the income provided with the referral is greater than the income shown in CAPS. The income shows as verified through the new hire database, as well as the DX. The MCO adds the child to the existing case, but must use the updated income information and determine eligibility using the most recent information available. In the case of this example, the child is enrolled in a higher category of CHIP than his siblings based upon the new income. The other children need not be reassessed because the income increased after their twelve (12) month eligibility period began (example: tax filer acquired new job). If this were not the case and it was due to omitted income, then all the children would be managed to the correct category of CHIP and premiums would need to be collected for the period of time the children were enrolled in the incorrect category.

## **11.4. REPORTED CHANGE OF ADDRESS**

### **11.4.1. WITHIN MCO'S COVERAGE AREA**

If a parent reports a change of address within the MCO's coverage area, no action is required by the MCO other than to promptly update the address and other relevant information in the data system. Depending upon the distance associated with the family's move to another address, it may be appropriate for the MCO to discuss a change of PCP with the parent.

### **11.4.2. OUTSIDE OF MCO'S COVERAGE AREA**

If a parent reports a change of address and the family is now located in a county for which an MCO does not have a contract to provide CHIP services, the child's case will be promptly updated. The MCO must inform the parent that the MCO does not provide coverage at the new location. The MCO informs the parent of the available MCOs in the area and explain the process of selecting a new MCO.

The losing MCO terminates the child using a future close date that is at least thirty (30) days after the reported change, unless an earlier start date can be arranged with the new MCO.

**EXAMPLE 11C:**

If the change is reported May 5, the future close date will be July 1.

If the change is reported May 1, the future close date will be June 1.

During this time, the family selects a new MCO and PCP.

When a transfer involves a child enrolled in Low-Cost or Full-Cost CHIP, the following actions are required:

1. If the parent has pre-paid for the following month of coverage, the current MCO does not further invoice the enrollee.
2. The MCO receiving the transfer must send written instructions to the parent regarding the invoice process.
3. The enrollee pays the premium(s) according to the rules of the newly selected MCO.

The newly selected MCO must send out a premium notice to the parent. If the parent of the enrollee does not pay the premium, coverage may be terminated in accordance with the newly selected MCO's rules.

The newly selected MCO receives the application through the "Received via MCOs" tab and must manage the child to an enrolled status promptly and action must be taken within forty-eight (48) hours.

**11.4.3. MOVE OUT OF STATE**

If a parent reports a change of address to a location that is not in Pennsylvania, the MCO must terminate the coverage at the end of the month in which the move occurred. A termination notice must be issued to the parent. The notice of termination must advise of the effective date of termination.

## **11.5. REQUEST VOLUNTARY TRANSFER TO ANOTHER MCO**

If an applicant requests that their child be transferred to another CHIP MCO, the losing MCO initiate the transfer within twenty-four (24) hours using the online process. The application should be in a complete status and not missing any information. The MCO is prohibited from restricting its enrollees from changing MCOs for any reason. The CHIP enrollee has the right to initiate a change in MCOs at any time.

The MCOs must work out a mutually acceptable effective date and ensure there is no lapse in coverage or access. The losing MCO also sends a notice to the family advising that a transfer is being initiated.

The gaining MCO receives a transaction advising that a transfer has been initiated and must activate benefits without any lapse in coverage. Action must be taken within forty-eight (48) hours. An informational packet must be sent to the child's applicant by the gaining MCO.

Additional action is required by the MCO when a transfer involves a child enrolled in Low-Cost or Full-Cost CHIP. The following actions are required:

1. If the applicant has pre-paid for the following month of coverage, the enrollee will not be invoiced during the last thirty (30) days of coverage with the losing MCO; and
2. The gaining MCO must send written instructions to the applicant regarding the invoice process. The enrollee is required to pay the premium(s) according to the rules of the gaining MCO.

### **11.5.1. TRANSFER REQUEST WHILE AN INPATIENT**

If a CHIP enrollee transfers to another CHIP MCO while admitted for inpatient treatment, the losing MCO is responsible for the inpatient facility bill.

The gaining MCO is responsible for all other covered services not included in the inpatient facility bill, starting with the enrollment begin date with the gaining MCO.

This procedure applies to voluntary transfers as well as a move to another service area.

## **11.6. PREGNANT ENROLLEES AND NEWBORN CHILDREN**

Pregnancy is covered by MA where, using adjusted eligibility criteria, the pregnant woman meets financial eligibility criteria.

Pregnancy, because it initiates financial rather than non-financial eligibility criteria, is not one of the non-financial exceptions to the twelve (12) month continuous eligibility policy.

### **11.6.1. NEWBORN BORN TO A CHIP ENROLLEE**

A child born to an enrollee is guaranteed one year of coverage through either CHIP or MA.

The newborn is presumed eligible for either CHIP or MA, as appropriate, until age 1, without a separate application being filed on the newborn's behalf and without an eligibility determination for the newborn. CHIP screens for MA eligibility at age one (1).

The MCO moves applications for newborns to the front of the queue for processing.

Upon notification of the birth, the CHIP MCO must enter the appropriate information into CAPS using the identification number of the newborn's mother.

The MCO temporarily enrolls the newborn in CHIP with an effective date of the first day of the month following birth.

During this application process, the newborn is immediately screened for MA eligibility using the appropriate information on income and family size contained on the mother's application.

The appropriate information to be used must be directly related to the newborn and the newborn's parent(s) and siblings and their associated income only.

The new grandparents and the new mother's siblings and their incomes are not to be counted for the newborn's eligibility determination.

In the majority of cases, the outcome is that the newborn is eligible for MA.

The MCO emails the receiving CAO contact person to inform them that an automated newborn referral is being made. The CAO has five (5) days to process eligibility for the newborn.

CHIP terminates an enrollee's coverage with CHIP when the monthly cross match with the Department is completed.

If not eligible for MA during the MA screening process, the MCO screens the newborn to determine in which category of CHIP the newborn is placed.

The newborn is guaranteed one (1) year of eligibility.

The normal renewal process remains in effect for the new mother. After one (1) year, the system synchronizes the newborn's renewal with his new mother's renewal due date. At the next renewal due date, the normal renewal process is followed.

**NOTE:** Newborns born to an enrollee or MA recipient are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States and further documentation of citizenship or identity at any subsequent MA or CHIP eligibility redetermination is not required.

#### **EXAMPLE 11D: CHILD BORN TO ENROLLEE**

Mary is 17 years old and is enrolled in CHIP. She lives with her mother, father, and 15-year old brother. Mom and dad have an adjusted income of \$44,238 per year. Mary's renewal due date is in July.

On October 15, the CHIP MCO is notified that Mary is two months pregnant.

The CHIP MCO reassesses Mary's eligibility by adding an additional enrollee to the household. The current income with a household size of five (5) would make Mary potentially eligible for MA (215% of poverty for a family size of five is \$61,146.01).

Mary could remain in CHIP, but be moved to Free CHIP, effective the first of the month following notification of the pregnancy.

On May 13, Mary delivers a baby. The family notifies the MCO of the birth on May 22 and requests coverage.

The MCO adds the pertinent information into CAPS and runs eligibility on the newborn using Mary's Unique Family Identifier (UFI).

Mary has no income, so the child is determined potentially eligible for MA. The child is referred to MA for an eligibility determination.

In the meantime, the MCO temporarily enrolls the newborn in CHIP.

If the child is eligible for MA, the child remains in MA until May 12 of the next year when a redetermination will be conducted.

Mary remains in CHIP until July when her renewal is due.

**EXAMPLE 11E: NEWBORN BORN TO A FAMILY WITH OTHER CHILDREN ENROLLED IN CHIP (MOTHER IS NOT A CHIP ENROLLEE HERSELF)**

If it is determined that the mother of a CHIP child is pregnant and requests benefits for herself, the CHIP MCO runs MA eligibility screening for potential referral of the mother to MA (screening would include adding the unborn as an additional family enrollee and would be at 215% of the FPL; this results in all Free CHIP moms being eligible for MA as well as many of the Low-Cost mothers).

If potentially eligible for MA, refers the mother to the local CAO for an eligibility determination.

If the child is born to a mother covered under MA, the child is then guaranteed ONE (1) year of MA eligibility.

If the mother is not eligible for MA or is not screened for MA eligibility when the child is born, the child is covered by the mother's private insurance, if any, for 31 days.

Upon notification of the birth, the CHIP MCO conducts an MA screening for the child.

If the child is potentially eligible for MA, the MCO refers the child to the local CAO.

The MCO must email the receiving CAO contact person to inform them that an automated newborn referral has been made.

If the child is not potentially eligible for MA, the MCO adds the child to the current CHIP children's case.

If the applicant informs the CHIP MCO within thirty (30) days of the birth of the child and the mother has private insurance, the MCO enrolls the child with an effective date of the first of the month following the month of birth (e.g., born on February 27, notified of birth on March 12, enrolled effective March 1). This provides for no gap in coverage.

The CHIP MCO remains the payer of last resort and is not responsible for any claims prior to the date following the last date of the coverage under the mother's insurance (in the example, March 30).

**NOTE:** The newborn's renewal due date is the same as the other children on the case.

If the child is eligible for one of the Low-Cost categories or Full-Cost CHIP, the parent may pay the premium to have the child retro-enrolled in CHIP to the first of the month following the month of birth. Otherwise, the MCO enrolls the child in CHIP the first of the month following the receipt of payment if the payment meets the timelines provided by the MCO.

If the mother is uninsured at the time of the birth of the child and an application for coverage is received within thirty (30) days of the date of birth, the MCO retro-enrolls the child to the 1st day of the month of birth. The MCO does not pay claims for services provided prior to the date of birth. This retroactivity does not include the birth itself, but any claims that are attributable directly to the child following the birth.

### **EXAMPLE 11F: NEWBORNS BORN TO FAMILIES WITH NO OTHER CHILD ENROLLED IN CHIP**

If an MCO receives a completed application prior to the 30th day following birth of the child, and the mother has private insurance, the MCO determines eligibility for the first day of the month following the month of birth. If there is an overlap of coverage in any of the scenarios below, CHIP remains the payer of last resort.

If the child is potentially eligible for MA, the MCO refers the child to the local CAO.

The MCO must email the receiving CAO contact person to inform them that an automated newborn referral is being made to their office.

If the child is eligible for one of the Low-Cost categories or Full-Cost CHIP, the parent may pay the premium in order to have the child retro-enrolled in CHIP to the first of the month following the month of birth. Otherwise, the MCO enrolls the child in CHIP the first of the month following the receipt of payment, if the payment meets the timelines provided by the MCO.

If the mother is uninsured at the time of the birth of the child and an application for coverage is received within 30 days of the date of birth, the MCO retro-enrolls the child to the 1st day of the month of birth. The MCO does not pay claims for services provided prior to the date of birth. This retroactivity does not include the birth itself, but any claims that are attributable directly to the child following the birth.

If the MCO receives the application after the 30th day following the birth of the child, the MCO processes the application as a normal application and follows all the eligibility rules for a normal application. In most cases, retroactivity is not permitted.

### **11.7. CHIP ENROLLEES WHO MAY BE ELIGIBLE FOR MEDICAL ASSISTANCE (MA) DUE TO A SPECIAL NEED (PH-95 REFERRAL)**

The Department has a program for children under the age of 18 with special needs who meet the SSA definition of a disability. The SSA's definition of a disability for a child is:

1. A physical or mental condition or a combination of conditions, that results in “marked and severe functional limitations”. This means that the condition(s) must very seriously limit the child’s activities; and
2. The child’s condition(s) must be permanent or have lasted or be expected to last at least 12 months; or must be expected to result in death.

#### **11.7.1. MA REFERRAL PROCESS**

**NOTE:** This referral process may take thirty (30) to forty-five (45) days. A child who is in urgent need of MA coverage is referred directly to the Executive Director of CHIP.

MCOs reviews history from medical claims management information to identify children enrolled in CHIP who may potentially be eligible for MA based on the child’s disability. The MCOs tracks all PH-95 Referrals in CAPS.

Once an MCO identifies a potential special needs child by reviewing history from medical claims information, the MCO follows the steps below to manually refer the child to DHS:

1. Confirm the child is currently enrolled in CHIP; the child will remain in CHIP during the referral process.
2. Contact the family by telephone or otherwise orally (with up to three attempts), using the Talking Points (Appendix 11-A).
3. Follow up by mailing the family the Referral Notice (Appendix 11-B) for possible MA eligibility; also include the Medical Release Form (Appendix 11-C) that has been populated with information specific to the child.
4. Contact the treating or diagnosing physician by telephone. Fax or mail the partially completed Physician Certification Form (Appendix 11-D) with a copy of the letter addressed to the physician from the Department (Appendix 11-E) which explains why the MCO is collecting the information for the CHIP PH-95 Referral and the importance of the need to verify the child's level of disability.
5. Makes a minimum two (2) follow-up telephone calls to the treating or diagnosing physician within the next twenty (20) days from the day the Physician Certification Form is sent. If the completed and signed Physician Certification Form is received, no further follow-up is necessary.

**NOTE:** If the Physician Certification Form indicates the child is not disabled, the child remains enrolled in CHIP.

Once the MCO has a signed Medical Release Form from the family and the signed Physician Certification Form indicating the child is or will be disabled for at least twelve (12) months, the MCO prints an CAPS consolidated application, complete the Referral Coversheet (Appendix 11-F) and send the entire CHIP to MA referral packet to the DHS Central Unit (DHS CU) at the address below:

Administrator, OIM Central Unit  
6<sup>th</sup> Floor Forum Place  
555 Walnut Street  
Harrisburg, PA 17101  
Telephone: 717-772-2592  
FAX: 717-346-0363

## **11.7.2. REFERRAL PROCESS FOR INCOMPLETE SCENARIOS**

### **11.7.2.1. INCOMPLETE MEDICAL RELEASE FORM**

The CHIP MCO sends the balance of the CHIP to MA referral packet to DHS CU even if the CHIP MCO has not received a signed Medical Release Form from the family. Since there is a Health Insurance and Portability and Accountability Act (HIPAA) exception for eligibility and there is a state law exception for DHS receiving 'sensitive information' for eligibility, there is no legal reason that an MCO may not forward the CHIP to MA packet to DHS CU even though the family has not signed and returned the Medical Release Form.

The MCO sends the incomplete referral packet to DHS CU if the following have occurred:

- 1.** The CHIP MCO has received a completed Physician Certification from the treating or diagnosing physician indicating a disability of at least twelve (12) months;
- 2.** Twenty (20) days have elapsed after the MCO sent the Referral Notice and the partially completed Medical Release Form to the family; and
- 3.** At least three (3) attempts have been made in total to reach the family other than by mail.

**Example 11G:** The Physician Certification Form is completed and returned indicating that Mary has a disability of at least twelve (12) months. After twenty (20) days from sending the Medical Release Form and three (3) telephone attempts requesting the signed release, Mary's family did not cooperate. The MCO documents this by entering a Comment in CAPS and sending the incomplete referral packet to DHS CU.

#### **11.7.2.2. INCOMPLETE PHYSICIAN CERTIFICATION FORM**

If the MCO has not received a signed Physician Certification Form, the MCO forwards the balance of the CHIP to MA referral packet to DHS CU, as long as:

1. The CHIP MCO has received the signed Medical Release Form from the family;
2. At least twenty (20) days have passed since the Physician Certification Form was sent to the physician and two (2) attempts have been made to contact the physician; and
3. The CHIP MCO has credible claims, case management, or other information indicating the child could meet the SSA's definition of a disability.

An MCO may allow or encourage a physician or other provider to complete and send the Physician Certification Form directly to DHS CU for CHIP to MA referrals rather than have the provider send the form to the MCO, as long as the MCO monitors whether each provider actually has sent the Physician Certification Form to DHS CU.

**Example 11H:** Through a review of her history of medical claims information, Angel has been identified as possibly having a disability. The MCO contacts the family and Angel's physician explaining the need to complete the referral process. Angel's family returned the signed Medical Release Form to the MCO but after twenty (20) days from sending the Physician Certification Form and two (2) attempts were made to contact the physician, the physician fails to return the signed Physician Certification Form to the MCO. The CHIP MCO documents this by entering a Comment in CAPS and forwarding the balance of the CHIP to MA referral packet to the DHS CU without the signed Physician Certification Form.

#### **11.7.2.3. INCOMPLETE MEDICAL RELEASE FORM AND PHYSICIAN CERTIFICATION FORM**

If neither the signed Medical Release Form from the family nor the Physician Certification Form are received, the MCO completes the Referral Coversheet and prints a CAPS consolidated application, and send to DHS CU as long as:

1. The CHIP MCO has credible claims, case management or other information indicating the child could meet the SSA' s definition of a disability;
2. At least twenty (20) days have passed since the Physician Certification Form was sent to the physician and two (2) attempts have been made to contact the physician;
3. Twenty (20) days have elapsed after the CHIP MCO sent the standard CHIP to MA notice to the family; and
4. At least three (3) attempts have been made in total to reach the family other than by mail.

**Example 11I:** The MCO has credible claims indicating David may have a disability of at least twelve (12) months. The family fails to return the signed Medical Release Form to the MCO. The Physician Certification Form is also not returned. However, because there is no legal reason that an MCO may not forward the CHIP to MA referral packet to DHS CU even though the family and the physician did not cooperate, the MCO documents this by entering a Comment in CAPS and sending the incomplete referral packet to DHS CU.

#### **11.7.2.4. REVOCATION OF CONSENT**

If a family returns the signed Medical Release Form to the MCO and then decides to revoke their consent to release medical information, the request must be relayed to both The Office of CHIP and DHS CU. DHS CU is responsible for maintaining all revocations.

**Example 11J:** The Physician Certification Form is completed and returned indicating that Heather has a disability of at least twelve (12) months. The family returned the signed Medical Release Form to the MCO. After a change of heart, the family decides to revoke their consent by writing to the CHIP Office, the MCO or DHS CU. However, because there is no legal reason that an MCO may not forward the CHIP to MA referral packet to DHS CU even though the family has revoked the Medical Release Form, the CHIP MCO sends the referral packet to DHS

CU regardless. Heather remains in CHIP until the Referral Coversheet is returned from DHS stating the PH-95 referral was approved and Heather has been enrolled in MA. Heather is terminated from CHIP without a lapse in coverage between CHIP and MA.

#### **11.7.2.5. MA ELIGIBILITY DETERMINATION**

Once the MCO receives the Referral Coversheet from DHS stating the child has been enrolled in MA, the MCO terminates the child from CHIP ensuring there is no lapse in coverage between CHIP and MA.

If the Referral Coversheet indicates the child is not disabled, the child remains enrolled in CHIP.

#### **11.7.2.6. FAILURE TO FURNISH REQUIRED INFORMATION**

If either the family or physician fails to cooperate with the PH-95 referral verification process by not furnishing the required information, the MCO must terminate CHIP coverage. This implements the Federal requirement that a child who is eligible for MA is not eligible for CHIP: the child may not be considered for CHIP until it is determined that the child is not eligible for MA.

## **CHAPTER 12: REASSESSMENT**

### **12.1. GENERAL REQUIREMENTS**

The process of changing a child's eligibility status during the enrollment period is known as reassessment. Except as noted in Chapter 11 (relating to Changes During the Enrollment Period), reassessment is completed when requested by the enrollee. A change in eligibility status that results from a reassessment requires agreement by the parent and remains in effect until the next renewal is completed, or until another change is reported and another reassessment is requested.

A reassessment also occurs during renewal. Prior to the initial renewal notice being sent to the household, electronic sources check for income verification. If income matches are found, the income is prepopulated on the renewal form, and the system performs a reassessment of the case. This may result in a lower category for the final three (3) months of the child's current enrollment period.

Reassessment does not extend the enrollment period or affect the renewal date.

### **12.2. CHANGE IN TAX HOUSEHOLD OR INCOME**

When a change in tax household size or income is reported, the MCO updates the child's record. In addition to informing the parent of the impact, the MCO adds comments relevant to the reported change in CAPS. The information is retained online until the time of the next renewal. Changes in tax household or income do not result in a change to the child's eligibility status during the enrollment period unless there is a request for a reassessment by the child's parent.

A parent may ask the MCO to determine if the reported change has an impact on the child's eligibility status. The MCO may complete an online inquiry to determine the effect that the reported change may have on the eligibility status. Examples of the potential impact of a reported change in tax household or income are:

1. A reported decrease in household income or increase in household size may result in a child who is enrolled in Low-Cost or Full-Cost CHIP becoming eligible for Free CHIP or MA; or
2. A reported increase in household size or decrease in household income may result in a child that is enrolled in Free CHIP becoming eligible for MA.

The MCO informs the parent of the impact that the reported change may have on the child's eligibility. Once informed, the parent may allow the child's eligibility status to continue unchanged until the end of the enrollment period, or, alternatively, request that the child's enrollment status be changed.

**EXAMPLE 12A:**

A child is enrolled in Low-Cost CHIP. The parent reports on February 3 that there has been a decrease in the household's income and asks how the decrease affects the child's eligibility. The MCO updates the child's record. An online inquiry is completed which shows that the child qualifies for Free CHIP, and the MCO informs the parent. The parent requests that the child's eligibility status be changed to Free CHIP. The MCO requests verification of new income. Once the MCO receives the new income verification, the MCO completes the reassessment by enrolling the child in Free CHIP. The MCO notifies the parent in writing that the child's status changes effective March 1. The renewal date remains unchanged.

**EXAMPLE 12B:**

A child is enrolled in Low-Cost CHIP. The parent reports on March 1 there has been a decrease in the household's income and asks how the decrease affects the child's eligibility. An online inquiry is completed which shows that the child may qualify for MA. With permission from the parent, the MCO transfers the application to MA (after enrolling the child in Free CHIP) where it is determined that the family income is too high to qualify for MA. Based upon the MCO's income determination, the family is given the option of enrolling the child in Free CHIP. The parent requests the child be enrolled in Free CHIP and the MCO enrolls the child in Free CHIP. The MCO notifies the parent in writing that the child's status will change effective April 1. The renewal date remains unchanged.

**EXAMPLE 12C:**

A child is enrolled in Low-Cost CHIP. The parent reports that there has been a decrease in the household's income and asks how the decrease affects the child's eligibility. An online inquiry is completed which shows that the child may qualify for MA. The MCO informs the parent and the parent requests that the child's application not be transferred to MA. No change is made to the child's enrollment status until renewal and the parent must continue to pay the Low-Cost CHIP premiums.

**EXAMPLE 12D:**

A child is enrolled in Free CHIP. The family reports an increase in the household's income. The MCO updates the child's record. An online inquiry is completed which shows that the child is now eligible for Low-Cost CHIP. The child remains enrolled in Free CHIP until the renewal due date when eligibility is re-determined, and the child is then placed into the program for which the child is eligible.

**EXAMPLE 12E:**

A child's twelve (12) month enrollment in Free CHIP began March 1. The parent reports on April 15 that there has been an increase in the household; the child's father has moved back into the home and he earns \$38,000 a year. The parents file next year's federal income tax return as 'married filing jointly'. The parent asks how the increase affects the child's eligibility. An online inquiry is completed which shows the child may now qualify for Low-Cost CHIP. The insurer informs the parent of the choice to be placed in Low-Cost CHIP by adding the individual and his income (verification documents to be obtained from the individual) or remain in Free CHIP until renewal.

**EXAMPLE 12G:**

A child's twelve (12) month enrollment in Low Cost CHIP began March 1. The parent reports on April 15 that there has been an increase in the household; the child's father has moved back into the home and has no income. The parents file next year's federal income tax return as 'married filing jointly'. The parent asks how the change affects the child's eligibility. An online inquiry is completed which shows the child may now qualify for MA. The MCO informs the parent and the parent requests that the child's application not be transferred to MA. No change is made to the child's enrollment status until renewal. This means the child remains enrolled in Low Cost CHIP.

## **CHAPTER 13: RENEWAL PROCEDURES**

### **13.1. RENEWAL OF COVERAGE**

Renewal of CHIP coverage must occur prior to the end of the twelve (12) month period of enrollment.) In order for renewal to occur, The MCO reviews eligibility for continued coverage. A child's coverage may be renewed, if eligible, every twelve (12) months until the child reaches the age of 19.

### **13.2. FACTORS TO BE REVIEWED**

At the time of renewal, the MCO only reviews family circumstances that are likely to change. Those factors include:

1. Household income according to MAGI guidelines;
2. Age of child (especially important for a child nearing their 19<sup>th</sup> birthday);
3. Number of household members (additions and deletions) according to MAGI guidelines;
4. Medicaid eligibility and/or enrollment;
5. Private health insurance;
6. Missing SSN of existing enrollee.

If a new child has become part of the tax household since the time of application or last renewal (e.g., birth of a child, reuniting with the family, adoption), the applicant will be offered the opportunity to apply for benefits for the child. Although this is an application for coverage for the new child, the MCO may exercise discretion in developing procedures for determining eligibility of the applicant when another child from the same family is already enrolled. For example, an abbreviated application developed by the MCO may be used to acquire information regarding the child to be added for coverage.

### **13.3. FACTORS TO BE VERIFIED**

The only factor of eligibility requiring verification at the time of renewal is family income. The MCO should request verification of other factors if there is a reason to question information provided on the renewal form.

If a new child is added, however, to the renewal application, citizenship and identity for the new applicant child must also be verified.

## **13.4. RENEWAL NOTIFICATION**

At one hundred-twenty (120) calendar days prior to the expiration of the twelve (12) month enrollment period, a reminder notice will be generated by CAPS to remind households that their renewal date is upcoming and any changes that have occurred must be reported. Reportable changes that may affect eligibility include:

1. New employment;
2. Income changes;
3. Change in household size;
4. Address change;
5. Marital status updates; and
6. Updates in private medical insurance coverage.

At intervals of ninety (90) and sixty (60) calendar days prior to expiration of the twelve (12) month enrollment period, the MCO must send notification to the parent informing them of the need to renew. A pre-populated renewal form and a postage-paid envelope of sufficient size are to be enclosed with the renewal notification to allow for the return of the renewal form along with all required verification documents.

### **13.4.1. DURING RENEWAL**

Prior to generating the ninety (90) day renewal notice, CAPS requests updated income information from the TALX interface during the ex-parte period. If TALX identifies income during the ex-parte period that has been received within the past three (3) months, the income is imported to the Income screen in CAPS. If the TALX data matches the FEIN or exact name of an existing employer in the CAPS, the income information is updated. If the FEIN or employer name does not match, the TALX match is entered into the CAPS as new income. The income is identified as verified by FDSH. This income is pre-populated in the renewal form. However, once the renewal is initiated in the CAPS, the TALX information reverts to “unverified” status and must be re-verified once the renewal is returned.

The notification of renewal must contain at least the following information:

1. The date that coverage IS terminated if renewal is not completed by the RDD;
2. An explanation of the factors to be reviewed and verification required;
3. The date by which the renewal form and verification must be submitted by the parent to the MCO;

4. The web address for COMPASS and instructions for online renewal; and
5. The MCO's customer service number if the parent has questions about the notice of renewal or the renewal process.

**NOTE:** The sixty (60) day renewal notification will serve as the intent to terminate. A termination notice will be sent at the RDD if the renewal is not completed

#### **EXAMPLE 13A: RENEWAL RECEIVED PRIOR TO RDD**

The child's RDD is May 31. On January 25, a reminder notice is mailed out to the household. By February 22, an ex-parte eligibility determination has been attempted. If the ex-parte review is unsuccessful, on February 23, a ninety (90) day letter is generated to alert the family to renew coverage by May 31 or the child's coverage will end on June 1. The family completes the prepopulated renewal form and returns it on May 12. The MCO determines eligibility for the child within the fifteen (15) day window and determines the child is eligible for Low-Cost CHIP. The MCO generates the appropriate letter and provides the family with adequate notice of the required premiums. The MCO receives payment on May 28 and the child is enrolled in Low-cost CHIP effective June 1.

#### **EXAMPLE 13B: PAYMENTS RECEIVED AFTER THE RDD**

The child's RDD is May 31. On March 17, the MCO mails a reminder notice to the household. Between March 17 and April 16, an ex-parte eligibility determination is attempted. If the ex-parte review is unsuccessful, on April 16, the ninety (90) day notice is generated as a reminder to renew and serves as the intent to terminate if the renewal form is not completed by June 1. The family reviews the prepopulated renewal form, determines no changes are needed, signs the renewal, and returns it on May 12. On May 25, the MCO verifies the household income using the TALX-FDSH tab in CAPS and determines eligibility.

### **13.5. EX-PARTE RENEWALS**

Between one hundred-twenty (120) and ninety (90) calendar days prior to a member's renewal, CAPS screens all upcoming eligible renewals through an electronic redetermination of eligibility without any action needed on the enrollee's behalf. An enrollee's eligibility that can be completed electronically is renewed for twelve (12) months. Renewals that fail to be electronically renewed through the ex-parte process will go through the standard renewal process.

### **13.6. RENEWAL OPTIONS**

Renewals may be initiated in one of the following methods:

1. By completing an online renewal through COMPASS and submitting all required documentation and a signature page, if required;
2. By completing a telephonic renewal, if the MCO wishes to take renewal applications over the phone, and submitting all required documentation and a signature page, if required; or
3. By returning the completed paper renewal form sent from the MCO and submitting all required documentation.

### **13.7. ELIGIBILITY FOR CHILDREN UNDER THE CARE AND CONTROL OF A COUNTY CHILDREN AND YOUTH ORGANIZATION**

Foster children are under the care and control of the County through The Office of Children Youth and Families (CYF) and not the foster parents with whom they reside. The foster parents are excluded from the foster child's household composition. Also, the foster child has income which exceeds MA income eligibility (e.g trust fund income).

MCOs accepts a signed statement from a County Children and Youth organization that indicates that a child remains in CYF custody. This is received along with the child's annual income verification documents. The statement, along with the updated income information, constitutes a signed renewal application for these children. No other application or verification documentation is required.

### **13.8. DETERMINATION OF ELIGIBILITY OR INELIGIBILITY FOR RENEWAL-COMPLETE APPLICATION**

The MCO makes a determination of a child's eligibility for renewal within fifteen (15) calendar days of the receipt of a complete renewal application. If the 15th calendar day falls on a non-working day, the determination is completed by close of business on the next working day. In no event may a processing delay attributable to an MCO result in the disruption of coverage for a child. A notice of eligibility or ineligibility must be sent to the parent. (See Chapter 8 related to Notices)

### **13.9. DETERMINATION OF ELIGIBILITY OR INELIGIBILITY FOR RENEWAL-INCOMPLETE APPLICATION**

When a renewal application is incomplete, the parent must be given the opportunity to submit the missing information or verification. The MCO must inform the parent either orally (e.g., by telephone) or in writing (e.g., by letter, fax, secure e-mail) of the additional information or verification required and the date by which it should be received. The timeframe established for the submission of the missing information should, if at all possible, avoid a disruption of coverage.

A narrative of any oral communication with the parent must be recorded in the “Comments” section of CAPS. In the case of a written communication, the MCO places a “hard copy” of the notification in the case file or maintain an electronic record of the notification and its text.

### **13.9.1. RENEWALS RECEIVED UP TO 90 DAYS AFTER THE RENEWAL DUE DATE**

#### **13.9.1.1. COMPLETED RENEWAL WITHIN NINETY (90) DAYS AFTER THE RDD**

If a child is terminated for failure to renew and the parent submits a completed renewal within ninety (90) days of the original renewal due date, and the child is found eligible, the child may be reinstated retroactively to the RDD if the family pays the premiums for the break in coverage. The family may elect to have a gap in coverage and start a new enrollment period.

#### **13.9.1.2. INCOMPLETE RENEWAL WITHIN NINETY (90) DAYS AFTER THE RDD**

When a child is terminated for failure to renew and the parent submits an incomplete renewal within ninety (90) days of the original renewal due date, the MCO follows the incomplete application as outlined in this chapter. Any pending information needed to complete the renewal can delay the eligibility process not more than ninety (90) days beyond the renewal due date.

#### **EXAMPLE 13C: CHIP TO MA**

The termination date is April 1, and a completed renewal form and required verification are received April 20. It is determined the child is potentially eligible for MA. The reinstatement functionality of CAPS is used to process eligibility for the child for CHIP. The child is not reinstated in CHIP because the child is not eligible for CHIP if potentially eligible for MA. If the child is

found ineligible for MA due to high income, the child may be reinstated in CHIP effective the date of termination to allow for no gap in coverage.

**EXAMPE 13D: FREE CHIP TO FREE CHIP**

The termination date is April 1, and a completed renewal form and required verification are received April 20. Reinstatement functionality is used to determine eligibility for CHIP. If the child remains eligible for Free CHIP, the child should be retro-enrolled to April 1. If the renewal form is not received until July 2, (more than ninety (90) days past the RDD, continued coverage is denied and a new application is required. The current process for processing applications remains in effect.

**EXAMPLE 13E: FREE CHIP TO LOW-COST CHIP OR FULL-COST CHIP**

The termination date is April 1, and a completed renewal form and required verification are received April 20. The child is determined to be eligible for Low-Cost CHIP. The family must pay the premiums beginning April 1 to be reinstated. If they are unwilling to pay the premiums beginning April 1, or if the renewal form is received more than ninety (90) days from the renewal due date, the family may reapply for coverage. The MCOs follows current policy for eligibility determination and start dates.

**EXAMPLE 13.6: LOW-COST OR FULL-COST CHIP TO LOW-COST OR FULL-COST CHIP**

The termination date is April 1, and a completed renewal form and required verification are received April 20. The child is determined to be eligible for Low-Cost or Full-Cost CHIP. The family must pay the premium payments for the new enrollment period that will begin April 1, in order for the child to remain eligible for CHIP. If the family is unwilling to pay the premiums for the new enrollment period that will begin April 1, or if the renewal form is received more than ninety (90) days from the renewal due date, the family may reapply for coverage. The MCOs follow current policy for eligibility determination and start dates.

**13.9.2. RENEWALS RECEIVED MORE THAN 90 DAYS AFTER THE RDD**

If a child is terminated for failure to renew and the parent submits the completed renewal and required verification, but more than ninety (90) days

have passed since the renewal due date, the renewal form is treated as a new application. There will be a lapse in coverage.

### **13.10. EFFECTIVE DATE OF RENEWAL**

#### **13.10.1. FREE CHIP**

The effective date of renewal is the first day of the calendar month following the renewal due date (RDD).

#### **13.10.2. FREE TO LOW OR FULL-COST CHIP**

The date the enrollee begins in the new program (Low-Cost or Full-Cost) is dependent on the time the enrollee renews and the premium is received in relation to the RDD. If the premium is paid prior to the RDD, the effective date of the renewal is the first day of the calendar month following the RDD.

If payment is received after the RDD, but within the ninety (90) days immediately following the RDD and the child has been terminated, the MCO will require premiums to be paid in full, resulting in no gap in coverage. If payment is not received within the ninety (90) days immediately following RDD, the child must reapply and a gap in coverage results.

#### **13.10.3. ELIGIBILITY NOTICE**

The MCO must send the parent a notice of the eligibility determination within fifteen (15) calendar days from the renewal receipt date. If the 15th calendar day falls on a non-working day, the determination must be completed by close of business on the next working day. At a minimum, the notice must contain the following information:

1. That the child is eligible for renewal;
2. The new enrollment period;
3. The MCO's customer service telephone number;
4. That additional information or materials will be sent by separate cover, if applicable (e.g., new ID card);
5. Notice regarding availability of enrollee handbook (i.e. whether it will be sent under separate cover, or directions on where to find it on the website and how to obtain it if the family does not have internet access);
6. Cost sharing limit, if applicable;
7. Premium payment amount and due date, if applicable;

8. Consequences for not paying the premium payment;
9. The right to an Eligibility Review. (See 10 - Eligibility Review Process).

**13.10.4. FOR A CHILD INELIGIBLE FOR RENEWAL**

1. That the child is ineligible for renewal;
2. Date CHIP coverage ends;
3. All of the reasons that the child is ineligible for renewal (e.g., income too low, failure to submit information necessary to determine continuing eligibility, failure to submit the application for renewal); and
4. If applicable, that the application has been forwarded to the local CAO because the family income is within the MA eligibility range.
5. The MCO's customer service telephone number;
6. The right to an Eligibility Review. (See 10 - Eligibility Review Process).
7. That the applicant may reapply if family circumstances change.

**NOTE:** If a child is going from Low-Cost or Full-Cost CHIP to an MA referral, the MCO must enrollee the child into Free CHIP, and then terminate the case for a CAO referral. (See Chapter 1 relating to Application Submission).

**NOTE:** The eligibility review process is not applicable if the termination is due to low income and a referral to MA is completed.

## **CHAPTER 14: TERMINATION PROCEDURES FOR INELIGIBLE CHILD**

### **14.1. TERMINATION**

A child is no longer eligible for CHIP if at the time of renewal:

1. Tax household income is less than the minimum income requirements for CHIP (e.g., eligible for MA,);
2. The child is covered by other health insurance;
3. The applicant fails to complete the renewal process (e.g., fails to respond to the notice of renewal, fails to provide required information or verification, etc.);
4. The child is eligible for coverage through a state health benefit plan based on a family member's employment with a state/public agency (See Section 5.2.1 – State Health Benefits for Government Employees).

Normally termination is effective the last day of the 12th calendar month of the period of enrollment. A notice of termination must be sent to the parent at least 30 calendar days prior to termination.

### **14.2. NON-PAYMENT OF PREMIUM FOR LOW-COST OR FULL-COST PROGRAM**

Failure to pay the premium for the Low-Cost or Full-Cost program will result in termination. Within 7 days of the start of the 30-day grace period, a notice of proposed termination must be sent to the parent at least 30 calendar days in advance of the effective date of termination. For example, a family's premium is due September 30 for the new coverage period beginning October 1. If the premium is not received by September 30, the MCO must send a notice to the family no later than October 8 (no later than seven days after the first day of the coverage period) stating that payment must be received by October 30 or coverage will be terminated effective September 30.

The notice must include at least the following information:

1. The effective date of termination;
2. The reason for termination (i.e., non-payment);
3. What corrective measures the parent may take to prevent termination from occurring;
4. The MCO's customer service telephone number; and
5. That the ninety (90)-day lock-out period will be imposed if they reapply.

### **14.3. PRIVATE INSURANCE – RETROACTIVE TERMINATION**

CHIP is by law the payer of last resort. The MCO shall not pay any claim unless all other federal, state, local or private resources available to the child are utilized first. If a child has obtained private insurance, the MCO must do the following:

1. Terminate CHIP retroactively to the 1<sup>st</sup> day of the month that private insurance was obtained. Contact the CEU for assistance in terminating any coverage in excess of 3 month.; There is no limit to how far back the termination can occur, whether that date is months prior or years prior to the discovery of private insurance;
2. Send any termination notice in a timely-fashion. The notice must include language stating that enrollees terminated in this situation may request an Eligibility Review; and
3. Refund all premiums paid to the MCO and submit any claims that have been paid to the private insurance for reimbursement.

MA coverage is not private insurance: therefore, retroactive terminations do not apply if the child is enrolled in MA. CHIP will be terminated the end of the month in which the MCO is notified of the MA enrollment.

#### **EXAMPLE 14A:**

Patricia is enrolled in CHIP May 1. On August 20, a letter is received at the MCO requesting termination of the CHIP coverage effective September 1, because other insurance was procured in August. Patricia's eligibility period runs from May 1 through August 31.

#### **EXAMPLE 14B:**

Brittany was enrolled in CHIP on November 1. Information is received on March 13 that Brittany is active in MA. Her CHIP eligibility period runs from November 1 through March 31.

#### **EXAMPLE 14C:**

Amy was enrolled in CHIP on January 1. In September, the MCO learned that Amy has had private insurance coverage since February 4. The MCO will terminate CHIP effective February 1.

#### **14.4. VOLUNTARY TERMINATION**

The tax filer or head of household may request termination. Such a request is a “voluntary termination.”

A request may be made either verbally or in writing. A case comment of any verbal request by the tax filer should be recorded in the case file.

Coverage should end the last day of the month in which termination was requested by the tax filer or head of household, if the request is in accordance with policy. A notice of termination must be sent to the tax filer advising of the date on which coverage will end and confirming that this action has been taken in accordance with their request. In all cases, the MCO must send a written confirmation of all requests.

**EXAMPLE 14D:** Mom contacts the MCO in May to request her child’s CHIP coverage be terminated in August due to an upcoming move out of state. The MCO should complete a future termination in CAPS for an August 31 termination with a September 1 effective date.

#### **14.5. SPECIAL CIRCUMSTANCES: THIRTY (30) DAY TERMINATION REQUIREMENT**

The requirement to send a written thirty (30) day termination notice prior to action being taken may be waived only if:

1. The tax filer or head of household requests, either orally or in writing, that their child’s coverage be terminated as soon as possible, and they have a compelling reason for the request;
2. The child moves out of state;
3. The child obtains private insurance or is enrolled in MA;
4. The child turns nineteen (19) years of age;
5. A child is terminated for providing misinformation or omitting information on an application or at renewal; or
6. The child is eligible for coverage through a state health benefit plan based on a family member’s employment with a state/public agency.

Coverage should be terminated effective the last day of the month in which the change occurs.

Case comments should document the circumstances and the reason that the exception to the thirty (30) day notice procedure occurred. In all cases, a letter must be sent to the applicant identifying the date on which coverage will be terminated.

#### **14.6. RETURNED MAIL “ADDRESS UNKNOWN”**

Mail returned to the MCO by the U.S. Postal Service that is marked “address unknown” may provide cause for termination. It is recommended that the MCO make an attempt to contact the applicant by telephone or other means to establish that the family is no longer at the address previously provided. Information about this attempt should be narrated in the case file.

Termination should be effective with the first of the calendar month for which a processing deadline can be met.

## **PART 2 – QUALITY MANAGEMENT**

### **CHAPTER 15: DIVISION OF QUALITY ASSURANCE**

#### **15.1. GENERAL REQUIREMENT**

Both state and federal law require that the Department conduct monitoring and oversight of MCOs. It is the responsibility of the Division of Quality Assurance to ensure that children are enrolled properly, that services being provided by each MCO are consistent with the requirements set forth in the Contract, and that funds appropriated for the program are properly expended.

#### **15.2. PROGRAM MONITORING**

The Department conducts program monitoring. Specifically, CHIP is responsible for:

1. Reviewing and compiling monthly, quarterly and annual reports submitted by MCOs;
2. Monitoring eligibility and enrollment application processing, including transfers between CHIP and MA<sup>1</sup>;
3. Conducting random sample reviews;
4. Reviewing consumer service and enforcement issues;
5. Coordinating audit reviews, i.e. Payment Error Rate Measurement (PERM) related, and other audits initiated by federal and state agencies;
6. Responding to the Bureau of Financial Operations MCO A-133 independent single audit inquiries;
7. Coordinating and implementing corrective action plans;
8. Detecting fraud and abuse;
9. On-site monitoring and readiness reviews;
10. Participating in ongoing CAPS development and redesign;
11. Complying with the ACA, HIPAA; and
12. Ensuring contract compliance.

### **15.3. MEDICAL SERVICES ANALYST**

The medical services analyst oversees utilization of services and directs Quality Improvement initiatives as described in the Contract and the CHIP Procedures Handbook. The Medical Services Analyst is not specifically assigned to any particular MCO but serves in an overall capacity. Areas of specific responsibility include, but are not limited to:

1. HEDIS®/CAHPS annual reviews;
2. Performance improvement projects (PIPs);
3. Provider network issues;
4. Oversight of the External Quality Review Organization (EQRO) contract;
5. Participation in the oversight of data warehouse claims and encounter data systems;
6. Participation in on-site monitoring and readiness reviews;
7. Development and implementation of corrective actions;
8. Review and compilation of monthly, quarterly, and annual reports;
9. Consumer and legislative inquiries and correspondence;
10. Coordination of ad hoc data requests; and
11. General contract compliance.

### **15.4. EXTERNAL QUALITY REVIEW**

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1902(a), 1932 (c), and 1903(a). States are required to obtain an independent, external review of the quality of services furnished under state contracts with Managed Care Organizations, including the evaluation of quality outcomes, timeliness, and access to services. The requirements for EQR were further outlined in 42 CFR Parts 433 and 438; External Quality Review of Medicaid Managed Care Organizations; Final Rule issued on May 6, 2016. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to enrollees. “Quality”, as it pertains to EQR, means the degree to which an 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 currently contracts with an EQRO that also contracts with Pennsylvania's Medical Assistance Program. Similar quality measurement tools were developed for the CHIP Program in order to more fully align both programs.

These core products and services include quality measurement and improvement surveys and studies, utilization and diagnosis related groups (DRG) management, encounter data validation, quality assurance, and health care process design and measurement activities. Additionally, the EQRO vendor is licensed by the National Committee for Quality Assurance (NCQA) to conduct Healthcare Effectiveness Data and Information Set (HEDIS®) Audits.

#### **15.5. RESPONSIBILITIES OF THE EQRO:**

1. Validating network adequacy
2. Preparing the HEDIS® reports, including a measure result comparison table with weighted averages for each measure.
3. Creating the annual HEDIS® reports, displaying data and rate comparison tables that are helpful for ongoing monitoring and performance improvement. The tables provide MCO and national benchmark comparative information (when available and appropriate).
4. Implementing selected Pennsylvania specific performance measures and preparing Pennsylvania performance measure comparison tables.
5. Selecting Pennsylvania specific performance measures used by the Department or Medicaid managed care enrollees that are implemented for the CHIP population (including HMO and PPO enrollees), as appropriate to the populations age range.
6. Preparing Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results and comparison tables.
7. Creating annual CAHPS data comparison tables that will provide MCO and national benchmark comparative information (when available and appropriate).
8. Developing "report cards" to display HEDIS®, CAHPS, and Pennsylvania performance measure results.
9. Developing an annual report card similar to MA's "A Consumer's Guide to the HealthChoices Health Plans." The annual report card displays each MCO's rates for selected CAHPS survey results, HEDIS® measures, and Pennsylvania performance measures.

These rates are compared to the statewide average using graphics.

10. Validating performance improvement projects (PIPs) per MCO per calendar year.
11. Validating performance improvement projects per calendar year per MCO in the CHIP Program. CHIP requests that each MCO develop projects to improve performance. The EQRO vendor will use the same validation methodology currently used for the Medicaid MCO PIPs that are based on HEDIS® measures.
12. Providing technical assistance in the development of a quality-monitoring program.
13. Providing technical assistance in the development of a state quality-monitoring program for CHIP to include strategic planning.
14. Proposing a pay-for-performance methodology using the HEDIS® measures.
15. Acting as a technical resource for data warehouse issues.

#### **15.6. QUALITY MANAGEMENT RESPONSIBILITIES OF THE MCO:**

The MCO must establish and implement an ongoing comprehensive quality assessment and performance improvement program that includes, at a minimum:

1. PIPs, including PIPs required by CMS, that focus on clinical and non-clinical areas. The MCO will design the PIPs to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and will include: (i) measurements of performance using objective quality indicators; (ii) implementation of interventions to achieve improvement in access to and quality of care; (iii) evaluation of the effectiveness of the interventions based on specified performance measures; and (iv) planning and initiation of activities for increasing or sustaining improvement. The CHIP MCO will report the status and results of each PIP as requested by the Department but not less than annually.
2. The collection and submission of standard performance measurement data identified by the Department. On an annual basis, the MCO will measure and report on performance using the standard measures and will submit to the Department performance data that enables the Department to calculate the MCO's performance.
3. Mechanisms to detect underutilization and overutilization of services.
4. Mechanisms to assess the quality and appropriateness of care to enrollees with special needs as defined in the managed care quality strategy.

As part of its QM responsibilities, the MCO must:

1. Accurately, completely and within the required timeframe identify eligible enrollees to the EQRO.
2. Correctly identify and report the numerator and denominator for each measure for HEDIS and PA Performance Measure data.
3. Actively encourage and require providers, including subcontractors, to provide complete and accurate Provider medical records within the timeframe specified by the EQRO.
4. Demonstrate how the results of the EQRO are incorporated into the plan's overall Quality Improvement Plan and demonstrate progressive improvements during the term of the Contract.
5. Improve encounter data in an effort to decrease the need for extensive provider medical record reviews.
6. Provide information to the EQRO as requested.
7. Make data, clinical records and workspace located at the MCO's work site available to the independent review team and to the Department, upon request.
8. Participate in PIPs whose target areas are dictated by the Department to address key quality areas of focus for improvements. The MCO will comply with the timelines as prescribed by the EQRO.

## **CHAPTER 16: QUALITY MANAGEMENT ROUTINE REPORTS**

### **16.1. GENERAL REQUIREMENTS**

These reports are required to enable the Department to assess the quality of care and the cost of services. These reports may also be used to spot-check potential problem areas for which the Department may provide technical assistance and develop corrective action plans.

Report templates will be emailed to the MCOs with the most current instructions and data collection tools. This chapter's appendices include the most current set of instructions (when applicable) as well as representations of the report template in table form. All collected data should be emailed back to the individual noted unless the MCOs have been instructed otherwise by official Departmental Transmittal. Reports are to be securely emailed individually with the report name noted in the email's subject line.

### **16.2. POTENTIAL PRECLUDED PROVIDER REPORT**

#### **16.2.1. CONTENT**

Providers identified by the Office of Inspector General (OIG) or the department, as excluded or precluded providers may not receive payments from government-funded health care programs. Because of this restriction, these providers may not furnish items or services, nor may they direct or prescribe care for any CHIP enrollee. In addition, businesses owned by these providers, and any staff employed by them are restricted from providing services for any CHIP enrollee.

On a quarterly basis, each MCO's network is compared against both the OIG List of Excluded Individuals & Entities (LEIE) and the DHS Medichex databases to determine if there are any potentially precluded providers in their current network. A Precluded Provider cross match report for each MCO is then published in the CAPS Report Repository documenting the results for each MCO.

This report documents the MCO's investigation into the providers identified in the cross match and indicates whether the providers found on LEIE or Medichex are in fact the same providers operating within their network.

If the provider in the MCO's network is determined to be a precluded entity, this report also documents whether the provider has been actively rendering services

to enrollees, the amount of any payments made to the provider, and the recovery of these funds.

#### **16.2.2. FREQUENCY**

The precluded provider cross match report will be available in the CAPS Report Repository as follows:

Quarter 1 (January, February, March) – April 15th

Quarter 2 (April, May, June) – July 15th

Quarter 3 (July, August, September) – October 15th

Quarter 4 (October, November, December) – January 15th

The response report is due to the Department as follows:

Quarter 1 – May 15th

Quarter 2 – August 15th

Quarter 3 – November 15th

Quarter 4 – February 15th

If the due date of the report (either for the cross match or the response portion) falls on a weekend or holiday, the next business day following the weekend or holiday will become the date the report is published or due.

**NOTE:** This report is submitted to:

Medical Facility Records Examiner  
Office of the Children's Health Insurance Program (CHIP)  
1142 Strawberry Square  
P.O. Box 2675  
Harrisburg, PA 17105-2675

**16.2.3. FORMAT**

An example of the report format template is given below. Templates are sent to the MCOs on the designated CHIP collaboration room. The template must be used by the MCO for reporting. Alternative formats are not accepted.

<b>Potential Precluded Provider Response Report</b>					
<b>MCO:</b>		<b>Quarter:</b> ___ 1st ___ 2nd ___ 3rd ___ 4th			<b>Year:</b> _____
<b>Provider Name</b>	<b>In Network ?</b>	<b>Any CHIP Claims ?</b>	<b>Amount of Claims Paid Out</b>	<b>Amount of Claims Recovered</b>	<b>Actions Taken and Other Comments</b>

**Instructions:**

After researching the providers identified on the potential precluded provider cross match, please complete the attached template.

The Provider Name field should have the provider name as specified on the cross match generated by the Department or its designee.

Answer the “In Network” field with a Yes, No, No\*, or Unable to Determine (UTD)”.

If the answer is “yes” then the purple fields must be completed as well as a description of the actions taken in the green field.

If this field is answered as a “No” there is no need to answer any of the purple fields and only a note in the green “Actions Taken and Other Comments” is required explaining why the provider identified is not actually in your network (i.e. not the same provider, previously terminated, etc.).

Utilize “No\*” in situations when the provider is still technically in the greater commercial network, but protocols have been put in place to prevent CHIP enrollees from seeing them. This information would then be documented in the Actions Taken and Other Comments field.

UTD should only be utilized if there is not enough information available via OIG or Medichex in order to verify whether the provider identified on the precluded list is the same individual as the provider in your network. What information you have discovered in your research should be documented in the Actions Taken and Other

Comments field. The CHIP Office takes actions to obtain the necessary missing information required to continue the investigation and forwards any additional information under separate cover.

It is understood that it may not always be possible to recover claims within the same quarter as they are identified. It is expected that the MCO will continue to document this provider until all claims are recovered and to report on this document in the quarter it is received, regardless of when the initial identification of the provider occurred. Claims recovery processes that are ongoing (i.e. the provider will be paying the MCO \$30/month for the next 10 years for example) should be explained in the "Actions Taken and Other Comments" section. Any costs paid out may not be included in the utilization costs used for the purposes of establishing rates for the CHIP Program. See appendix 16-B for potential precluded provider report questions and answers.

### **16.3. ABORTION SERVICES REPORT**

#### **16.3.1. CONTENT**

This report provides documentation that all abortion services paid for by the CHIP Program are compliant with the requirements set forth in 18 Pa. C.S.A. § 3204-3206 and 35 P.S. §§ 10101, 10103-10105.

#### **16.3.2. FREQUENCY**

This report is due annually by January 31st of the following year.

If the due date of the report falls on a weekend or holiday, the next business day following the weekend or holiday will become the date the report is published or due.

**NOTE:** This report is submitted via secure email to CHIP Medical Facility Records Examiner (Medical Services Analyst).

### 16.3.3. FORMAT

An example of the report format template is given below. Templates will be sent to the MCOs via email. No alternative format will be accepted.

#### EXAMPLE:

Abortion Services Report					
MCO:		CHIP Program		Year: _____	
UCINumber	Date of Service	Claim Paid?	Amount Paid	Documentation of Compliance Available?	Actions Taken, Funds Recovered, & Other Comments

#### Instructions:

Use the current ICD-9 or ICD-10 codes, Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) associated with abortions to identify all abortion services that have occurred over the previous calendar year including legally induced, illegally induced, and unspecified abortions categories. Reporting excludes abortions that are performed as a result of an ectopic or molar pregnancy.

For each abortion service, document the following:

1. The enrollee's UCI number. If an enrollee has received more than one abortion within the calendar year, they should be listed more than once.
2. The date the service was rendered.
3. Whether the claim has been paid or not. This should be populated with a "Y" for yes or an "N" for no. If the answer is "N", no further documentation regarding that enrollee's service is necessary. If the answer is "Y" then information relating to the next four columns must be documented.
4. The amount paid for the abortion service. This is the cost of the abortion procedure itself and does not include any other services associated with the claim in question.

5. Whether the MCO possesses information that the enrollee's circumstances meet the necessary statutory requirements for the abortion to be a covered service. A "Y" for yes or an "N" for no should be used to populate this field. It is not necessary to specify the type of the documentation or send it at this time. The question is simply looking to verify that should the CHIP Office request proof of compliance, that you are satisfied that you can provide sufficient documentation to verify that the abortion met the necessary criteria to be considered a covered service.

If sufficient documentation is not available, the MCO must attempt and document recovery of funds. Information relating to the recovery of funds and any other actions or comments should be documented in the "Actions Taken, Funds Recovered, & Other Comments" column. See appendix 16-A for abortion services report questions and answers.

#### **16.4. InsureKidsNow (IKN) DENTAL PROVIDER REPORT**

Each MCO must maintain a file of its entire provider network for oral health services, including the networks of its subcontractors. The information on oral health providers must be sufficient to fulfill the requirements for populating the InsureKidsNow website. The MCO or its subcontractor must upload the information on the oral health provider network to the InsureKidsNow website. The MCO must ensure the information is consistent with all requirements specified by InsureKidsNow. If the Centers for Medicare and Medicaid Services (CMS) determines that only the Department may upload the information on the supplier's oral health provider network to the InsureKidsNow website, then the MCO must provide this information, instead, to the Department.

The MCO must submit a validation report confirming successful submission of the report to CHIP quarterly. The MCO consults the annual routine reporting requirements transmittal for instructions on where to submit the report.

## **CHAPTER 17: QUALITY MANAGEMENT INTERMITTENT REPORTS**

### **17.1. AD HOC REPORTING**

#### **17.1.1. CONTENT**

The Department may request the MCOs to submit ad hoc reports to meet a specific reporting need. These requests may result from federal or state legislative/gubernatorial data calls, requests from other state agencies, or requests from public sector entities.

#### **17.1.2. FREQUENCY**

The Department may request ad hoc reports at any time and in any amount.

#### **17.1.3. FORMAT**

The request for an ad hoc report will be made to MCOs in written form (e.g., email, letter, or fax). The written request will provide:

1. A description of the nature and purpose of the report;
2. The format of the report (e.g., a template may be included and must be used to submit data);
3. A data governance release form that must be completed, if needed;
4. The means of transmission (e.g., fax or regular mail, email or secure email) for all reports containing HIPAA information;
5. The person to whom the report should be submitted; and
6. The due date for submission

### **17.2. CONSUMER AND CONSTITUENT LEGISLATIVE CORRESPONDENCE**

#### **17.2.1. CONTENT**

The Office of CHIP receives constituent correspondence/telephone calls and inquiries for investigation and resolution from various sources such as the Governor's Office, legislators, other state agencies or authorities, and the public. In order to respond to these inquiries, CHIP Quality Assurance staff will contact the appropriate MCO to obtain additional information as necessary. All correspondence/telephone call inquiries that require investigation are logged in by administrative support staff. While this is an internal tracking system to manage inquiries, the log will also be used to track performance in conjunction with program

monitoring activities. The log will also be used to determine areas of the program which might require further explanation in the form of a policy clarification.

**17.2.2. FREQUENCY**

MCOs will be contacted as needed by telephone, email, or fax. Due dates and a control number will be assigned to each inquiry, also known as a Blue Sheet, by CHIP administrative support staff. Due dates for internal CHIP staff normally fall within two weeks of the origination date. MCOs responds within five (5) business days to any inquiry submitted in order for CHIP staff to respond by the assigned, internal due date.

**17.2.3. FORMAT**

No specific format is required. Responses can be submitted by telephone, email, fax, or regular mail by the CHIP staff member investigating the issue.

## **CHAPTER 18: INTERNAL AND EXTERNAL AUDITS**

### **18.1. GENERAL REQUIREMENTS**

Both state and federal law require that the Department conduct monitoring and oversight of MCOs. It is the responsibility of the Department to ensure that children are enrolled properly, that services being provided by each MCO are consistent with the requirements set forth in the RFP, and that funds appropriated for the program are properly expended.

Each MCO, at its own expense, is required to make all records, including all subcontractor records, available for audit, review, or evaluation, and allow for the inspection of physical facilities at any time, by the Commonwealth, its agencies and/or their designated representatives and by Federal Agencies and their representatives. All contracts must provide that the State, CMS, the federal Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect, review and audit any records or documents of the MCO, PIHP, PAHP, Primary Care Case Management (PCCM) or PCCM entity, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where CHIP-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Access shall be provided as directed by the Department either on-site, during normal business hours, or through the mail. During the contract and record retention period, records shall be available at each MCO's chosen location, subject to approval of the Commonwealth. Each MCO must fully cooperate with any and all reviews and/or audits by the Commonwealth and its designated representatives, by having appropriate employees and involved parties available for interviews relating to reviews or audits. All records to be sent by mail must be sent 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.

Each MCO shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity as well as to all required programmatic activity and data. Records may be kept in an original paper state or preserved on micro media or electronic format. 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 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 Department may inspect physical facilities at any time during this period as well.

Each MCO must include the above provisions in all risk sharing subcontract agreements.

If circumstances arise in which the Commonwealth or the MCO invoke the contractual termination clause or determine the contract will cease, the audit for the period ending with the termination date or the last date the MCO is responsible to provide benefits to CHIP enrollees shall be submitted to the Commonwealth within 180 days after the contract termination date or the last date the MCO is responsible to provide such benefits.

## **18.2. SINGLE AUDITS IN ACCORDANCE WITH 45 CFR PART 75 AND COMMONWEALTH POLICY (“SINGLE AUDITS”)**

### **18.2.1. CONTENT**

Non-Profit entities that expend total federal awards of \$750,000 or more during a fiscal year received either directly from the federal government or indirectly from a recipient of federal funds, are required to have an audit performed in accordance with the provision of Uniform Guidance. The Uniform Guidance can be accessed at <https://www.gpo.gov/fdsys/granule/CFR-2016-title45-vol1/CFR-2016-title45-vol1-part75/content-detail.html>.

For-Profit entities that expend total federal awards of \$750,000 or more during a fiscal year have two options: 1) a financial related audit (as defined in the Government Auditing Standards) of a particular award in accordance with Government Auditing Standards, in those cases where the sub recipient receives awards under only one HHS; or 2) a Single Audit performed in accordance with the Uniform Guidance (45 CFR § 75.501(i)).

Expenditures for single audits are the responsibility of the MCO.

The MCO must comply with the Commonwealth audit requirements in the applicable Audit Clause attached to the Contract, as amended.

### **18.2.2. FREQUENCY**

Audits must cover the fiscal year covered by the MCO. The audit must be electronically submitted to the Commonwealth’s Office of Budget, Bureau of Audits, nine (9) months after the end of the fiscal year.

### **18.2.3. FORMAT**

Reports must be submitted in the format deemed appropriate by the state or federal entity requiring the report.

All CHIP MCOs who are submitting a single audit in accordance with 45 CFR Part 75, Subpart F must also include in their single ing package a supplemental schedule. (See Appendix 18-A).

## **18.3. HEALTH CARE EFFECTIVENESS DATA INFORMATION SET AND CONSUMER ASSESSMENT HEALTH PLAN SURVEY (HEDIS®/CAHPS)**

### **18.3.1. Content (HEDIS®)**

MCOs must report CHIP-specific data for the measures listed below based on the latest version of HEDIS®. Measures may change from year-to-year.

The Department will notify MCOs annually, by official Department transmittal, of any changes to measures or permissible rotations. All MCOs must follow HEDIS® Medicaid product line technical specifications, including Medicaid continuous enrollment requirements per NCQA's specifications.

MCOs must HEDIS® results audited and validated by an NCQA licensed compliance vendor. The MCO may utilize these validation results for other purposes such as pursuit of accreditation.

The Department currently contracts with an EQRO to collect and analyze data unless otherwise advised via official Departmental transmittal. The EQRO is also be responsible for developing an official report and report card which will be publicly reported.

It is important to refer to the most recent HEDIS® and CAHPS transmittal to determine the most current measures the Department is requiring CHIP MCOs to collect. The following HEDIS® measures were required by the Department specifically for the CHIP population HEDIS® reporting year 2017. However, these measures are subject to change:

1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC): This measure assesses the percentage of children and adolescents age three (3) to seventeen (17) years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following three rates during the designated calendar year.
  - a. BMI (body mass index) Percentile Documentation
  - b. Counseling for nutrition

**c. Counseling for physical activity**

- 2. Childhood Immunization Status (CIS):** The percentage of children two (2) years of age who had four (4) diphtheria, tetanus and acellular pertussis (DTaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) H influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); one (1) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.
- 3. Immunizations for Adolescents (IMA):** The percentage of adolescents thirteen (13) years of age who had one dose of meningococcal conjugate vaccine and one (1) tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one (1) tetanus, diphtheria toxoids vaccine (Td), and three (3) doses of the human papillomavirus by their thirteenth birthday. The measure calculates a rate for each vaccine and two (2) combination rates.
- 4. Lead Screening in Children (LSC):** The percentage of children two (2) years of age who had one (1) or more capillary or venous lead blood test(s) for lead poisoning by their second birthday.
- 5. Chlamydia Screening in Women (CHL):** The percentage of women sixteen (16) to (24) years of age who were identified as sexually active and who had at least one (1) test for Chlamydia during the measurement year.
- 6. Age stratifications for CHIP:** Sixteen (16) to nineteen (19) years of age.

**NOTE:** The sixteen (16) to nineteen (19) age stratification range differs from HEDIS® 2016 technical specifications.

- 7. Appropriate Testing for Children with Pharyngitis (CWP):** The percentage of children two (2) to eighteen (18) years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).
- 8. Appropriate Treatment for Children with Upper Respiratory Infection (URI):** The percentage of children three (3) months to eighteen (18) years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. The measure is reported as an inverted rate [ $1 - (\text{numerator}/\text{eligible population})$ ]. A higher rate indicates appropriate treatment of children with URI, (i.e., the proportion for whom antibiotics were not prescribed).
- 9. Medication Management for People with Asthma (MMA):** The percentage of enrollees five (5) to eighty-five (85) years of age during the measurement year who

were identified as having persistent asthma and who were dispensed appropriate medications that they remained on during the treatment period. Two (2) rates are reported.

- a. The percentage of enrollees who remained on an asthma controller medication for at least 50% of their treatment period.
- b. The percentage of enrollees who remained on an asthma control medication for at least 75% of their treatment period.

**NOTE:** The CHIP age range of five (5) to nineteen (19) differs from HEDIS® 2016 technical specifications.

**10. Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder Medication (ADD):** The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a ten (10) month period, one of which was within thirty (30) days of when the first ADHD medication was dispensed. Two (2) rates are reported:

- a. **Initiation Phase.** The percentage of enrollees six (6) to (12) years of age as of the Initiation Phase start date with an ambulatory dispensed ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the thirty (30) day Initiation Phase.
- b. **Continuation and Maintenance (C&M) Phase.** The percentage of enrollees six (6) to twelve (12) years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
- c. **Follow-Up after Hospitalization for Mental Illness (FUH):** The percentage of discharges for enrollees six (6) years of age and older who were hospitalized for treatment of selected mental health diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:
  - i. The percentage of discharges for which the enrollee received follow-up within thirty (30) days of discharge.
  - ii. The percentage of discharges for which the enrollee received follow-up within seven (7) days of discharge.

**11. Children and Adolescents' Access to Primary Care Practitioners (CAP):** The percentage of enrollees twelve (12) months to nineteen (19) years of age who had a visit with a primary care practitioner (PCP). The organization reports four (4) separate rates for each product line.

- a. Children twelve (12) to twenty-four (24) months and twenty-five (25) months to six (6) years who had a visit with a PCP during the measurement year.
- b. Children seven (7) to eleven (11) years of age and adolescents twelve (12) to nineteen (19) years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year.
- c. Annual Dental Visit (ADV): The percentage of enrollees two (2) to twenty-one (21) years of age who had at least one dental visit during the measurement year.
- d. Age stratifications for CHIP: two (2) to nineteen (19) years of age.

**NOTE:** The sixteen (16) to nineteen (19) age stratification range differs from HEDIS® 2016 technical specifications.

- 12. Well-child visits in the first fifteen (15) months of life (W15): The percentage of enrollees who turned fifteen (15) months old during the measurement year and who had the following number of well-child visits with a PCP during their first fifteen (15) months of life:
  - a. No (0) well-child visits, one (1) well-child visit, two (2) well-child visits, three (3) well-child visits, four well-child visits, five (5) well-child visits, or six (6) or more well-child visits.
  - b. Well-child visits in 3rd, 4th, 5th and 6th Years of Life (W34): The percentage of enrollees three (3) to six (6) years of age who had one (1) or more well-child visits with a PCP during the measurement year.

- 13. Adolescent Well-Care Visits (AWC): The percentage of enrolled enrollees twelve (12) to twenty-one (21) years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Age stratifications for CHIP: Twelve (12) to nineteen (19) years.

**NOTE:** The twelve (12) to nineteen (19) age stratification range differs from HEDIS® 2016 technical specifications.

- 14. Ambulatory Care (AMB): This measure summarizes utilization of ambulatory care in the following service categories:
  - a. Outpatient Visits
  - b. Emergency Department (ED) visits

- 15. Age stratifications for CHIP: <1 year, one (1) to nine (9) years, ten (10) to nineteen (19) years, and Total.

- 16. Inpatient Utilization: General Hospital/Acute Care (IPU):** This measure summarizes utilization of acute inpatient care and services in the following categories:
- a. Total Inpatient
  - b. Medicine
  - c. Surgery
  - d. Maternity
- 17. Age stratifications for CHIP:** < 1 year, one (1) to nine (9) years, ten (10) to nineteen (19) years, and Total.
- 18. Identification of Alcohol and Other Drug Services (IAD):** This measure summarizes the number and percentage of enrollees with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year:
- a. Any service
  - b. Inpatient
  - c. Intensive outpatient or partial hospitalization
  - d. Outpatient or ED
- 19. Age/gender stratifications for CHIP:** Newborn (0) to twelve (12) years, thirteen (13)-seventeen (17) years, eighteen (18) to nineteen (19) years; Each for Male, Female and Total.

**NOTE:** The eighteen (18) to nineteen (19) age stratification range differs from HEDIS® 2016 technical specifications.

- 20. Mental Health Utilization- Percentage of Enrollees Receiving Inpatient and Intermediate Care and Ambulatory Services (MPT):** This measure summarizes the number and percentage of enrollees receiving the following mental health services during the measurement year:
- a. Any service
  - b. Inpatient
  - c. Intensive outpatient or partial hospitalization
  - d. Outpatient or ED
  - e. Age/gender stratifications for CHIP: Newborn (0) to twelve (12) years of age, thirteen (13) to seventeen (17) years of age, eighteen (18) to nineteen (19) years of age; Each for Male, Female, and Total.

**NOTE:** The eighteen (18) to nineteen (19) age stratification range differs from HEDIS® 2016 technical specifications.

- 21. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC):** The percentage of children and adolescents one (1) to seventeen (17) years of age who were on two (2) or more concurrent antipsychotic medications.

**NOTE:** A lower rate indicates better performance.

22. Age/gender stratifications for CHIP: one (1) to five (5) years of age; six (6) to eleven (11) years of age, twelve (12) to seventeen (17) years of age; total.
23. Metabolic monitoring for Children and Adolescents on Antipsychotics (APM): The percentage of children and adolescents one (1) to seventeen (17) years of age who had two (2) or more antipsychotic prescriptions and had metabolic testing.
24. Age/gender stratifications for CHIP: one (1) to five (5) years of age; six (6) to eleven (11) years of age; twelve (12) to seventeen (17) years of age; total.
25. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP): The percentage of children and adolescents one (1) to seventeen (17) years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
26. Age/gender stratifications for CHIP: one (1) to five (5) years; six (6) to eleven (11) years; twelve (12) to seventeen (17) years; total.
27. Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM): The percentage of emergency department visits for members six (6) years of age and older with a principle diagnosis of mental illness who had a follow-up visit for mental illness. Two (2) rates are reported:
  - a. The percentage of ED visits for which the member received follow-up within thirty (30) days of the ED visit.
  - b. The percentage of ED visits for which the member received follow-up within seven (7) days of the ED visit.
28. Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): The percentage of emergency department (ED) visits for members thirteen (13) years of age and older who had a follow-up visit for AOD. Two (2) rates are reported:
  - a. The percentage of ED visits for which the member received follow-up within thirty (30) days of the ED visit.
  - b. The percentage of ED visits for which the member received follow-up within seven (7) days of the ED visit.

### **18.3.2. FREQUENCY (HEDIS®)**

This is an annual audit. The deadline for submission of CHIP data to NCQA is June 15<sup>th</sup> or otherwise specified by the official HEDIS submission timeline. If the 15<sup>th</sup> falls on a weekend, it will be due the following Monday or next business day.

### **18.3.3. FORMAT (HEDIS®)**

MCOs shall submit their data through NCQA's Interactive Data Submission System's (IDSS) web-based tool. MCOs shall contact NCQA for direction regarding the HEDIS® IDSS submission process.

## **18.4. CAHPS**

### **18.4.1. CONTENT (CAHPS)**

MCOs are required to complete a CHIP-specific CAHPS Survey (CPC). All MCOs follow NCQA's Specifications for Survey Measures "General Guidelines for Data Collection and Reporting" chapter using the Medicaid product line specifications except for additional questions added to the survey by the Department for the purposes of evaluating PA CHIP. MCOs must contract with a certified vendor to administer the CAHPS survey. MCOs are responsible for the costs incurred in performing the survey. The survey must include the current additional CHIP specific child CAHPS questions. These questions are included on the annual HEDIS®/ CAHPS® transmittal.

### **18.4.2. FREQUENCY (CAHPS)**

This is an annual survey. CAHPS data must be submitted to the Department's EQRO, by July 15th, but may be submitted prior to this deadline. Detailed instructions regarding submission to the EQRO will be provided to the MCOs each year.

### **18.4.3. FORMAT (CAHPS)**

Each year, the EQRO provides detailed format and submission instructions.

## **18.5. CHIP PERFORMANCE IMPROVEMENT PROJECTS (PIPs)**

### **18.5.1. GENERAL REQUIREMENT**

The Department's EQRO performs the validation of CHIP MCO PIPs. The PIP process and timeline, as well as EQRO's validation, are conducted according to the Centers for Medicare and Medicaid (CMS) protocols. As outlined in these protocols, the PIP cycle spans several years and includes multiple steps. CHIP MCOs must document all PIP activities on the PIP Submission Form.

Each year the EQRO validates progress on the PIP during the measurement year (i.e., a "snapshot" of activities during one year of the cycle).

## **18.5.2. CONTENT**

### **18.5.2.1. TOPIC SELECTION**

- 18.5.2.1.1.** The overall PIP topic is selected by the Department.
- 18.5.2.1.2.** The MCO must do a root cause or similar analysis to determine the reasons for over/under-utilization in the CHIP population.
- 18.5.2.1.3.** The MCO clearly states the reason why the topic is relevant to the MCO's CHIP population.
- 18.5.2.1.4.** The MCO may choose an entire population for the topic or a subset of this population for MCO developed measures. However, MCOs are reminded that smaller populations may introduce increased variability of results and potentially more error.
- 18.5.2.1.5.** In general, topic selection is based upon continuous data collection, analysis and monitoring of all aspects of patient care and service delivery, and should consider the prevalence of a condition, enrollee need for a specified service, enrollee demographics and the interests of consumers and providers.
- 18.5.2.1.6.** Clinical focus areas should include prevention and care of acute and chronic conditions, high-volume services, and/or high-risk services.

### **18.5.2.2. STUDY INDICATORS**

- 18.5.2.2.1.** The indicators selected by the MCO should be consistent with current clinical standards and health services research.
- 18.5.2.2.2.** MCO developed indicators should be evidenced-based, use recognized clinical guidelines, or be accompanied by a consensus among expert practitioners
- 18.5.2.2.3.** The PIP describes the event being assessed or the enrollees who are eligible for the service or care. The PIP indicates whether all events or eligible enrollees are included, or whether the denominator is a sample.
- 18.5.2.2.4.** Indicators should relate directly to the project topic and type of indicator.

### **18.5.2.3. STUDY DESIGN**

- 18.5.2.3.1.** The study design must:
  - 18.5.2.3.1.1.** Clearly specify the data to be collected;
  - 18.5.2.3.1.2.** Specify the sources of data;
  - 18.5.2.3.1.3.** Specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply; and

**18.5.2.3.1.4.** Prospectively specify a data analysis plan.

#### **18.5.2.4. BASELINE MEASUREMENT**

CHIP MCOs use data from the specified period (service dates) as baseline data for the first year of the measure. The data is obtained through retrospective review of administrative data or medical records. As noted, MCOs submit data collection methodology, rates and barrier analyses – via the PIP Submission Form.

#### **18.5.2.5. INTERVENTION CYCLE**

It is expected that interventions associated with improvement on CHIP quality indicators will be:

1. System interventions or affect a wide range of participants;
2. Timely, most typically having been implemented after measurement or early in the next measurement period;
3. Targeted at the indicator and the population studied. The MCO should be able to demonstrate that its data have been corrected for any major confounding variables with an obvious impact on the outcomes, and that interventions that are developed or continued are the result of analysis of these data.

While MCOs may conduct continuous, ongoing interventions, validation of PIPs focuses on examining interventions at two points in time: interventions that occur after baseline and subsequent interventions that occur after the first re-measurement.

The second measurement (calendar) year is dedicated to the development of interventions after baseline to control for the effects of barriers to quality care. Documentation of Intervention Activities are submitted to the EQRO in November of the second project year. No rates will be documented in the second submission.

#### **18.5.2.6. RE-MEASUREMENT**

CHIP MCOs will use data (service dates) from the second measurement year as re-measurement to determine if there is improvement over baseline. This takes into account the impact of interventions enacted in the second measurement year. Additionally, MCOs use measurement year two for subsequent interventions, in which they will implement new interventions or continue existing ones. Re-measurement data and subsequent interventions are submitted to the EQRO in November of year three.

### **18.5.2.7. SUSTAINED IMPROVEMENT**

Sustained improvement is a second re-measurement. It is measured as improvement relative to baseline and is demonstrated based on performance in the year following the re-measurement year. Data for sustained improvement will be submitted to the EQRO in November of year four.

MCOs must submit a corrective action plan, as determined by the Department, and within timeframes established by the Department to resolve any performance or quality of care deficiencies identified either by an independent assessor and/or by the Department.

### **18.5.3. SCHEDULE OF PIP SUBMISSIONS- EMERGENCY DEPARTMENT UTILIZATION (CURRENT PIP)**

The EQRO reviews each PIP using a standard scoring tool and provides feedback to the Office of CHIP and the MCO. Findings from this review will be included in the annual CHIP Report.

#### **18.5.3.1. FREQUENCY**

This report is due annually in March.

**NOTE:** This report should be submitted via email to the EQRO.

#### **18.5.3.2. FORMAT**

Each year, the EQRO provides detailed format and submission instructions.

### **18.5.4. SCHEDULE OF PIP SUBMISSIONS – LEAD SCREENING IN CHILDREN (CURRENT PIP)**

The EQRO reviews each PIP using a standard scoring tool and provides feedback to the Office of CHIP and the MCO. Findings from this review will be included in the annual CHIP Report.

#### **18.5.4.1. FREQUENCY**

This report is due annually in November.

**NOTE:** This report should be submitted via email to the EQRO.

#### **18.5.4.2. FORMAT**

The EQRO provides detailed format and submission instructions each year.

## **18.6. PERFORMANCE MEASURES**

### **18.6.1. GENERAL REQUIREMENTS**

The Department specific performance measures that MCOS implement for the CHIP population. The performance measures allow CHIP to monitor particular clinical areas of interest for the Office of CHIP, DHS, or CHIP Advocates. These performance measures may reflect changes in the Child Core Set, CMS initiatives, and PADOH projects. Four Pennsylvania performance measures are currently collected for CHIP.

### **18.6.2. CONTENT and PROCESS OVERVIEW**

The EQRO provides a list of required Performance Measures annually.

#### **18.6.2.1. PROCESS OVERVIEW**

An overview of the validation process for Performance Measures follows

1. enrollee level detail file (Data file) and Source Code validation is conducted by the EQRO for all Performance Measures.
2. MCOs submit a Source Code and a data file for each Performance Measure for review and validation each year prior to or on the specified due date.
3. All files containing protected health information (PHI) are submitted via secure ftp.
4. The EQRO reviews the Source Code to ensure that the appropriate eligible populations are selected for each performance measure and that the appropriate enrollees are selected as numerator positives for each measure.
5. The EQRO reviews each data file to confirm that all data elements are present in the specified position.
6. As appropriate, MCOs are permitted to provide corrective action to pass validation (i.e., correcting the cause of the discrepancy and re-submitting both the Source Code and data files).
7. If the errors are not resolvable, the MCO receives a “Not Report” for the measure(s).
8. At the completion of validation, the EQRO submits the final rate sheet to MCOs for each measure.
9. MCOs review, sign, and return a copy of the final rate sheet to the EQRO to signify agreement with the final rates.

### **18.6.2.2. FREQUENCY**

Each measure is due in August of each year.

### **18.7. PAY FOR PERFORMANCE PROGRAMS**

The Department may conduct a Pay for Performance (P4P) Program that provides financial incentives for MCOs that meet quality goals. The Department may establish other P4Ps designed to meet quality goals in subsequent years.

### **18.8. VALUE-BASED PURCHASING**

**18.8.1.** The MCO must enter into arrangements with Providers that incorporate value-based purchasing (VBP) strategies such as:

- a.** Provider pay for performance programs;
- b.** Patient Centered Medical Homes (PCMH);
- c.** Shared savings contractual arrangements;
- d.** Bundled or global payment arrangements; or
- e.** Full risk or Accountable Care Organization payment arrangements.

**18.8.2.** The financial goals for the VBP strategies for each calendar year are based on a percentage of the MCO's expenditures to the medical portion of the capitation or revenue adjustments. These goals apply collectively to all Agreements between the MCO and the Department. For the purpose of this requirement, Capitation revenue is the medical expenditure portion of the capitation. The MCO must achieve the following percentages through VBP arrangements:

- a.** Calendar year inclusive of 3/1/2020 to 12/31/2020- 5% of the medical portion of the rate capitation must be expended through VBP strategies. The 5% may be from any combination of the five (5) strategies listed.
- b.** Calendar year 2021 – 10% of the medical portion of the capitation rate must be expended through VBP strategies. At least 50% of the 10% must be from a combination of strategies ii. through v.

- c. Calendar year 2022 – 20% of the medical portion of the capitation rate must be expended through VBP. At least 50% of the 20 must be from a combination of strategies iii. through v.
- d. Calendar year 2023 inclusive of time through the end of contracting period- 30% of the medical portion of the capitation rate must be expended through VBP. At least 50% of the 30% must be from a combination of strategies iii. through v.

**18.8.2.1.** By January 1 of each calendar year, the MCO submits its proposed VBP plan to the Department that outlines and describes its plan for compliance in that calendar year. The Department reviews and provide feedback on the plan to the MCO. By the last work day of every quarter, the MCO submits a progress report.

**18.8.2.2.** By June 30 of the subsequent calendar year, the MCO submits a report on accomplishments from the prior year. This annual report includes 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:

- a. Provider pay for performance programs – dollar value of performance (bonus) payments and direct payments made to the Provider for Members attributed to the provider’s panel during the calendar year.
- b. 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 MCO for Members of the provider’s panel during the time period of the calendar year the Member was attributed to the provider’s panel.
- c. Shared savings contractual arrangements – dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the MCO for Members of the provider’s panel during the time period of the calendar year the Member was attributed to the provider’s panel.
- d. Bundled or global payment arrangements – dollar value of bundled payments made to providers.
- e. Full risk or Accountable Care Organization payment arrangements – dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the MCO for Members of the provider’s panel inclusive of any previous (bonus) payments

during the time period of the calendar year the Member was attributed to the provider's panel.

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

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

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

**18.8.2.4.** The 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:

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

## **18.9. SOCIAL DETERMINANTS OF HEALTH**

The Department is instituting a Social Determinants of Health (SDOH) initiative. The MCO shall collaborate with the Department to develop, adopt and disseminate a SDOH assessment tool. MCOs will be required to develop, institute, maintain and report on the SDOH initiative(s) that the MCO is engaged in.

## **18.10. COMMUNITY BASED CARE MANAGEMENT**

**18.10.1.** The Community Based Care Management (CBCM) Program requirements described in this Handbook are for care rendered during a

calendar year (CY). CBCM programs will be piloted by CHIP starting in calendar year 2021. CBCM programs program requirements strive to increase the use of community health workers and emphasize activities to address social determinates of health.

- 18.10.2.** CBCM Program Requirements must primarily be focused on:
- a.** reducing preventable admissions and readmissions;
  - b.** reducing non-emergent visits to the emergency department;
  - c.** addressing social determinants of health;
  - d.** supporting a diabetes reduction;
  - e.** enhancing behavioral and physical health coordination of services;
  - f.** targeting providers/organizations that serve a large volume of complex CHIP enrollees; and
  - g.** increasing access to pediatric dental preventive and restorative services.
- 18.10.3.** A member of the CBCM team spends the majority of time in face-to face-encounters with members either in the community setting, provider outpatient setting, hospital, or Emergency Department (ED). They can be embedded in one outpatient service site, float between multiple outpatient sites, provide transition of care services from the hospital or ED setting, and provide home based care coordination.
- 18.10.4.** CBCM activity can involve care coordination by licensed and non-licensed team members. Emphasis should be placed on expanding the use of non- licensed professionals to focus on face-to-face interaction with members. Examples of licensed providers include but are not limited to: physicians, dentists, dental hygienists, public health dental hygiene practitioners (PHDHPs), physician's assistants, Certified Registered Nurse Practitioners (CRNPs), certified nurse midwives, RNs, LPNs, MSWs, dieticians, psychologists, and pharmacists. Examples of non-licensed team members include but are not limited to: medical assistants/technicians, community health workers, doulas, paramedics/EMTs, faith-based ministries, and peer specialists. This list of examples is not fully inclusive.
- 18.10.5.** Members of the CBCM team can be employed by the MCO, employed by a provider organization, or hired by a third party through a contract with the MCO. The MCO is responsible for reporting the targeted providers/organizations, targeted enrollees, and define the financial spending for each arrangement (see more details below).
- 18.10.6.** The MCO should target providers/organizations that serve a large volume of complex CHIP recipients. Preference should be given to large health systems, FQHCs and high volume dental providers. Preference should be given to programs that focus on co-location of

care management services for consumers with persistent serious mental illness (PSMI) and substance use disorder (SUD).

**18.10.7.** The Department may choose to perform a clinical review of the CBCM program. The MCO must reasonably cooperate with Department staff during the clinical review process.

**18.10.8.** The MCO must submit an analysis of their CBCM program quarterly to the CHIP office on a form stipulated by the Department.

**18.11. ASSESSMENT TOOL**

The MCO collaborates with the Department to develop, adopt and use an SDOH Assessment Tool to use for new enrollees and at any time that there is a change in circumstances for enrollees.

**18.12. ACCREDITATION VERIFICATION**

**18.12.1. CONTENT**

MCOs must have NCQA accreditation and inform the Department of accreditation status annually. MCOs must also authorize private independent accrediting entities to provide to the Department a copy of its most recent accreditation review; including accreditation status; survey type and level, as applicable; accreditation results, including recommended actions or improvements; corrective action plans and summary of findings and the expiration date. The PADOH informs Office of CHIP of any changes that they need to be aware of. MCOs are required to send copies of their NCQA accreditation reports and certificates to CHIP upon renewal. The Office of CHIP will track due dates for recertification and dates of submission of reports and certificates. A reminder email will be sent to the MCO at the beginning of the month recertification is due for the MCO to submit copies of the report and certificate to a CHIP Medical Services analyst.

**18.13. PAYMENT ERROR RATE MEASUREMENT (PERM)**

**18.13.1. GENERAL REQUIREMENTS**

The Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act (IPERA)), requires federal agencies to annually review programs, which are identified by the Office of Management and Budget (OMB) as at risk for improper payments, e.g. CHIP. Improper payments are any payments that have been made in error, including payments that should not have been made, payments that were made in the incorrect amount, and inappropriate denials of payment

or services. PERM was created by CMS to aid in compliance with IPIA by measuring improper payments and procedures error rates. Per IPIA the final estimates are submitted to Congress and used by CHIP to reduce the improper payments.

#### **18.13.2. CONTENT**

Under PERM, reviews will be conducted in three areas:

1. fee-for-service (FFS);
2. managed care; and
3. program eligibility for both the Medicaid and SCHIP Programs.

Detailed information can be found at [www.cms.hhs.gov/PERM](http://www.cms.hhs.gov/PERM).

#### **18.13.3. FREQUENCY**

Each year, PERM will review payment error rates for a rotating subset of one-third of all states, or about 17 states each year. Pennsylvania was selected to participate in Cycle 1.

#### **18.13.4. FORMAT**

MCOs will be contacted on specifications regarding information to be submitted and a timeline.

### **18.14. MEDICAL LOSS RATIO (MLR)**

The MCO must calculate the Medical Loss Ratio (MLR) for each MLR Reporting Year in accordance with the calculation standards in 42 CFR § 457.1203(c) incorporating 42 CFR § 438.8 and report the MLR experience to the Department with the information specified in 42 CFR § 438.8(k) within twelve (12) months of the close of the MLR Reporting Year. The MCO will owe a remittance to the Department if an MLR of at least 85 percent is not achieved for the MLR Reporting Year. See Appendix 18-B for the Medical Loss Ratio Template that the Department will use to track MLR for each MCO.

## CHAPTER 19: DATA WAREHOUSE

### 19.1. GENERAL REQUIREMENTS

The MCO complies with state and federal reporting requirements that are set forth in the Handbook, including this section and the Contract, as amended. The MCO must submit to the Department specified data, including encounter data in the form and manner described in 42 C.F.R. § 438.818 relating to enrollee encounter data, data that demonstrates compliance with medical loss ratio requirements of 42 C.F.R. § 438.8, data to confirm adequate provision against the risk of insolvency, documentation described in 42 C.F.R. § 438.207(b) relating to assurances of adequate capacity and services, information on ownership and control as specified by 42 C.F.R. § 438.602(c), the annual overpayment recovery reports specified in 42 C.F.R. § 438.608(d)(3), and any additional data, documentation or information required by the Department or CMS.

The MCO must submit certification concurrently with the submitted data, information and documentation as to the accuracy, completeness, and truthfulness of the data, information and documentation and the certification 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 so that the CEO or the CFO is ultimately responsible for the certification. The MCO must certify, under penalty of perjury, that data submitted to the Department meets the requirements of 42 CFR § 457.1285, incorporating 42 CFR § 438.604, (except the terms of 438.604(a)(2) do not apply) whether in written or electronic form. The MCO provides the certification via hard copy or electronic format, on the form provided by the Department.

The MCO adheres to the Claims and Encounter Data format prescribed by the Department. This includes the file size, format specifications and file submission schedule. The Department provides sixty (60) days advance written notice of any changes to Claims and/or Encounter Data requirements.

Each MCO electronically transmits enrollee claims and encounter level data to the Department, including any data gathered through subcontractors. The reported data is held via the CAPS Data Warehouse.

The Department has developed unique file formats to communicate the necessary information to satisfy all reporting requirements including ad hoc reporting for the CAPS Data Warehouse. Use of ASC X12N 5010 837 and NCPDP D2 file formats for health care claim transactions are mandated by HIPAA Transactions and Code Sets regulations when electronically communicating claim information. File specifications and/or any upgrades will be provided to MCOs when changes are required.

## **19.2. DATA REPORTING TO THE DEPARTMENT**

The MCO must record for internal use and submit Claims and Encounter Data to the Department. The MCO shall only submit Claims and Encounter Data for Enrollees on date of service and not submit any duplicate records.

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

Following is the list of the data files that will be provided to the Department by the MCO:

1. Provider(PROVR)
2. 837 Institutional
3. 837 Professional
4. 837 Dental
5. NCPDP – Pharmacy Encounter records

## **19.3. PROVIDER FILE**

### **19.3.1. CONTENT**

This is a proprietary file format that contains a list of all the active providers (individuals, groups, and facilities) in the MCO's CHIP Provider Network in Pennsylvania.

### **19.3.2. FREQUENCY**

The MCO submits this file to the Department by the 20<sup>th</sup> of each month.

### **19.3.3. FORMAT**

The details of the content are provided in the CAPS Provider File Specifications.

## **19.4. 837 INSTITUTIONAL FILE**

### **19.4.1. CONTENT**

This file contains the institutional claims and/or encounters filed in the prior month for CHIP enrollees and follows the HIPAA 5010 837 Institutional mandated guidelines.

**19.4.2. FREQUENCY**

The MCO submits this file to the Department by the 20<sup>th</sup> of each month.

**19.4.3. FORMAT**

The details of the content are provided in the CHIP Application Processing System 837 Institutional Companion Guide.

**19.5. 837 PROFESSIONAL FILE**

**19.5.1. CONTENT**

This file contains the professional claims and/or encounters filed in the prior month for CHIP enrollees and follows the HIPAA 5010 837 Professional mandated guidelines.

**19.5.2. FREQUENCY**

The MCO submits this file to the Department by the 20<sup>th</sup> of each month.

**19.5.3. FORMAT**

The details of the content are provided in the CHIP Application Processing System 837 Professional Companion Guide.

**19.6. 837 DENTAL FILE**

**19.6.1. CONTENT**

This file contains the dental claims and/or encounters filed in the prior month for CHIP enrollees and follows the HIPAA 5010 837 Dental mandated guidelines.

**19.6.2. FREQUENCY**

The MCO submits this file to the Department by the 20<sup>th</sup> of each month.

**19.6.3. FORMAT**

The details of the content are provided in the CHIP Application Processing System 837 Dental Companion Guide.

## **19.7. NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAM (NCPDP) FILE**

### **19.7.1. CONTENT**

This file contains the pharmacy claims and/or encounters filed in the prior month for CHIP enrollees and follows NCPDP D.2 guidelines.

### **19.7.2. FREQUENCY**

The MCO submits this file to the Department by the 20<sup>th</sup> of each month.

### **19.7.3. FORMAT**

The details of the content are provided in the CHIP Application processing system NCPDP Companion Guide.

## **19.8. DATA REPORTING TO THE MCOs**

### **19.8.1. 834 ENROLLMENT FILES**

The MCO provides the following is the list of the data files to the Department:

1. 834 Daily Enrollment File
2. 834 Monthly Audit Enrollment File

### **19.8.2. 834 DAILY ENROLLMENT FILE**

The Department will provide to the MCO an 834 Daily Enrollment File that contains a single record for each CHIP enrollee for which data has changed that day. The file will contain add, termination, and change records. The file contains demographic changes, eligibility changes, and enrollment changes. The MCO must process this file within 24 hours of receipt.

The MCO must reconcile this file against its internal Enrollment information and notify the Department of any discrepancies within thirty (30) business days.

### **19.8.3. 834 MONTHLY AUDIT ENROLLMENT FILE**

The Department will provide an 834 Monthly Enrollment File for each MCO on the first day of each month for the previous month. The file contains the CHIP Eligibility Period, MCO coverage, and other demographic information for CHIP enrollees. This file is not a history file, it will contain only one record for each CHIP enrollee for the previous month. The MCO must reconcile this audit enrollment file against its internal membership information and notify the Department of any discrepancies found within the data on the file within thirty (30) business days.

## **19.9. CLAIMS AND ENCOUNTER SUBMISSIONS**

### **19.9.1. PROVIDER CLAIMS**

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

The 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 MCO by the end of the month following the month of adjudication.

### **19.9.2. ENCOUNTER SUBMISSIONS**

All Encounter Data, except pharmacy transactions, must be submitted by the MCO and determined acceptable by the Department on or before the last calendar day of the second month after the payment or adjudication calendar month in which the MCO paid or adjudicated the Claim. Pharmacy transactions must be submitted and approved in MMIS within 30 days following the adjudication date.

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

Encounter Data that get denied due to Department edits will be returned to the MCO and must be corrected. Denied Encounter records must be resubmitted as a “new” Encounter record if appropriate and within the timeframes referenced above.

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

**19.9.3. RESPONSE FILES**

The MCO Encounter Data system must have a mechanism in place to receive and process all response files; and to store the MMIS ICN associated with each processed Encounter Data returned on the files.

**19.10. DATA COMPLETENESS**

The MCO submits records each time an enrollee has an Encounter with a Provider. The MCO must have a data completeness monitoring program in place that:

1. Demonstrates that all Claims and Encounters submitted to the MCO by Providers, including Subcontractors, are submitted accurately and timely as Encounters to the Department and that demonstrates denied Encounters are resolved and resubmitted;
2. Evaluates Provider and Subcontractor compliance with contractual reporting requirements; and
3. Demonstrates the MCO has processes in place to act on the information from the monitoring program and takes appropriate action to achieve full compliance with Encounter Data reporting to the Department.

The MCO must submit an annual Data Completeness Plan for review and approval. This Data Completeness Plan must include the three elements listed above.

**19.11. LIQUIDATED DAMAGES**

The MCO must provide complete, accurate, and timely Encounter Data to the Department. The Department may impose liquidated damages as provided in the Contract, as amended, in instances of the MCO's failure to meet the standards. In addition, the MCO must maintain complete medical service history data.

For any deficiency, the Department may request the MCO submit a Corrective Action Plan (CAP) when areas of noncompliance are identified. If the CAP is successful, the financial penalties may be waived.

Percentage of the sample that includes an error	Sanction
Less than 1.0 percent	None

1.0 to less than 1.5 percent	Up to \$4,000
1.5 to less than 2.0 percent	Up to \$10,000
2.0 to less than 3.0 percent	Up to \$16,000
3.0 to less than 4.0 percent	Up to \$22,000
4.0 to less than 5.0 percent	Up to \$28,000
5.0 to less than 6.0 percent	Up to \$34,000
6.0 to less than 7.0 percent	Up to \$40,000
7.0 to less than 8.0 percent	Up to \$46,000
8.0 to less than 9.0 percent	Up to \$52,000
9.0 to less than 10.0 percent	Up to \$58,000
10.0 percent and higher	Up to \$100,000

**19.12. DATA VALIDATION**

The MCO assists the Department in its validation of Encounter Data by making available medical records and Claims data as requested. The validation may be completed by Department staff, an independent external review organization, or both.

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

**19.13. SECONDARY RELEASE OF ENCOUNTER DATA**

The Department owns all Encounter Data recorded to document services rendered to enrollees. The Department provides access to this data to the MCO and its agents for the sole purpose of operating the CHIP Program. The MCO and its agents cannot release any data resulting from the 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 MCO or its agents in the routine operation of an MCO.

**19.14. PCP ASSIGNMENT FOR ENROLLEES**

The MCO must provide a file to the data warehouse PCP assignments for all its enrollees.

The MCO must provide this file at least monthly or more frequently if requested by the Department. The 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 MCO must use this report to reconcile and correct any errors. The MCO must comply with the file submission requirements found in the CHIP Procedures Handbook.

#### **19.15. PROVIDER NETWORK**

The MCO must provide a file to the CAPS data warehouse of its entire CHIP Provider Network, including its Subcontractors.

The MCO must provide this file monthly. The MCO must confirm the information is consistent with all requirements specified by the Department by utilizing the response report provided by the Department. The MCO must use this report to reconcile and correct any errors. The MCO must comply with the file submission requirements.

#### **19.16. ALERTS**

The MCO must confirm the information is consistent with all requirements specified by the Department in the CHIP Procedures Handbook.

#### **19.17. OPERATIONS REPORTING**

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

##### **19.17.1. FINANCIAL REPORTS**

The MCO submits an annual audited financial report to the Department. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

The MCO submits such reports as specified by the Department to assist the Department in assessing the MCO's financial viability and compliance with its Contract, as amended.

The Department distributes financial reporting requirements to the MCO. The 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 in this CHIP Procedures Handbook.

##### **19.17.2. ANNUAL AUDITED FINANCIAL REPORT**

The MCO submits an annual audited financial report within timeframes specified by the Department.

### **19.17.3. MEDICAL LOSS RATIO REPORT**

The MCO must calculate the Medical Loss Ratio (MLR) for each MLR Reporting Year in accordance with the calculation standards in 42 CFR 457.1203(c) in reference to 42 CFR 438.8 and report the MLR experience to the Department with the information specified in 42 CFR 438.8(k) within twelve (12) months of the close of the MLR Reporting Year. The MCO owes a remittance to the Department if an MLR of at least 85 percent is not achieved for the MLR Reporting Year. See Appendix 16-B for the Medical Loss Ratio Template that the Department will use to track MLR for each MCO.

### **19.17.4. CLAIMS PROCESSING REPORTS**

The MCO must provide the Department with monthly Claims processing reports with content and in a format specified by the Department by the fifth (5<sup>th</sup>) calendar day of the second subsequent month. The Department does not consider claims returned by a web-based clearinghouse (i.e. WebMD Envoy) as claims received and they are excluded from claims reports.

If the 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.

### **19.18. PRESENTATION OF FINDINGS**

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

## **CHAPTER 20: FRAUD, WASTE, AND ABUSE**

### **20.1. GENERAL REQUIREMENTS: FRAUD, WASTE, AND ABUSE DETECTION**

The MCO must implement and maintain and require its subcontractors who have delegated responsibility for service provision or claim payment to implement and maintain administrative and management arrangements and procedures that are designed to detect and prevent fraud, waste, and abuse according to the program integrity requirements described in 42 C.F.R. § 438.608(a)(1) (i-vii).

These procedures must include compliance program that includes, at a minimum, the following:

- 20.1.1.** Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards all applicable Federal, State and Contract requirements.
- 20.1.2.** The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to provide compliance with Contract requirements and who reports directly to the Chief Executive Officer and the Board of Directors.
- 20.1.3.** The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level that is charged with overseeing the MCO's compliance program and its compliance with Contract requirements.
- 20.1.4.** A system of training and education of the Compliance Officer, the MCO's senior management, and the MCO's employees on Federal, State and Contract standards and requirements, including health care fraud laws, the MCO's policies and procedures for preventing and detecting fraud, waste, and abuse and the rights of employees to act as whistleblowers .
- 20.1.5.** Effective lines of communication between the Compliance Officer and the MCO's employees.
- 20.1.6.** Enforcement of standards through well publicized disciplinary guidelines.
- 20.1.7.** Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and audit of compliance issues, investigation of potential compliance problems, correction of problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence and ongoing compliance.

**20.1.8.** In addition, the MCO's arrangements and procedures must include:

- Prompt reporting to the Department of overpayments identified or recovered, specifying overpayments due to fraud.
- Prompt notification to the Department of information that may impact an enrollee's eligibility.
- Prompt notification to the Department of information that that may affect a provider's eligibility to participate in CHIP.
- A method to verify, through sampling or other method whether services represented to have been delivered were received by enrollees and the use of the verification method on a regular basis.
- The provision for written policies for employees, contractors and agents that provide information on the False Claims Act and other federal and state laws as described in 42 U.S.C. § 1396a(a)(68), including information relating to whistleblower protection.
- Prompt referral of any potential fraud, waste, or abuse to the Department or the Pennsylvania Office of Attorney General Medicaid Fraud Control Unit.
- Suspension of payments by the MCO to a Network Provider for which the Department determines a credible allegation of fraud exists.
- Enforcement of compliance with applicable federal, state and Contract statutes, regulations and standards.
- Prohibition of personal contact with potential enrollees by an employee or agent for the purpose of influencing the individual to enroll with the MCO.
- A mechanism to report to the Department, CMS or the U.S. Office of Inspector General, as appropriate, information on violation by subcontractors, providers and enrollees when the violations pertain to enrollment in the CHIP MCO or the provision of or payment for health services.

## **20.2. FRAUD, WASTE, AND ABUSE UNIT**

**20.2.1.** The MCO must address risks, provide prompt response to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly (or coordinate suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ensure ongoing compliance with the requirement.

- 20.2.2.** The MCO must have provisions for prompt reporting to the State of all overpayments identified or recovered, specifying the overpayments due to potential fraud.
- 20.2.3.** The MCO must establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance
- 20.2.4.** The MCO must have provisions for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including all of the following:
  - 1.** Changes in the enrollee's residence and
  - 2.** The death of an enrollee
- 20.2.5.** The MCO must have provisions for notifying the State when it receives information about a change in a Network Provider's circumstances that may affect the provider's eligibility to participate in the CHIP, including the termination of the provider agreement with the MCO.
- 20.2.6.** The MCO must have a method to verify that services reported as rendered to enrollees by its providers have been delivered. The MCO may verify service delivery by sampling or other methods.
- 20.2.7.** The MCO must have a mechanism for Network Providers to report when it has received an overpayment, to return the overpayment within sixty (60) calendar days after it has been identified and to notify the MCO in writing of the reason for the overpayment.

## **20.7 REFERRAL TO THE DEPARTMENT**

The MCO must establish a policy for referral of any potential fraud, waste, or abuse that the MCO identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit. Refer to Appendix 20-B for a checklist of supporting documentation for referrals.

## **20.8 REFERRAL TO SENIOR MANAGEMENT**

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

## **20.9. 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 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.

## **20.10. DUTY TO NOTIFY**

### **20.10.1. DEPARTMENT'S RESPONSIBILITY**

The Department provides the MCO with immediate notice via electronic transmission or access to Medichex listings or upon request if a Provider with whom the MCO has entered into a Provider Agreement is subsequently suspended or terminated from participation in the 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 MCO must immediately act to terminate the Provider from its Network. Terminations for loss of licensure and criminal convictions must coincide with the MA or CHIP effective date of the action.

The MCO must check the Social Security Administration Death Master File (SSADMF), and National Plan and Provider Enumeration System (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 Medichex list on a monthly basis.

### **20.10.2 MCO'S RESPONSIBILITY TO DISCLOSE**

The MCO must provide written disclosures to the Department of prohibited affiliations specified in 42 C.F.R. § 438.610 and section 24.6.5 of this Handbook and information on ownership and control as specified in 42 C.F.R. § 455.104. The MCO also must report to the Department any excess payments, including capitation payments, within sixty (60) calendar days of identification of the overpayment.

## **20.11. SANCTIONS**

The Department may impose sanctions or take other actions if it determines that the MCO, a Network Provider, employee, caregiver or Subcontractor has committed "Fraud", "Waste" or "Abuse" as defined in the Contract, as amended or this Handbook or has otherwise violated applicable law.

### **20.11.1. SANCTIONS REGARDING FRAUD, WASTE, AND ABUSE**

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

To maintain the integrity of the CHIP Program and to ensure that 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 MCOs as deemed appropriate where there is evidence of violations involving Fraud, Waste, and Abuse issues in the CHIP Program.

To that end, program compliance and improvement assessments, including financial assessments payable to the Bureau of Program Integrity (BPI), will be applied by BPI for the MCOs' identified program integrity compliance deficiencies. Note that the Department retains discretion to impose additional remedies available under applicable law and regulations.

### **20.11.2. FRAUD, WASTE, AND ABUSE ISSUES WHICH MAY RESULT IN SANCTIONS**

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

- 1.** Failure to implement, develop, monitor, continue 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;
- 2.** 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;
- 3.** Failure to adhere to applicable state and federal laws and regulations;
- 4.** Failure to adhere to the terms of the CHIP Contract, as amended and this Handbook that relate to Fraud, Waste, and Abuse issues;

- 5.** Failure to provide the relevant requesting 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 MCO to enrollees;
- 6.** Actions that indicate a pattern of wrongful denial of payment for a health-care benefit, service or item that the MCO is required to provide;
- 7.** Substantial failure to furnish services or to provide enrollees a health benefit, service or item that the MCO is required to provide under law or its Contract, as amended and this Handbook;
- 8.** Actions that indicate a pattern of wrongful delay of at least forty-five (45) days but not to exceed sixty (60) days in making payment for a health-care benefit, service or item that the MCO is required to make to provider under its agreement with the provider;
- 9.** The imposition of premiums or charges on enrollees in excess of premiums and charges permitted under CHIP or the Contract, as amended;
- 10.** Discrimination against enrollees or prospective enrollees on any prohibited basis, including without limitation, age, gender, ethnic origin, health status or need for health care services, including termination of enrollment, refusal to enroll and any practice that may discourage enrollment;
- 11.** Misrepresentation or falsification of information furnished to CMS, the Department, enrollees, potential enrollees or health care providers;
- 12.** Failure to comply with PIP requirements;
- 13.** Distribution, either directly or indirectly, of marketing material that has not been approved by the Department or that contains false or misleading information;
- 14.** Violation of applicable requirements of 42 U.S.C. § 1396u-2 relating to managed care; and
- 15.** Failure to pay overpayments to the Department as identified through network provider audits, reviews, investigations conducted by BPI or its designee and other state and federal agencies.

The MCO conducts preliminary investigations and may consult with state agencies or law enforcement to determine credible allegations of fraud for which an investigation is pending under CHIP program against an individual, provider, or other entity exist (42 C.F.R. § 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 C.F.R. § 455.2).

### **20.11.3. RANGE OF SANCTIONS**

The Department may impose any of the following sanctions including, but not limited to:

1. Preclusion or exclusion of the MCO, its officers, managing employees or other individuals with direct or indirect ownership or control interest;
2. Corrective Action Plans;
3. Monetary Sanctions;
4. Recoupment of overpayments to the MCO or providers;
5. Enrollment Restrictions;
6. Withholding of Capitation Payments;
7. Preclusion of Corporate Officers and other individuals identified as being involved in fraudulent or abusive practices; and
8. Termination of Contract.

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

### **20.12. SUBCONTRACTS**

The MCO requires that all network providers and all subcontractors take such actions as are necessary to permit the MCO to comply with the Fraud, Waste, and Abuse requirements listed in this Agreement as well as federal regulations including but not limited to 42 C.F.R. § 438.608.

To the extent that the MCO delegates oversight responsibilities to a third party (such as a Pharmacy Benefit Manager), the MCO must require that such third party complies with the applicable provisions of this Handbook relating to Fraud, Waste, and Abuse.

The MCO requires, via its Provider Agreement, that Network Providers comply with CHIP regulations and enforcement actions directly initiated by

the Department under its regulations, including termination and restitution actions.

The MCO's contracts or agreements with its Subcontractors must meet the requirements set forth at 42 CFR § 438.230(c)(3).

## **20.13. FRAUD AND ABUSE REPORTING REQUIREMENTS**

**20.13.1.** The MCO must submit to the Department on an annual basis a statistical report which relates to its fraud, waste, and abuse detection and sanctioning activities to include the following elements:

**20.13.1.1.** Section I of the report generally requires MCOs to provide:

1. Information regarding internal company policies and procedures;
2. Organization chart of office responsible for fraud and abuse activity;
3. Fraud training and frequency;
4. Instances of successful prosecution of either an MCO, subcontractor, provider, enrollee or employee and subsequent corrective actions;
5. Methods of detecting fraud and abuse;
6. Process for referral to appropriate law enforcement authorities;
7. Provider application content regarding fraud and abuse;
8. Toll free number or website, or both, for reporting fraud and abuse for both providers and enrollees;
9. Contract language for providers and subcontractors regarding fraud and abuse; and
10. Monitoring of subcontractors.

**20.13.1.2.** Section II of the report requires information specific to the number, dollar amounts, and content of fraud and abuse cases referred to law enforcement authorities within the contract year from the standpoint of either: providers, enrollees, employees, or MCO/subcontractors.

**20.13.1.3.** Attachments 20-A and 20-B provide the details of the confirmed and dismissed or unfounded fraud and abuse cases by category.

**NOTE:** The Department refers calls from the public ("whistleblowers") to the appropriate MCO for investigation. The MCOs reports back to the Department on case status within the first ten (10) calendar days following the referral and in thirty (30) day increments thereafter until resolved.

#### **20.13.1.4.FORMAT**

(See Appendix 20-AA). No other format is acceptable.

#### **20.13.1.5.FREQUENCY OF FRAUD AND ABUSE ANNUAL REPORT**

This report is due annually on March 1. 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.

**NOTE:** This report can be submitted via regular mail, fax, or email to:

CHIP Division of Quality Assurance  
1142 Strawberry Square.  
P.O. Box 2675  
Harrisburg, PA 17105-2675

## **CHAPTER 21: MANAGED CARE ORGANIZATIONS QUALITY REQUIREMENTS**

### **21.1. GENERAL REQUIREMENTS**

MCOs must provide all benefits as described in the CHIP Eligibility and Benefits Handbook. The Department may change the benefit package as required by state or federal law or as the Department deems appropriate to meet the needs of the CHIP population. Implementation of such changes by the MCOs are on the date determined by the Department. If changes to the benefit package or eligibility criteria occur, the Department conducts an actuarial analysis to determine if there is a need for a rate change based upon data provided by the MCOs.

### **21.2. IN-PLAN SERVICES**

The MCO must ensure that all services provided are Medically Necessary. The MCO must require that determinations of Medically Necessary services be documented in writing and conform to the provision of those Medically Necessary services. Determination of medical necessity also includes medical information provided by an enrollee, the enrollee's family or caretaker and PCP, as well as other providers, programs or agencies that have evaluated the enrollee. A determination of Medically Necessary services must be made by a qualified and trained CHIP provider with clinical expertise comparable to the prescribing provider.

### **21.3. AMOUNT, DURATION, AND SCOPE**

At a minimum, the MCO must provide In-Plan Services in the amount, duration, and scope set forth in the CHIP Managed Care Program and be based on the enrollee's benefit package, unless otherwise specified by the Department. The MCO must provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. If services or eligible consumers are added to the CHIP Program, or if covered services or eligible consumers are expanded or eliminated, implementation by the MCO must be on the same day as the Department's, unless the MCO is notified by the Department of an alternative implementation date.

The 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. The MCO must make medically necessary covered services available 24 hours a day, seven days a week.

#### **21.4. EXPANDED SERVICES**

The 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 may include various seminars and educational programs promoting healthy living or illness prevention, enrollment in health clubs and facilities promoting physical fitness, and expanded eyeglass or eye care benefits. These services must be generally available to all enrollees and must be made available at all appropriate network providers. These services must be provided at no additional cost to the enrollee or the Department. 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. Previously approved services must continue to remain in effect, unless the MCO is notified, in writing, by the Department, to discontinue the expanded service.

For information about expanded services to be included in any enrollee information provided by the MCO, the 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 MCO may modify or eliminate any expanded service. Such services, as modified or eliminated, must supersede those specified in the Agreement. The 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.

#### **21.5. REFERRALS**

The MCO must establish and maintain a referral process to effectively utilize and manage the care of its Enrollees. The MCO may require a referral for any medical services, which cannot be provided by the PCP except where specifically provided for in this Agreement. The MCO may not avoid costs for covered services by referring Enrollees to publicly supported health care resources.

## **21.6. SELF-REFERRAL AND DIRECT ACCESS**

The MCO cannot require referrals from a PCP for certain services. 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.

The MCO may not use either the referral process or prior authorization to manage the utilization of family planning services. The MCO may not restrict the right of enrollees to choose a provider for family planning services and must make such services available without regard to marital status, age, gender identity, sex or parenthood, and such services must be provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning as required in 42 CFR § 457.1230(d) incorporating to 42 CFR § 438.210(A)(3)(ii)(C). 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. Enrollees are free to choose the method of family planning.

The MCO must provide enrollees with direct access to OB/GYN services, including access for routine and preventative health care services. The MCO cannot charge a co-pay when services are received at a network provider.

The 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 or non-participating 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.

## **21.7. CHIP PROVIDER AGREEMENTS**

MCOs must develop and implement written agreements regarding the interaction and coordination of all physical, behavioral, dental and vision services provided to enrollees in the CHIP Program. Complete agreements, including operational procedures, must be available for review by the Department upon request. The MCOs have written Provider Agreements with a sufficient number of Providers to provide Enrollees with adequate access to all services covered by the CHIP Program.

Written agreements contain, at a minimum:

1. A requirement that all providers and other practitioners who order, refer or prescribe items or render services to CHIP enrollees must enroll with the Department as a CHIP provider;
2. Provisions for ongoing communications including the exchange of relevant enrollment and individual health related information; service needs among the 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;
3. 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;
4. A requirement that the MCO must not exclude or terminate a provider from participation in the 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;
5. A requirement that the MCO must not exclude a provider from the 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;
6. Notification of the prohibition and sanctions for submission of false claims and statements;

7. The definition of medically necessary from this handbook;
8. 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:
  - a. Information regarding the nature of treatment options; risks of treatment;
  - b. Alternative treatments; or
  - c. The availability of alternative therapies, consultation or tests that may be self-administered;
9. 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;
10. A requirement that the MCO cannot terminate a contract or employment with a provider for filing a grievance on an enrollee's behalf;
11. A clause which specifies that the agreement will not be construed as requiring the 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;
12. A requirement securing cooperation with the QM and UM program standards (See Appendix 21-A);
13. 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 MCO either directly or indirectly through capitation;
14. A continuation of benefits provision which states that the provider agrees that in the event of the MCO's insolvency or other cessation of operations, the provider must continue to provide benefits to the MCO's Enrollees, including Enrollees in an

inpatient setting, through the period for which the Capitation has been paid;

- 15.**A requirement that the PCPs who serve Enrollees under nineteen (19) years of age are responsible for conducting all Bright Futures screens for individuals on their panel under nineteen (19) years of age. 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 ensure that all relevant medical information, including the results of the screens, are incorporated into the enrollee's PCP medical record. For details on access requirements, (See Section 21.9: Provider Network Composition/Service Access of the CHIP Procedures Handbook);
- 16.**A requirement that PCPs who serve enrollees under nineteen (19) years of age report encounter data associated with Bright Futures screens, using a format approved by the Department, to the MCO within ninety (90) days from the date of service;
- 17.**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 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 with the standards
- 18.**A requirement that ensures each physician providing services to enrollees eligible for CHIP under the CHIP State Plan have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act
- 19.**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;
- 20.**A requirement that health care facilities and ambulatory surgical facilities develop and implement, in accordance with 40 P.S. §§ 1303.401 – 1303.411 an internal infection control plan that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures

for the detection, control and prevention of Health Care-Associated Infections;

**21.** A provision that the 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 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. The 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 MCO must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care;

**22.** Requirements regarding coordination with Behavioral Health Providers (if applicable) include:

- a. Complying with all applicable laws and regulations pertaining to the confidentiality of enrollees' medical records, including obtaining any required written enrollee consent to disclose confidential medical records;
- b. Making referrals for social, vocational, education or human services when a need for such service is identified through assessment;
- c. Providing health records if requested by the behavioral health (BH) Provider;
- d. Notifying the BH Provider of all prescriptions, and when deemed advisable, checking with the BH Provider before prescribing medication. Making certain BH clinicians have complete, up-to-date record of medications.
- e. Being available to the BH Provider on a timely basis for consultations;

**23.** 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;

- 24.** A requirement that each provider furnishing services to enrollees maintains and shares, as appropriate, the enrollee health record in accordance with professional standards;
- 25.** 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 provider;
- 26.** Provisions for jointly identifying the services to be delivered and monitored by the MCO to determine the quality of the service delivered;
- 27.** Provisions for the MCO and the Provider to work cooperatively to establish programmatic responsibility for each enrollee;
- 28.** Provisions for serving on interagency teams, when requested;
- 29.** Provisions for assisting, when appropriate, in the coordination of services with the BH provider, including pharmacy coordination, to the extent permitted by law;
- 30.** 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);
- 31.** Provisions for a timely resolution of any disputes;
- 32.** Provisions for training and consultations between the MCO and the MCO's providers to facilitate continuity of care and the cost-effective use of resources;
- 33.** Provisions for assisting, when appropriate, in the development of an adequate provider network to serve enrollees with chronic and complex medical conditions;
- 34.** Provisions for obtaining the appropriate releases necessary to share clinical information and health records as requested, consistent with state and federal laws;
- 35.** Provisions for the development and implementation of corrective action plans in the event the provisions of the agreement are not being met;

36. 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);
  37. Provisions for the maintenance and confidentiality of medical records and other information considered confidential, including provisions for resolving confidentiality problems;
  38. Provisions for the collection of information on the service(s) delivered to be shared with the Department, upon request;
  39. Provisions for collaboration on identifying and reducing the frequency of Fraud, Waste, and Abuse, overuse, under use, inappropriate or unnecessary medical care; and
  40. Provisions for the reporting of health-related information to the appropriate regulatory agency, if necessary.
- 21.7.1. The MCO may not enter into a provider agreement that prohibits the provider from contracting with another MCO or that prohibits or penalizes the MCO for contracting with other providers.
  - 21.7.2. The 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 the current MCO contract with the Department, 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 MCO within the time frames specified in this handbook.

## **21.8. MCO REQUIREMENTS FOR PROVIDER TERMINATIONS**

- 21.8.1. The MCO must comply with the requirements outlined below when the MCO terminates a provider. The requirements have been delineated to identify the requirements for terminations that are initiated by the MCO and terminations that are initiated by the provider. Also provided 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 enrollees to access services.
- 21.8.2. **TERMINATION BY THE MCO**

**21.8.2.1.** The 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, or a large provider group, or combination of these) sixty (60) days prior to the effective date of the termination.

**21.8.2.2.** The MCO must submit a Provider termination work plan and supporting documentation within ten (10) business days of the MCO notifying the Department of the termination and must provide weekly updates to this information. The requirements for the workplan and supporting documentation are under this section, Workplans and Supporting Documentation.

**21.8.2.3. CONTINUITY OF CARE**

**21.8.2.3.1.** 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 C.F.R. § 1216 incorporating 42 C.F.R. § 438.62(b).

**21.8.2.3.2.** Unless the Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), the 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 MCO of the termination or pending termination of the provider, or for up to sixty (60) days from the date of provider termination, whichever is greater. 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. Any child (under 19 years of age) with a previously scheduled appointment, including an appointment for well child care, is determined to be in receipt of an ongoing course of treatment from the provider. Per PADOH regulation 28 Pa. Code § 9.684(d), the transitional period may be extended by the MCO if the extension is determined to be clinically appropriate. The MCO shall consult with the enrollee and the provider in making the determination. The 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.

**21.8.2.3.3.** The 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 two (2) business days. If the MCO determines what the enrollee is requesting is not an ongoing course of treatment, the MCO must issue the enrollee a denial notice

- 21.8.2.3.4.** The 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.

#### **21.8.2.4. NOTIFICATION TO ENROLLEES**

- 21.8.2.4.1.** If the provider that is being terminated from the network, within fifteen calendar days of receipt or issuance of notice of termination, the MCO must make a good faith effort to provide written notice of the termination to and must notify all enrollees who receive primary care services from the provider or who were seen on a regular basis by the provider. 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 enrollees are notified of the termination or pending termination of the provider, or for up to sixty (60) days from the date of provider termination, whichever is greater.

- 21.8.2.4.2.** If the provider that is being terminated from the network is not a PCP or a hospital, the MCO 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. 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 enrollees are notified of the termination or pending termination of the provider, or for up to sixty (60) days from the date of provider termination, whichever is greater.

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

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

**21.8.2.4.5.** The Department, in coordination with PADOH, may require the MCO to include additional information in the notice of termination to Enrollees.

**21.8.2.4.6.** The thirty (30) day advance written notice requirement does not apply to terminations by the MCO for cause in accordance with 40 P.S. § 991.2117(b). The MCO must notify enrollees within five (5) business days of the MCO's termination action.

### **21.8.3. TERMINATION BY THE PROVIDER**

#### **21.8.3.1. NOTIFICATION TO DEPARTMENT**

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

**21.8.3.1.2.** The MCO must submit a Provider termination work plan within ten (10) Business Days of the 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 chapter.

**21.8.3.1.3.** The MCO must comply with both this section and the PADOH requirements found at 28 Pa. Code § 9.684.

#### **21.8.3.2. NOTIFICATION TO ENROLLEES**

**21.8.3.2.1.** If the provider that is terminating its participation in the network is a PCP, the MCO must notify all enrollees who receive primary care services from the provider or were seen regularly by the terminating provider.

**21.8.3.2.2.** If the provider that is terminating its participation in the network is not a PCP or a hospital, the MCO 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. The MCO must use referral and claims data to identify these enrollees.

**21.8.3.2.3.** If the provider that is terminating its participation in the network is a hospital or specialty unit within a facility, the MCO must notify all enrollees assigned to a PCP with admitting privileges at the hospital or specialty unit, all enrollees assigned to a PCP that is owned by the hospital or specialty unit, and all enrollees who have utilized the terminating hospital or specialty unit's services within the past twelve (12) months. Notification must be mailed at least thirty (30) days prior to the effective date of the hospital or specialty unit's termination. The MCO must use referral and claims data to identify these enrollees.

**21.8.3.2.4.** 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 MCO to provide thirty (30) days advance written notice to a specific enrollee population or to all enrollees, based on the impact of the termination.

**21.8.3.2.5.** The Department, in coordination with PADOH, may require additional information be included in the notice of a termination to enrollees.

**21.8.3.2.6.** The MCO must update hard copy and web-based provider directories to reflect changes in the provider network.

#### **21.8.4. WORKPLANS AND SUPPORTING DOCUMENTATION**

##### **21.8.4.1. WORKPLAN SUBMISSION**

The MCO must submit a provider termination work plan within ten (10) Business Days of the MCO notifying the Department of the termination and must provide 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 is organized by Task, Responsible Person(s), Target Dates, Completed Date, and Status. The workplan defines the steps within each of the Tasks. The tasks may include, but not be limited to:

1. Commonwealth Notifications (the Department and PADOH);
2. Provider Impact and Analysis;
3. Provider Notification of the Termination;
4. enrollee Impact and Analysis;
5. enrollee Notification of the Termination;
6. enrollee Transition;
7. enrollee Continuity of Care;

8. Systems Changes;
9. Provider Directory Updates for Enrollment MCO (include date when all updates will appear on Provider files sent);
10. MCO Online Directory Updates;
11. enrollee Service and Provider Service Script Updates;
12. Submission of Required Documents to the Department (enrollee notices and scripts for prior approval);
13. Submission of Final enrollee Notices to the Department (also include date that PADOH received the final notices);
14. Communication with the Public related to the termination; and
15. Termination Retraction Plan, if necessary.

#### **21.8.4.2. Supporting Documentation**

- 21.8.4.2.1. The MCO submits the following supporting documentation, in addition to the workplan, within ten (10) Business Days of the 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 but prefers electronic submission.

#### **21.8.4.3. Background Information**

- 21.8.4.3.1. The MCO submits a summary of issues and reasons for termination; and information on negotiations or outreach that has occurred between the MCO and the Provider including dates, parties present and outcomes.

#### **21.8.5. Enrollees Access to Provider Services**

- 21.8.5.1. The MCO submits information that identifies providers remaining in the network by provider type and location that would be available within the appropriate travel times for those enrollees once the termination is effective. The MCO provides the travel times for the remaining providers based upon the travel standards outlined in the PCP paragraph found in this section. For PCPs, the MCO also lists current panel sizes and the number of additional enrollees that are able to be assigned to those PCPs.
- 21.8.5.2. The MCO must 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.

**21.8.5.3.** The MCO must submit a comprehensive list of all providers, broken out by provider type, who are affected by the termination and also indicate the current number of enrollees either assigned to PCPs or utilizing these providers.

**21.8.5.4.** The MCO must submit information that includes the admitting privileges at other hospitals or facilities for each affected Provider and whether each affected provider can serve the MCO 's enrollees at another hospital or facility.

**21.8.5.5.** The MCO must submit a copy of the final provider notices to the Department.

#### **21.8.6. Enrollee Identification and Notification Process**

**21.8.6.1.** The MCO submits 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.

**21.8.6.2.** The MCO submits information on the number of enrollees with prior authorizations in place that will extend beyond the provider termination date.

**21.8.6.3.** The MCO submits draft and final enrollee notices as appropriate, for Department review and prior approval.

### **21.9. PROVIDER NETWORK COMPOSITION/SERVICE ACCESS**

#### **21.9.1. NETWORK COMPOSITION**

**21.9.1.1.** The MCO must require all Network Providers and ordering, referring and prescribing providers to be screened and enrolled in the Department's Management Information System ("MMIS") as a CHIP provider. The MCO must require all Network Providers to be enrolled with the Department and possess an active MMIS Provider ID for each location in which they provide services for the MCO.

**21.9.1.2.** The MCO must consider, at a minimum, the following in establishing and maintaining its provider network:

1. The anticipated CHIP enrollment;
2. The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHIP populations represented in the MCO;

3. The number and types, in terms of training, experience, and specialization, of providers required to furnish the contracted services;
4. The number of network providers who have closed panels;
5. 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;
6. Ability of providers to communicate with enrollees with Limited English Proficiency (LEP) in their preferred language;
7. Ability of providers to ensure physical access, reasonable accommodations, culturally competent communication, and accessible equipment to enrollees with physical or mental disabilities; and
8. Availability of triage lines or screening systems, telemedicine and e-visits, or other evolving and innovative technological solutions, or both.

**21.9.1.3.** The MCO must develop and maintain a provider network that is adequate to provide the enrollees in its service area with access to quality care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon a request from the Department, the 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 the enrollees. The Department may require additional numbers of specialists and ancillary providers should it be determined that geographic access is not adequate. The MCO must also have a process in place that requires the MCO to know the capacity of their network PCP panels at all times and has the ability to report on this capacity.

**21.9.1.4.** If the CHIP MCO's provider network is unable to provide covered services to an enrollee, the CHIP MCO must adequately and timely cover services out-of-network for as long as it is unable to provide the services in network and must coordinate with the out-of-network provider with respect to payment, including that the cost to the enrollee is no greater than the cost of services if provided in network.

## **21.10. PROVIDER AGREEMENTS**

The MCO must have written provider agreements with a sufficient number of providers to provide enrollee access to all medically necessary services

covered by the CHIP Program. The requirements for these provider agreements are set forth in this handbook.

The MCO may execute provider agreements pending the outcome of Department's screening, enrollment, and revalidation of providers for up to one hundred-twenty (120) days but must immediately terminate an agreement upon notification from the Department that the provider cannot be enrolled or the expiration of the one hundred-twenty (120) day period. The MCO must notify affected enrollees of the termination.

Both the 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.

MCOs must submit documentation relating to its services and network providers in a format specified by the Department to demonstrate compliance with network adequacy standards. This documentation must be submitted when the MCO enters into a contract with the Commonwealth and subsequently, this documentation must be provided at least annually. The MCO must submit documentation at any time there has been a significant change that would affect adequacy and capacity of services.

The MCO must make all reasonable efforts to honor an enrollee's choice of providers who are credentialed in the network. An enrollee is permitted to choose any providers in the MCO's provider network. Additionally, the MCO must have and demonstrate that the following provider network and access requirements are established and maintained for the entire CHIP service area in which the MCO operates if providers exist.

An MCO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license of certification under applicable state law solely on the basis of that license or certification. If an MCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for the decision. This does not require the MCO to contract with

more providers than necessary to meet the needs of its enrollees or preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or from establishing measures that are designed to maintain the quality of services and control costs which are consistent with the needs of its enrollees (see 42 CFR § 457.1208 incorporating 42 CFR § 438.12).

#### **21.10.1. PCPs**

The MCO makes 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.

#### **21.10.2. PEDIATRICIANS AS PCPS**

The MCO ensures 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) for their child within the travel time limits (30 minutes in urban areas, 60 minutes in rural areas).

#### **21.10.3. PRIMARY CARE PRACTITIONER RESPONSIBILITIES**

The 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 MCO Network PCP is responsible for:

1. Providing primary and preventive care and acting as the enrollee's advocate, providing, recommending, and arranging for care;
2. Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the Department's data specifications;
3. Maintaining continuity of each enrollee's health care, participating in or coordinating with an overall chronic care management team, where appropriate;
4. Communicating effectively with the enrollee by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for an enrollee with LEP when needed by the enrollee.

Services must be free of charge to the enrollee;

5. Making referrals for specialty care and other medically necessary services, both in and out-of-plan;
6. 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;
7. Arranging for behavioral health services in accordance with Section 19.8 of this Handbook, Behavioral Health Services;
8. Providing office hours accessible to an enrollee for a minimum of twenty (20) hours per week and directly or through on-call arrangements with other qualified, plan-participating PCPs twenty-four (24) hours per day, seven (7) days a week for urgent and emergency care; and
9. Complying with all conditions and standards applicable to managed care plans set forth in 40 P.S. §§ 991.2101 – 991.2194 unless otherwise specified. The MCO retains responsibility for monitoring PCP actions to ensure they comply with the provisions of this handbook.

#### **21.10.4. SPECIALISTS AS PCPS**

An enrollee with a life-threatening, degenerative, or disabling disease or condition shall have access to a specialist as a PCP or medical home, consistent with the procedure developed by the MCO pursuant to 40 P.S. § 991.211(6). An enrollee shall have the right to request and receive an evaluation, and if the plan's standards are met, the enrollee shall receive either a standing referral to a specialist with clinical expertise in treating the disease or the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

An MCO is not required to maintain specific enrollee-to-specialist provider ratios. However, each MCO must agree to provide adequate access to physician specialists for PCP or medical home referrals and to employ or contract with pediatric specialists in sufficient numbers to ensure specialty services can be made available in a timely and geographically accessible manner, as determined by the Department in consultation with the PADOH.

The MCO must adopt and maintain procedures by which an enrollee, including enrollees with special needs, with a life-threatening,

degenerative or disabling disease or condition requiring an ongoing course of treatment, care and monitoring shall upon request, receive an evaluation by appropriate health care professionals and, if the MCO's established standards are met, be permitted to receive direct access to an appropriate specialist through:

1. A standing referral to a specialist with clinical expertise in treating the disease or condition; or
2. 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 MCO, in consultation with the PCP, the enrollee and, as appropriate, the specialist. When possible, the specialist must be a provider participating in the MCO's network. If the specialist is not a network provider, the MCO may require the specialist to meet the requirements of the MCO's network providers, including the MCO's credentialing criteria and QM and 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:

1. A standing referral to a specialist with clinical expertise in treating the disease or condition; or
2. The designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

The 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 the Insurance Company Law of 1921 as amended (P.L. 464, No, 68). The MCO must establish and maintain its own credentialing and recredentialing policies and procedures to ensure compliance with these specifications.

The MCO must require that providers credentialed as specialists and as PCPs agree to meet all of the MCO's standards for credentialing PCPs and specialists, including compliance with record keeping standards, the Department's access and availability standards and other QM and UM program standards. The specialist as a PCP must agree to provide or arrange for all primary care, consistent with MCO preventive care guidelines, including routine preventive care, and to provide those specialty medical services consistent with the enrollee's needs in accordance with the 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 MCO's network.

For the following provider types, the MCO must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

1. General Surgery;
2. Obstetrics & Gynecology;
3. Oncology;
4. Physical Therapy;
5. General Dentistry;
6. Cardiology;
7. Pharmacy; and
8. Orthopedic Surgery

For the following provider types, the MCO 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 CHIP Zone:

1. Oral Surgery;
2. Nursing Facility;
3. Dermatology;
4. Urology;
5. Neurology; and
6. Otolaryngology

For all other specialists and subspecialists, the MCO must have a choice of two (2) providers who are accepting new patients within the CHIP Zone.

#### **21.10.5. HOSPITALS**

The MCO shall ensure there is at least one (1) hospital within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice within the CHIP service area.

An MCO that is a related entity to a hospital or system must ensure that the related party is willing to negotiate in good faith with other MCOs regarding the provision of services to enrollees. The Department will terminate an agreement with the MCO if it determines that a hospital related to the MCO has refused to negotiate in good faith with other MCOs.

#### **21.10.6. ANESTHESIA FOR DENTAL CARE**

For enrollees needing anesthesia for dental care, the 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.

#### **21.10.7. CERTIFIED NURSE MIDWIVES AND CERTIFIED REGISTERED NURSE PRACTITIONERS**

The MCO must ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs). The MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs, CRNPs and other providers and maintain payment policies that reimburse CNMs, CRNPs and other 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.

#### **21.10.8. REHABILITATION FACILITIES**

The MCO must ensure a choice of at least two (2) rehabilitation facilities within the provider network.

#### **21.10.9. BEHAVIORAL HEALTH PROVIDERS**

The MCO ensures a choice of at least two (2) behavioral health providers within the provider network who are accepting new patients within the travel times of thirty (30) minutes in urban areas, and sixty (60) minutes in rural areas. The MCO must demonstrate its efforts to contract in good faith with a sufficient number of psychiatrists, psychologists, licensed clinical social workers, and other behavioral providers to serve the needs of enrollees.

#### **21.11. QUALIFIED PROVIDERS**

The MCO must limit its PCP Network to appropriately qualified providers. MCOs must verify that enrolled providers have and maintain the necessary licensure and certifications required by the state to practice in their field. The MCO's PCP network must meet the following requirements:

Seventy-five to one hundred percent (75-100%) of the network must consist 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 may consist 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.

The MCO must have written policies and procedures for selection and retention of Network Providers, including, at a minimum, a written policy and documented process for credentialing and re-credentialing Network Providers that complies with the Department's credentialing and re-credentialing policies. These policies and procedures also must comply with the non-discrimination provisions of 42 C.F.R. § 438.12, including non-discrimination of providers that serve high-risk populations or specialize in conditions that require costly treatment.

The MCO may not employ or contract with providers that have been excluded from participation in federal health care programs.

#### **21.12. Enrollees Freedom of Choice**

The MCO must demonstrate the ability to offer enrollees freedom of choice in selecting a PCP. At a minimum, the MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) patients. 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 one 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 one FTE regardless of the number of hours worked. If the PCP and the PCP Site employs Certified Registered Nurse Practitioners (CRNPs) and Physician Assistants (PAs), then the Provider/ and Provider Site will be permitted to add an additional one thousand (1,000) enrollees to the panel. The number of enrollees assigned to a PCP may be decreased by the MCO, if necessary, to maintain the appointment availability standards.

The MCO must make reasonable efforts to honor an enrollee's choice of providers among network providers as long as:

1. The MCO's agreement with the network provider covers the services required by the enrollees; and
2. The MCO has not determined that the enrollee's choice is clinically inappropriate.

#### **21.13. MAINSTREAMING**

The MCO must prohibit network providers from intentionally segregating their

enrollees in any way from other persons receiving services.

The 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, sexual orientation, language, 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:

1. Denying or not providing an enrollee any CHIP covered service or availability of a facility within the MCO's network. The 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 or her own behalf;
2. Subjecting Enrollees 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. MCOs cannot discriminate against CHIP enrollees by offering them access to physician services which differ from the access offered commercial enrollees. For example, a plan may not specifically close a practice to CHIP enrollees if the practice is open to commercial enrollees; and
3. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, language, MA status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the enrollees to be served.

If the 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 MCO shall be in breach of this Agreement.

## **21.14. NETWORK CHANGES AND PROVIDER TERMINATIONS**

### **21.14.1. NETWORK CHANGES**

#### **21.14.1.1. NOTIFICATION TO THE DEPARTMENT**

Other than terminations outlined in Section 21.8 (MCO Requirements for Provider Terminations), the 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 monthly additions/deletions provider network reporting. The MCO must notify the Department of any changes to its provider network that materially affect the MCO's ability to make available all services in a timely manner. Each MCO also must have procedures to address changes in its network that negatively affect the ability of enrollees to access services.

PADOH regulations require that an MCO report any probable loss from the network of any general acute care hospital and any primary care provider, whether an individual practice or a group practice, with 2,000 or more assigned enrollees. At such time as an MCO submits such a report to PADOH, a copy of the report shall be sent to the Department.

#### **21.14.2. PROCEDURES AND WORK PLANS**

The MCO must have procedures to address changes in its Network that impact an enrollee's access to services, in accordance with the requirements of this Handbook, as applicable. Failure of the MCO to address changes in Network composition that negatively affect an enrollee's access to services may be grounds for termination of the Agreement.

#### **21.14.3. TIMEFRAMES FOR NOTIFICATION TO AN ENROLLEE**

The MCO must notify an enrollee thirty (30) days prior to the termination of the assigned PCP. The MCO must update web-based Provider directories to reflect any changes in the provider network as specified in this handbook.

#### **21.14.4. PROVIDER TERMINATIONS**

The MCO must comply with the Department's requirements for provider terminations as outlined in this Handbook

#### **21.15. FQHCs / RHCs**

The MCO must include in its Provider Network every FQHC and RHC that is willing to accept Prospective Payment System (PPS) rates as payment in full and is located within the operational CHIP service area in which the MCO operates. The MCO must have an internal claims system in place to ensure the Medicaid rate is being paid to all FQHCs/RHCs. If the MCO's primary care Network includes FQHCs and RHCs, these sites may be designated as PCP sites.

#### **21.16. MEDICALLY NECESSARY EMERGENCY SERVICES**

The MCO must comply with the provisions of 40 P.S. §§ 3401-3402, 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 and as outlined in 42 CFR § 438.114.

#### **21.17. ADA Accessibility Guidelines**

The MCO must inspect the office of any PCP or dentist who seeks to participate in the 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.

If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the MCO's Provider Network provided that the PCP or dentist: 1) requests and is determined by the 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 MCO identified the barrier.

The MCO must document its efforts to determine architectural accessibility. The MCO must submit this documentation to the Department upon request.

#### **21.18. LABORATORY TESTING SITES**

The 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.

#### **21.19. SECOND OPINIONS**

The MCO must provide for a second opinion from a qualified Network Provider, at no cost to the enrollee. If a qualified Network Provider is

not available, the MCO must arrange for a second opinion from a qualified Out-of-Network Provider, at no cost to the enrollee, unless co-payments apply.

## **21.20. APPOINTMENT STANDARDS**

The MCO must have written policies and procedures for disseminating appointment standards to all enrollees through its enrollee handbook and through other means. In addition, the MCO must have written policies and procedures to educate the Provider Network about appointment standards. The MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

The MCO 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.

### **21.20.1. PCP scheduling procedures must ensure that:**

1. Emergency Medical Condition cases must be immediately seen or referred to an emergency facility;
2. Urgent Medical Condition cases must be scheduled within twenty-four (24) hours;
3. Routine appointments must be scheduled within ten (10) Business Days;
4. A physical and behavioral health assessment, general physical examination and first examination must be scheduled within three (3) weeks of enrollment;
5. The average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than one (1) hour when the physician encounters an unanticipated Urgent Medical Condition or is treating an enrollee with a difficult medical need. The enrollee must be informed of scheduling time frames through educational outreach efforts; and
6. There is monitoring of the adequacy of the appointment processes and reduction in the use of unnecessary emergency room visits.

## **21.21. PERSONS WITH HIV/AIDS**

The MCO must have adequate PCP scheduling procedures in place to ensure that an appointment with a PCP or specialist is scheduled within seven (7) days from the effective date of Enrollment for any person known to the 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.

## **21.22. SPECIALTY REFERRALS**

For specialty referrals, the MCO must be able to provide for:

1. Emergency Medical Condition appointments immediately upon referral;
2. Urgent Medical Condition care appointments within twenty-four (24) hours of referral; and
3. Scheduling of appointments for routine care within fifteen (15) business days for the following specialty provider types:
  - a. Otolaryngology;
  - b. Orthopedic Surgery;
  - c. Dermatology;
  - d. Pediatric Dentist;
  - e. Allergy & Immunology;
  - f. Pediatric Endocrinology;
  - g. Pediatric Gastroenterology;
  - h. Pediatric General Surgery;
  - i. Pediatric Hematology;
  - j. Pediatric Infectious Disease;
  - k. Pediatric Nephrology;
  - l. Pediatric Neurology;
  - m. Pediatric Oncology;
  - n. Pediatric Pulmonology;
  - o. Pediatric Rehab Medicine;
  - p. Pediatric Rheumatology; and
  - q. Pediatric Urology

The MCO schedules appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.

## **21.23. PREGNANT WOMEN**

Should the enrollee notify the MCO that a new enrollee is pregnant or there is a pregnancy indication on the information provided to the MCO by the Department, the 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 MCO must arrange initial prenatal care appointments for enrolled pregnant Enrollees as follows:

1. First trimester- within ten (10) business days of the enrollee being identified as being pregnant;
2. Second trimester- within five (5) business days of the enrollee being identified

as being pregnant; and

3. Third trimester- within four (4) business days of the enrollee being identified as being pregnant.

High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the MCO or maternity care provider, or immediately if an emergency exists.

#### **21.24. MCO'S CORRECTIVE ACTION**

The 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 Department gives the MCO an opportunity to institute a corrective action plan. The 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 MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the Department notifies the MCO of the deficiencies of the corrective action plan. In such event, the 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 MCO. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in the Agreement.

#### **21.25. DEPARTMENT QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS**

- 21.25.1. The Department monitors the QM and UM programs of all MCOs. The MCO's QM and UM programs must be designed to promote and improve the accessibility, availability, and quality of care being provided to enrollees. The MCO's QM and UM programs must, at a minimum:

1. Contain a written program description, work plan, evaluation and policies/procedures that meet requirements outlined in this handbook;
2. Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the MCO in collaboration with the Department;
3. 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, case and disease management initiatives;

4. Allow for the continuous evaluation of activities and adjustments to the program based on these evaluations;
5. Demonstrate sustained improvement for clinical performance over time; and
6. Allow for the timely, complete and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including CAHPS and Healthcare Effectiveness Data and Information Set (HEDIS®).

**21.25.2.** The Department includes processes for the investigation and resolution of individual performance or quality of care issues whether identified by the MCO or the Department that:

1. Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care; and
2. Allow for submission of improvement plans, as determined by and within time frames established by the Department. Failure by the MCO to comply with the requirements and improvement actions requested by the Department may result in the application of penalties and/or sanctions.

**21.25.3.** The MCO obtains accreditation by a nationally recognized organization, such as the National Committee of Quality Assurance (NCQA).

**21.25.4.** The MCO incorporated the QM and UM program standards as listed under Appendix 21-J into its provider agreements.

## **21.18. SPECIAL NEEDS/CASE MANAGEMENT UNITS**

### **21.18.1. ESTABLISHMENT OF SPECIAL NEEDS/CASE MANAGEMENT UNITS**

The MCO develops, trains, and maintains a unit within its organizational structure whose primary responsibility will be to deal, in a timely manner, with issues relating to an enrollee with more complex or chronic health conditions. This unit is headed by a Special Needs/Case Management Coordinator who must have access to and periodically consult with the Medical Director. The MCO staffs the Special Needs/Case Management Unit with individuals who have either a medical and/or social services background, in sufficient number to initiate a response to an enrollee's inquiry within two (2) Business Days or sooner in urgent situations. The core staff members of the Special Needs/Case Management Unit is responsible primarily for the functions and operations associated with the unit. At times, the Special Needs/Case Management Unit staff have access to the resources of other departments within the MCO to supplement the Unit in assisting an enrollee. The

MCO must show evidence of their access to and use of individuals with expertise in the treatment of an enrollee with chronic and complex health needs to provide consultation to the Special Needs/Case Management Unit staff, as needed.

The primary purpose of the Special Needs/Case Management Unit is to ensure that each enrollee receives access to appropriate primary care, access to specialists trained and skilled in the needs of the enrollee, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the enrollee's condition or circumstance, including pharmaceuticals and durable medical equipment, and access to needed community services. The Special Needs/Care Management Unit must have a direct link to the Utilization Management functions of the MCO and have input into the case review process. The MCO must have procedures in place that ensure the proactive identification of and outreach to an enrollee with Special Needs who may not self-identify as having a chronic or complex health need.

Services are available to all CHIP enrollees. An enrollee must have an active policy with the MCO to qualify for services. There are no requirements for a case management referral. An enrollee is required to participate in the case management program and may opt out. The MCO cannot limit the enrollee's enrollee access to case management.

#### **21.18.2. IDENTIFICATION OF ENROLLEES**

Identification of enrollees in need of case management services is based on:

1. Health assessment questionnaires to identify general physical and behavioral health status and concerns;
2. Family concerns;
3. Overall knowledge of their diagnosis and ability to manage their health condition;
4. Concurrent review activities;
5. Post payment review of high dollar claims;
6. Review of claims for emergency room visits and inpatient stays;
7. Review of pharmacy data;
8. Need for extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve the level of functioning for the individual;
9. Need for primary care to be managed by a specialist, due to the nature of the condition;
10. Potential for higher morbidity without intervention and coordination in the care of the individual;
11. Care and/or services that necessitate coordination and communication among network providers or Out-of-Network Providers;

12. Need for language, communication, or mobility accommodations;
13. Need for an enrollee to be accompanied or assisted while seeking or receiving care by an individual who may act on the enrollee's behalf;
14. Need for assistance in discharge planning from an inpatient or long-term care setting to ensure the enrollee will receive services in the least restrictive environment possible; and
15. Any condition, event, or life circumstance that as a result inhibits an enrollee's access to any necessary service or support needed to address their medical condition or maintain their current level of functioning

### **21.18.3. FUNCTIONS OF THE SPECIAL NEEDS/CASE MANAGEMENT UNIT**

The staff of the MCO Special Needs/Case Management Unit ensures the receipt of care and/or services by acting as the MCO case manager for each enrollee with an identified need. The case manager is responsible for coordinating the delivery of all services for which the enrollee is eligible under the MCO benefit package. In the event that an enrollee is not satisfied with an MCO's performance in any area, the case manager is responsible for facilitating dispute resolution and for informing the enrollee of the complaint, grievance, and external review mechanisms that are available and assisting in that process as needed or requested. An enrollee determined to have ongoing needs for assistance is assigned to a case manager and has ready access to the enrollee's case manager if the enrollee is enrolled in the MCO. An enrollee is permitted to change case managers as needed during enrollment.

Special Needs/Case Management Unit Functions include:

1. Provide education to Enrollees and their families to better understand and take care of their condition;
2. Assist in finding community resources, and assistance locating specialist services for Enrollees;
3. Assist with questions regarding medications, making appointments;
4. Develop a plan of care based on the level of intervention and support needed to address the identified issues;
5. Coordinate care between providers, such as physical health and behavioral health providers;
6. Assist families with disabled children to find the support resources they need;

7. Assist the family with the application to transfer from CHIP to MA and remain involved in the child's care during the transfer process; and
8. Provide services telephonically, face-to-face in the doctor's office, at home or the hospital.

#### **21.18.4. MCO RESPONSIBILITIES**

The MCO must:

1. Conduct necessary training for all MCO staff to acquaint them with the purpose and function of the Special Needs Unit and the need to coordinate within departments to serve Enrollees with Special Needs;
2. Provide sufficient telephone and alternative communication channels to allow ready and timely interactions between the MCO Special Needs/Case Management Unit Coordinator and case managers and the Office of CHIP, Enrollees, and Providers (Network and Out-of-Network);
3. Provide services to effectively assist Enrollees with Special Needs who speak languages other than English in accordance with the RFP and Agreement requirements. In addition, efforts must be made to match Enrollees with communication barriers due to disability or linguistic background with Providers with whom they can effectively communicate;
4. Ensure cooperation of the MCO's Provider Network. Special Needs Unit case managers must facilitate communication and coordinate service delivery between primary care, specialty, ancillary, and behavioral health Providers to ensure an enrollee's timely and uninterrupted access to care;
5. Assist in the development of adequate Provider Networks, such as pediatric specialists, to serve an enrollee. A case manager assists and supports an enrollee in making an informed choice between providers of equivalent services within the network. When adequate network capacity does not exist to allow for choice between network providers of equivalent services, case managers must facilitate, and coordinate services rendered by Out-of-Network providers.
6. Conduct necessary training for all MCO providers to acquaint them with the purpose and function of the Special Needs/Case Management Unit and identify a contact as a direct contact for any provider to refer an enrollee with special needs for assistance.
7. Conduct face-to-face case management activities with an enrollee for whom telephonic case management has proven ineffective, and desired goals have not been attained.

## **21.19. PRIOR AUTHORIZATION GUIDELINES**

### **21.19.1. GENERAL REQUIREMENT**

The MCO must submit to the Department written policies and procedures for the prior authorization of services. The MCO notifies the Department of services it will prior authorize and the basis for determining if the service is Medically Necessary. The policies and procedures must:

1. Be submitted in writing, for all new and revised criteria, prior to implementation;
2. Be approved by the Department in writing prior to implementation; to specifications of the Contract, as amended, federal regulations, and applicable policy;
3. Require that physical health care is Medically Necessary and provided in an appropriate, effective, timely, and cost-efficient manner;
4. Include an expedited review process to address those situations when an item or service must be provided on an urgent basis; and
5. Be consistently applied and provide for consultation with the requesting provider, as appropriate.

Future changes in state and federal law, state and federal regulations, and court cases may require re-evaluation of any previously approved Prior Authorization proposal. Any deviation from the policies and procedures approved by the Department, including time frames for decisions, is considered to be a change and requires a new request for approval.

### **21.19.2. GUIDELINES FOR REVIEW**

#### **21.19.2.1. Basic Requirements:**

1. The MCO must identify individual service(s), medical item(s), and/or therapeutic categories of drugs to be Prior Authorized.
2. If the Prior Authorization is limited to specific populations, the MCO must identify all populations who will be affected by the proposal for Prior Authorization.

### **21.19.2.2. Medically Necessary Requirements:**

The MCO must describe the process to validate medical necessity for:

1. Covered care and services;
2. Procedures and level of care; and
3. Medical or therapeutic items.

The 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 the Utilization Review Criteria Assessment Process (URCAP) prior to implementation.

For MCOs, if the criteria being used are:

1. Purchased and licensed, the MCO must identify the vendor;
2. Developed, recommended, or endorsed by a national or state provider association or society, the MCO must identify the association or society;
3. Based on national best practice guidelines, the MCO must identify the source of those guidelines; or
4. Based on the medical training, qualifications, and experience of the MCO's Medical Director or other qualified and trained practitioners, the MCO must identify the individuals who will determine if the service or benefit is Medically Necessary.

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

The MCO must identify the qualifications of staff that will determine if a service or item is Medically Necessary. Providers, with the appropriate expertise in addressing an enrollee's medical and behavioral health and trained in accordance with the CMS Guidelines, , the CHIP Contract, and applicable legal requirements must make the determination of Medically Necessary services and items. The

MCO may not structure compensation or payments to Providers performing Prior Authorization services to provide incentives to deny, limit or discontinue Medically Necessary services.

The MCO cannot deny a request for service 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:

1. That the prescriber did not make a good faith effort to submit a complete request; or
2. That the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

### **21.19.2.3. Administrative Timeframes:**

The MCO's written policies and procedures must identify the time frames for review and decisions and the MCO must process and notify enrollees and requesting providers of its decision as expeditiously as an enrollee's health requires but no later than the following time frames:

1. Immediate: Inpatient Place of Service Review for emergency and urgent admissions;
  2. 24 hours from receipt of request: All drugs; and items or services which must be provided on an urgent basis;
  3. 48 hours from receipt of request: (following receipt of required documentation): Home Health Services; and
  4. 14 days from receipt of request: All other services. If a requesting provider indicates or if the MCO determines that the fourteen (14) day timeframe may seriously jeopardize the enrollee's life, health or ability to regain maximum function, the MCO will make a determination as expeditiously as the enrollee's health requires but no later than seventy-two (72) hours after receipt of the request. The fourteen (14) day or seventy-two (72) hour timeframe may be extended for an additional fourteen (14) calendar days if the enrollee or provider requests an extension or if the MCO reasonably identifies a need for additional information and the extension is in the enrollee's best interest.
- a. The MCOs demonstrates how the MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas in written policies and procedures.

- b. The MCO's explains how Prior Authorization data will be incorporated into the MCO's overall Quality Management plan in written policies and procedures.

#### **21.19.2.4. NOTICE OF DENIAL PROCEDURES**

The MCO must provide enrollees and requesting providers a written notice of denial for the following:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial of a requested service because it is not a covered service for the enrollee; and
4. The denial of a requested service but approval of an alternative service.

#### **21.19.2.5. NOTIFICATION, GRIEVANCE, AND COMPLAINT REQUIREMENTS.**

1. The MCO must comply and integrate its written policies and procedures for requests for Prior Authorization with the enrollee and Provider notification requirements and enrollee Complaint and Grievance requirements of federal and state law and regulations, the Contract, as amended, and this Handbook.

#### **21.19.2.6. REQUIREMENTS FOR CARE MANAGEMENT/CARE COORDINATION OF NON-PRIOR AUTHORIZED SERVICE(S)/ITEMS(S)**

1. For purposes of tracking care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the MCO may choose to establish a process or protocol requiring notification prior to service delivery. This process must not involve any approvals/denials or delays in receiving the service. The MCO must notify Providers of this notification requirement. This process may not be administratively cumbersome to Providers and Enrollees.

#### **21.19.3. PRIMARY AND PREVENTIVE CARE GUIDELINES**

An MCO must provide primary and preventive care to an enrollee as outlined in the CHIP Eligibility and Benefits Handbook. This includes well-child care in accordance with the schedule established by the American Academy of Pediatrics and the services related to those visits, including, but not limited to: immunizations, health education (to include all types of tobacco use prevention and cessation), tuberculosis testing, and developmental screening in accordance with the routine schedule of well-child visits. Allergy diagnosis and treatment is also covered. Outpatient physical health services relating to ambulatory surgery, outpatient hospitalization, specialist office visits and consults, and follow-up appointments or sick visits are covered.

The primary and preventive services are based on recommendations from organizations such as the American Academy of Pediatrics; the American Academy of Pediatric Dentistry; the American College of Physicians; the U.S. Preventive Services Task Force (USPSTF), all items or services with a rate of A or B in the current recommendations; the American Cancer Society; and the Health Resources and Services Administration (HRSA).

The Department may change the primary and preventive services to be included during the contract period as recommendations of the above referenced bodies are updated. These changes will be communicated to the MCO and must be implemented as specified in the transmittal.

### **21.19.3.1.SCREENING**

The MCO must ensure that Bright Futures periodic screens are conducted for all eligible enrollees to identify health and developmental problems. These screens must be in accordance with the most current periodicity schedule and recommended pediatric immunization schedules based on guidelines issued by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC).

Per guidelines of the 2017 Bright Futures Periodicity schedule and the CMS, CHIP policy requires that MCOs cover a maternal depression screen. Screening may be done in the PCP or pediatrician's office as part of the well-child visit and covered under the child's benefit when screening is for the direct benefit of the child. Validated screening tools such as the Edinburgh Postnatal Depression Scale or Post-Partum Depression Screening Scale are to be used. Other validated tools may be used, however tools specific to maternal depression screening should be used. The Bright Futures Periodicity Schedule recommends screening at one, two, four, and six-month visits. Screening will be covered for infants under one year of age. Coding for maternal depression screening performed as a preventative service as part of the well child visit incurs no copay or cost to

the enrollee. CPT 96161 is to be used when coding for maternal depression screening under the child's CHIP benefit. ICD-10 codes that designate screening is done for the welfare of the child are to be used.

Pediatric preventive care must include blood lead levels testing of all children at ages one and two years old and for all children aged three through six without a confirmed prior lead blood test consistent with current PADOH and MA program requirements.

Care must also include a comprehensive physical examination, including x-rays, if necessary, for any child exhibiting symptoms of possible child abuse. Upon notification by the county children and youth agency system, the MCO must provide an enrollee under evaluation as a possible victim of child abuse or neglect and who presents for a physical examination for a 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.

The MCO must ensure that ED staff and physicians know the procedures for reporting suspected abuse and neglect. This requirement must be included in all applicable Provider Agreements.

Should a PCP determine that a mental health assessment is needed, the PCP must inform the enrollee, or enrollee's parent or legal guardian, on how to access these mental health services and coordinate access to these services, when necessary.

#### **21.19.4.      DIAGNOSES AND TREATMENT**

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. If the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, the provider refers the child for the appropriate service. The MCO develops a system that tracks treatment needs as they are identified and ensures that appropriate follow-up is pursued and reflected in the medical record.

The MCO covers any Medically Necessary health care, eligible under the CHIP program, required to treat conditions detected during a visit.

The MCO must have policies in place to connect an enrollee identified as in need of services with providers appropriate to the enrollee's needs. Such policies must be clearly communicated to providers and enrollees through the Provider Manual and the Enrollees Handbook. If a Provider prescribes services or equipment for an enrollee, which is not normally covered by the CHIP

Program, or for which the MCO requires Prior Authorization, the MCO must follow the Prior Authorization requirements outlined in 21.19 (Prior Authorization Guidelines).

#### **21.19.5. TRACKING**

**21.19.5.1.** The MCO must establish a tracking system that provides information on adherence with the Bright Futures periodicity schedule which includes:

1. Initial visit for newborns. The initial screen shall be the newborn physical exam in the hospital;
2. Bright Futures screening and reporting of all screening results; and
3. Diagnosis and/or treatment, or other referrals for children.

**21.19.5.2.** The other tracking activities include:

1. Number of comprehensive screens (reported by age);
2. Hearing and vision examinations;
3. Dental screens;
4. Age appropriate screens;
5. Complete age appropriate immunizations;
6. Blood lead screens;
7. Prenatal care for teen mothers;
8. Provision of eyeglasses to those in need of them;
9. Dental sealants; newborn home visits;
10. Referral of very low birth weight babies to early intervention;
11. Referral of enrollees with elevated blood lead levels to early intervention;
12. Routine evaluation for iron deficiencies; and
13. Timely identification and treatment of asthma.

#### **21.19.6. FOLLOW-UPS AND OUTREACH**

The MCO must have an established process for reminders, follow-ups, and outreach to enrollees that includes:

1. Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of enrollees;

2. Telephone protocols to remind enrollees of upcoming visits and follow-up on missed appointments within a set time period; and
3. Protocols for conducting outreach with non-compliant enrollees, including home visits, as appropriate.

The MCO may develop alternate processes for follow up and outreach subject to prior written approval from the Department.

The MCO submits reports to the Department that identify the MCO's performance in Screening, Diagnosis and Treatment, Tracking and Follow-up, and Outreach.

Medically necessary follow-up care for health care services is an integral part of the Provider's continuing care responsibility after a screen or any other health care contact.

The goal is to ensure that children have access to appropriate, coordinated, comprehensive health care. To achieve this goal, The MCO must ensure the following:

1. Children have access to adequate pediatric care;
2. Development of adequate specialty Provider Networks;
3. Prevention against duplication of services;
4. Adherence to state and federal laws, regulations and court requirements relating to individuals with Special Needs;
5. Cooperation of MCO Provider Networks; and
6. Applicable training for PCPs and Providers including the identification of MCO contact persons.

The MCO works with PADOH 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 MCO must designate a single contact person to facilitate the implementation of this requirement

#### **21.19.7. EMERGENCY SERVICES**

The MCO will provide Emergency Services as defined in the Contract, as amended, this Handbook and federal and state law. The MCO may not use case management protocols where they interfere with the treatment of

Emergency Medical Conditions. In the case of a pregnant woman who is having contractions, if the MCO attempts to utilize its case management protocols to direct the enrollee from an out-of-network provider to a network provider, the MCO shall collect and maintain data to demonstrate that there was adequate time to effect a safe transfer to another hospital before delivery or that the transfer would not pose a threat to the health and safety of the patient or the unborn child. Where a transfer is enacted, the MCO demonstrates that its case management protocols did not interfere with the transferring hospital's obligation to:

1. Restrict transfer until the enrollee is stabilized;
2. Effect an appropriate transfer or provide medical treatment within its capacity to minimize the risk of transfer to the enrollee's health;
3. Require a supervised transfer;
4. Offer the enrollee an informed refusal to consent to transfer along with documentation of the associated risks and benefits and;
5. Not divert an enrollee being transported by emergency vehicle from its emergency service on the basis of insurance.

Emergency providers may initiate the necessary intervention to stabilize the condition of the patient without seeking or receiving prospective authorization by the MCO.

The MCO must pay for Emergency Services without regard to prior authorization, case management or the emergency providers' contractual relationship with the MCO. The MCO must pay for Emergency Services in or outside of the service area (including outside of Pennsylvania). Payment for emergency services is made in accordance with applicable law.

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

1. An enrollee has an Emergency Medical Condition; or
2. A representative of the MCO instructs the enrollee to seek Emergency Services.

The MCO cannot:

1. Limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms;
2. Refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care practitioner, MCO,

or applicable state entity of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services; or

3. Hold an enrollee who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The MCO must develop and use a process to have PCPs promptly see an enrollee who does not require or receive hospital Emergency Services for the symptoms prompting the attempted emergency room visit.

The MCO is responsible for all emergency services, including those categorized as mental health and those for drug and alcohol overdose.

### **21.19.8. POST-STABILIZATION SERVICES**

The MCO must cover and pay for Post-stabilization Services, as defined in the Contract, as amended, this Handbook and federal regulations, regardless of whether services were provided within or outside its Provider Network when:

- Services are administered to maintain an enrollee's stabilized condition within one hour of provider's request for pre-approval of Post-stabilization services.
- Services have been pre-approved by a MCO representative.
- Services are administered to maintain, improve, or resolve an enrollee's stabilized condition when the MCO does not respond to a pre-approval request within one hour, when the provider cannot reach the MCO, or when the MCO and the treating physician cannot reach agreement concerning an enrollee's care and a MCO physician is not available for consultation.

The MCO's financial responsibility for Post-stabilization services that it has not been pre-approved ends when: a network physician with privileges at the treating hospital assumes responsibility for the enrollee's care; a network physician assumes responsibility for the enrollee's care through transfer; the MCO and treating physician reach agreement as to the enrollee's care; and upon the enrollee's discharge.

### **21.19.9. 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 include the following:

1. Insertion, implantable contraceptive capsules;
2. Implantation of contraceptives, including device (e.g. Norplant) (once every five years) (females only);

3. Removal, implantable contraceptive capsules;
4. Removal with reinsertion, implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only);
5. Destruction of vaginal lesion(s); simple, any method (females only);
6. Biopsy of vaginal mucosa; simple (separate procedure) (females only);
7. Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only);
8. Colposcopy (vagoscopy); separate procedure (females only). The medical record must show a Class II or higher pathology;
9. Colposcopy (vagoscopy); with biopsy(s) of the cervix or endocervical curettage. The medical record must show a Class II or higher pathology;
10. Colposcopy (vagoscopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only). The medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure;
11. Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only). The medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure;
12. Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure) (females only);
13. Cauterization of cervix; electro or thermal (females only);
14. Cauterization of cervix; cryocautery, initial or repeat (females only);
15. Cauterization of cervix; laser ablation (females only);
16. Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only);
17. Alpha-fetoprotein; serum (females only);

18. Nuclear molecular diagnostics; nucleic acid probe;
19. Nuclear molecular diagnosis; nucleic acid probe,;
20. Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each;
21. Fluorescent antibody; screen, each antibody;
22. Immunoassay for infectious agent antibody; quantitative, not elsewhere specified;
23. Antibody; HIV-1;
24. Antibody; HIV-2;
25. Treponema pallidum, confirmatory test (e.g., FTA-abs);
26. Culture, chlamydia;
27. Cytopathology, any other source; preparation, screening and interpretation;
28. Progestasert I.U.D. (females only);
29. Depo-Provera injection (once per 60 days) (females only);
30. ParaGuard I.U.D. (females only);
31. Hemoglobin electrophoresis (e.g., A2, S, C);
32. Microbial identification, nucleic acid Probes, each probe used; and
33. Microbial identification, nucleic acid probes, each probe used; with amplification (PCR).

Procedures which may be included with a planning clinic problem visit:

1. Gonadotropin, chorionic, (hCG); quantitative;
2. Gonadotropin, chorionic, (hCG); qualitative;
3. Syphilis test; qualitative (e.g., VDRL, RPR, ART);

4. Culture, bacterial, definitive; any other source;
5. Culture, bacterial, any source; anaerobic (isolation);

A medical record shows a class II or higher pathology.

A medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure.

1. Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography;
2. Culture, bacterial, urine; quantitative, colony count;
3. Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection;
4. Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types;
5. Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes);
6. Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites;
7. Smear, primary source, with interpretation; wet and dry mount, for ova and parasites;
8. Cytopathology, smears, cervical or vaginal, The Bethesda System (TBS), up to three smears; screening by technician under physician supervision;
9. Level IV - Surgical pathology, gross and microscopic examination;
10. Antibiotics for sexually transmitted diseases (course of treatment for 10 days) (two units may be dispensed per visit);
11. Medication for vaginal infection (course of treatment for 10 days) two units may be dispensed per visit;
12. Breast cancer screen (females only);
13. Mammography, bilateral (females only); and

#### 14. Genetic risk assessment.

### 21.19.10. BEHAVIORAL HEALTH SERVICES

The MCO shall comply with the mental health parity regulations (see 42 CFR § 457.496). Section 1302(b) of the ACA includes ambulatory (outpatient) care and hospitalization, as well as mental health and substance use disorder (SUD) services, as EHBs. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that limitations on benefits for mental health and SUD be no more restrictive than those for physical health. As for services for physical health issues, there are no day limits on inpatient care or visit limits for outpatient care for mental health and SUD services. There are no copays.

The MCO provides timely access to diagnostic, assessment, referral, and treatment services for enrollees for the following benefits:

1. Inpatient psychiatric hospital services, except when provided in a state mental hospital;
2. Inpatient drug and alcohol detoxification;
3. Psychiatric partial hospitalization services;
4. Inpatient drug and alcohol rehabilitation;
5. Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol dependence/addiction;
6. Emergency room evaluations for voluntary and involuntary commitments pursuant to the Mental Health Procedures Act of 1976, 50 P.S. 7101 et seq.;
7. Psychiatric outpatient clinic services, licensed psychologist, and psychiatrist services;
8. Behavioral health rehabilitation services (BHRS) for individuals under 19 years of age with psychiatric, substance abuse disorders or developmental disabilities;
9. Residential treatment services for individuals under 19 years of age whether treatment is provided in facilities that are Joint Commission for the Accreditation for Healthcare Organizations (JCAHO) accredited and/or without JCAHO accreditation;
10. Outpatient drug and alcohol services, including methadone

maintenance clinic;

11. Methadone when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services provider; and

12. Laboratory studies ordered by behavioral health providers and clozapine support services;

- a. Crisis intervention with in-home capability;
- b. Family-based mental health services for individuals under 19 years of age;
- c. Targeted mental health case management (intensive case management and resource coordination);
- d. Partial hospitalization for drug and alcohol dependence/addiction; or
- e. Targeted drug and alcohol case management and intensive outpatient services.

## **21.19.11. PHARMACY SERVICES**

### **21.19.11.1. General Requirements**

The MCO provides pharmacy services for prescription drugs and over-the-counter medications prescribed by licensed providers.

Pharmacy services for prescription drugs includes any substance taken by mouth, injected into a muscle, the skin, a blood vessel, or a cavity of the body, or applied topically to treat or prevent a disease or condition, dispensed by order of a provider with applicable prescriptive authority. MCOs may use a closed or restrictive formulary provided it meets the minimum clinical needs of enrollees. A mail order or designated pharmacy process can be used for maintenance prescriptions. Generic drugs are automatically substituted for a brand-name drug whenever a generic formulation is available unless the physician indicates the brand-name version is medically necessary.

Pharmacy services for over-the-counter medications are covered when the drug is a part of the formulary, the enrollee has a prescription for the drug, and a documented medical condition indicates the drug is medically necessary.

Co-pays may apply for prescription drugs and over-the-counter medications.

The MCO covers following medications when they are used as preventive medications, such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene. The medications are part of pharmacy services and are covered at no cost to the enrollee when filled at a participating network pharmacy with a valid prescription.

The MCO provides drug benefit 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.

Unless financial responsibility is otherwise assigned, all covered Outpatient drugs are the payment responsibility of the enrollee's MCO.

All covered outpatient drugs are required be dispensed through MCO Network providers.

The MCO cannot permit the therapeutic substitution of an outpatient drug by a pharmacist without explicit authorization from the licensed prescriber.

The MCO submits proposed pharmacy programs and drug utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill- splitting, etc. to the Department for review and approval prior to implementation.

The MCO includes in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for covered outpatient drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, reporting, notices of decision, etc. will apply, regardless of whether the covered outpatient drug is provided as an outpatient drug benefit or as a "medical benefit" incident to a medical service and billed by the prescribing provider using codes such as the HCPCS.

The MCO ensures access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, and peer-reviewed medical literature.

The MCO complies 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 MCO complies with the procedures outlined in section "Continuity of Care" of the Agreement. The MCO policy and procedures for continuity of care for outpatient drugs, and all subsequent

changes to the Department-approved policy and procedures, are submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to outpatient drugs that the enrollee was prescribed before enrolling in the MCO.

#### **21.19.12. COVERAGE EXCLUSIONS**

The MCO cannot provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

The MCO excludes coverage of non-compensable drugs in accordance with 55 PA Code §1121.54.

#### **21.19.13. FORMULARIES AND PREFERRED DRUG LISTS (PDLs)**

The MCO may use a formulary or a Preferred Drug List (PDL). All drugs must be covered outpatient drugs.

The formulary or PDL must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee.

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 determines if the formulary or PDL meets the clinical needs of the CHIP population.

The formulary or PDL must be clinically based. Only those drugs that do not have a significant, clinically meaningful therapeutic advantage, in terms of safety, effectiveness, or clinical outcomes, over other drugs included in the formulary or PDL, may be designated as non-formulary or non-preferred.

The MCO makes a satisfactory written explanation of the reason(s) for designating a drug as non-formulary or non-preferred available to the Department upon request.

The MCO allows access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be medically necessary through a process such as prior authorization (including Step Therapy), in accordance with prior authorization of services and this handbook.

The MCO receives written approval from the Department of the formulary or PDL, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-

preferred, prior to implementation of the formulary or PDL and the requirements.

The MCO submits all formulary or PDL changes (other than additions) and deletions to the Department for review and written approval prior to implementation.

The MCO submits written notification of any formulary or PDL additions to the Department within fifteen (15) days of implementation.

The formulary or PDL must be re-submitted for Department review and approval annually.

The MCO allows access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a covered outpatient drug either by addition to the formulary or PDL, or through prior authorization, within ten (10) days from their availability in the marketplace.

#### **21.19.14. PRIOR AUTHORIZATION OF OUTPATIENT DRUGS**

The MCO may require prior authorization (includes step therapy) as a condition of coverage or payment for a covered outpatient Drug provided that:

1. The MCO provides a response to the request for prior authorization by telephone or other telecommunication device indicating approval or denial of the prescription within twenty-four (24) hours of the request; and
2. 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 MCO instructs the pharmacist to dispense either a:
  - a. Fifteen (15) day supply if the prescription qualifies as an ongoing medication, unless the MCO or its designated subcontractor issued a proper written notice of benefit reduction or termination at least ten (10) days prior to the end of the period for which the medication was previously authorized and a grievance or external review request has not been filed; or
  - b. A seventy-two (72) hour supply of a new medication.

For drugs not able to be divided and dispensed into individual doses, the MCO instructs 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.

The requirement that enrollees 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 enrollees may be taking, would jeopardize the health or safety of the enrollees.

In such an event, the MCO and/or its subcontractor requires that its participating dispensing provider make good faith efforts to contact the prescriber.

If the MCO denies the request for prior authorization, the MCO issues a written denial notice within twenty-four (24) hours of receiving the request for prior authorization.

The MCO establishes and maintains written prior authorization policies, procedures, and guidelines to determine medical necessity of covered outpatient drugs that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred.

The MCO complies with the requirements for prior authorization of services and prior authorization guidelines for participating MCOs in the CHIP Program and receive written approval from the Department prior to implementation.

The MCO submits additions, changes, and deletions to prior authorization (including Step Therapy) policies, procedures and any associated medical necessity guidelines for Department review and written approval prior to implementation.

#### **21.19.15. Provider and Enrollee Notification**

The MCO has policies and procedures for notification to providers and enrollees of changes to the formulary or PDL and prior authorization requirements.

Written and electronic notification for changes to the formulary or PDL and prior authorization requirements are provided to all affected providers and enrollees at least thirty (30) days prior to the effective date of the change.

The MCO provides all other providers and enrollees written notification and electronic notification of changes to the formulary or PDL and prior authorization requirements upon request.

The MCO notifies providers and enrollees of formulary or PDL and prior authorization changes through enrollee and provider newsletters, the MCO's website in a readable format, or other regularly published media of general distribution.

#### **21.19.16. MCO Pharmacy & Therapeutics (P&T) Committee**

The P&T Committee membership includes physicians, including a minimum of two

(2) behavioral health physicians, pharmacists, CHIP program consumers, and other appropriate clinicians. CHIP program consumer representative membership includes the following:

1. One (1) physical health consumer representative. The physical health consumer representative is a consumer enrolled in the MCO, or a physician, a pharmacist, or a physical health consumer advocate designated by consumers enrolled in the MCO to represent them; and
2. One (1) behavioral health consumer representative. The behavioral health consumer representative is a consumer enrolled in the MCO, or a physician, a pharmacist, a behavioral health consumer advocate, or a family member designated by consumers enrolled in the MCO to represent them.

The MCO submits a P&T Committee membership list for Department review and approval upon request.

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 are added as non-voting, ad hoc members.

The minutes from each MCO P&T Committee meeting are posted for public view on the MCO's website within 30 days of the date of the meeting at which the minutes are approved. Minutes include vote totals.

#### **21.19.17. PHARMACY PROVIDER NETWORK - ANY WILLING PHARMACY**

The MCO contracts on an equal basis with any pharmacy qualified to participate in the CHIP Program that is willing to comply with the MCO's payment rates and terms.

The provisions for any willing pharmacy apply if the MCO Subcontracts with specialty pharmacies or designates specific network pharmacies as the preferred provider(s) of specialty drugs(s). MCOs contracts on an equal basis with any pharmacy qualified to participate in the CHIP program that is willing to accept the same payment rate(s) as the preferred provider(s) of specialty drugs and comply with the same terms and conditions for quality standards and reporting as the preferred provider(s) of specialty drugs.

#### **21.19.17.1. DRUG UTILIZATION REVIEW (DUR) PROGRAM**

The MCO provides a DUR Program to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes, and to enhance the quality of patient care by educating

prescribers, pharmacists, and enrollees.

#### **21.19.17.1.1. Prospective Drug Utilization Review (Pro-DUR)**

The MCO provides 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 includes 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.

The MCO provides for counseling of enrollees receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

#### **21.19.17.1.2. Retrospective Drug Utilization Review (Retro-DUR)**

The MCO, through its drug claims processing and information retrieval system, examines claims data and other records to identify patterns of fraud, waste, and abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and enrollees.

The MCO, on an ongoing basis, assesses 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.

The MCO provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.

1. In no case will an MCO's DUR program provide any financial or other incentive to a pharmacist, the pharmacist's employer, or a PBM for encouraging the physician to change a prescription order. Changes are accepted only when warranted by clinical reasons of enrollee safety and approved efficacy.
2. The MCO submits an annual report on the operation of its Pennsylvania Medicaid DUR program in a format designated by the Department. The format of the report includes a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on

quality of care, and an estimate of the cost savings generated as a result of the DUR program.

#### **21.19.17.1.3. DRUG UTILIZATION REVIEW BOARD (DUR BOARD)**

The Department maintains a DUR Board that reflects the structure of the health care delivery model that includes both a managed care and a fee-for-service delivery system. Each MCO is required to include a representative to serve on the DUR Board. The DUR Board is a standing advisory committee that recommends the application of predetermined standards related to Pro-DUR, Retro-DUR, and related administrative and educational interventions designed to protect the health and safety of the CHIP program enrollees. The Board reviews and evaluates pharmacy claims data and prescribing practices for efficacy, safety, and quality against predetermined standards using nationally recognized drug compendia and peer reviewed medical literature as a source. The Board recommends appropriate utilization controls and protocols including prior authorization, automated prior authorization, system edits, and guidelines to determine medical necessity, generic substitution, and quantity limits for individual medications or for therapeutic categories.

#### **21.19.17.1.4. PHARMACY BENEFIT MANAGER (PBM)**

The MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions within Appendix 21-A (relating to Standards) and has received advance written approval by the Department. The standards for Network composition and adequacy for outpatient drug services includes the requirements for any willing pharmacy as described above. The MCO indicates the intent to use a PBM, identify the proposed PBM Subcontract and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly or in part by an MCO, retail pharmacy provider, chain drug store, or pharmaceutical manufacturer, the MCO submits 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 are submitted and receive advance written approval by the Department prior to initiating the PBM Subcontract. The Department allows the continued operation of existing PBM Subcontracts while the Department is reviewing new contracts.

#### **21.19.18. COVERAGE EXCLUSIONS**

The MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

The MCO must exclude coverage of non-compensable drugs in accordance with 55 PA Code §1121.54.

#### **21.19.19. FORMULARIES AND PREFERRED DRUG LISTS (PDLs)**

The MCO may use a Formulary or a Preferred Drug List (PDL). All drugs must be Covered Outpatient Drugs.

The Formulary or PDL must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee.

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 determines if the Formulary or PDL meets the clinical needs of the CHIP population.

The Formulary or PDL must be clinically based. Only those drugs that do not have a significant, clinically meaningful therapeutic advantage, in terms of safety, effectiveness, or clinical outcomes, over other drugs included in the Formulary or PDL, may be designated as non-formulary or non-preferred.

The 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.

The MCO must allow access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy), in accordance with Prior Authorization Guidelines.

The MCO must receive written approval from the Department of the Formulary or PDL, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred, prior to implementation of the Formulary or PDL and the requirements.

The MCO must submit all Formulary or PDL changes (other than additions) and deletions to the Department for review and written approval prior to implementation.

The MCO must submit written notification of any Formulary or PDL additions to the Department within fifteen (15) days of implementation.

The Formulary or PDL must be re-submitted for Department review and approval annually.

The MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Outpatient Drug either by addition to the Formulary or PDL, or through prior authorization, within ten (10) days from their availability in the marketplace.

#### **21.19.19.1. Continuity of Care**

When an enrollee transfers between MCOs or from MA to CHIP, provisions are made for the continuity of care to avoid disruption in any prior authorized services or treatments. This does not provide for the continuity of providers, but for the continuance of prior authorized services and /or treatments for the amount, durations, and scope specified by the prior authorization.

1. The MCO the enrollee is transferring from (losing MCO) must provide the MCO transferred to (receiving MCO) with a copy of the prior authorized services at least ten (10) days prior to the end of the previously approved time frame.
2. Approve services are continued by the receiving MCO for up to 60 days
3. The receiving MCO approves the prior authorized services pending concurrent medical review after which the enrollee and prescribing provider must be notified of any changes in the amount, duration, and scope of services. Notification will be at least ten (10) days prior to the effective date of the change in service. The MCO may not deny coverage of the prior authorized services during the review process.
4. The enrollee may appeal the decision of the medical review by the receiving MCO within ten (10) days of the date of the notice. Services will continue during the appeal process.
5. If the provider is not participating in the network of the MCO that the enrollee is transferring to, the new MCO may choose to recruit the provider or assist the enrollee in finding a new network provider. The enrollee may use their non-participating provider for up to sixty (60) days from the effective date of transfer to the new MCO. This period may be extended, if medically appropriate. A pregnant enrollee may continue with

her prior provider through her pregnancy and post-partum care related to the delivery.

6. If the enrollee does not want to switch providers and if transfer to another provider is medically contraindicated, the MCO and provider may come to a mutually agreeable rate and billing procedures for services.
7. Services covered under continuity of care are covered under the same terms and conditions as applicable to network providers. An MCO is not required to cover services which would not otherwise be covered under the terms of the Agreement.

The MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. §991.2117 and 42 CFR 457.1230(c) in reference to 42 CFR 438.208, regarding continuity of care requirements, and 28 Pa. Code §9.684 and 31 Pa. Code §154.15.

The MCO must make a good faith effort to provide notice of the termination of a network provider to each affected enrollee within fifteen (15) days of the receipt or issuance of a termination notice. An affected enrollee is one who received primary care from the provider or was seen on a regular basis by the provider.

When a provider stops participating with an MCO, an enrollee may continue an ongoing course of treatment with that provider for a transitional period up to sixty (60) days. For pregnant enrollees in their second or third trimester who, except under certain circumstances, may continue to seek treatment from their OB/GYN for both their current pregnancy and postpartum care.

#### **21.19.19.2. Coordination of Care**

Each MCO must implement procedures to deliver care to and coordinate services for all enrollees. These procedures must meet State requirements and must do the following:

1. Provide that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity;

2. Coordinate the services the MCO furnishes to the enrollee with the services the enrollee receives from any other MCO, through a fee-for-service arrangement or by a community or social support provider;
3. Share with other MCOs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities;
4. Conduct an initial screening of each enrollee's needs, within ninety (90) days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful;
5. Require that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
6. Require that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

### **21.19.19.3. NOTICE OF DENIAL PROCEDURES**

A written notice of denial must be issued to the enrollee for the following:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial of a requested service because it is not a covered service for the enrollee; and
4. The denial of a requested service but approval of an alternative service.

## **Part 3 – MARKETING AND OUTREACH**

### **CHAPTER 22: MARKETING AND OUTREACH**

#### **22.1. General Requirements**

MCOs produce outreach materials and activities to identify and inform potentially eligible families of the program and aid in the choosing of an MCO. The Contract, as amended, and this section provides requirements on marketing, outreach materials and activities. The 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. 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 individual's to enroll in that particular MCO or to not enroll or disenroll from another MCO.

Questions and/or requests for information, CHIP Graphic Standards Manual, CHIP logos, additional camera-ready reproduction art, and electronic files should be sent to:

Office of the Children's Health Insurance Program  
1142 Strawberry Square  
P.O. Box 2675  
Harrisburg, PA 17105-2675  
Fax: (717) 705-1643  
Phone: (717) 705-0009

The Department may impose monetary or restricted enrollment sanctions on an MCO for the use of unapproved or prohibited outreach materials or practices. 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.

#### **22.2. Required Activities**

MCOs must:

1. Submit marketing and outreach materials, activities, and advertisements for review and written approval by the Department prior to production or distribution;
2. Use the most up-to-date CHIP logo on all marketing and outreach materials;

3. Follow the CHIP Graphic Standards Manual;
4. Display materials utilizing CHIP and the MCO's name using the phrase, "CHIP, brought to you by \_\_\_\_\_";
5. 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;
6. Forward requests to the Department via the standard programmatic request process when implementing electronic transmissions in place of written materials;
7. Distribute marketing materials throughout its entire services area; and
8. Create materials that comply with information requirements of the Contract, as amended, this Handbook and federal regulations.

### **22.3. OPTIONAL ACTIVITIES**

The MCOs may:

1. Use agents and subcontractors in marketing and outreach activities, as long as the, agents and subcontractor follow CMS regulations;
2. Offer health related services to members within the MCO network and feature expanded services in approved materials. All services must meet the requirements of 21.4, Expanded Services;
3. 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 MCO's enrollment activity;
4. Offer consumer incentives that directly relate to improving health outcomes; however, the incentive cannot exceed the total cost of service; and
5. 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.

### **22.4. Prohibited Activities**

The MCOs may not:

1. Distribute, directly or through any agent, outreach materials that contain false or misleading information;

2. Use the Department's CAPS systems to identify and market to eligible children or members enrolled with another MCO;
3. Sell or share a CHIP consumer list with other organizations;
4. 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 MCO with a potential enrollee for purposes of marketing;
5. Issue charts which compare another MCO to itself, which is disparaging to the other MCO;
6. Engage in any marketing activities associated with enrollment in counties where the MCO does not have a Provider Network;
7. Seek compensation from the CHIP program for marketing and outreach;
8. Influence enrollment in conjunction with the sale or offering of any private insurance (this excludes Qualified Health Plans);
9. Include any statement that an enrollee must enroll in the MCO to obtain benefits or not lose benefits or that the MCO is endorsed by CMS, the federal government or the Commonwealth..

#### **22.5. Limited English Proficiency (LEP) Requirements**

The MCO must identify enrollees who speak a language other than English as their first language.

Upon an enrollee's request, the 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.

The 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.

The 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 MCO's website.

The 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.

#### **22.5.1. Alternate Format Requirements**

The MCO provides 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. Upon the request of the enrollee, the MCO makes all written materials disseminated to enrollees accessible to visually impaired enrollees. The MCO provides TTY and/or Pennsylvania Telecommunication Relay Service for enrollees who are deaf or hearing impaired, upon request.

The MCO includes appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternate format.

#### **22.6. FREQUENCY**

The MCO submits marketing, outreach materials, and activities requiring prior approval as soon as the MCO has the materials and activities available. The Department allows a minimum of two (2) weeks for the review and approval process.

#### **22.7. FORMAT**

The MCO submits materials requiring prior approval via the Department's "MCO Report on Company or Programmatic Changes" form (See Appendix 22-A). 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. Television and radio advertisements are submitted via media file compatible with Windows Media Player.

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 (See Appendix 22-A).

The Department responds to an MCO's marketing and outreach approval requests via the CHIP Approval/Review Form (See Appendix 22-B).

**NOTE:** Requests for prior approval and notices of marketing and outreach materials and activities may be submitted via email, fax or mail, as the MCO deems appropriate. Requests should be submitted to:

CHIP Outreach Coordinator  
Office of the Children's Health Insurance Program  
1142 Strawberry Square  
P.O. Box 2675  
Harrisburg, PA 17105-2675  
Fax: (717) 705-1643  
Phone: (717) 705-0009

## **CHAPTER 23: MCO REPORT ON COMPANY OR PROGRAMMATIC CHANGES**

### **23.1. MCO REPORT ON COMPANY OR PROGRAMMATIC CHANGES**

#### **23.1.1. CONTENT**

The MCO submits this 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's have marketing/outreach materials that need approval.

#### **23.1.2. FREQUENCY**

This report is submitted when changes occur. However, changes imposed by the Department or state/federal mandates need not be reported on this form.

#### **23.1.3. FORMAT**

The MCO submits the report in the format noted in Appendix 22-A. No alternative format will be accepted.

When lengthy documents such as handbooks, subscriber agreements, etc. are being submitted for review/approval, the specific text being revised is highlighted in the document and noted on the Programmatic Change Form. If the entire document is being revised, please note this on the Programmatic Change form.

The Department will respond to the MCO's notices via the CHIP Approval/Review Form (See Appendix 22-B).

**NOTE:** The report may be submitted via mail, fax, or email as the MCO deems appropriate. All requests for reviews and approvals (along with the Programmatic Change form) are directed to:

Office of the Children's Health Insurance Program  
1142 Strawberry Square  
P.O. Box 2675  
Harrisburg, PA 17105-2675  
Fax: (717) 705-1643  
Phone: (717) 705-0009

(See form at Appendix 22-A). Requests will be directed to the appropriate Division(s) within the office for review and approval. The Division that will be reviewing/approving a request is noted on the Programmatic Change form.

## **23.2. INTENDED MARKETING AND OUTREACH SUMMARY**

In an effort to strengthen coordination between the Department's marketing and outreach activities with those of the MCOs, MCOs report intended marketing and outreach activities to the Department on a quarterly basis. This report includes 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.

### **23.2.1. CONTENT**

The Intended Marketing and Outreach Summary describes marketing and outreach activities planned for the upcoming quarter.

#### **Intended Marketing and Outreach Summary (See Appendix 23-A)**

The MCO is reports through a quarterly notification that outlines planned activity and non-activity is required using the report form provided by the Department. MCOs submit this report, designate planned/unplanned marketing and outreach activity, and provide an informal summary of planned activities.

Where television, cable, or radio advertising is planned, MCOs must list the relevant station, channel, program, flight dates, and time period information, if available.

### **23.2.2. FREQUENCY**

The Intended Marketing and Outreach Summary are submitted to the Department at the beginning of each quarter in accordance with the following schedule:

<b>Quarter reporting on</b>	<b>Dates quarter includes</b>	<b>Due Date</b>
First quarter	January 1-March 31	January 1
Second quarter	April 1-June 30	April 1

Third quarter	July 1-September 30	July 1
Fourth quarter	October 1-December 31	October 1

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.

**NOTE:** MCOs submit the report even when no reportable activity is planned.

**23.2.3. Format**

See Appendix 23-A. No alternative format will be accepted.

These reports are submitted to:

CHIP Outreach Coordinator  
Office of the Children’s Health Insurance Program  
1142 Strawberry Square  
P.O. Box 2675  
Harrisburg, PA 17105-2675  
Fax: (717) 705-1643  
Phone: (717) 705-0009

**23.3. COMPLETED MARKETING AND OUTREACH ACTIVITY AND EXPENDITURE REPORT**

**23.3.1. Content**

To strengthen coordination between the Department’s marketing and outreach activities with those of the MCOs, MCOs 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.

**Completed Marketing and Outreach Summary (See Appendix 23-B)**

The Department requires a quarterly notification of completed activity as well as non-activity using this report. MCOs 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.

Please refer to “Instructions for Marketing and Outreach Report” in Appendix 23-C.

**23.3.2. Completed Marketing and Outreach Expenditure Report** (See Appendix 23-D)

This report outlines total expenditures by category, corresponding to the activities reported in Appendices 23-E and 23-F

MCOs report aggregate costs for each category.

Note that 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 cannot report the aggregate cost for number of items merely taken to events. MCOs cannot report the aggregate costs paid for materials during the quarter. MCOs cannot include the costs of producing or mailing any materials related to contractual obligations.

**23.3.2.1. Frequency**

Post Marketing/Outreach and Expenditure Reports are submitted to the Department two months after the quarter in accordance with the following schedule:

<b>Quarter reporting on</b>	<b>Dates quarter includes</b>	<b>Due Date</b>
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

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.

**NOTE:** The MCO is reports through a quarterly notification that outlines planned activity and non-activity is required using the report form provided by the

Department. MCOs are not required to submit a report for each marketing area, but they are required to submit this report and designate for which marketing areas there was activity and, if any, for which marketing areas there was no activity (See Appendix 23-B).

#### **23.3.2.2. Format**

See Appendices 23-A, 23-B, 23-C, 23-D, 23-E, and 23-F. No alternative format will be accepted.

Expenditures for marketing and outreach materials and activities are listed in Appendix 23-D.

**NOTE:** These reports are submitted to:

CHIP Outreach & Marketing Division  
1142 Strawberry Square  
P.O. Box 2675  
Harrisburg, PA 17120  
Fax: (717) 705-1643  
Phone: (717) 705-0009

## **PART 4: ADMINISTRATIVE REQUIREMENTS**

### **CHAPTER 24: Administrative Requirements**

#### **24.1. Certification of Authority and County Operational Authority**

The MCO maintains a Certificate of Authority to operate as an MCO in Pennsylvania. The MCO provides a copy of its Certificate of Authority upon request to the Department.

The MCO maintains operating authority in each county covered by its Contract. The MCO provides to the Department a copy of the PADOH correspondence granting operating authority in each county covered by this Agreement upon request.

#### **24.2. Executive Management**

The MCO Executive Management structure includes the following. These full-time positions must be solely dedicated to PA CHIP.

1. A full-time Administrator with authority over the entire operation of the MCO;
2. A full-time CHIP Program Manager to oversee the operation of the Agreement, if different than the Administrator;
3. A full-time Medical Director who is a current Pennsylvania-licensed physician. The Medical Director must be actively involved in all major clinical program components of the MCO and directly participate in the oversight of the skilled nursing unit, Case Management, QM Department and UM Department. The Medical Director and his/her staff/consultant physicians must devote sufficient time to the MCO to provide timely medical decisions including after-hours consultation, as needed;
4. A full-time Pharmacy Director who is a current Pennsylvania-licensed pharmacist. The Pharmacy Director oversees the outpatient drug management and serves on the MCO P&T Committee;
5. A full-time CFO to oversee the budget and accounting systems implemented by the 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; and

6. A full-time Information Systems (IS) Coordinator, who is responsible for the oversight of all information systems issues with the Department. The IS Coordinator must have a good working knowledge of the MCO's entire program and operation, as well as the technical expertise to answer questions related to the operation of the information system. These full-time positions must be solely dedicated to PA CHIP.

### **24.3. Other Administrative Components**

The MCO provides an administrator for each of the administrative functions listed below.

1. A QM Coordinator who is a Pennsylvania-licensed physician, registered nurse, or physician's assistant with experience or education in QM systems. The Department may consider other advanced degrees relevant to QM in lieu of professional licensure;
2. A UM Coordinator who is a Pennsylvania-licensed physician, registered nurse, or physician's assistant with experience or education in UM systems. The Department may consider other advanced degrees relevant to UM in lieu of professional licensure;
3. A full-time Special Needs or Case Management Coordinator who is a Pennsylvania-licensed or certified medical professional (or other health related license or certification), or has a bachelor's degree in social work, teaching, or human services. In addition, the individual must have a minimum of three years of experience in dealing with special needs populations. The Special Needs or Case Management Coordinator must have access to and periodically consult with the MCO's Medical Director. They must work in close collaboration with the Special Needs Unit. The MCO notifies the Department within thirty (30) days of a change of this Coordinator;
4. A full-time Government Liaison who serves as the Department's primary point of contact with the MCO for the day-to-day management of contractual and operational issues. The 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;
5. 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;

6. 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;
7. A Provider Services Manager who oversees staff to coordinate communications between the MCO and its Providers. There must be sufficient MCO Provider Services staff to promptly resolve provider disputes, problems or inquiries;
8. A complaint, grievance, and external review coordinator whose qualifications demonstrate the ability to assist enrollees throughout the complaint, grievance, and external review;
9. 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 MCO;
10. A contract compliance officer who ensures that the MCO follows all the requirements of the Agreement; and
11. A designated HEDIS project manager who acts as the point person with the Department and the Department's EQRO.
  - a. The MCO staff must have appropriate training, education, experience, and orientation to fulfill the requirements of the position. The MCO is required to update job descriptions for each of the positions if responsibilities for these positions change.
  - b. The MCO's staffing needs to represent
  - c. the racial, ethnic, and cultural diversity of the Program and comply with all requirements of Exhibit A, Standard Terms and Conditions for Services. Cultural Competency may be reflected by the MCO's pursuit to:
    - i. Identify and value differences;

- ii. Acknowledge the interactive dynamics of cultural differences;
- iii. Continually expand cultural knowledge and resources about the populations served;
- iv. Recruit racial and ethnic minority staff in proportion to the populations served;
- v. Collaborate with the community regarding service provisions and delivery; and
- vi. Commit to cross-cultural training of staff and the development of policies to provide relevant, effective programs for the diversity of people served.

The MCO must have in place sufficient administrative staff and organizational components to comply with the requirements of its Contract and this Handbook. The positions must be staffed by qualified persons in numbers appropriate to the MCO's size of enrollment. The Department makes the final determination regarding whether the MCO is in compliance.

The 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 position are being carried out. Similarly, the MCO may contract with a third party to perform one (1) or more of these functions, subject to the subcontractor conditions described in this Handbook. The MCO keeps the Department informed at all times of the management individual(s) whose duties include each of the responsibilities outlined in this section.

#### **24.4. Administration**

The MCO must have an administrative office within Pennsylvania that is in compliance with all standards set forth by the PADOH, PID, and the Department.

The MCO's organizational structure listing the function of each executive as well as administrative staff are submitted to the Department for review. Staff positions outlined in this Handbook must be approved and maintained in accordance with the Department's requirements. The CHIP key personnel must be accessible.

#### **24.5. Contracts and Subcontracts**

The 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 the MCO. Notwithstanding its use of subcontractor(s), the MCO must comply with the Contract and this Handbook, including:

1. For the provision of and/or arrangement for the services to be provided under the Contract, as amended and this Handbook;
2. For the evaluation of the prospective subcontractor's ability to perform the activities to be delegated;
3. For the payment of any and all claims payment liabilities owed to providers for services rendered to enrollees, 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 MCO. For the purposes of this section, the term "Insolvent" means:
  - a. The adjudication by a court of competent jurisdiction or administrative tribunal of a party as 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
  - b. 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
4. For the oversight and accountability for any functions and responsibilities delegated to any subcontractor.
5. The above notwithstanding, if the 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 MCO, the MCO is responsible for any obligation by the subcontractor to a provider that is overdue by at least sixty (60) days.

The MCO indemnifies and holds 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 its Contract, as amended, for which a subcontractor is the primary obligor, except to the extent that the MCO and/or subcontractor has acted with respect to such provider claims in accordance with the terms of the Contract, as amended and this Handbook.

The MCO makes all subcontracts available 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 the Handbook.

The MCO submits for prior approval subcontracts between the MCO and any individual, firm, corporation, or any other entity to perform part or all of the selected MCO's responsibilities under the Contract, as amended. This provision includes, but is not limited to, contracts for vision services, dental services, claims processing, enrollee services, and pharmacy services.

## **24.6. Records Retention**

The MCO complies with the program standards regarding records retention, which are set forth in federal and state law and regulations and of the Contract, as amended, except that, for purposes of the Agreement, all records must be retained for a period of ten (10) years beyond expiration or termination of the Contract, unless otherwise authorized by the Department. Upon thirty (30) days' notice from the Department, the MCO provides copies of all records to the Department at the MCO's site or other location determined by the Department, if requested. This thirty (30) days' notice does not apply to records requested by the state or federal government for purposes of fiscal audits or fraud and/or abuse investigations. In the event records requested by the state or federal government for the purposes of fiscal audits or fraud and/or abuse investigations, the MCO provides copies of the records to the Department in the timeframe designated. The retention requirements in this section do not apply to Department-generated Remittance Advices.

### **24.6.1. PROVIDER ENROLLMENT STANDARDS**

The MCO complies with the program standards regarding provider enrollment that are set forth in the Contract and this Handbook.

The MCO requires all Network Providers to be enrolled with the Department and possess an active MMIS Provider ID for each location in which the

providers render services for the MCO. In addition, the MCO stores and utilizes the MMIS Provider ID and NPI stored in MMIS for each location.

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

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

#### **24.6.2. COMPLIANCE WITH APPLICABLE LAWS**

The MCO complies with all applicable Federal and State laws and regulations including 42 USC § 1397aa et seq. and 42 CFR part 457, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

#### **24.6.3. ENROLLEE LIABILITY**

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

1. Debts of the MCO in the event of the MCO's insolvency;
2. Covered services provided to enrollees in the event the MCO fails to receive payment from the Department;
3. Covered services provided to enrollees in the event a provider with a contractual, referral or other arrangement with the MCO fails to receive payment from the Department or the MCO for such services; or
4. Payments for covered services to a provider that furnishes compensable services under a contractual, referral, or other arrangement with the MCO in excess of the amount that would be owed by the enrollees if the MCO had directly provided the services.

#### **24.6.4. HEALTH INFORMATION SYSTEMS**

The MCO must have and maintain a health information system that complies with the requirements in the Contract, as amended and 42 CFR § 438.242. At a minimum, the system must collect, analyze, integrate and report information, including information relating to utilization, claims, grievances and appeals, and dis-enrollments other than for loss of eligibility. The MCO must verify the accuracy and timeliness of reported data from all providers, screen data for completeness, logic and consistency, collect data from providers in a standardized format to the extent possible, including use of secure information exchanges; and make all collected data available to the Department and upon request to CMS. The MCO must: (i) collect and maintain sufficient enrollee encounter data to identify the provider who delivers item(s) or service(s) to enrollees; (ii) submit timely, accurate and complete enrollee encounter data to the Department at a level of detail specified by CMS and the Department, based on program administration, oversight, and program integrity needs; (iii) submit all enrollee encounter data that the Department is required to report to CMS under 42 C.F.R. § 438.818; and (iv) submit encounter data in standardized formats as listed in the Contract, as amended and this Handbook, as appropriate.

#### **24.6.5. PROHIBITED AFFILIATIONS**

The MCO may not knowingly have a relationship with:

- An individual or entity that is barred, suspended or otherwise excluded from participating in procurement activities under the federal acquisition regulations, in non-procurement activities under Executive Order No. 12549, or under guidelines implementing Executive Order No. 12549.
- An individual or entity that is an affiliate of a person or entity described above. An affiliate is an individual or entity that either controls or can control the other individual or entity or a third party that controls or can control both.
- An individual or entity that is excluded from participation in any federal health care program.

A prohibited relationship is defined as:

- A director, officer or partner of the MCO.
- A subcontractor of the MCO.
- A person with beneficial ownership of five percent (5%) or more of the MCO's equity.
- A Network Provider or person with an employment, consulting or other arrangement with the MCO for the provision of items and services significant and material to the MCO's obligations under the Contract.

## **ACRONYMS**

**ACA-** Patient Protection and Affordable Care Act.

**ACR-** Awaiting Contractor Response.

**APTC-** Advance Premium Tax Credits.

**BHA-** Pennsylvania Department of Human Services' Bureau of Hearing and Appeals

**BPI-** Pennsylvania Department of Human Services' Bureau of Program Integrity

**CAO-** County Assistance Office.

**CAPS-** CHIP Application Processing System.

**CEU-** CHIP Central Eligibility Unit.

**CHIP-** Pennsylvania Children's Health Insurance Program.

**CIS-** Client Information System.

**CMS-** Centers for Medicare and Medicaid Services.

**COBRA-** Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272).

**COLA-** Cost of Living Adjustment

**COMPASS-** Commonwealth of Pennsylvania Application for Social Services.

**CPT-** Current Procedural Terminology.

**CYF-** Pennsylvania Office of Children, Youth, and Families.

**DHS-** Pennsylvania Department of Human Services.

**DX-** Data Exchanges.

**eCIS-** Electronic Client Information System.

**EHC-** Enrollment Health Center.

**ERP-** Eligibility Review Process.

**FDSH-** Federal Data Services Hub.

**FEIN-** Federal Employer Identification Number

**FFM-** Federally Facilitated Marketplace.

**FFS-** Fee-for-Service.

**FPL-** Federal Poverty Level.

**FQHC-** Federally Qualified Health Center.

**HCHS-** HealthCare Handshake.

**HCPCS-** Healthcare Common Procedure Coding System.

**HEDIS®-** Healthcare Effectiveness Data and Information Set.

**HHS-** United States Department of Health and Human Services.

**HIPAA-** Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

**HMO-** Health Maintenance Organization.

**HMS-** Health Management System.

**INA-** Immigration and Nationality Act of 1965 (P.L. 89-236).

**IRC-** Internal Revenue Code.

**IRS-** Internal Revenue Service.

**LEP-** Limited English proficiency.

**MA-** Medical Assistance.

**MAGI-** Modified Adjusted Gross Income.

**MCI-** Master Client Index.

**MCO-** Managed Care Organization.

**MEC-** Minimum Essential Coverage.

**MNO-** Medically Needy Only.

**NCQA-** National Council for Quality Assurance.

**NPES-** National Plan and Provider Enumeration System.

**PCP-** Primary care provider.

**PCCM-** Primary Care Case Management.

**PERM-** Payment Error Rate Measurement.

**PPS-** Prospective Payment System.

**QM-** Quality Management.

**RDD-** Renewal Due Date

**REMIC-** Real Estate Mortgage Investment Conduits.

**RTF-** Residential treatment facility.

**SAVE-** Systematic Alien Verification for Entitlements.

**SCHIP-** State Children's Health Insurance Program.

**SEP-** Simplified Employee Pension

**SNAP-** Supplemental Nutrition Assistance Program.

**SSA-** Social Security Administration.

**SSB-** Social Security Benefit.

**SSD-** Social Security Disability.

**SSDMF-** Social Security Administration Death Master File.

**SSI-** Supplemental Security Income.

**SSN-** Social Security Number.

**TANF-** Temporary Assistance for Needy Families

**TPL-** Third Party Liability.

**UM-** Utilization Management.

**USCIS-** United States Citizenship and Immigration Services.

**VBP-** Value-Based Purchasing.

**VLP-** Verified Lawful Presence.

**WC-** Worker's Compensation.

**YTD-** Year-to-date.