



PENNSYLVANIA

HealthChoices

Community
HealthChoices

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES**

**HEALTHCHOICES
BEHAVIORAL/PHYSICAL HEALTH AND
COMMUNITY HEALTHCHOICES
EXAMINATION GUIDE**

Updated as of December 2023

**DEPARTMENT OF HUMAN SERVICES
HEALTHCHOICES
BEHAVIORAL/PHYSICAL HEALTH AND
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EXAMINATION GUIDE**

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INTRODUCTION

Overview

This Examination Guide (Guide) is designed to assist the Independent Public Accountant (IPA) with examination criteria, established by the Pennsylvania Department of Human Services (Department), as it relates to the HealthChoices Behavioral/Physical Health and Community HealthChoices (CHC) Programs. The Compliance Requirements of the Guide are divided into the following four sections:

- ◆ Claims Processing
- ◆ Management Information System (MIS)/Encounter Data Reporting
- ◆ Health Services Delivery System/Managed Care Organization (MCO)/MCO Subcontractor/Administrative Services Organization (ASO) Incentive Arrangements
- ◆ Financial Management

The categories above can be further subdivided as follows:

- A. Compliance Objective
- B. Compliance Requirement/Suggested Procedures
- C. Compliance Criteria

The Department also publishes separate Financial Reporting and Claims Processing Requirements for all three programs. Those schedules supplement this document and should be utilized in conjunction with this document when performing examinations. The Behavioral Health supplemental guidance can be found [here](#), the Physical Health supplemental guidance can be found [here](#), and the Community HealthChoices supplemental guide can be found [here](#).

The Guide provides the minimum procedures the IPA should perform. Neither the list of compliance issues to be tested, nor the suggested procedures in this Guide are meant to be all-inclusive. The IPA is responsible for determining the nature, timing, and extent of the procedures to be performed, based on the IPA's professional judgment.

Engagement Requirement

The examination should be performed in accordance with the attestation standards established by the American Institute of Certified Public Accountants, and the standards applicable to attestation engagements contained in [Government Auditing Standards](#), issued by the Comptroller General of the United States, and should utilize the following guidance that can be found at the links above:

- Behavioral Health - Examination Guide; Appendix W of the Behavioral Health Program Standards and Requirements; Section 2.0, page 3 of DHS's Behavioral Health Financial Reporting Requirements (FRR) for the period in question.

- Physical Health - Examination Guide; Physical Health Agreements, Exhibit WW, and DHS' Physical Health Financial Reporting Requirements (FRR) and Claims Processing Reporting Requirements (CPRR) for the applicable period in question. A request to obtain a digital copy of the applicable FRRs and CPRRs can be sent via email to FinancialGatekeeper@pa.gov).
- CHC - Examination Guide; CHC Agreement, Exhibit O, and DHS's CHC Financial Reporting Requirements (FRR) for the applicable period in question (note that the CHC FRR includes information on the Claims Processing Reporting Requirements). A request to obtain a digital copy of the applicable FRRs can be sent via email to RA-PWCHCFinRepReq@pa.gov.

Report Submission

A reporting package consisting of the IPA's examination of the Contractor's HealthChoices Behavioral/Physical Health and/or the Community HealthChoices Program performed in accordance with the requirements of this Guide is required to be submitted to the Commonwealth by:

- Behavioral Health-
 - ✓ **May 15** – All zones/counties

The reporting package can be submitted to Office of Mental Health & Substance Abuse Services (OMHSAS) by:

- 1) Uploading the reports to the OMHSAS Financial Reporting Website, or
- 2) Submitting the reports to RA-PWOMHBFMAREPORTS@pa.gov.

- Physical Health –
 - ✓ **June 30** - All zones/counties - If the contractor's responsibility to provide Medical Assistance (MA) benefits to HealthChoices recipients ends during a calendar year, the report package is due 180 days after the last day the contractor is responsible to provide these services.

The report package should be submitted to the Office of Medical Assistance Programs (OMAP) via the Physical Health electronic reporting system for financial reporting (E-FRM).

- CHC –
 - ✓ **June 30** - All zones/rating regions - If the contractor's responsibility to provide MA benefits to Community HealthChoices recipients ends during a calendar year, the report package is due 180 days after the last day the contractor is responsible to provide these services.

The report package should be submitted to the Office of Long-Term Living (OLTL)

via the CHC E-FRM system.

If a management letter has been issued as a result of the IPA's examination, copies of this letter must be submitted with, but not necessarily as part of the report on the IPA's examination.

Questions/Comments

Updates in the form of amendments to the FRRs, Claims Processing Reporting Requirements (CPRR), policy statements, and contract, etc. may be issued in the future or during the examination period. It is the responsibility of the IPA to inquire of management if any updates subsequent to the issuance of the Guide have been issued by DHS that may affect the contract examination.

Behavioral Health updates will be posted to [DHS's HealthChoices Behavioral Health Publications website](#).

A request to obtain a digital copy of the applicable Physical Health (PH) FRRs and CPRRs can be sent via email to FinancialGatekeeper@pa.gov.

A request to obtain a digital copy of the applicable Community HealthChoices (CHC) FRRs can be sent via email to RA-OBMCORevenue@pa.gov.

- General comments or inquiries related to the Examination Guide should be submitted to RA-pwauditresolution@pa.gov.
- Specific questions related to the Behavioral Health Examination should be submitted to kbutsch@pa.gov (Kimberly Butsch).
- Specific questions related to the Physical Health Examination should be submitted to FinancialGatekeeper@pa.gov.
- Specific questions related to the Community HealthChoices Examination should be submitted to: mpenney@pa.gov (Mike Penney).

ENGAGEMENT ADMINISTRATION

Confirmation of Schedules

Contractors submit electronic reports/schedules to the Department in compliance with the following:

- Behavioral Health - HealthChoices Behavioral Health Financial Reporting Instructions for Primary Contractors. Various reports are cumulative and year-to-date and/or contract-to-date amounts are calculated based on prior submissions. The IPA must confirm that the reports they are examining represent the data received electronically by DHS on or prior to the submission deadline.
- Physical Health – Electronic Financial Reporting and Monitoring System– (E-FRM). This electronic reporting process utilizes locked templates (format) supplied by DHS for the Contractor to complete and upload.
- CHC – CHC E-FRM system. This electronic reporting process utilizes locked templates (format) supplied by DHS for the Contractor to complete and upload.

When DHS receives the contract year-end submissions, the respective office (OMHSAS, OMAP, or OLTL) will forward an electronic copy of the reports/schedules to be examined to the IPA. It is the responsibility of the IPA to determine if the reports provided by the office correspond to the reports to be examined provided by the contractor, and to report any variances as examination adjustments.

OMAP requests that the IPA recommend to the HC physical health contractor that the reports/schedules should be resubmitted through the OMAP's HC E-FRM if the IPA determines variances exist.

OMAP will also forward the HC physical health Claims Processing Report #1 that is selected for examination. In addition, OMAP will inform the IPA of the monthly report selected for sample testing of claims receipt and processing.

OLTL requests that the IPA recommend to the CHC- MCO that the reports/schedules should be resubmitted through OLTL's CHC E-FRM site if the IPA determines variances exist.

OLTL will also forward the CHC Claims Processing Reports #3(A and B) that are selected for examination. In addition, OLTL will inform the IPA of the monthly report selected for sample testing of claims receipt and processing.

Outlined below are the OMAP HC steps and due dates for the IPA's reporting package:

OMAP Due Date	HC Physical Health Task
August 31 of the previous calendar year	MCO submits annual Report 40 through E-FRM
November 1 of the previous calendar year	MCO submits annual Report 26 and Report 27 through E-FRM
November 30 of the previous calendar year	MCO submits annual Report 42 through E-FRM
March 10	MCO completes submission of 4 th quarter reports (#2, 4 A-D, 5 A-D, F-I(V, W, X, & Z), 6 A& B, 7E, 8 A-C, 13 A&B, and Claims Processing Report #1) through HC Physical Health E-FRM DHS forwards the reports to the IPA as the confirmed schedules
May 1	MCO submits annual Report 41 through HC Physical Health E-FRM DHS forwards the reports to the IPA as the confirmed schedules Based on procedures performed, the IPA recommends adjustments, if any, to the MCO
June 16	Last day for MCO to submit revised reports to DHS DHS forwards the reports to the IPA as confirmed schedules
June 30	IPA will review the revised reports and submit the completed IPA package

Outlined below are the OLTL CHC steps and due dates for the IPA's reporting package:

CHC Due Date	CHC Task
November 30 of the previous calendar year	MCO submits annual Report #42 through E-FRM.
March 11	MCO completes submission of 4 th quarter reports (#2, 4 A-H, 5 A - V, 6 A-B, 8 A-C, 13 A&B, and Claims Processing Report #3 A) through CHC E-FRM DHS forwards the reports to the IPA as the confirmed schedules
May 1	Based on procedures performed, the IPA recommends adjustments, if any, to the MCO
June 17	Last day for MCO to submit revised reports to DHS DHS forwards the reports to the IPA as confirmed schedules
July 1	IPA will review the revised reports and submit the completed IPA package

Confirmation of Payments

Confirmation of payments received directly from DHS is available from the Comptroller Operations, Bureau of Payable Services, which processes all requests for confirmation. Such requests should always include the number of the contract and or MA Provider Identification number/Location number as well as the name of the program (e.g.: HealthChoices or Community HealthChoices). Requests must include the type of payments to be confirmed, the time period to be confirmed for each type of payment, as well as the total of the payments per type (e.g., capitation, pay for performance). Amounts to be confirmed should consist of capitation or gross payments (without sanctions deducted). The amount to be confirmed should not be reduced by the amount of the Managed Care Assessment

When requesting confirmation of capitation payments where a delay exists, the amounts must be based on:

- Behavioral - the date of service. For example, if the request is for dates of service within calendar year (CY) ended December 31, the confirmation would be based on the actual month of service regardless of payment date (e.g., December 31 dates of service pay in January; the Bureau of Payable Services, would confirm December's amount as part of the CY December 31 confirmation).
- Physical - the date of payment. For example, if the request is for dates of payment within calendar year (CY), the confirmation would be based on actual cash payments (regardless of the date of service) for the CY and would not consider the capitation payment delay.
- CHC - the date of payment. For example, if the request is for dates of payment within calendar year (CY), the confirmation would be based on actual cash payments (regardless of the date of service) for the CY and would not consider the capitation payment delay.

Confirmation of rates is also available from Comptroller Operations, Bureau of Payable Services. Requests for the confirmation of rates should include the following:

1. Program (HC Behavioral Health, HC Physical Health or CHC)
2. Provider Number
3. Zone
4. Rate Period
5. County Grouping (Include Rate Region for CHC)
6. Rate Type (RARs, Base, Interim, Final)
7. Category of Aid / Rate Cell Description
8. With or Without Assessment

Confirmation requests should be emailed to RA-OBMCORevenue@pa.gov.

Examination Adjustments – Behavioral

Examination adjustments should be determined based on materiality at the financial schedule level. Various financial schedules (Supplemental Guidance) require that examination adjustments result in the submission of revised schedules with detailed explanations included in the footnotes. If no adjustments are required, a definitive statement to that effect should be included on the schedule in question. Examination adjustments specified in the schedules must be explained in sufficient detail in the footnotes by rating group and category of service (where applicable).

Independent Accountant’s Reports

The following reports are considered an integral part of the IPA’s report package required to be submitted by this Guide. The IPA’s report package should include: the Independent Accountant’s Attestation Examination Report on Financial Schedules, Financial Schedules, Notes to the Financial Schedules, Independent Accountant’s Compliance Attestation Examination Report on Management’s Assertions, and the Management’s Assertion Letter.

Independent Accountant’s Attestation Examination Report on Financial Schedules

A separate Attestation Examination Report should be issued to address the following Financial Management Compliance Requirements contained in the Program Compliance portion of this Audit Guide:

Behavioral

- A. Report #2, Primary Contractor Summary of Transactions
- B. Report #3, Subcontractor Summary of Transactions
- C. Report #4, Related Party Transactions and Obligations
- D. Report #6, Claims Payable (Received But Unpaid Claims (RBUC) and Incurred But Not Reported (IBNR))
- E. Report #7, Lag Reports
- F. Report #9, Analysis of Revenues and Expenses
- G. Report #12, Reinvestment Report
- H. Report #13, Balance Sheet/Statement of Net Assets
- I. Report #29, Community Based Care Management

Physical

- A. Report #2, Related Party Transactions and Obligations
- B. Report #4 (A, B, C, D), Lag Reports
- C. Report #5 (A-D, F-I, V, X, W and Z), Income Statement
- D. Report #6A, Inpatient, Physician and Dental Statistics Report #6B, Pharmaceutical Price and Utilization Statistics
- E. Report #7E, Emergency Department Utilization
- F. Report #8 (A, B, C), Coordination of Benefits Reports
- G. Report #13 (A, B), Subcapitation Summary and Detail Data Reports
- H. Report #26 (A, B), Maternity Revenue and Medical Expense Annual Statement
- I. Report #27, Maternity Outcome Counts
- J. Report #40, Provider Pay for Performance (P4P) Reconciliation
- K. Report #41, (A, B), Risk Pool

- L. Report #42, MLR Reports

CHC

- A. Report #2, Related Party Transactions and Obligations
- B. Report #4 (A-H), Lag Reports
- C. Report #5 (A – H, and V), Income Statement
- D. Report #6A, Nursing Facility and Person Assistance Statistics
- E. Report #6B, Pharmaceutical Price and Utilization Statistics
- F. Report #8 (A, B, C), Coordination of Benefits Reports
- G. Report #13 (A, B), Subcapitation Summary and Detail Data Reports
- H. Report #14, In-Lieu Of Services Summary Report
- I. Report #15, Expanded/Value-added Services Summary Report
- J. Report #42, Medical Loss Ratio Report

This Attestation Examination Report should be prepared in accordance with [GAGAS](#) and with [Standards for Attestation Engagements](#) established by the AICPA. If the auditors have a finding in the audit, the appropriate Bureau will follow-up with the MCO, and if necessary, will request a corrective action plan. The contractor response to IPA findings should include specific steps that will be implemented by the contractor to ensure that the finding is not repeated in subsequent years.

Independent Accountant's Compliance Attestation Examination Report on Management's Assertions

A separate Compliance Attestation Examination Report on management's assertions should be issued to address the following sections contained in the Program Compliance portion of this Audit Guide:

Behavioral

- ◆ Claims Processing (Compliance Requirement A through F)
- ◆ MIS/Encounter Data Reporting (Compliance Requirement G through H)
- ◆ Health Services Delivery System/MCO/MCO Subcontractor Incentive Arrangements (Compliance Requirement I and J)
- ◆ Financial Management Compliance Reports (Compliance Requirement K)
- ◆ Financial Management Report #17 Contract Reserves (Compliance Requirement L)
- ◆ Financial Management Accountability of Revenues and Expenses (Compliance Requirement M)
- ◆ Financial Management Co-Mingling of Funds (Compliance Requirement N)
- ◆ Financial Management Parental Guaranty (Compliance Requirement O)

Physical

- ◆ Claims Processing
- ◆ MIS/Encounter Data Reporting
- ◆ Health Service Delivery System/Provider Incentive Arrangements
- ◆ Financial Management Compliance Reports

CHC

- ◆ Claims Processing
- ◆ MIS/Encounter Data Reporting

- ◆ Health Service Delivery System/Provider Incentive Arrangements
- ◆ Financial Management Compliance Reports

Management’s assertions should be prepared and reported on as a separate document and included with the Accountant’s Compliance Attestation Examination Report. Management’s assertions should be presented on management’s letterhead, signed by a responsible primary contractor official, and dated. The following additional reports should be attached:

Behavioral - Report #17

Physical - Claims Processing Report #1 (A-D)

CHC - Claims Processing Report #3A

This compliance attestation examination report should be submitted concurrently with the annual HealthChoices Behavioral/Physical Health and CHC financial schedule examination. It should be prepared in accordance with [GAGAS](#) and with AICPA’s [Statements on Standards for Attestation Engagements](#). If the auditors have a finding in the audit, the appropriate Bureau will follow-up with the MCO, and if necessary, will request a corrective action plan.

Behavioral Health – Defined Regions

- Southeast Zone: Bucks, Chester, Delaware, Montgomery, Philadelphia
- Southwest Zone: Allegheny, Beaver, Fayette, Southwest Behavioral Health Management (Armstrong/Indiana Behavioral & Development Health Program, Butler, Lawrence, Washington, and Westmoreland),
- North Central Zone: Behavioral Health Alliance of Rural Pennsylvania (BHARP) (Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Greene, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, Wayne)
- Lehigh Capital Zone: Adams/York Joinder Board, Berks, Capital Area Behavioral Health Collaborative (CABHC) (Cumberland, Dauphin, Lancaster, Lebanon, and Perry), Lehigh, Northampton
- Northeast Zone: Northeast Behavioral Health Care Consortium (NBHCC), (Lackawanna, Luzerne, Susquehanna, Wyoming)

North Central County Option: Behavioral Health Services of Somerset & Bedford Counties, Central PA Behavioral Health Collaborative (Blair), Cambria, CMP Joinder Board (Carbon/Monroe/Pike), Erie County, Lycoming/Clinton Joinder Board, Northwest Behavioral Partnership (Crawford, Mercer, Venango), Tuscarora Managed Care Alliance (Franklin/Fulton)

Physical Health – Defined Regions

Southeast Zone: Bucks, Chester, Delaware, Montgomery, Philadelphia

Southwest Zone: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, Westmoreland

Lehigh/Capital Zone: Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, York

New West Zone: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, Warren

New East Zone: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming

Community Health Choices – Defined Regions

Southeast Zone: Bucks, Chester, Delaware, Montgomery, Philadelphia

Southwest Zone: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, Westmoreland

Lehigh/Capital Zone: Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, York

Northeast Zone: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming

Northwest Zone: Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, Warren

BEHAVIORAL HEALTH

PROGRAM COMPLIANCE – BEHAVIORAL HEALTH

Claims Processing

Objectives

The purpose of a claims processing system is to:

- ♦ Arrange for and reimburse in-network health care providers accurately and timely for covered services rendered, and non-participating or unauthorized health care providers for any appropriate out-of-plan services.
- ♦ Provide for claims administration which includes maintenance of fee schedules; procedure coding; benefit determination - including the arrangement for and reimbursement of in-network providers for covered services rendered and non- participating or unauthorized providers for any appropriate out-of-plan services; claims processing - including timely and accurate adjudication, auditing and quality review; claims payment - including timely payment to providers and subrogation investigation/pursuit of potential third party recoveries.
- ♦ Maintain a current membership management information system that has the capability to receive data transfers of member enrollment/disenrollment information via electronic Health Information Portability Accountability Act (HIPAA) Compliant 834 files. Data files must provide accurate information on dates of MCO coverage for each recipient consistent with information provided by the Department. Member enrollment/disenrollment information may be maintained on a system separate from the claims processing system.
- ♦ Maintain a provider management system that has the capability to pay providers appropriately and timely.
- ♦ Provide reports that can be utilized by member services, provider relations, utilization management and quality improvement departments of the managed care organization.
- ♦ Enable the Contractor to accept encounters from in-network health care providers accurately and timely for covered services rendered.
- ♦ Enable the Contractor to identify liable third parties for services rendered to recipients, avoid payments where a third party is responsible as appropriate, and recover payments when a third party is subsequently identified.
- ♦ Enable the Contractor to support data reporting requirements defined in the HealthChoices contracts, and generate data necessary for financial and program evaluation, both at the Contractor and Commonwealth level.
- ♦ Detect suspected instances of recipient and provider fraud and abuse

Adequate and timely payment procedures for non-participating providers ensures appropriate use of HealthChoices program funds and assures enrollees and providers that appropriate services are accessible.

HealthChoices Agreement Requirements

The Contractor must provide DHS with accurate reports on provider payments and claims processing.

The Contractor must have appropriate procedures to pay for or deny provider claims. Claims reviewed and denied should be communicated appropriately to the health care provider with opportunity given to appeal denied claims within time frames established in the HealthChoices contract.

The Contractor must have procedures and reporting mechanisms to accurately identify liable third parties, to avoid and recover costs as appropriate, and to make a payment where a third party has made a partial payment for a service.

NOTE: The Contractor is required to process and pay Intensive Behavioral Health Services (IBHS) claims prior to initiating any cost recovery procedures.

The Contractor must have a strategy to detect and report recipient and health care provider fraud and abuse. Suspected and substantiated fraud and abuse must be reported to the DHS, OMHSAS Field Office, Bureau of Program Integrity (BPI), or the OMAP, Bureau of Managed Care Operations as applicable.

With respect to member enrollment/disenrollment, the Contractor must have in effect written administrative policies and procedures which direct the receipt, update and testing of electronic HIPPA compliant 834 files from DHS. The DHS will provide the Contractor with enrollment information for its members including the beginning and ending effective dates of enrollment. The data provided will include new enrollments, disenrollments and demographic changes. It is the responsibility of the Contractor to take necessary administrative steps consistent with dates established by the DHS.

Pennsylvania Autism Insurance Act 62 of 2008 (Act 62)

Most sections of Act 62 went into effect on July 1, 2009. Broadly speaking, Act 62 has three primary requirements:

- ♦ It requires many private insurers to begin covering the costs of diagnostic assessments for autism and of services for individuals with autism who are under the age of 21, up to a specified amount published annually. The maximum benefit is adjusted annually, by April 1, by the Pennsylvania Insurance Department, and can be found in the [PA Bulletin](#);
- ♦ It requires DHS to cover those costs for eligible individuals who have no private insurance coverage, or for individuals whose costs exceed the published maximum benefit that year. For policies issued or renewed during the calendar year under audit, see the [PA Bulletin](#) for maximum costs established annually, by April 1, by the Pennsylvania Insurance Department; and
- ♦ It requires the Pennsylvania Department of State to license professional behavior specialists, and to establish minimum licensure qualifications for them.

We expect that affected claims may require additional processing time; therefore, the DHS is extending the time period to 180 days for processing Act 62 claims.

Compliance Requirements and Suggested Procedures

A. Compliance Requirement

The Contractor must have a claims processing system and MIS sufficient to support the provider payment and data reporting requirements specified in Part II-7, Section M of the HealthChoices Program Standards and Requirements (PSR).

Suggested Procedure:

1. Obtain and review the policies and procedures related to the application requirements defined in the PSR. Verify that specific requirements address the completeness, timeliness, and accuracy of claim data and standing reference (i.e., diagnosis codes, pricing, effective dates, DHS-assigned codes, PSR codes, etc.) data input for processing, the ongoing control and maintenance of this data, and the payment of claims. Testing for completeness, timeliness, and accuracy of claims should include, but is not limited to, the following verifications:
 - a. Universe of Behavioral claims for the period of the engagement is complete.
 - b. Sample selected is representative of the Universe.
 - 1) A portion of the claims tested must be adjusted claims and manually entered claims. These adjusted claims should be further tested to determine that the adjustment process defined in the PSR has been followed and that the adjusted claims contain the necessary information to link the adjusted claims with the original claims.
 - 2) In determining if the sample is representative, the IPA should consider whether the sample included each of the following types of claims: institutional, professional, and voided. The IPA should also consider the extent to which each type of claim exists in the entire Universe.
 - c. Both the HIPAA standard data element code sets that are submitted on electronic claims, and the data element code sets that are submitted on manual claims can be successfully cross walked to the codes that are acceptable on DHS encounter records.
 - d. The claim reference information on the claim form can be linked with the Encounter Claim Reference Number.
 - e. The information on the original and adjusted claims can be matched for accuracy and completeness to the encounters.
 - f. The recipient identification number agrees with, or can be cross walked to, the DHS's Recipient CIS Number.
 - g. The recipient is eligible for service on the date(s) service is provided.
 - h. The recipient is eligible for the type of service provided.
 - i. If the claim does not indicate other insurance or Medicare as a third-party payer, ensure that the file does not include information that the recipient is covered by other insurance or Medicare on the date(s) service is provided. If the claim does indicate other insurance or Medicare as a third-party payer, ensure that the amount paid is calculated correctly.
 - j. The provider identification number agrees with, or can be cross walked to, the DHS's MA Provider Number.
 - k. The amount paid to the provider by the Contractor is in accordance with the

HealthChoices contract and the provider agreement.

1. Where the claims information is manually input, the information on the system regarding the diagnosis code, type of service, procedure code, and revenue code, units of service and dates of service agrees with information on the input document.

B. Compliance Requirement

Under Section 1902(a) (25) of the Social Security Act, DHS is required to take all reasonable measures to identify legally liable third parties and treat verified Third Party Liability (TPL) as a resource of the MA recipient. Under the HealthChoices Program, TPL activities will be shared between DHS's TPL Section, and the Contractor as described in Part II-7, Section L. of the PSR.

Suggested Procedures:

1. Determine if adequate policies and procedures are in place for the payment of claims with health-related insurance (i.e.: cost avoidance through the identification of liable third parties).
2. Determine if adequate policies and procedures are in place for the payment of accident/injury claims (i.e.: the contractor is responsible for payment of accident/injury claims and reporting accident/injury claims to DHS for recovery of identified liable third parties).
3. Determine if adequate policies and procedures are in place for the recovery of claims when health-related insurance is identified after a claim is paid(retroactive).
4. Determine if adequate policies and procedures are in place to supply the Department's TPL Division Third Party Resources identified by the Contractor or its Subcontractors, which do not appear on the Department's TPL database, within two weeks of its receipt by the Contractor in accordance with the HealthChoices Program Standards and Requirements, Primary Contractor, Part II-7(L), Third Party Liability.
5. Determine if adequate policies and procedures are in place to verify the validity of a resource in question supplied by the Department to the Contractor timely as outlined and in accordance with HealthChoices Program Standards and Requirements, Primary Contractor, Part II-7(L), Third Party Liability.
6. Determine if adequate policies and procedures are in place for providing, at the Department's request, information included in the Encounter Data submissions that may be necessary for the administration of TPL activity in accordance HealthChoices Program Standards and Requirements, Primary Contractor, Part II-7(L)(4), Requests for Additional Data.
7. Evaluate the policies and procedures for reporting COB/TPL Financial Reports (Report #11-C) to DHS. The IPA should review the Agreement and Financial Reporting Requirements (FRR) requirements for COB/TPL, then evaluate the Contractor's policies and procedures to determine if they adequately address all TPL requirements. The IPA should then review the Contractor's compliance with the Agreement and FRR requirements for reporting to DHS.
8. Determine if the policies and procedures ensure that the required information is reported timely and accurately to DHS. The IPA should ensure that there are policies and procedures in place to (1) submit Report #11 within the timeframes referenced in Section 3.11 of the FRR, (2) properly report all required TPL activity within the timeframe that it occurred, and (3) include the information required in Section 3.11 of the FRR.

C. Compliance Requirement

The Contractor must establish a mandatory written compliance plan designed to guard against fraud and abuse as described in the PSR (Behavioral – PSR Section II-5.I. and Appendix F).

Suggested Procedures:

1. Obtain the Contractor's compliance plan, policies, and procedures to prevent and detect fraud and abuse by members, providers, and employees in relation to the HealthChoicesPSR (Behavioral - PSR Section II-5. I. and Appendix F). Review the policies and procedures to ensure that they identify the specific controls in place for fraud and abuse detection, and the process for preventing, investigating, and reporting any fraud or abuse.
2. Ensure that there is a designated compliance officer, a regulatory compliance committee on the board of directors, and staff who have designated as part of their responsibilities the proactive detection, prevention, and elimination of instances or patterns of fraud and abuse. Verify that procedures have been developed and communicated to the appropriate personnel.

D. Compliance Requirement

As described in Section II-5.I. and Appendix F of the PSR, the Contractor shall maintain and comply with written policies and procedures for the prevention, detection and reporting of suspected fraud and abuse. These policies and procedures are subject to the approval of DHS's BPI. One of these required policies and procedures is a method for verifying with a portion of recipients whether services billed by providers were received.

Suggested Procedures:

1. For the policies and procedures covering the prevention, detection and reporting of suspected fraud and abuse, verify that any revisions were submitted to DHS's BPI for approval.
2. Review examples of the Contractor's verification with recipients that services billed by providers were received.
 - a. Confirm the verification took place during the program year.
 - b. Verify the recipient was enrolled in HealthChoices at the time of service.

E. Compliance Requirement

As described in Section II-5.I. and Appendix F of the PSR, the Contractor must immediately notify DHS's BPI when a provider has disclosed information regarding a criminal conviction related to Medicare, Medicaid, or Title XX when making application to be credentialed as a Behavioral Health (BH)- MCO network provider or upon renewal of their credentialing. The Contractor shall also notify DHS's BPI of an adverse action, such as convictions, exclusions, revocations, and suspensions taken on provider applications including denial of initial enrollment.

Suggested Procedures:

1. Determine if the Contractor has adequate policies and procedures for notifying DHS when a provider has disclosed information regarding a criminal conviction related to Medicare, Medicaid, or Title XX.
2. Confirm the Contractor requires providers to disclose information regarding a criminal conviction related to Medicare, Medicaid, or Title XX when making application to be credentialed as a BH-MCO network provider, or upon renewal of their credentialing.
3. Determine if the Contractor has adequate policies and procedures for notifying DHS of any adverse actions.

E. Compliance Requirement

1. The Contractor must have access for on-line inquiries and file transfers as specified in Appendices M and O of the PSR.
2. The Contractor accesses the following system files as required by any relevant Departmental communications.
 - a. Client Information System/Eligibility Verification System
 - b. Procedure Code Extract File
 - c. Provider Files
 - d. Third Party Liability File
 - e. Diagnosis File
3. The Contractor receives and processes in house, the following files:
 - a. 834 Daily Enrollment/Disenrollment File
 - b. 834 Monthly Enrollment/Disenrollment File
 - c. MCO Payment Summary File (Monthly)
 - d. Procedure Code Extract File (Monthly)
 - e. Reference Diagnosis Code File (Monthly)
 - f. PRV 414/PRV 415 MA Provider File (Weekly/Monthly)
 - g. ARM568 Report File (Monthly)
 - h. 820 Capitation File (Monthly)
 - i. TPL File (Monthly)
 - j. PRV 430 NPI Crosswalk
 - k. PRV 435 Special Indicator File
 - l. PRV 720 Provider Revalidation File

Suggested Procedures:

1. Obtain and review the Contractor's policies and procedures related to accessing and retrieving DHS files as specified in the PSR. Ensure the policies and procedures identify each of the files listed above.
2. Request a demonstration of the access of DHS files by the Contractor. Through the demonstration verify the Contractor is knowledgeable of the files to be accessed and the use of the file access system.
3. Review the Contractor's computer system daily logs for evidence of the connection and file transfer and timely update of the Contractor's files.
4. Confirm that the Contractor has processed and loaded the daily 834 files in their entirety within 24 hours of receipt.

Management Information System (MIS)/Encounter Data Reporting

Objective

The Contractor, MCO, MCO Subcontractor, and ASO as applicable must have effective

procedures to compile, analyze, evaluate, and report data critical to the operations of the HealthChoices program managed care product, including encounter data. Encounter data or other appropriate information can assist to determine how and when Plan services are being utilized, to set future rates, to determine program effectiveness, and to evaluate performance management. MIS is a critical area for any MCO to understand and monitor the financing, delivery, and effectiveness of the health care. It is only through information collection, reporting, and analysis that a contractor will be able to determine, in a managed care environment, how services are being delivered and whether adequate resources are available.

Compliance Requirements and Suggested Procedures

G. Compliance Requirement

The Contractor shall be responsible for maintaining appropriate systems and mechanisms to obtain all necessary data from its health care providers to ensure its ability to comply with the encounter data (and other data reporting) requirements as required by Appendix M and Appendix R of the PSR.

Suggested Procedures:

1. Obtain and review the Contractor's procedures related to the input of claims and encounters data submitted (consider paper and/or electronic submissions) by the provider. Ensure the procedures address manual steps and/or electronic edits designed to ensure the complete and accurate input of the data. Specifically, identify the process for resolving missing, incomplete, or invalid claims and encounter data received from the health care provider.
2. Obtain and review the Contractor's procedures related to monitoring the continued completeness and accuracy of the claims and encounter data once input and residing on a standing data file. The procedures should address run-to-run balancing routines and programmer and user access restrictions to the data files.
3. Obtain a sample (representative of the Universe) of individual encounters as submitted by the Contractor to DHS throughout the period under review. A portion of the encounters tested must be adjusted encounters. Ensure that the Contractor's procedures related to converting the claim or encounter to the 837I and 837P record format required by DHS are complete and accurate.
 - a. Ensure that the Contractor's procedures related to converting the claim or encounter to the 837I and 837P record format required by DHS are complete and accurate.
 - b. Evaluate the length of time between the claim's date of the Contractor's adjudication and the date of the encounter's receipt in PROMISE. All Contractor approved encounters and those specified Contractor denied encounters must be approved in PROMISE by the last day of the third month following the month of initial Contractor adjudication. Compare the sample encounter records to the claims and encounters submitted by health care providers to the Contractor for accuracy of recipient identification, procedure coding, including modifiers, diagnosis coding, revenue codes where applicable, place of service, category of service coding, amount paid, service date, units of service delivered, appropriate bill type when applicable, Provider ID, COB/TPL information, and date of receipt by the Contractor. The comparison should consider any differences in converting the HIPAA standard data element code sets that are submitted on electronic claims and

the data element code sets that are submitted on manual claims to the DHS required codes for encounter reporting.

- c. Review the Contractor's documentation of its capabilities to transfer files.
4. Determine whether the Contractor has issued a data confidentiality policy to all employees with access to the various applications and data and verify that this data confidentiality policy is enforced.

NOTE: Claims and encounters codes may have to be cross walked to the codes required by DHS for encounter reporting.

H. Compliance Requirement

DHS requires the Contractor to submit a separate record or "encounter" each time a member has an encounter with a provider.

Person-Level Record The person level record must include, at a minimum, the data elements as required for a HIPAA compliant 837 transaction.

Suggested Procedures:

1. Compare a sample of the encounters data received by the Contractor from the provider with the records submitted in the Encounter file to ensure that the Contractors are reporting all encounters as person-level Encounter records. The Rating Group should be determined in accordance with the Managed Care Payment System Table (See Supplemental Guidance), and category of service should be determined in accordance with the HealthChoices BHSRCC (See Supplemental Guidance).
2. Compare a sample of payments made to the providers for any payment agreements other than fee-for-service (i.e.: Alternative Payment Arrangement (APA) retainer, case rates, bundled case rates, etc.) with the Financial APA records to ensure that all provider payments are being reported completely and accurately to DHS.
3. Verify that the Alternative Payment Arrangement has been approved by DHS.

Health Service Delivery System/MCO/MCO Subcontractor/ASO Incentive Arrangements

Requirement Objective

The Commonwealth has offered Counties the right of first opportunity to administer the HealthChoices program in order to better coordinate behavioral health services provided under MA, with other publicly funded behavioral health and human services. The Commonwealth wishes to ensure that contractual incentive arrangements between the Counties and their MCO/MCO Subcontractor/ASO are appropriate, and that the amounts due to/from the MCO/MCO Subcontractor/ASO and the Counties are accurately calculated. Errors in calculations may result in inaccurate amounts being reported for reinvestment plans, or amounts required to be returned to the Counties or the Commonwealth. The Commonwealth also wishes to ensure that the Counties' policies and procedures for oversight and monitoring of any incentive arrangements are complete and effective.

Additionally, in subsequent years of the HealthChoices program, the Commonwealth may audit the provider incentive arrangements between the Contractor and its providers, and/or the County's MCO/MCO Subcontractor/ASO and its providers, if such arrangements exist.

The Commonwealth will pay the Contractors a capitation payment for state-plan services. The Contractors are at full risk for providing services and the Commonwealth must be assured that the Contractors do not inappropriately motivate their MCO/MCO Subcontractor/ASO.

Compliance Requirements and Suggested Procedures

I. Compliance Requirement

The contractual arrangement, and any contract amendments between the Contractors and their MCO/MCO Subcontractor/ASO, should define the financial incentive plan and any related objective benchmarks.

Suggested Procedure:

Examine the contracts between the Contractors and the MCO/MCO Subcontractor/ASO for the financial incentive provision.

- a. Review the financial incentive provision in the contract, and any contract amendments.
- b. Assure that the provision is clear by defining the benchmarks that the MCO/MCO Subcontractor/ASO must attain to receive the incentive.
- c. Ensure that the benchmarks are reasonable and do not create a disincentive for the MCO/MCO Subcontractor/ASO to provide proper care or utilize medically necessary services.
- d. Determine if the MCO/MCO Subcontractor/ASO is responsible for attaining savings on behavioral health services or administrative services in order to achieve the incentive payment.

J. Compliance Requirement

The Contractors must have control procedures in place to determine whether the MCO/MCO Subcontractor/ASO is eligible for an incentive payment, the amount of the payment, and the timing of the payment. These controls will be related to the policies and procedures of the Contractor.

Subcontracts may contain provisions requiring MCO/MCO Subcontractor/ASO to have audits of the incentive payment calculations. Where such provisions exist, the County should have in place procedures to ensure that such audit reports are both submitted and reviewed timely, and that needed adjustments are made.

Suggested Procedures:

1. Review the Contractor's policies and procedures relating to the collection of necessary financial and program information for purposes of monitoring and assuring the appropriateness of the calculation, amount, and timing of the incentive payment. Review any quarterly or annual reports submitted in accordance with contractual or Contractor - directed requirements.
2. If the MCO/MCO Subcontractor/ASO is eligible for an incentive payment, determine that the amount of incentive payment calculated meets all the contractual requirements and does not exceed the amount set aside for this purpose.
 - a. The amount available for the incentive payment is held by the Primary Contractor. This amount should agree with the amount on the Annual Counterpart Report #2, Line 6, plus any accrued interest or other increases/decreases indicated in the contracts or amendments.
 - b. If the amount available for the incentive payment is held by the Subcontractor, this amount should agree with the amount on the Annual Counterpart Report #3, Line 6, plus any accrued interest or other increases/decreases indicated in the contracts or amendments.
3. Where Contractor subcontracts contain provisions requiring MCO/MCO Subcontractor/ASO to have audits of the incentive payment calculations, determine that procedures are in effect to obtain and review such audit reports, and to make needed adjustments.

Financial Management Compliance Reports

K. Compliance Requirement

Each participating Contractor, at its expense, is required to provide to DHS an annual HealthChoices contract examination prepared by an IPA. This examination must include the specific financial schedules described in Table 1, below, along with accompanying Notes to the Financial Schedules. These Notes must contain descriptions of methodologies regarding revenue and expense allocation used in preparing the financial schedules.

NOTE: The IPA should also see related guidance in the Notes to the Financial Schedules in Supplemental Guidance. The formats for the contract examination financial schedules are included in Supplemental Guidance.

Table 1

<i>Report #</i>	<i>Name</i>	<i>Description</i>	<i>Required by:</i>
2	Primary Contractor Summary of Transactions	Report containing all capitation, investment and other revenue received during the year, as well as disposition of these funds.	ALL
3	Subcontractor Summary of Transactions	Report containing Subcontractor receipt of capitation revenues from the Contractor and investment and other revenues earned during the year, as well as disposition of these funds.	N/A for counties with ASO contracts
4	Related Party Transactions and Obligations	Report that provides for the proper disclosure of all related party transactions, including the description of relationship, types of transactions conducted during the past year, and the resultant revenue and/or expense generated by each transaction. It should be further noted that the Contractor and the MCO/MCO Subcontractor are required to submit separate reports.	ALL
6	Claims Payable (RBUCs and IBNRs)	Report presenting RBUC and IBNR balances at year end.	ALL
7	LAG Reports	Report containing historical payment patterns.	ALL
9	Analysis of Revenues & Expenses	Presents an analysis of revenues and expenses, by category of service and rating group.	ALL
12	Reinvestment Report	Reports expenditures for approved reinvestment plans, by contract year.	ALL
13	Balance Sheet/ Statement of Net Assets	Reports assets and liabilities of Enterprise/ Special Revenue Fund for the reporting period.	ALL
29	Community Based Care Management (CBCM) Program	Report containing expenditures for approved CBCM yearly proposals	ALL

Contract Requirements

Each Contractor will provide a Report on the Examination of Financial Schedules. Along with the applicable financial schedules, this package should include a report of independent accountants on

financial schedules #2, #3, #4, #6, #7, #9, #12 and #29. Additionally, any Primary Contractor who is not a private-sector BH-MCO with a Risk and Contingency Fund should include Report #13 in their reports. All report packages should include accompanying Notes to the Financial Schedules.

Accountability of Revenue and Expenses

The HealthChoices Contractors and their MCO/MCO Subcontractors are required to have separate bank accounts for all HealthChoices transactions.

Co-Mingling of Funds

The HealthChoices Counties are prohibited from using state and federal funds allocated to the County's mental health and/or drug and alcohol programs to fund the HealthChoices Program.

Parental Guaranty

Many contractors use a Parental Guaranty as a method of meeting the Insolvency Requirement. As a condition of accepting the Parental Guaranty, the DHS requires quarterly monitoring of the parent's financial condition by either the Primary Contractor, or the BH-MCO.

Compliance Requirements and Suggested Procedures

Compliance Requirement - Report #2

This report should be accurately compiled in accordance with instructions included in the FRR.

The objective of Report #2 is to assist the Commonwealth in understanding the **current year** costs incurred at the Contractor level to administer the HealthChoices program, to provide assurance as to the completeness of revenue reporting, and to be assured that financial sub contractual arrangements are in accordance with contract terms.

The Contractor must report all capitation revenue, as well as investment or other revenue related to the HealthChoices contract (excluding reinvestment account investment income), received during the contract period, and the disposition of these funds, in this report.

The Contractor should report actual HealthChoices administrative expenses on Report #2. It is to the advantage of the County to show these actual costs correctly because any possible future increases in rates for administrative expenses cannot be justified without showing that actual expenses exceeded the amounts received under the administrative portion of the capitation.

Report #2 is to show only actual HealthChoices transactions (i.e.: no funds other than HealthChoices should be included on this report). Since this report is not based on generally accepted accounting principles, it is acceptable to show expenses greater than revenues.

Suggested Procedures:

1. The contract with any subcontractor should be reviewed to recalculate distributions to subcontractor amounts and distributions to management corporation/ASO amounts.
2. All current year revenues and expenses should be classified accurately by rating group (column). Detailed amounts should be tested to substantiate proper classification and accuracy of amounts.
3. Detailed records should be tested to ascertain completeness, accuracy, cutoff, existence, and appropriateness of revenues and expenses included on the schedule. Revenues and expenses should be tested for appropriateness pertaining to the HealthChoices contract.
4. Amounts, where appropriate, should be recalculated to assess the accuracy and completeness of amounts included in each schedule.
5. Schedules and detailed records should be verified for mathematical accuracy.
6. Expense allocations used in preparing the report should be verified for reasonableness and accuracy. Amounts should be agreed to appropriate supporting documentation with recalculations performed, where necessary. Methodologies for allocation, including staff time allocations, should be verified with acceptable methodologies, if any, contained in the contract.
7. Administrative Expenses should be tested to ensure that the costs reported reflect expenses incurred for purposes of administering the HealthChoices Behavioral Health Program **only**.
8. Administrative Expenses should be tested to determine accuracy. This should include ensuring separate reporting of Clinical Care/Medical Management expenses as described in the FRR, Section 3.3, and instructions. Attachment F of the FRR, "Administrative Overhead and Clinical Care/Medical Management Cost Definitions," should be applied in determining which costs are clinical care/medical management, or which costs are administrative overhead for DHS reporting purposes. Indirect overhead and administrative costs should **not** be included in Clinical Care/Medical Management costs.
9. If the County's administrative expenses are equal to either the amount withheld for county administration, or the amount withheld for county administration plus investment income earned, additional testing may be required to ensure that the amounts are complete and accurate.
10. Determine if costs related to changes in organization structure or changes in major subcontractors are included as part of administrative costs. If so, determine whether costs are separately identified on the report so that they can be excluded from the administrative cost base for rate setting projections.
11. Confirm capitation recouped by the Department for members that were in an IMD over 15 days is reported as an offset to Capitation Revenue for any applicable members.

NOTE: Adjustments should result in submission of a revised Report #2, with the notation made in the "Revised Report, see Adjustment List" block on the face of the report. **For this report, and all reports listed below, it is important that adjustments are explained in sufficient detail in the footnotes by rating group. The IPA should consider including a separate page showing adjustments only.**

Compliance Requirement - Report #3

This report should be accurately compiled in accordance with instructions included in the FRR.

The objective of Report #3 is to assist the Commonwealth in understanding the **current year** revenues and expenditures being incurred at the MCO/MCO Subcontractor level to administer the HealthChoices program; to provide assurance as to the completeness of revenue reporting; and to be assured that financial sub contractual arrangements are in accordance with contract terms.

The MCO/MCO Subcontractor must report all capitation revenue received from the Contractor, as well as investment or other revenue related to the HealthChoices contract (excluding reinvestment account investment income) received during the contract period, and the disposition of these funds, in this report.

Suggested Procedures:

1. All current year revenues and expenses should be classified accurately by rating group (column). Detailed amounts should be tested to substantiate proper classification and accuracy of amounts.
2. Detailed records should be tested to ascertain completeness, accuracy, cutoff, existence, and appropriateness of revenues and expenses included on the schedule. Revenues and expenses should be tested for appropriateness pertaining to the HealthChoices contract.
3. Amounts, where appropriate, should be recalculated to assess the accuracy and completeness of amounts included in the schedule in accordance with subcontractor/agreements/contracts.
4. Schedules and detailed records should be verified for mathematical accuracy.
5. Expense allocations used in preparing the report should be verified for reasonableness and accuracy. Amounts should be agreed to appropriate supporting documentation with recalculations performed, where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the contract.
6. Administrative Expenses should be tested to determine accuracy. This should include ensuring separate reporting of Clinical Care/Medical Management expenses as described in the FRR, Section 3.4 instructions. Attachment F of the FRR, "Administrative Overhead and Clinical Care/Medical Management Cost Definitions," should be applied in determining which costs are clinical care/medical management or which costs are administrative overhead for DHS reporting purposes. Indirect overhead and administrative costs should not be included in Clinical Care/Medical Management costs.

NOTE: Adjustments should result in submission of a revised Report #3, with the notation made in the "Revised Report, see Adjustment List" block on the face of the report.

Compliance Requirement - Report #4

This report should be accurately compiled in accordance with instructions included in the FRR.

The objective of Report #4 is to provide the Commonwealth with information regarding costs being incurred via transactions and obligations with related parties or affiliates, particularly those transactions that are not preapproved by the Pennsylvania Insurance Department for licensed entities.

Suggested Procedures:

1. Test the completeness of Report #4 - Related Party Transactions, to ascertain that all related parties and affiliates, as defined by the contract, are listed on the report by performing procedures such as a review of Board minutes, reviewing prior year examination documentation for names of known related parties, reviewing filings with other regulatory/authoritative bodies, and inquiry of management to assist in determining completeness. (An additional source of information for determining completeness of related party transactions is Schedule Y, of the Contractor's annual statement, submitted to the Pennsylvania Insurance Department. Schedule Y is entitled "Summary of the Insurer's Transactions with any Affiliates.")
2. Detailed tests of transactions and balances should include steps to ascertain the completeness of the related party and affiliate transactions.
3. Confirmation of account balances (including loans receivable and payable), paying particular attention to transactions recognized at, or near the end of the period should be performed. The confirmation process should be supplemented with a review of accounting records for evidence of loan guarantees, large, unusual, and/or nonrecurring transactions with officers, directors, and affiliated companies.
4. The "Transaction Code" column data should be traced and agreed to the specific transaction contained within that respective row to ensure the accuracy of transaction codes included in the report.

NOTE: Adjustments should result in submission of a revised Report #4, with the notation made in the "Revised Report, see Adjustment List" block on the face of the report. Adjustments should be explained in sufficient detail in the footnotes.

Compliance Requirements - Report #6

This report should be accurately compiled in accordance with instructions included in the FRR.

NOTE: The Behavioral Health FRR Section 3.7 states that claim liabilities should not include the administrative portion of claim settlement expenses. Any liability for future claim settlement expense must be disclosed separately from the unpaid claim liability.

The objective of Report #6 is to provide information to the Commonwealth on the claims liability each Contractor is experiencing; to be assured that the Contractor has an adequate claims and accrual system in place; to ensure that the methodology being used is adequate; and to ensure that the Contractor is reviewing the liability on a timely basis, particularly for Contractors who have no historical data/experience on which to base their estimates.

The Contractor or its MCO/MCO Subcontractor/ASO is required to report RBUC and IBNR claims payable, by category of service.

Suggested Procedures:

1. RBUCs aging should be tested and evaluated to ensure the accuracy as included on the report by Service Group and Days.
2. IBNRs should be tested and evaluated to ensure the accuracy as included on the report.
3. Items included in the report should be tested and agreed to detailed records to ensure

completeness, accuracy, cut off, and existence of information.

4. Detailed listings should be scanned for unusual items.
5. Determine that appropriate adjustments to IBNR amounts are made where there is a non-routine delay in the notification of claims, a significant volume of unprocessed claims, or a change in the date of closing records.
6. Determine that any claim settlement administrative expenses are reported separately as required in the FRR.
7. Amounts, where appropriate, should be recalculated to assess the accuracy of amounts included in the schedule.
8. Consider the need to have an actuary involved to perform a reserve analysis to ensure the proper valuation of the claims payable. Compare information contained in the actuary's analysis to detailed claim files, as appropriate, to verify the accuracy, completeness, cutoff, and existence of detailed claim information reviewed by the actuary.

NOTE: Adjustments should result in submission of a revised Report #6 with the notation made in the "Revised Report, see Adjustment List" block on the face of the report.

Compliance Requirement - Report #7

This report should be accurately compiled in accordance with the *detailed* instructions included in the FRR. Materiality should be determined at each financial schedule level for Report #7.

The objective of Report #7 is to provide information to the Commonwealth on the historical payment patterns being experienced. Since this data provides a basis for IBNR estimates, it is essential that the lag tables are being developed properly.

The Contractor, or its MCO/MCO Subcontractor/ASO, is required to report its Lag Tables monthly, by category of service.

Suggested Procedures:

1. Claims payments should be tested and evaluated to ensure the accuracy and completeness as included on the report for correct service grouping, month of payment, and month of service provided.
2. Claim files and IBNR amounts should be tested and agreed to detailed records and to the report to ensure completeness, accuracy, cutoff, and existence of information.
3. Detailed listings should be scanned for unusual items.
4. Determine that appropriate adjustments to IBNR amounts are made where there is a non-routine delay in the notification of claims, a significant volume of unprocessed claims, or a change in the date of closing records.
5. Amounts, where appropriate, should be recalculated to assess the accuracy of amounts included in the schedule.
6. Consider the need to have an actuary involved to perform a reserve analysis to ensure the proper valuation of the IBNR claims estimate. Compare information contained in the actuary's analysis to detailed claim files, as appropriate, to verify the accuracy, completeness, cutoff, and existence of detailed claim information reviewed by the actuary.
7. Assess lag technique methodologies for reasonableness.

NOTE: Adjustments should result in submission of a revised Report #7 with the notation made in the “Revised Report, see Adjustment List” block on the face of the report.

The amount in the 24th & prior column on the confirmation schedules will only reflect activity in the 24th prior month. For report purposes, the IPA may identify either the 24th prior month or cumulative data for the 24th & prior months. In either case, the report does not have to be marked “Revised Report” unless other changes have been made to the report.

Compliance Requirement - Report #9

This report should be accurately compiled in accordance with instructions included in the FRR. For purposes of the engagement, quarterly Reports #9, Part A and Part B have been combined. Report #9, for the report package, contains a Per Member Per Month (PMPM) column in lieu of the complete quarterly Report #9, Part B. The PMPM column should be completed in accordance with the FRR instructions for Report #9, Part B.

The objective of Report #9 is to provide the Commonwealth with information on combined Contractor and MCO/MCO Subcontractor **current year** revenues and expenditures for the HealthChoices Behavioral Health program. The rating groups and categories of service crosswalk to the rating groups and service categories contained in the Contractors’ cost proposals when applicable.

For purposes of Report #9, all “Other” revenue reported on Report #2 and Report #3 that represent a transfer of funds between entities should **not** be included on Report #9 (i.e.: sanctions imposed by the County on the BH-MCO, or a transfer of medical management funds.) See line 3, Other Revenue, Section 3.10, of the FRR.

For purposes of Report #9, individual stop loss reinsurance premiums should be reported on line 15a. Reinsurance Recoveries should be reported in the appropriate category of service and rating group. See FRR Section 3.1 for specific instructions for reporting additional amounts as “Other” on Line 15b. (Section 3.10, of the FRR)

For purposes of Report #9, costs must be properly classified as “medical” or “administrative.” “Medical costs” for this report means those costs that represent claims or service costs, which will also have an encounter record, and reinsurance premiums and reinsurance recoveries. All other costs should be classified as “administrative.” Medical costs should be classified by rating group and category of service, as incurred. Administrative costs may be allocated based on an appropriate allocation method, such as the applicable percentage of capitation revenue. Refer to Section 3.10 of the FRR for guidelines for allocating administrative expense amounts. Clinical Care/Medical Management expenses should be reported separately from other administrative costs. Attachment F of the FRR provides a chart to assist in identifying these costs. Refer to revised expense reporting requirements in Section 3.10 of the FRR. **ALL** “Other Medical Services” should be disclosed within the footnotes to Report #9 **by amount, type of service and procedure code** as discussed in Section 3.1, of the FRR. Additionally, Section 3.1, of the FRR discusses the reporting of sanctions.

Suggested Procedures:

1. All current year revenues and expenses should be classified accurately by both category

of service (row) and rating group (column). Detailed amounts should be tested to substantiate proper classification and accuracy of amounts. Rating Group should be determined in accordance with the Managed Care Payment System Table (See Supplemental Guidance).

2. Detailed records should be tested to ascertain completeness, accuracy, cutoff, existence, and appropriateness of revenues and expenses by rating group and category of service included on the schedule. Revenues and expenses should be tested for appropriateness pertaining to the HealthChoices contract. Amounts, where appropriate, should be recalculated to assess the accuracy of amounts included in the schedule. For example, Line #10, IBHS and Line #12, RTF Non-Accredited, should be tested to ascertain that treatment and room and board costs are accurately reported.
3. Schedules and detailed records should be verified for mathematical accuracy.
4. Expense allocations used in preparing the report should be verified for reasonableness and accuracy. Amounts should agree with appropriate supporting documentation and recalculations performed where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the contract.
5. IBNR accrual allocations to the various rating groups should be verified for reasonableness and accuracy. Amounts should agree with appropriate supporting documentation and recalculations performed where necessary.
6. Administrative Expenses should be tested to determine accuracy. This should include ensuring separate reporting of Clinical Care/Medical Management expenses as described in the FRR, section 3.10, instructions. Attachment F of the FRR, "Administrative Overhead and Clinical Care/Medical Management Cost Definitions," should be applied in determining which costs are clinical care/medical management or which costs are administrative overhead for DHS reporting purposes. Indirect overhead and administrative costs should **not** be included in Clinical Care/Medical Management costs.
7. Confirm payments to Opioid Use Disorder Centers of Excellence providers were made in accordance with the OUD-COE appendix to the DHS – Primary Contractor agreement, effective 1/1/17.

NOTE: Adjustments should result in submission of a revised Report #9 with the notation made in the "Revised Report, see Adjustment List" block on the face of the report.

ALL 'Other Medical Services' should be disclosed within the footnotes to Report #9 **by amount, type of service, and procedure code** as discussed in Section 3.1, pages 6 -9 of the FRR.

Compliance Requirement - Report #12

This report should be accurately compiled in accordance with instructions included in the FRR.

The objective of Report #12 is to assist the Commonwealth in tracking expenditures resulting from DHS-approved Reinvestment Plan(s); to provide assurance as to the completeness of expenditure reporting; and to provide assurance that financial information is being reported in accordance with contract and FRR requirements.

The Contractor must report all reinvestment account revenue and expenditures (on a cash basis), as well as other revenue, allocations or contributions, related to the Reinvestment account, in this report. The amounts reported on Report #12 must be segregated and reported by contract year. One report is required for each year and each category only if funds are allocated to or used from

an approved Reinvestment Plan year.

For all Primary Contractors, effective January 1, 2023, the Department will recoup any reinvestment savings in excess of 3% of total HealthChoices Behavioral Health revenue, net of the Managed Care Assessment, in accordance with Appendix 1, Reinvestment Sharing Arrangement, of the January 1, 2023 contract amendment.

The notes to the financial schedules MUST include a calculation of estimated funds identified as being available for reinvestment from the year being examined. Refer to the suggested format for calculating excess funds available for reinvestment within the Supplemental Guidance for Behavioral Health.

Suggested Procedures:

1. Reinvestment funds must be maintained in a separate reinvestment bank account.
2. Revenues and expenditures should be tested to substantiate proper classification by contract year and rating group.
3. Estimated funds available for reinvestment from the current year should be calculated in accordance with the contracts and subcontracts between DHS and the counties and/or the counties and the BH-MCO as applicable.
4. Reinvestment expenditures are only permitted for initiatives contained in DHS approved reinvestment plans. All expenditures on Report #12 should be compared to the appropriate plan for accuracy of initiative amounts, and to substantiate proper classification by plan.
5. Detailed records should be tested to ascertain completeness, accuracy, cutoff, existence, and appropriateness of revenues and expenses included on the schedule. Revenues and expenses should be tested for appropriateness pertaining to the HealthChoices contract, FRR, and DHS-approved Reinvestment Plan. Verify beginning balance agrees with ending balance of prior year (NOTE: Beginning balance for the first year of participation is 0).
6. Schedules and detailed records should be verified for mathematical accuracy.
7. Expense allocations used in preparing the report should be verified for reasonableness and accuracy. Amounts should be agreed to appropriate supporting documentation with recalculations performed, where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the FRR or Reinvestment Plan.
8. The IPA must examine the approved Reinvestment Plan incurred expenditures each year and include all years in the contract report package. For instance, contract year 2004 reinvestment funds spent in 2009 must be reported in the report package for 2009. This is also true for any other contract year reinvestment funds since Report #12 is on a cash basis.

NOTE: Adjustments should result in submission of a revised Report #12 with the notation made in the “Revised Report, see Adjustment List” block on the face of the report.

Compliance Requirement - Report #13

The purpose of the requirement for an examined Balance Sheet/Statement of Net Assets is to ensure the Commonwealth that as of the last day of the contract year under examination:

1. The assets and liabilities of the Enterprise/Special Revenue Fund were in existence.
2. Recorded transactions actually occurred during the contract year.
3. All transactions and accounts that should be presented are properly included.
4. The Contractor had actual ownership of the assets as presented.
5. Assets and liabilities were included at the appropriate amounts; and
6. Assets and liabilities are properly classified, described, and disclosed.

This report should include all HealthChoices Behavioral Health contract assets and liabilities. (NOTE: IBNRs and RBUCs should be reported separately.) The Balance Sheet/Statement of Net Assets should be broken out, at a minimum, into current and non-current assets and liabilities. If any single balance sheet/statement of net assets item classified under “Other” Current Asset/Liability or Non-Current Asset/Liability is ≥ 5 percent (5%) of the total for that section, provide an itemized list and dollar amount for that item.

All cash assets **must** be broken down into sufficient detail to report the purpose of the cash accounts (i.e.: risk and contingency amounts, reinvestment amounts must be reported separately).

To clarify the FRR instructions for reporting a claims payable amount on the Balance Sheet/Statement of Net Assets that ties into Report #6 (Claims Payable) and Report #7 (Lag Report): Tie-in’s to Reports #6 and #7 are specific to those entities that have an Enterprise Fund or non-governmental entities that contract directly with DHS.

NOTE: There is no standard format for Report #13.

Suggested Procedures:

1. Obtain year-end bank statements.
2. Obtain, directly from the bank, “cut-off statements” subsequent to the end of the contract year.
3. Obtain and review confirmations at the end of the contract period concerning account balances, interest rates on interest-bearing accounts and information on direct indebtedness to financial institutions.
4. Perform tests of bank reconciliations to verify that the recorded cash balance agrees with the actual cash in bank.
5. Prepare an interbank transfer schedule to ascertain the possibility of double counting of cash, kiting, etc.
6. Ensure claims liability for RBUCs and IBNRs agree with Report #6 and Report #7.
7. Make inquiries concerning contingencies.
8. Confirm that any risk and contingency fund is included as a separate line item and the fund is in conformance with contract requirements. See Section II-7, H of the PSR.

9. Observe inventories and gain satisfaction as to prior inventory counts.
10. Inspect securities or obtain written confirmation from custodian.
11. Apply analytical procedures to financial and non-financial data.

NOTE: Adjustments are to be made in the column “ADJUSTMENT” with a corrected total in the column “BALANCE.” All adjustments should be explained in detail in a separate listing included with the Balance Sheet/Statement of Net Assets.

Compliance Requirement – Report #29

This report should be accurately compiled in accordance with the instructions included in the FRR.

The objective of Report #29 is to assist the Commonwealth in tracking expenditures resulting from the DHS-approved Community Based Care Management Initiative(s); to provide assurance as to the completeness of expenditures reporting; and to provide assurance that financial information is being reported in accordance with contract and FRR requirements.

The Contractor must report all HealthChoices funded CBCM program expenditure activities, whether operated by the Primary Contractor or contracted through a vendor and/or provider. The report must include CBCM expenditures for every approved HealthChoices funded CBCM initiative to show spending of the CBCM funds for each initiative undertaken during the calendar year.

Suggested Procedures:

1. All current year expenses should be classified accurately by month of spend. Detailed amounts should be tested to substantiate proper classification and accuracy of amounts.
2. Detailed records should be tested to ascertain completeness, accuracy, and appropriateness of expenses included on the schedule. Expenses should be tested for appropriateness pertaining to the HealthChoices contract.
3. Amounts, where appropriate, should be recalculated to assess the accuracy and completeness of amounts included in each schedule.
4. Schedules and detailed records should be verified for mathematical accuracy.
5. Expense allocations used in preparing the report should be verified for reasonableness and accuracy. Amounts should be agreed to appropriate supporting documentation with recalculations performed, where necessary.
6. Monthly expenses calculated should agree to Year to Date Totals and align with proposal total costs.

NOTE: Adjustments should result in submission of a revised Report #29 with the notation made in the “Revised Report, see Adjustment List” block on the face of the report.

L. Compliance Requirement - Report #17

The HealthChoices Contractors, and/or their MCO/MCO Subcontractors, must meet and maintain certain equity and reserve requirements as specified in Part II-7, Sections A. 4) and 5) of the HCPSR and Section 6.1 D of the HealthChoices Behavioral Health contracts. The DHS requires assurance that the equity and reserve balances are properly reported.

All Contractors must submit a report in accordance with the FRR detailing the calculation used to determine its compliance with the equity requirement. This report is known as Report #17 and should be accurately compiled in accordance with the guidance referenced above.

All HealthChoices capitation revenues, net of MCO Assessment, must be included in the calculation for the reserve requirement. If there is a lack of compliance, the report must include an analysis of the fiscal status of the contract and the steps for fiscal improvement that management plans to take.

Suggested Procedures:

1. Confirm the “Capitation Payments for Applicable Period” paid to the Primary Contractor(s) on Report #17 as of the end of the last quarter of the contract year being examined by sending a confirmation request to Comptroller Operations, Bureau of Payable Services at the email address in the Confirmation of Payments Section of this guide. (The confirmation request should include a request for capitation revenue for each county/contract included in Report #17). The amount to be confirmed as Capitation Payments should not be reduced by the amount of the MCO Assessment. However, the MCO Assessment must be deducted prior to calculating the equity requirement.
2. Verify that the “Required % of Capitation Payments” for each Primary Contractor is accurate based on the applicable DHS/Primary Contractor Agreement. (The required % is the minimum equity defined as a percentage of annual capitation revenue.)
3. Verify that the sum of each Primary Contractor’s “Required % of Capitation Payments” equals the Managed Care Organization’s Total “Equity Reserve Requirement.”
4. Confirm that “Total Equity” per Report #17, agrees with the “Total Equity” reported by the MCO on the applicable Department of Insurance (DOI) annual/quarterly filing or annual audit. This confirmation should include inquiry as to any amended DOI filings that may exist for the applicable quarter.
5. Verify the sum of the Managed Care Organization’s “Total Equity” is equal to or greater than the sum of the Primary Contractors’ “Equity/Reserve Requirement.”
6. Verify that for County Operated ASO contractors, the Equity Reserve Fund does not exceed 105% of the Equity Reserve Requirement.
7. If there is a lack of compliance, review the analysis of the fiscal status of the situation and steps for fiscal improvement that management planned to take. Confirm that the steps for fiscal improvement were taken.
8. Confirm that the Primary Contractor’s policies and procedures regarding monitoring MCO’s equity are in place and are being performed in accordance with said policies and procedures.
9. Verify that the financial condition of related parties will not impact the MCO as an ongoing concern.

NOTE: Adjustments are to be made in an “ADJUSTMENT” column with a corrected total in an “ADJUSTED BALANCE” column. Adjustments should be explained in sufficient detail in the footnotes.

Reporting Requirement

These compliance requirements should be addressed in the Compliance Attestation Examination Report, described in the Independent Accountant's Report Section. Report #17 should be included in the contract report package as an attachment to the Management Assertion Letter. (See Supplemental Guidance)

M. Compliance Requirement

The HealthChoices Contractors, and their MCO/MCO Subcontractors, are required to have contract specific bank accounts for 1) HealthChoices capitation transactions, 2) reinvestment transactions, 3) restricted reserve funds where applicable, and 4) risk and contingency funds. The Contractors and their MCO/MCO Subcontractors must also have procedures for accurately recording, tracking, monitoring, and reporting HealthChoices revenues and expenses separately from any non-HealthChoices revenues and expenses. In addition, Contractors and MCO/MCO Subcontractors who operate in more than one County, must have procedures for accurately recording, tracking, monitoring, and reporting HealthChoices revenues and expenses by individual County as stated in Part II-7, Sections A. 8 of the PSR and the HealthChoices Behavioral Health Contract Section 6.1: Section 7.1 for Philadelphia.

Suggested Procedures:

1. Verify that the bank accounts utilized by the Contractors and the MCO/MCO Subcontractors are designated specifically for HealthChoices for the four areas listed above.
2. Verify that all HealthChoices transactions flow through these accounts, and that there are no non-HealthChoices transactions occurring within the accounts.
3. Identify reinvestment plans approved by OMHSAS during the engagement period. Verify that the Contractor deposited Reinvestment Funds in a restricted account within 30 days of the OMHSAS written approval of the reinvestment plan(s).
4. Review procedures of the Contractors and their MCO/MCO Subcontractors to determine that only HealthChoices revenue and expenses are tracked, monitored, and reported separately from all non-HealthChoices revenue and expenses.
5. Verify that the Contractor, MCO/MCO Subcontractors and Management Corporations have a process in place to record staff time spent on HealthChoices duties separate from non-HealthChoices duties. Also, verify that MCO/MCO Subcontractors and Management Corporations with multiple contracts have a process in place to allocate staff time by contract. Expense allocations charged to HealthChoices based on time studies should be verified for reasonableness and accuracy. Amounts should be agreed to supporting documentation with recalculations performed, where necessary.

N. Compliance Requirement

The HealthChoices Counties must maintain separate fiscal accountability for Medicaid funding under the HealthChoices waiver, apart from mental health and substance abuse programs funded by State, County, and/or other Federal program monies.

Suggested Procedures:

1. Verify that the County has maintained separate fiscal accountability for Medicaid funding under the HealthChoices waiver apart from mental health and substance abuse programs

- funded by State, County, and/or other Federal program monies.
2. Verify the utilization of State and Federal funds allocated to the County's mental health and/or drug and alcohol programs to determine that these funds were not used for in-plan services by examining payments for these services and bank statements to determine that co-mingling did not occur.

Q. Compliance Requirement

Each HealthChoices Contractor must submit a plan to provide for payment to Providers by a secondary liable party after a default in payment to Providers resulting from bankruptcy or insolvency. The arrangement must be, at a minimum, the equivalent of two months' worth of paid claims, when determinable, or two months of expected capitation revenue.

One method of meeting this requirement is through a guaranty from an entity, acceptable to the DHS, with sufficient financial strength and credit worthiness to assume the payment obligations, as specified in Part II-7, Section A. 3) c. of the PSR.

Many contractors are using a Parental Guaranty as a method of meeting the Insolvency Requirement. As a condition of accepting the Parental Guaranty, DHS requires quarterly monitoring of the parent's financial condition by either the Primary Contractor or the BH-MCO.

Suggested Procedures:

1. Determine whether the Contractor has entered into a Parental Guaranty agreement in order to meet the insolvency requirement. ***If a Parental Guaranty is not in place, no further testing is necessary.***
2. Verify that the Primary Contractor has policies and procedures in place for quarterly monitoring of the parent's financial condition, and that the procedures are being performed in accordance with the policy.
3. Verify timeliness of financial monitoring and submission of reports and results to the DHS.
4. Determine whether the quarterly monitoring identified financial concerns. If so, verify that the contractor took appropriate steps in accordance with the policies and procedures. These steps may include notification of DHS, development of a corrective action plan, or arrangements for other insolvency protection.

PHYSICAL HEALTH

PROGRAM COMPLIANCE –PHYSICAL HEALTH

Claims Processing

Objectives

The purpose of a claims processing system is to:

- Arrange for and reimburse in-network health care providers accurately and timely for covered services rendered, and non-participating or unauthorized health care providers for any appropriate out-of-plan services.
- Provide for claims administration which includes maintenance of fee schedules; procedure coding; benefit determination - including the arrangement for and reimbursement of in-network providers for covered services rendered and non- participating or unauthorized providers for any appropriate out-of-plan services; claims processing - including timely and accurate adjudication, auditing and quality review; claims payment - including timely payment to providers and subrogation investigation/pursuit of potential third party recoveries.
- Maintain a current membership management information system that has the capability to receive on-line data transfers of member enrollment/disenrollment information via the Department Information Resource Management Business Partner Network. Data files must provide accurate information on dates of MCO coverage for each recipient consistent with information provided by the Department. Member enrollment/disenrollment information may be maintained on a system separate from the claims processing system.
- Maintain a provider management system that has the capability to pay providers appropriately and timely.
- Provide reports that can be utilized by member services, provider relations, utilization management and quality improvement departments of the managed care organization.
- Enable the MCO to identify liable third parties for services rendered to recipients, avoid payments where a third party is responsible as appropriate, and recover payments when a third party is subsequently identified.
- Enable the MCO to support data reporting requirements defined in the HealthChoices agreement, and generate data necessary for financial and program evaluation, both at the MCO and Commonwealth level.
- Detect suspected instances of recipient and provider fraud and abuse.

Adequate and timely payment procedures for non-participating providers ensures appropriate use of HealthChoices program funds and assures enrollees and providers that appropriate services are accessible.

HealthChoices Agreement Requirements

The MCO must provide DHS with accurate reports on provider payments and claims processing.

The Contractor must have appropriate procedures to pay for or deny provider claims. Claims reviewed and denied should be communicated appropriately to the health care provider with opportunity given to appeal denied claims within time frames established in the HealthChoices agreement.

The Contractor must have procedures and reporting mechanisms to accurately identify liable third parties, to avoid and recover costs as appropriate, and to make a payment where a third party has made a partial payment for a service.

The Contractor must have a strategy to detect and report recipient and health care provider fraud and abuse.

The contractor must have in effect written administrative policies and procedures that direct the receipt, update, and testing of on-line transfer of member data from DHS. The DHS will provide the MCO with enrollment information for its members including the beginning and ending effective dates of enrollment. The data provided will include new enrollments, disenrollments, and demographic changes. It is the responsibility of the MCO to take necessary administrative steps consistent with dates established by the DHS. It is the responsibility of the MCO to maintain a membership management system that includes accurate recipient information, including dates of MCO coverage and category of aid.

Compliance Requirements and Suggested Procedures

A. Compliance Requirement

The Contractor must have a claim processing system and MIS sufficient to support the provider payment and data reporting requirements specified in HealthChoices Physical Health Agreement, Section V. Management Information Systems and Section VII. Financial Requirements.

Suggested Procedures:

1. Obtain and review the application requirements defined in the HealthChoices Physical Health Agreement. Verify that specific requirements address the completeness, timeliness, and accuracy of claim data and standing reference (i.e.: diagnosis codes, pricing, effective dates, DHS assigned codes, HCPCS codes, etc.) data input for processing, the on-going control and maintenance of this data, and the payment of claims. Testing for completeness, timeliness, and accuracy of claims should include, but is not limited to, the following verifications:
 - a. Universe of Physical Health claims for the period of the engagement is complete.
 - b. Sample selected is representative of the Universe.
 - 1) A portion of the claims tested must be adjusted claims and manually entered claims. These adjusted claims should be further tested to determine that the adjusted claims contain the necessary information to link the adjusted claims with the original claims.
 - 2) In determining if the sample is representative, the IPA should consider whether the sample included each of the following types of claims:

pharmacy, inpatient, professional, outpatient, dental and voided. The IPA should also consider the extent to which each type of claim exists in the entire Universe.

- c. Both the HIPAA standard data element code sets that are submitted on electronic claims and the data element code sets that are submitted on manual claims can be successfully cross walked to the codes that are acceptable on the DHS encounter records.
- d. The claim reference information on the claim form can be linked with the Encounter Claim Reference Number.
- e. The recipient identification number agrees with, or can be cross walked to, the DHS's Recipient CIS Number.
- f. The recipient is eligible for service on the date(s) service is provided.
- g. The recipient is eligible for the type of service provided.
- h. If the claim does not indicate other insurance or Medicare as a third-party payer, ensure that the file does not include information that the recipient is covered by other insurance or Medicare on the date(s) service is provided. If the claim does indicate other insurance or Medicare as a third-party payer, ensure that the amount paid is calculated correctly.
- i. The provider identification number agrees with, or can be cross walked to, the DHS's MA Provider Number.
- j. The amount paid to the provider by the Contractor is in accordance with the HealthChoices agreement and the provider agreement.
- k. Where the claims information is manually input, the information on the system regarding the diagnosis code, type of service, procedure code, and revenue code, units of service and dates of service agrees with information on the input document.

B. Compliance Requirement

Under Section 1902(a) (25) of the Social Security Act, DHS is required to take all reasonable measures to identify legally liable third parties and treat verified Third Party Liability (TPL) as a resource of the MA recipient. Under the HealthChoices Program, TPL activities will be shared between DHS's TPL Section, and the Contractor as described in Section VII. Third Party Liability, of the HealthChoices Physical Health Agreement.

Suggested Procedures:

1. Determine if adequate policies and procedures are in place for the payment of claims with health-related insurance (i.e.: cost avoidance through the identification of liable third parties).
2. Determine if adequate policies and procedures are in place for the payment of accident/injury claims (i.e.: the contractor is responsible for payment of accident/injury claims and reporting accident/injury claims to DHS for recovery of identified liable third parties).
3. Determine if adequate policies and procedures are in place for the recovery of claims when health-related insurance is identified after a claim is paid(retroactive).
4. Determine if adequate policies and procedures are in place to supply the Department's TPL Division Third Party Resources identified by the MCO or its Subcontractors, which do not appear on the Department's TPL database, within two weeks of its receipt by the MCO in

accordance with the HealthChoices Physical Health Agreement, Section VII. Third Party Resource Identification.

5. Determine if adequate policies and procedures are in place to verify the validity of a resource in question supplied by the Department to the MCO timely as outlined and in accordance with HealthChoices Physical Health Agreement, Section VII. Third Party Resource Identification.
6. Determine if adequate policies and procedures are in place for providing, at the Department's request, information included in the Encounter Data submissions that may be necessary for the administration of TPL activity in accordance with the HealthChoices Physical Health Agreement, Section VII. Requests for Additional Data.
7. Evaluate the policies and procedures for reporting COB/TPL Financial Reports (Report #8-C) to DHS. The IPA should review the Agreement and Financial Reporting Requirements (FRR) requirements for COB/TPL, then evaluate the MCO's policies and procedures to determine if they adequately address all TPL requirements. The IPA should then review the MCO's compliance with the Agreement and FRR requirements for reporting to DHS.
8. Determine if the policies and procedures ensure that the required information is reported timely and accurately to DHS. The IPA should ensure that there are policies and procedures in place to (1) submit Report #8 within the timeframes referenced in Section 1.0 of the FRR, (2) properly report all required TPL activity within the timeframe that it occurred, and (3) include the information required in Section 2.9 of the FRR.

C. Compliance Requirement

The MCO must establish written policies and procedures for the detection and prevention of fraud and abuse by health care providers, recipients, or MCO employees as described in the HealthChoices Physical Health Agreement, Section V, Fraud and Abuse.

1. Obtain the Contractor's compliance plan, policies, and procedures to prevent and detect fraud and abuse by members, providers, and employees in relation to the HealthChoices Physical Health Agreement requirements. Review the policies and procedures to ensure that they identify the specific controls in place for fraud and abuse detection, and the process for preventing, investigating, and reporting any fraud or abuse.
2. Ensure that there is a designated compliance officer, a regulatory compliance committee on the board of directors, and staff who have designated as part of their responsibilities the proactive detection, prevention, and elimination of instances or patterns of fraud and abuse. Verify that procedures have been developed and communicated to the appropriate personnel.

D. Compliance Requirement

The PH-MCO must develop, implement, and maintain a Provider Dispute Resolution Process, which provides for informal resolution of Provider Disputes at the lowest level and a formal process for Provider Appeals. (HealthChoices Physical Health Agreement, Section V. K. Provider Dispute Resolution System).

Suggested Procedures:

1. Evaluate the MCO's Provider Dispute Resolution policies and procedures. The policies should establish a Provider Dispute Resolution Process, which provides for informal

resolution of Provider Disputes at the lowest level and a formal process for Provider Appeals. The system must, at a minimum:

- a. Acceptance and usage of the Department's definition of Provider Disputes and Provider Appeals
 - b. Delineate between informal and formal processes for settlement of a Provider Dispute and Provider Appeal
 - c. Include time frames to ensure prompt review of Provider Disputes and Provider Appeals
 - d. Be equitable to all providers.
 - e. Ensure that all providers have access to all documentation pertaining to the resolution of the dispute or appeal.
 - f. Ensure that staff appropriately report and handle provider disputes and provider appeals.
 - g. Ensure the participation of individuals within the MCO have the appropriate authority, training, and expertise to address provider disputes and provider appeals, and to require corrective action.
 - h. Establish a committee to process formal appeals, which consists of at least one-quarter provider/peer representation.
2. Review documentation that demonstrates that providers have been made aware of the existence of the provider dispute and provider appeal process, and of how a provider may file.
 3. Examine a sample of provider disputes and provider appeals to determine whether the policies and procedures are being applied, and whether all disputers are being treated equitably.
 4. Determine whether the Provider Services Manager is qualified to facilitate and manage provider disputes and provider appeals.
 5. Determine whether sufficient staff resources are committed to the function to ensure that disputes and appeals are afforded due process, and that the time frames delineated in the MCO's provider dispute and provider appeal processes are met.”

E. Compliance Requirement

Report #1 - Monthly Claims Processing

This monthly report should be accurately compiled in accordance with instructions included in the applicable Claims Processing Reporting Requirements (CPRR) as required by the HealthChoices Physical Health Agreement, Section VII. Claims Processing Standards, Monthly Reports and Penalties.

DHS utilizes the following definitions, which can be found in the CPRR effective as of 2010:

Clean Claim – A claim that can be processed without obtaining additional information from the provider of the service and/or from the DHS. Therefore, an unclean claim is one that is pended within the claims processing system, waiting for external provider information. A clean claim includes a claim with errors originating in the MCO's claim system. Claims under investigation for fraud, abuse, or awaiting a newborn MAID are unclean claims. The MCO should consider a claim is clean if delays/suspensions are caused by the MCO claims processing system, and not

due to the need of obtaining additional information from the provider. A claim that needs clinical review without requiring provider records is clean. An out-of-network claim the MCO requires a single case agreement to process is clean.

Unclean Claim – A claim that is pended and requires additional information from the provider of the service and/or the Department before adjudication can occur. This can also include claims under investigation for fraud or abuse. An example of an unclean claim can be a claim pended awaiting a recipient identification number for a newborn. Another example of an unclean claim would be a claim that is pended waiting for the provider to submit a third-party insurer Explanation of Benefits (EOB). In each case, the MCO cannot process the claim until the necessary information is provided.

Rejected Claim – A claim with a provider that the MCO cannot identify. Also, a non-claim that has erroneously been assigned a unique identifier and is removed from the claims processing system prior to adjudication. In addition, the MCO may categorize as rejected, a claim where the recipient cannot be identified or was never a member of the MCO. Claims returned by a web-based clearinghouse that is not a contractor of the MCO are not considered as claims received and would be excluded from claims reports.

Denied Claim – An adjudicated claim that does not result in a payment obligation to a provider. Example: A claim containing a recipient who was not a plan member as of the date of service should be denied and the provider notified.

Report #1 provides data to DHS on key measures of claims processing timeliness. DHS requires the MCO to process and adjudicate provider claims within 30, 45, and 90- day compliance standards as required by the HealthChoices Agreement. This report provides information on claims received during the month, and subsequently processed by the MCO. The report serves as a monitoring tool to ensure MCO claim systems adjudicate claims to meet contractually required standards. This report is also analyzed to determine adjudication trends and aids in identification of problems being experienced by the MCO.

The Monthly Claims Processing Report #1 consists of 5 Excel worksheets (1 tab for each month). Each monthly report provides information on claims received during the month and each of the previous four months. For illustrative purposes, the December 2023 monthly report submission is due to DHS on February 6, 2024 and is used to determine processing penalties for September 2023. The months included in the report would be August, September, October, November, and December.

The submission(s) to be examined will be determined by DHS and disclosed to the IPA when the confirmed schedules are forwarded by the Single Point of Contact. The IPA will be requested to perform sample testing on one monthly report, which contains 5 months of claims receipt and processing.

Report #1 – Provides information on claims identified as clean and, on all claims, as of the date the report is prepared. Each of the five tabs contains the following elements:

1. Inpatient Claims Processed by the MCO
 - a. Clean Claims (Part A)
 - b. All Claims (Part B)
2. Inpatient Claims Processed by Subcontractors
 - a. Clean Claims (Part A)
 - b. All Claims (Part B)
3. Other than Inpatient or Drugs Claims Processed by the MCO
 - a. Clean Claims (Part C)
 - b. All Claims (Part D)
4. Other than Inpatient or Drugs Claims Processed by the Subcontractor (Subcontractor, Dental Subcontractor, Vision Subcontractor and Other Subcontractor)
 - a. Clean Claims (Part C)
 - b. All Claims (Part D)

Suggested Procedures:

1. Confirm that the MCO/Subcontractor has established policies and procedures in place and are being performed to assure Report #1 is accurately compiled in accordance with the CPRR. Specifically, policies and procedures are followed to assure:
 - a. Every claim entered into the claims processing/computer information system that is not a rejected claim is adjudicated.
 - b. An electronic file of rejected claims, including a reason or reason code for rejection, is maintained.
 - c. **The amount of time required to adjudicate a paid claim is computed by comparing the date the claim was received with the check date or the transmission date of an electronic payment. (The check/e-payment date MUST be used for this comparison.)** For provider negative balance situations, where a check may not be produced until a balance is cleared, provider paid notice date can be used in lieu of the check date.
 - d. The amount of time required to adjudicate a denied claim is computed by comparing the date the claim was received with the denial notice date or the transmission date of an electronic denial notice.
 - e. Checks are mailed no later than three workdays from the check date.
2. For the monthly report to be determined, ensure the completeness, accuracy, cutoff, and existence of the data included on Report #1.
3. Ensure that the count of claims reported as received by the MCO's is accurate.
4. Ensure reported Member month count is accurate.
5. Count figures, where appropriate, should be recalculated to assess the accuracy of figures included in Report #1.
6. Ensure that claims held by the MCO's Special Investigation Unit are classified as Not Yet Adjudicated, and that adjudication occurred at a later time for these claims. The MCO should provide in the comments box explanations for claims that are not yet adjudicated.

Clean Claims - Inpatient and Other than Inpatient and Drug

1. Design a sampling methodology for testing Clean Claims.
2. Sample testing should be designed to include, at the minimum, procedures to ensure:
 - a. For the monthly report selected for audit, the MCO provided accurate counts of all Clean Claims within the following categories:
 - Claims Paid and Denied in 30 days or less
 - Claims Paid and Denied in 31 to 45 days
 - Claims Paid and Denied in 46 to 90 days
 - Claims Paid and Denied in more than 90 days
 - Claims Rejected
 - b. Claims were properly classified as Clean Claim or Rejected Claim in accordance with the CPRR.

All Claims - Inpatient and Other than Inpatient and Drug (Unclean Claims)

1. Determine the number of Unclean Claims for each adjudication period by calculating the difference between the All Claims line and the Clean Claims line.
2. Design a sampling methodology for testing Unclean Claims.
3. Sample testing should be designed to include, at the minimum, procedures to ensure:
 - a. For the monthly report selected for audit, the MCO must have processed all Unclean Claims within the following categories:
 - Claims Paid and Denied in 30 days or less
 - Claims Paid and Denied in 31 to 45 days
 - Claims Paid and Denied in 46 to 90 days
 - Claims Paid and Denied in more than 90 days
 - Claims Not Adjudicated
 - b. Claims were properly classified as an Unclean Claim, in accordance with the CPRR.

Reporting Requirement

This compliance requirement should be addressed in the Compliance Attestation Examination Report described in the Engagement Administration, Independent Accountants Report Section. Claims Processing Report #1 should be included in the HealthChoices agreement report package as an attachment to the Management Assertion Letter.

Each Monthly Claims Processing Report #1 must include the five worksheets for individual months. The Single Point of Contact will forward all applicable required Report #1s to the IPA along with the confirmed financial schedules.

Management Information System (MIS)/Encounter Data Reporting

Objective

The MCO and MCO Subcontractor must have effective procedures to compile, analyze, evaluate, and report data critical to the operations of the HealthChoices program managed care product, including encounter data. Encounter data or other appropriate information can assist to determine how and when Plan services are being utilized, to set future rates, to determine program

effectiveness, and to evaluate performance management.

MIS is a critical area for any MCO to understand and monitor the financing, delivery, and effectiveness of the health care. It is only through information collection, reporting, and analysis that a contractor will be able to determine, in a managed care environment, how services are being delivered, and whether adequate resources are available.

Compliance Requirements and Suggested Procedures

E. Compliance Requirement

The Contractor shall be responsible for maintaining appropriate systems and mechanisms to obtain all necessary data from its health care providers to ensure its ability to comply with the encounter data reporting requirements as required by HealthChoices Physical Health Agreement (Section VIII. System Reporting; Section V. Administration, Management Information Systems; Exhibit XX). The failure of an MCO, MCO Subcontractor, third party administrator, or third-party processor to provide the MCO with necessary encounter data shall not excuse the MCO's compliance with this requirement.

Suggested Procedures:

1. Obtain and review the Contractor's procedures related to the input of claims and encounters data submitted (consider paper and/or electronic submissions) by the provider. Ensure the procedures address manual steps and/or electronic edits designed to ensure the complete and accurate input of the data. Specifically, identify the process for resolving missing, incomplete, or invalid claims and encounter data received from the health care provider.
2. Obtain and review the Contractor's procedures related to monitoring the continued completeness and accuracy of the claims and encounters data once input and residing on a standing data file. The procedures should address run-to-run balancing routines and programmer and user access restrictions to the data files. The Physical procedures should also address receiving, processing, and reconciling the U277 and NCPDP response files; and the ability to store and provide to DHS the PROMISE ICN associated with each processed Encounter Data record returned on the files.
3. Obtain a sample (representative of the Universe) of individual encounters as submitted by the Contractor to DHS throughout the period under review. A portion of the encounters tested must be adjusted encounters. Ensure that the Contractor's testing includes pharmacy, inpatient, professional, outpatient, dental, professional drug, outpatient drug and voided encounters.
 - a. Ensure that the MCO's procedures related to converting the claim or encounter to the HIPAA like compliant transaction formats required by DHS are complete and accurate.
 - b. Evaluate the length of time between the claim's date of MCO adjudication and the date of the encounter's receipt in PROMISE. Except for NCPDP encounters, all MCO approved encounters and those specified MCO denied encounters must be approved in PROMISE by the last day of the third month following the month of initial MCO adjudication. NCPDP encounters must be submitted and approved in PROMISE within 30 days following the MCO adjudication.
 - c. Compare the sample encounter records to the claims and encounters submitted by

health care providers to the MCO for accuracy of recipient identification, procedure coding including modifiers, diagnosis coding, revenue codes where applicable, place of service, amount paid, service date, units of service delivered, appropriate bill type when applicable, Provider ID, TPL/COB information, and date of adjudication by the MCO. The comparison should consider any differences in converting the HIPAA standard data element code sets that are submitted on electronic claims and the data element code sets that are submitted on manual claims to the DHS required codes for encounter reporting.

4. Determine whether the MCO has issued a data confidentiality policy to all employees with access to the various applications.

NOTE: Claims and encounters codes may have to be cross walked to the codes required by DHS for encounter reporting.

G. Compliance Requirement

DHS requires the Contractor to submit a separate record or “encounter” each time a member has an encounter with a provider.

Person-Level Record The person level record must include, at a minimum, the data elements as required for a HIPAA compliant 837 transaction and NCPDP transactions as defined by the Department.

Suggested Procedures:

1. Compare a sample of the encounters data received by the Contractor from the provider with the records submitted in the Encounter file to ensure that the Contractors are reporting all encounters as person-level Encounter records.
2. Compare a sample of payments made to the providers for any payment agreements other than fee-for-service, i.e.: Alternative Payment Arrangement (APA) retainer, case rates, bundled case rates, etc., with the Financial APA records to ensure that all provider payments are being reported completely and accurately to DHS.

H. Compliance Requirement

Patient Protection and Affordable Care Act (PPACA) includes language to extend the federal rebate to outpatient drugs covered under the Medical Assistance Program and paid for by the MCOs. The language requires the State to collect paid claims data from each MCO and invoice the manufacturers for the Federal Rebates. The following Systems Notices outline the MCO requirements for outpatient drug information to support the Department’s Federal Drug Rebate Program:

- SYS-2010-030 Requirements for Drug Rebate Processing
- SYS-2012-008 Prescription Number
- SYS-2013-007 Institutional Outpatient Drugs
- SYS-2014-013 Supplemental File
- SYS-2015-033 Supplemental File
- SYS-2017-006 Supplemental Drug File Layout Changes
- SYS-2017-017 MCO Federal Supplemental Drug Pricing Reporting Changes

Section VIII: Reporting Requirements, B.1(b)ii. Encounter Submissions requires that NCPDP transactions must be submitted and approved in PROMISE within 30 days following the adjudication date.

Suggested Procedures:

1. Determine if the MCO has adequate policies and procedures in place to ensure compliance with the encounter data requirements.
2. Ensure completeness and accuracy of the supplemental monthly file and that the files are submitted within required timeframes.
3. Ensure timely submission of NCPDP encounters.
4. Compare a sample of the MCO paid NCPDP claims submitted by providers to the MCOs with the NCPDP encounters submitted by the MCOs to DHS to ensure complete, accurate, and consistent information.”

Health Service Delivery System/Provider Incentive Arrangements

Requirement Objective

One of the advantages offered by managed care is the opportunity that it affords MCOs and providers to enter into creative payment arrangements that provide an incentive for the MCO and provider alike to provide effectively managed, high quality care. Consequently, the DHS has given its MCOs and providers wide latitude in negotiating payment arrangements. **However, regardless of the arrangements, they must comply** with the federal regulations designed to discourage provider incentive arrangements or physician incentive plans (PIP) that may create an incentive for physicians to inappropriately limit or deny care.

A PIP is defined as “any compensation arrangement between an MCO and a physician or physician’s group that may directly or indirectly have the effect of reducing, or limiting services furnished to Medicaid recipients enrolled in the MCO.” The compensation arrangements negotiated between subcontractors of an MCO (i.e.: Physician-Hospital Organizations (PHOs), Individual Practice Associations) and a physician or group, are of particular importance given that the compensation arrangements with which a physician is most familiar will have the greatest potential to affect a physician’s referral behavior.

PIPs may not be designed to offer any payments (whether direct or indirect) to a physician or physician’s group that motivates them to limit or reduce medically necessary services to any individual enrollee who is covered under the MCO’s contract. Indirect payments include offerings of monetary value (i.e.: stock options or waivers of debt) measured in the present or future. Disallowance of specific payments should not be interpreted as a measure to preclude physicians from authorizing only those services that are medically necessary.

HealthChoices Agreement Requirements

The MCO must have in effect written policies and procedures for determining its compliance with 42 CFR Section 417.479, the federal regulation governing physician incentive payments, and must be prepared to provide documentation verifying its compliance with this rule.

Policies and procedures must address all requirements of the federal regulation including

determination of substantial financial risk (Compliance Requirement A), disclosure of contracting arrangements (Compliance Requirement B), maintenance of stop-loss protection (Compliance Requirement C), and completion of annual customer satisfaction surveys (Compliance Requirement D).

Compliance Requirements and Suggested Procedures

I. Compliance Requirement

The MCO agrees that its provider contracts and subcontracts comply with 42 CFR Section 417.479 regarding Physician Incentive Arrangements as outlined in the HealthChoices Physical Health Agreement, Section VII.

Provider or provider groups are subject to requirements outlined in the Final Rule if determined to be at Substantial Financial Risk (SFR). Providers or provider groups not at SFR or with member panels greater than 25,000 members are not subject to regulations requiring annual disclosure of contracting arrangements, maintenance of stop-loss protection, or annual customer satisfaction surveys.

If a physician or physician's group patient panel is greater than 25,000 patients, then PIP is not considered to put the group at SFR because the risk is spread over the large patient panel. The 25,000 patients may be a pool of Medicare, Medicaid, and commercial members across the MCOs that have contracted with the physician's group. However, the physician's group can only pool categories of patients for which the following criteria are true:

1. Referral risk must have been transferred in each of the physician incentive arrangements applicable to the pooled enrollees,
2. The incentive arrangements related to the compensation for those enrollees must be comparable with respect to the nature and extent of the risk born,
3. The payments for all pooled enrollees must be held in a common risk pool,
4. The distribution of payments from the risk pool must not be calculated separately by patient category or by MCO; and,
5. No provider contract can require that risk be segmented by MCO or patient category.

Suggested Procedures:

1. Assess the provider panel size (this is not the same as the patient panel size) of the MCO. If the provider panel size is greater than 25,000, then the MCO is determined not to place its physicians at SFR.
2. Review policies and procedures, which outline the process for determining SFR both with the providers of the MCO and its subcontracts.
3. Assess compliance of the policies and procedures with the requirements of 42 CFR 417.479, the federal regulation regarding physician incentive payments.
4. Review the MCO's process for determining SFR with its contracts and subcontracts and assess compliance with requirements of 42 CFR 417.479, the federal regulation regarding physician incentive payments.
5. Select a sample of contracts and subcontracts and test the validity and accuracy of the process to determine SFR. To determine the validity and accuracy of the SFR determination process, use the following steps.

- a. Evaluate whether the provider or provider group is at SFR by reviewing the capitation arrangement (the contract between the provider and the MCO). The entity is at SFR if the difference between the maximum and minimum possible payment is more than 25% of the maximum possible payments, or if the capitation arrangement is not clearly explained in the provider/group's contract (e.g.: the minimum capitation payments – maximum payments = x. If x is greater than 25% of the maximum possible payment, then the group is at SFR).
- b. Evaluate whether the entity has any other arrangement that could hold it liable for more than 25% of potential payments. If yes, then the entity is at SFR.

J. Compliance Requirement

The MCO is responsible for monitoring disclosure requirements that apply to the MCO's direct contracting and subcontracting arrangements with providers. If a provider or provider group does not transfer SFR to its own employees or members, then disclosure requirements are limited to this fact only.

NOTE: The regulation differentiates between physician's groups and "intermediate entities", which contract between MCOs and physician's groups. Intermediate entities must disclose their incentive arrangements, regardless of the level of risk transferred in those arrangements. Examples of intermediate entities include Individual Practice Associations that contract only with an individual physician and not with physician's groups, are considered physician's groups under this rule.

NOTE: MCOs (contracting and subcontracting) must provide information indicating whether the MCO or any of its contractors or subcontracts uses PIP that may affect the use of referral services, the type of incentive arrangement(s) used, and whether stop-loss protection is provided to any Medicaid beneficiaries who request this information. Additionally, if the MCO is required to conduct a customer satisfaction survey, they must also provide beneficiary requesters with a summary of survey results.

Suggested Procedures:

1. Evaluate the MCO's policies and procedures regarding disclosure requirements to determine if provisions of these documents meet the federal regulations governing disclosure requirements.
2. Review actual documentation/incentive arrangements to determine if provider or provider groups disclose all required information.
3. Review dates of documentation submission to determine if provider or provider groups disclose the information in the appropriate time frames. Contracts must report capitation data by April 1 of the year following the contract's initial effective date. The April 1 reporting date was suspended until further notice. All other requirements remain in effect. Customer satisfaction survey results should be submitted to regulators within a reasonable period of time after conducting the survey (average length of time is four months).
4. Providers and provider groups are required to disclose the following information:
 - a. The physician or physician's group discloses whether referral services are covered by the PIP. If only services furnished by the physician or group are addressed by the PIP, then there is no need for disclosure of other aspects of the PIP.

- b. The physician or physician’s group discloses the type of physician incentive arrangements (i.e.: withhold, bonus, capitation).
- c. The physician or physician’s group discloses the percent of total income at risk for referrals.
- d. The physician or physician’s group discloses the amount and type of stop-loss insurance protection (See Compliance Requirement C).
- e. The physician or physician’s group discloses the panel size and whether enrollees were pooled in order to achieve the panel size.
- f. For capitated physicians or groups: The physician or physician’s group discloses the percentage data from the previous calendar year showing how capitation payments paid to primary care physicians were used to pay for primary care services, referral services to specialists, hospital services, and other types of providers.
- g. The physician or physician’s group discloses a summary of customer satisfaction results if the MCO is required by this regulation to conduct a survey (See Compliance Requirement D).
- h. The physician or physician’s group provides referral disclosure information to beneficiaries when requested specifically by the beneficiary.
- i. If required to conduct a customer satisfaction survey, the physician or physician’s group provides a summary of customer satisfaction results to beneficiaries when requested specifically by the beneficiary (See Compliance Requirement D).

K. Compliance Requirement

The MCO shall be responsible for monitoring the adequacy of stop-loss protection for physicians and/or physician’s groups at SFR.

Suggested Procedures:

1. Evaluate the MCO’s policies and procedures regarding monitoring the adequacy of stop-loss protection for physicians and/or physician’s groups who are at significant risk.
2. Review an appropriate sample of arrangements to determine the type of stop-loss protection acquired by physician or physician’s groups and measure compliance with adequacy of coverage using the grid provided below. Either aggregate or per patient stop-loss may be acquired. The rule specifies that if aggregate stop-loss is provided, it must cover 90% of the cost of referral services that exceeds 25% of potential payments. Physicians and physician’s groups can be held liable for only 10%. If per patient stop-loss is acquired, it must be determined based on the physician or physician’s group’s patient panel size and cover 90% of the referral costs that exceed the following per patient limits.

Patient Panel Size	Single Combined Limit	Separate Institutional Limit	Separate Professional Limit
1-1,000	\$ 6,000*	\$ 10,000*	\$ 3,000*
1,001-5,000	30,000	40,000	10,000
5,001-8,000	40,000	60,000	15,000
8,001-10,000	75,000	100,000	20,000
10,001-25,000	150,000	200,000	25,000
25,001+	none	none	none

*In these situations, stop-loss insurance would be impractical. Not only would the premiums be prohibitively expensive, but also the protections for patients would likely not be adequate for panels of fewer than 500 patients. MCOs and physician's groups clearly should not be putting physicians at financial risk for panel sizes this small. It is our understanding that doing so is not common. For completeness, however, we do show what the limits would be in these circumstances.

L. Compliance Requirement

If the physician or physician's groups contracting or subcontracting with the MCO are found to be at substantial financial risk, the MCO must perform a customer satisfaction survey of its current Medicaid enrollees, as well as those who disenrolled in the last 12 months (for reasons other than loss of eligibility or relocation outside of the service area).

If a survey is required, it must be conducted within one year of the date on which the MCO is required to disclose referral withhold and bonus payments (as listed in the disclosure section of this document). It must be conducted annually thereafter for as long as the physician or physician's group is at SFR.

Suggested Procedures:

Evaluate compliance regarding the distribution of customer satisfaction surveys. This evaluation should include:

1. A review of the content of the survey tool to determine if all required elements are included.
2. A review of the structure and format of the survey tool to determine if the design meets generally accepted survey principles.
3. A review of the distribution list to determine if the sample size was appropriate.
4. A review of the results report to determine if surveys were distributed and reported according to time frame requirements.

Items one through six provided below can be used as a checklist when reviewing customer satisfaction documentation, survey tools, and results to determine compliance with the federal regulation governing provider or provider groups at SFR which require the distribution of customer satisfaction surveys and the reporting of results.

1. A physician or physician's group at SFR distributes customer satisfaction surveys.
2. A physician or physician's group at SFR discloses results in the required time frames or at the request of a beneficiary.
3. The survey is conducted on an adequate size of the sample population.
4. The survey is designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis.
5. The survey questions address enrollee/disenrollee satisfaction with access to services (including referral services).
6. The survey questions address enrollee/disenrollee satisfaction with quality of care.

Financial Management Compliance Reports

NOTE: A request to obtain a digital copy of the applicable PH FRRs can be sent via email to FinancialGatekeeper@pa.gov.

Requirement Objective

Each participating Contractor, at its expense, is required to provide to DHS an annual HealthChoices agreement examination prepared by an IPA. This examination must include the specific financial schedules described in Table 1 below, along with accompanying Notes to the Financial Schedules. These Notes must contain descriptions of methodologies regarding revenue and expense allocation used in preparing the financial schedules.

NOTE: The IPA should also see related guidance in the Notes to the Financial Schedules in Supplemental Guidance.

Physical – Table 1

<i>Report #</i>	<i>Name</i>	<i>Description</i>	<i>Required MCOs</i>
2	Related Party Transactions and Obligations	Provides a summary of transactions and obligations with related parties/affiliates	All
4 (A, B, C, D)	Lag Reports	Provides an analysis that assists in determining the accuracy of historical medical claims liability estimates, which is helpful in assessing the adequacy of current liabilities.	All
5 (A-H)	Income Statement	Provides an analysis of revenues and expenses completed for each recipient group.	All
5 (I)	Income Statement	Provides additional revenues and expenses, specific to Pay for Performance programs.	All
5 (V)	Income Statement	Provides additional revenues and expenses, specific to COVID-19 Vaccine Non-Risk Arrangement.	All
5 (W)	Income Statement	Provides additional revenues and expenses, specific to Shadow Nurse Non-Risk Arrangement.	All
5 (X)	Income Statement	Provides additional revenues and expenses, specific to High-Cost Gene Therapy Non-Risk Arrangement.	All
5 (Z)	Income Statement	Provides an analysis of revenues and expenses completed for all recipient groups in total along with Pay for Performance programs, COVID-19 Vaccine Non-Risk Arrangement, Shadow Nurse Non-Risk Arrangement	All

		and High-Cost Gene Therapy Non-Risk Arrangement.	
6 (A)	Inpatient, Physician and Dental Statistics	Provides data on key measures of price and utilization for physician, inpatient and dental services	All
6 (B)	Pharmaceutical Price and Utilization Statistics	Provides data on key measures of price and utilization for pharmaceutical services.	All
7 (E)	Emergency Department Utilization	Provides a summary of emergency department visits and observation room stays that result in discharge.	All
8 (A, B1, B2, C)	Coordination of Benefits Reports	Captures MCO activities involving coordination of benefits utilizing third party resources	All
13 (A, B)	Subcapitation Data Summary and Data Detail Reports	Provides summary information on all MCO subcapitation payments made during the quarter	All
26 (A, B)	Maternity Revenue and Medical Expense Annual Statement	Provides an analysis of maternity care revenues and expenses for all rating groups combined.	All
27	Maternity Outcome Counts	Provides counts of second and third trimester maternity outcomes.	All
40	Provider Pay for Performance Reconciliation	Provides details on Revenues and Expenditures made under the approved MCO plan for Provider	All
41 (A, B)	Risk Pool Analysis	Monitors risk pool activity. All revenues and expenses allocated to the risk pool are shown on this	Specific MCO(s)
42	Medical Loss Ratio Reporting	Provides an analysis of revenue and costs that are specific to the PH HC program.	All

HealthChoices Agreement Requirement

Each MCO will provide a Report on the Examination of Financial Schedules by June 30. This package should include a report of independent accountants on the financial schedules specified in Table 1 and include accompanying Notes to the Financial Schedules.

M. Compliance Requirements and Suggested Procedures

Compliance Requirement Report #2

Related Party Transactions and Obligations

This report should be accurately compiled in accordance with instructions included in the FRR.

NOTE: The FRR defines related parties as required for preparation of this report.

The objective of Report #2 is to assist the Commonwealth in understanding the nature and extent of transactions with related parties and obligations to or from related parties. This report is used to ensure that transactions with related parties reflect efficient business practices.

Suggested Procedures:

1. Test the completeness of Report #2 - Related Party Transactions and Obligations to ascertain that all related parties and affiliates are listed on the report by performing procedures such as a review of Board minutes, reviewing prior year engagement documentation for names of known related parties, reviewing filings with other regulatory/authoritative bodies, and inquiry of management. An additional source of information for determining completeness of related party transactions is Schedule Y of the MCO's annual statement submitted to the Insurance Department. Schedule Y is entitled "Summary of the Insurer's Transactions with Affiliates."
2. Detailed tests of transactions and balances should include steps to ascertain the completeness of the related party and affiliate transactions as defined in the HealthChoices Physical Health Agreement, Section II.
3. The confirmation of related party balances should be supplemented with a review of accounting records for evidence of loan guarantees, large, unusual, and/or nonrecurring transactions with officers, directors, and affiliated companies. Attention to transactions recognized at, or near the end of the period (including loans receivable and payable), should be considered for confirmation.

Compliance Requirement Report #4

Part A - Lag Reports For Hospital Inpatient Payments

Part B - Lag Report For Physician Payments

Part C - Lag Report For Pharmaceutical Payments

Part D - Lag Report For Other Medical Payments

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #4 provides information on the relationship between reported expenses and paid claims. This helps the Commonwealth understand the adequacy of accruals reported for prior periods and provides information useful to evaluate the adequacy of expenses reported for current periods. Since this data provides a basis for incurred but not reported (IBNR) estimates, it is essential that the lag tables be developed properly.

Suggested Procedures:

1. Items included in the report should be tested to ensure that they are categorically accurate according to service group (i.e.: Hospital Inpatient, Physician, Pharmaceutical, and Other).
2. Claims payable aging should be tested and evaluated to ensure accuracy as included on the report.
3. Items included in the report should be tested to ensure that the amounts are net of any returns, recoveries, and/or rebates.
4. Claim files should be tested and agreed to detailed records and to the report to ensure completeness, accuracy, cutoff, and existence of information.
5. Detailed listings should be scanned for unusual items.
6. Determine that appropriate adjustments are made to the claims liability where there is a non-routine delay in the notification of claims, a significant volume of unprocessed claims, or a change in the date of closing records.
7. Review the results obtained from applying analytical procedures and consider their impact on substantive tests to be performed.

8. Amounts, where appropriate, should be recalculated to assess the accuracy of amounts included in the schedule.
9. Assess lag technique methodologies for reasonableness.
10. Consider the need for actuarial review to determine the calculations and methodologies involved in determining that the IBNR recorded on Line 44 are accurately stated.

Compliance Requirement Report #5

Parts A to H - Income Statement

Part I – Income Statement – Provider Pay for Performance, Community Based Care Management, and Hospital Quality Incentive

Part V – Income Statement - COVID-19 Vaccine Non-Risk Arrangement

Part W – Income Statement – Shadow Nurse Non-Risk Arrangement

Part X – Income Statement – High Cost Gene Therapy Non-Risk Arrangement

Part Z – Income Statement Summary – Report #5 – Part H, I, V, W, & X.

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #5 Parts A through G provides a HealthChoices agreement income statement for each recipient group. Report #5 H provides a HealthChoices agreement income statement for all recipient groups combined. These reports are intended to provide an understanding of the amount of profit earned from the HealthChoices agreement, along with components of administrative and medical costs. Comparisons by Commonwealth staff between the costs reported by each contractor, and between costs that have been reported, and costs predicted by actuaries help provide an understanding of the contractors' financial performance.

Report #5 Part I is a HealthChoices agreement income statement for total combined recipient groups, which provides only the revenue and expenses associated with certain Provider Pay for Performance, Community Based Care Management and Hospital Quality Incentive programs. Report #5 Part I is intended for the MCO to provide a separate accrual, and accounting of, pay for performance and community-based care program dollars received from the Department which are, in turn, paid to providers to enhance performance outcomes.

Report #5 Part V is a HealthChoices agreement income statement for total combined recipient groups, which provides only the revenue and expenses associated with the COVID-19 Vaccine Non-Risk Arrangement program. Report #5 Part V is intended for the MCO to provide a separate accrual, and accounting of, Departmental payments to MCOs, and MCO payouts to providers, for the COVID-19 Vaccine Non-Risk Arrangement program.

Report #5 Part W is a HealthChoices agreement income statement for total combined recipient groups, which provides only the revenue and expenses associated with the Shadow Nurse Non-Risk Arrangement program. Report #5 Part W is intended for the MCO to provide a separate accrual, and accounting of, Departmental payments to MCOs, and MCO payouts to providers, for the Shadow Nurse Non-Risk Arrangement program.

Report #5 Part X is a HealthChoices agreement income statement for total combined recipient groups, which provides only the revenue and expenses associated with the High-Cost Gene Therapy Non-Risk Arrangement program. Report #5 Part X is intended for the MCO to provide a

separate accrual, and accounting of, Departmental payments to MCOs, and MCO payouts to providers, for the High-Cost Gene Therapy Non-Risk Arrangement program.

Report #5 Part Z provides a HealthChoices agreement income statement that includes the Report #5H summary, plus the additions of Report #5 Part I, Report #5 V, Report #5W and Report #5X.

Each HealthChoices MCO submitted a proposal to the Department for advance approval of their specific targets for improved Provider Pay for Performance and Community Based Care Management.

NOTE: It is imperative to the DHS's rate setting process that the totals of Hospital, Pharmaceutical, Physician, and Other Medical are correctly classified by service group and recipient group.

Suggested Procedures:

Income Statement (Report #5 A-H)

NOTE: A Service Group Hierarchy Chart has been included with the FRR describing the service categories to be included on each expense line.

1. Ensure the completeness, accuracy and existence of data included on Report#5A-H.
2. Reporting of Revenue is accurate and properly classified by:
 - ♦ **County group/Rate Region**
 - ♦ **Recipient group**
 - ♦ **Service group**
3. Capitation payments should be confirmed with Comptroller Operations, Bureau of Payable Services.
4. Design a sampling methodology for testing of Report #5A-H.
5. Claims files testing should be designed to include, at the minimum, procedures to ensure:
 - a. Claims files, as reported, agree to detailed records of claims.
 - b. Reporting of accrued cost amounts on Report #5A-G are accurately and appropriately reported using criteria established by DHS and provided in the Financial Reporting Requirements. The amounts should be accurately classified by:
 - ♦ **County group/Rate Region**
 - ♦ **Recipient group**
 - ♦ **Service group**
 - c. Data included on report applies only to HealthChoices agreement.
 - d. Data included on report is consistent with requirements of HealthChoices agreement.
6. Reporting of administrative expenses on Report #5H is accurate and properly classified.
7. Expense allocations, if any, used in preparing the report should be verified for reasonableness and accuracy, and disclosed in the footnotes. Amounts should be tested to appropriate supporting documentation, with recalculations performed where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the HealthChoices agreement.
8. Mathematical accuracy of report should be verified.
9. Amounts where appropriate should be recalculated to assess the accuracy of amounts included in the schedule.

Income Statement – Provider Pay for Performance, Community Based Care Management and Hospital Quality Incentive (Report #5I)

1. Determine if policies and procedures are in place, and are utilized, to identify methods of accrual and accounting of the Provider Pay for Performance/Community Based Care Management/Hospital Quality Incentive dollars.
2. Ensure the completeness, accuracy and existence of data included on Report #5I.
3. Design a sampling methodology for testing of Report #5I revenue and expenses.
4. Testing should be designed to include, at the minimum, procedures to ensure:
 - a. Revenue is specific to Provider Pay for Performance/Community Based Care Management/Hospital Quality Incentive PMPM payments to the MCO by the Department.
 - b. Expenses pertain to only expenses associated with Provider Pay for Performance/Community Based Care Management/Hospital Quality Incentive payments to providers. Additional expenses incurred by the MCO over/above the Provider Pay for Performance/Community Based Care Management/Hospital Quality Incentive PMPM dollars accrued and/or received should not be reported in Report #5I. All MCO expenses that exceed the total Provider Pay for Performance/Community Based Care Management/Hospital Quality Incentive PMPM dollars accrued/received should be reported on Report #5H.
 - c. Reporting of accrued amounts on Report #5I are accurately and appropriately reported using criteria established by the DHS within the Financial Reporting Requirements, and as specified in the HealthChoices Agreement, Exhibit B (3) “Provider Pay-for-Performance”, Exhibit B(5) “Community Based Care Management” and Exhibit B(4) “Hospital Quality Incentive Program.”
 - d. Report #5I does not include any administrative expenses.
5. Mathematical accuracy of report should be verified.

Income Statement – Income Statement - COVID-19 Vaccine Non-Risk Arrangement (Report #5V)

1. Determine if policies and procedures are in place, and are utilized, to identify methods of accrual and accounting of the COVID-19 Vaccine Non-Risk Arrangement dollars.
2. Ensure the completeness, accuracy and existence of data included on Report #5V.
3. Design a sampling methodology for testing of Report #5V revenue and expenses.
4. Testing should be designed to include, at the minimum, procedures to ensure:
 - a. Revenue is specific to COVID-19 Vaccine Non-Risk Arrangement.
 - b. Expenses pertain to only expenses associated with COVID-19 Vaccine Non-Risk Arrangement. All MCO expenses not associated specifically to address vaccines for COVID-19 are to be reported on Report #5H.
 - c. Reporting of accrued amounts on Report #5V are accurately and appropriately reported using criteria established by the DHS within the Financial Reporting Requirements, and as specified in the HealthChoices Agreement, Appendix 18 “COVID-19 Vaccine Non-Risk Arrangement.”
5. Mathematical accuracy of report should be verified.

Income Statement – Income Statement – Shadow Nurse Non-Risk Arrangement (Report #5W)

1. Determine if policies and procedures are in place, and are utilized, to identify methods of

- accrual and accounting of the Shadow Nurse Non-Risk Arrangement dollars.
- 2. Ensure the completeness, accuracy and existence of data included on Report #5W.
- 3. Design a sampling methodology for testing of Report #5W revenue and expenses.
- 4. Testing should be designed to include, at the minimum, procedures to ensure:
 - a. Revenue is specific to Shadow Nurse Non-Risk Arrangement.
 - b. Expenses pertain to only expenses associated with Shadow Nurse Non- Risk Arrangement. All MCO expenses not associated specifically to address Shadow Nurse are to be reported on Report #5H.
 - c. Reporting of accrued amounts on Report #5W are accurately and appropriately reported using criteria established by the DHS within the Financial Reporting Requirements, and as specified in the HealthChoices Agreement, Appendix 18A “Shift Nursing Shadow Nurse Non-Risk Arrangement.”
- 5. Mathematical accuracy of report should be verified.

Income Statement – Income Statement – High-Cost Gene Therapy Non-Risk Arrangement (Report #5X)

- 1. Determine if policies and procedures are in place, and are utilized, to identify methods of accrual and accounting of the High-Cost Gene Therapy Non-Risk Arrangement dollars.
- 2. Ensure the completeness, accuracy and existence of data included on Report #5X.
- 3. Design a sampling methodology for testing of Report #5X revenue and expenses.
- 4. Testing should be designed to include, at the minimum, procedures to ensure:
 - a. Revenue is specific to High-Cost Gene Therapy Non-Risk Arrangement.
 - b. Expenses pertain to only expenses associated with High-Cost Gene Therapy Non-Risk Arrangement. All MCO expenses not associated specifically to address High-Cost Gene Therapy are to be reported on Report #5H.
 - c. Reporting of accrued amounts on Report #X are accurately and appropriately reported using criteria established by the DHS within the Financial Reporting Requirements, and as specified in the HealthChoices Agreement, Appendix 18B “High-Cost Gene Therapy Non-Risk Arrangement.”
- 5. Mathematical accuracy of report should be verified.

Compliance Requirement Report #6

Part A - Inpatient, Physician and Dental Statistics

Part B - Pharmaceutical Price and Utilization Statistics

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #6 (A) provides data to DHS on key measures of price and utilization for physician, inpatient and dental services. Additionally, these reports also provide data on costs for inpatient services and are provided by Recipient Group. Report #6 will provide data available through the last day of the year under examination. Additionally, this report must show the Data Cutoff Date on each report and include data for which the MCO is both the primary and secondary payer. Each quarterly submission contains two sets of reports representing the first previous and 2nd previous quarters. The submission to be examined will be the 4th Quarter submission, for service periods 1) July through September and 2) April through June of the examination year, with a Cutoff Date of January 31 of the following year.

Report #6 (B) provides DHS with data on key measures of price and utilization for pharmaceutical

services. The submission to be examined will be the 4th quarter submission for the service period October through December of the examination year, with a Cutoff Date of January 31 of the following year.

Inpatient, Physician and Dental Statistics (Report #6-A):

Suggested Procedures:

1. Design a sampling methodology for testing of Report #6 (A).
2. The sample items in support of Report #6 (A) should be tested to ensure that they are categorically accurate according to:
 - **Service group (i.e.: Inpatient, Physician and Dental)**
 - **Recipient group (i.e.: TANF-MAGI 21+, TANF-MAGI 1-20, Under Age1, etc.)**
3. Claim files should be tested and agreed to detailed records and to the report to ensure completeness, accuracy, cutoff, and existence of information for Report #6(A).
4. Detailed listings should be scanned for unusual items.
5. Confirm that data included on report applies only to the HealthChoices agreement.
6. Review the results obtained from applying analytical procedures and consider their impact on substantive tests to be performed.
7. Utilization and Cost figures, where appropriate, should be recalculated to assess the accuracy of figures included in Report #6 (A).

Pharmaceutical Price and Utilization Statistics (Report #6-B):

Suggested Procedures:

1. Design a sampling methodology for testing of Report #6 (B).
2. The sample items in support of Report #6 (B) should be tested to ensure that they are categorically accurate according to:
 - **Service group (Pharmaceutical)**
 - **Recipient group (i.e.: TANF-MAGI 21+, TANF-MAGI 1-20, Under Age1, etc.)**
3. Claim files should be tested and agreed to detailed records and to the report to ensure completeness, accuracy, cutoff, and existence of information for Report #6(B).
4. Detailed listings should be scanned for unusual items.
5. Confirm data included on report applies only to the HealthChoices agreement.
6. Utilization figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Report #6 (B).
7. Costs, where appropriate, should be recalculated to assess the accuracy of amounts included in the Report #6 (B).
8. If the MCO was unable to utilize any of the recommended definitions stated in the FRR, ensure their methodology used is sufficiently explained in the methodology description, including data field indicators and indicator descriptions.

Compliance Requirement Report #7

Part E - Emergency Department Utilization

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #7 (E) provides data to DHS on key measurement of summarized utilization of Emergency Department visits and Observation Room stays **that do not result in an inpatient admission**. Utilization measurement is on an annualized, “per 1,000 basis.” Per 1,000 is defined as annualized utilization per 1,000 average population. Report #7 (E) provides utilization data for a specific service period (quarter), with additional run-out days through a specified cut-off date. Each quarterly submission contains one report for the second previous quarter of utilization. This report must show the quarter ended (service period) and data cutoff dates. Utilization data includes that which the MCO is both the primary and secondary payer. Visits to Urgent Care Centers are not included in this measurement. The reported data should not include MCO denied claims. Reference the FRR for DHS instructions pertinent to certain claim denials that should be included in the calculation of this utilization.

The Report #7 (E) to be examined is the 4th Quarter submission, which is the service period April through June of the examination year.

Suggested Procedures:

1. Design a sampling methodology for testing of Report #7 (E).
2. The sample items in support of Report #7 (E) should be tested to ensure that they are categorically accurate according to:
 - **Age (i.e.: Under 21; 21 and Over)**
 - **Type of Visit (i.e.: Emergency Department or Observation Room)**
3. Claim files should be tested and agreed to detailed records and to the report to ensure completeness, accuracy, cutoff, and existence of information.
4. Detailed listings should be scanned for unusual items.
5. Confirm that data included on report applies only to the HealthChoices agreement.
6. Review the results obtained from applying analytical procedures and consider their impact on substantive tests to be performed.
7. Utilization, where appropriate, should be recalculated to assess the accuracy of figures included in Report #7 (E).

Compliance Requirement Report #8

Coordination of Benefits Reports

Part A - Claims Cost Avoided

Part B1 - Provider Reported

Part B2 – MCO Recovered

Part C – Third Party Direct or Vendor Recovered

This report should be accurately compiled in accordance with instructions included in the FRR. Report #8 (A-C) is used to capture MCO activities involving coordination of benefits with third party resources. Each report is separated into the type of claim that the service represents. These

correspond to the report types used in the encounter data. Each report is also divided by resource type - Commercial and Medicare. On each report, there are fields for the **Commercial Total** and the **Medicare Total**. Within each resource type, the figures should equal the resource total. On each report, the final line is the combination of both the **Commercial** and **Medicare** totals for all claim types. The report is compiled using quarterly data. The reports are submitted quarterly, however, each report contains three months of accumulated history. The submission to be examined will include October, November, and December of the examination year.

Suggested Procedures:

Claims Cost Avoided (Report #8-A):

1. Ensure completeness, accuracy, cutoff, and existence of data included on this schedule.
2. Design a sampling methodology for testing of Report #8 (A).
3. The sample items in support of Report #8 (A) should be tested to ensure that they are categorically accurate according to:
 - **Type of Resource (i.e.: Commercial or Medicare)**
 - **Type of Claim (i.e.: Inpatient, Outpatient/Professional, Long-Term Care, Dental, or Drug)**
4. Confirm the “**Total Number of Claims with Coordination of Benefits Processed with a Known TPL Resource**” reported for each category listed above.
5. Confirm the “**Total Number of Claims Denied Due to a Known TPL Resource without an Explanation of Benefits (EOB) attached**” reported for Commercial Subtotal and Medicare Subtotal.
6. Confirm the “**Total Number of Active Members with a TPL Resource at the End of the Reporting Period (Commercial, Medicare, Total Commercial and Medicare)**” reported for Commercial Subtotal and Medicare Subtotal.
7. Figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Totals.

Provider Reported (Report #8-B1):

1. Ensure completeness, accuracy, cutoff, and existence of data included on this schedule.
2. Design a sampling methodology for testing of Report #8 (B1).
3. The sample items in support of Report #8 (B1) should be tested to ensure that they are categorically accurate according to:
 - **Type of Resource (i.e.: Commercial or Medicare)**
 - **Type of Claim (i.e.: Inpatient, Outpatient/Professional, Long-Term Care, Dental or Drug)**
4. Confirm the “**Number of Claims**” reported for each category listed above.
5. Confirm the “**Allowed Amount**” reported for each category listed above.
6. Confirm the “**Amount Reported**” reported for each category listed above.
7. Figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Totals.

Provider Reported (Report #8-B2):

1. Ensure completeness, accuracy, cutoff, and existence of data included on this schedule.
2. Design a sampling methodology for testing of Report #8 (B2).
3. The sample items in support of Report #8 (B2) should be tested to ensure that they are categorically accurate according to:
 - **Type of Resource (i.e.: Commercial or Medicare)**
 - **Type of Claim (i.e.: Inpatient, Outpatient/Professional, Long-Term Care, Dental or Drug)**
4. Confirm the “**Number of Claims**” reported for each category listed above.
5. Confirm the “**Gross Amount Recovered**” reported for each category listed above.
6. Confirm the “**Net Dollar Amount Recovered**” reported for each category listed above.
7. Figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Totals.

Recovered (Report #8-C):

1. Ensure completeness, accuracy, cutoff, and existence of data included on this schedule.
2. Design a sampling methodology for testing of Report #8 (C).
3. The sample items in support of Report #8 (C) should be tested to ensure that they are categorically accurate according to:
 - **Type of Resource (i.e.: Commercial or Medicare)**
 - **Type of Claim (i.e.: Inpatient, Outpatient/Professional, Long-Term Care, Dental, or Drug)**
4. Confirm the “**Number of Claims**” reported for each category listed above.
5. Confirm the “**Gross Amount Recovered**” reported for each category listed above.
6. Confirm the “**Net Dollar Amount Recovered by the MCO**” reported for each category listed above.
7. Figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Totals.

Compliance Requirement Report #13

Part A – Subcapitation Data Summary Report

Part B – Subcapitation Data Detail Report

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #13 provides summary information on all HealthChoices MCO Subcapitation payments made during the quarter. A quarterly Subcapitation summary and detail reports are required to be submitted by each MCO.

The objective of these reports is to provide the Department with MCO costs associated with services being provided to their members through subcapitation arrangements between the MCO

and its providers.

Report #13 (A) will summarize all subcapitation payment information that is being reported on Report #13 (B).

Report #13 Part (B) is a separate Subcapitation Data Detail Report for each Category of Provider and Payment Method. The Category of Provider indicates the type of provider/subcontractor to whom the MCO paid the subcapitation payment. The two types of Payment Methods are FFS-YES and FFS-NO.

The Report #13 to be examined is the 4th quarter submission, which is the period October through December of the examination year. Report #13 quarters 1-3 should not be included in the report package.

Subcapitation Data Summary Report (Report #13-A):

Suggested Procedures:

1. Ensure the completeness, accuracy, and existence of data included on Report #13(A).
2. Compare the amounts listed by category of provider to their respective Report #4 – Lag Report by month.
3. Mathematical accuracy of Report #13 (A) should be verified.
4. Mathematical accuracy between Report #13 (A) and #13 (B) should be verified.

Subcapitation Data Detail Report (Report #13-B):

Suggested Procedures:

1. Ensure completeness, accuracy, cutoff, and existence of data included on Report #13 (B).
2. Design a sampling methodology for testing of Report #13 (B).
3. The sample testing should be designed to include, at the minimum, procedures to ensure:
 - a. The MCO provided accurate counts by **recipient group** and amounts of **subcapitation payments** within each of the following categories of provider:
 - Physician
 - Dental / Oral Surgery
 - Laboratory / Radiology
 - Pharmacy
 - Inpatient Hospital
 - Vision
 - Other
 - b. The MCO accurately classified payment methods as “**FFS-YES**” or “**FSS-NO**”.
4. On a sample basis, confirm “**Number of Providers Paid**” reported by month for the categories listed above is accurate.

Compliance Requirement - Report #26

Part A - Maternity Revenue and Medical Expense Annual Statement

Part B - Maternity Revenue and Medical Expense - Allocations Annual Statement

This report should be accurately compiled in accordance with instructions included in the FRR.

NOTE: The reporting period for Report #26 is **January 1, 2022 through December 31, 2022**. This differs from the remaining HealthChoices agreement examination reporting periods.

The DHS pays HealthChoices MCOs separately for maternity care. Report #26 is DHS's only source of data on maternity care expenses. The report is intended to provide an understanding of the amount of maternity care revenue earned, along with medical cost components for all rating groups combined. The DHS's actuaries will use Report #26 as the primary source of data to develop maternity care rates. In addition, comparisons by Commonwealth staff between the costs that have been reported and costs predicted by actuaries are used to determine the appropriateness of the rates. The DHS requires assurance that Report #26 provides accurate data on costs incurred by the MCOs to provide medical care to women during the period 90 days before the maternity outcome and ends with the maternity outcome or at the end of the hospital stay if applicable.

Suggested Procedures:

1. Ensure the completeness, accuracy and existence of data included on this schedule.
2. Confirm the maternity care revenue reported.
3. Verify source documents to determine that the expenses reported are for persons with a maternity care outcome.
4. Verify that the expenses reported fall in the timeframe of 90 days before the maternity outcome and ends with the maternity outcome.
5. Ensure medical expenses are for paid/approved claims only and do not include any IBNR claims or include expenses for any type of completion factor.
6. Review MCO case rates for certain services (for example, admissions). If the rates include costs related to both mother and baby, then:
 - a. Review the allocation methodology for reasonableness.
 - b. Review the allocation calculation for mathematical accuracy.
 - c. Ensure that the MCO includes an explanation in Report #26 B of the method of allocation, including the calculations supporting expenses reported on the respective lines of Report #26 A. If the MCO does not pay a case rate, ensure that a statement to that effect is included in Report #26.
7. Design a sampling methodology for testing of Report #26.
8. Claims files testing should be designed to include, at the minimum, procedures to ensure:
 - a. Claims files, as reported, agree to detailed records of claims.
 - b. Medical costs components are accurately reported by:
 - C-Section births
 - Vaginal births
 - c. Data included on report applies **only** to the HealthChoices agreement.
 - d. Data included on report is consistent with requirements of the HealthChoices agreement.

9. Revenue and expense allocations, if any, used in preparing this report should be verified for reasonableness, consistency, and accuracy. Allocation methodologies **must** be disclosed in Report #26 B. Amounts should be tested to appropriate supporting documentation with recalculations performed, where necessary. Methodologies for allocations should be verified with acceptable methodologies, if any, contained in the agreement.
10. Mathematical accuracy of report should be verified.

Compliance Requirement - Report #27

Maternity Outcome Counts

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #27 provides DHS with counts of second and third trimester maternity outcomes.

Suggested Procedures:

1. Ensure the completeness, accuracy, and existence of data included on Report #27.
2. Design a sampling methodology for testing of Report #27.
3. Sample testing should be designed to include, at the minimum, procedures to ensure:
 - a. The MCO provided accurate counts by **recipient group** and **rate region** for Live Births, with 2 categories:
 - Cesarean Section
 - Vaginal
 - b. Confirm multiple births were counted as one maternity outcome.
4. Count figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Report #26 (A).

NOTE: This is an annual report that provides quarterly data for the quarters ended September 30, 20XX; December 31, 20XX; March 31, 20YY; June 30, 20YY; September 30, 20YY; and December 31, 20YY.

Compliance Requirement - Report #40

This report should be accurately compiled in accordance with instructions included in the FRR.

NOTE: The reporting period for Report #40 is for the prior calendar year January 1, 2022 through December 31, 2022. This differs from the remaining HealthChoices agreement examination reporting periods, as the MCO has until June 30, 2023 to pay all obligations resulting from services rendered during this calendar year.

Each MCO must submit a proposal on how to incentivize Network Physicians for attaining certain quality of care measures. This plan is reviewed annually and approved by the Department. The MCO must adhere to the approved plan for a given calendar year, and all funds for the calendar year must be disbursed within six months subsequent to the end of calendar year.

Suggested Procedures:

1. Verify mathematical accuracy of the report.
2. Ensure revenue is properly report per the Provider Pay-for-Performance payment letters.
3. Recalculate Gross Receipts Tax Revenue.
4. Verify approval of the Provider Pay-for-Performance program for the applicable Calendar Year by obtaining the DHS's Provider Pay-for-Performance approval letter.
5. Design a sampling methodology to ensure claims payments disbursed and recorded on Report #40 adhere to the approved program. These procedures should include, at a minimum, assurances on the following:
 - a. Disbursements are for service dates within the program period.
 - b. Ensure all disbursements were made on or before June 30 of the subsequent calendar year. If disbursements are made after June 30 of the subsequent year, DHS should be contacted to determine the materiality of the finding.
 - c. Disbursements are only made for qualified members and eligible services. Disbursements comply with the payment frequency noted for each measure with no duplication.
 - d. Claims documentation supports the pay-for-performance payment disbursed.
6. If applicable, ensure payment of residual funds is in accordance with standards set forth with in the approved program.
7. Verify the ending fund balance for the applicable program year is equal to zero.

Compliance Requirement Report #41

Part A - Risk Pool Analysis

Part B - Risk Pool Listing by Participant

This report should be accurately compiled in accordance with instructions included in the FRR.

The objective of Report #41 is to provide information that will help the Commonwealth understand how risk pools affect financial results reported by the contractor. The Commonwealth wants to understand the extent to which MCOs are passing risk on to providers through risk pools, as well as the extent to which risk pool providers are incurring medical costs, in excess of revenue, that do not affect HealthChoices agreement net income.

Suggested Procedures:

1. Determine if risk pools exist by inquiring with management, reviewing board minutes, selected provider contracts, and subsequent cash payments.
2. Test accounts to substantiate proper classification and accuracy of amounts. All revenues and expenses should be classified to the appropriate service category, i.e.: hospital, physician, pharmaceutical, and other in Report #41A.
3. Examine detailed records to ascertain completeness, accuracy, cutoff, existence, and appropriateness of revenues and expenses included on the schedule. Revenues and expenses should be tested for appropriateness pertaining to the HealthChoices agreement. Verify that the beginning balance agrees with the ending balance of the prior year. (Note: The beginning balance for the first year of participation is 0).
4. Recalculate amounts, where appropriate, to assess the accuracy of amounts included in

the schedule. Determine that pool distributions/ contributions are calculated according to appropriate risk pool agreements.

5. Verify schedules for mathematical accuracy.
6. Verify the mathematical accuracy of accounts supporting financial schedules.
7. Verify expense allocations, if any, used in preparing the report for reasonableness and accuracy. Test amounts to appropriate supporting documentation with recalculations performed, where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the HealthChoices agreement and disclosed in the footnotes.
8. Determine that some form of a risk pool agreement, which specifies the terms, exists for each entity listed as a participant.
9. Determine that risk pool payables/receivables are in accordance with the HealthChoices agreement.
10. Determine that the withhold percentage is in accordance with the HealthChoices agreement and that withhold is accumulated to fund an incentive payment.

Compliance Requirement Report #42 MLR Reporting

This report should be accurately compiled in accordance with instructions included in the FRR.

NOTE: The reporting period for Report #42 is for the prior calendar year January 1, 2022 through December 31, 2022.

The report establishes requirements for the PH-MCO'S to calculate and report their medical loss ratio (MLR) to the Department. The objective of Report #42 is to provide the Commonwealth with information regarding the revenue and costs that the MCOs report specific to the PH HC program. A comparison of the financial amounts included in this report and what is reported in audited financials is required.

Suggested Procedures:

1. Ensure the completeness, accuracy and existence of data included on Report#42.
2. Confirm data included on the report applies only to the PH HC program.
3. Revenue and expense allocations used in preparing this report should be verified for reasonableness, consistency, and accuracy.
4. Design a sampling methodology for testing of Report #42 revenue and costs.
5. Mathematical accuracy of report should be verified.
6. Amounts where appropriate should be recalculated to assess the accuracy of amounts included in the schedule.

COMMUNITY HEALTHCHOICES

PROGRAM COMPLIANCE – COMMUNITY HEALTHCHOICES

Claims Processing

Objectives

The purpose of a claims processing system is to:

- Arrange for and reimburse in-network health care providers accurately and timely for covered services rendered, and non-participating or unauthorized health care providers for any appropriate out-of-plan services.
- Provide for claims administration which includes maintenance of fee schedules; procedure coding; benefit determination - including the arrangement for and reimbursement of in-network providers for covered services rendered and non- participating or unauthorized providers for any appropriate out-of-plan services; claims processing - including timely and accurate adjudication, auditing and quality review; claims payment - including timely payment to providers and subrogation investigation/pursuit of potential third party recoveries.
- Maintain a current membership management information system that has the capability to receive on-line data transfers of member enrollment/disenrollment information via the Department Information Resource Management Business Partner Network. Data files must provide accurate information on dates of MCO coverage for each recipient consistent with information provided by the Department. Member enrollment/disenrollment information may be maintained on a system separate from the claims processing system.
- Maintain a provider management system that has the capability to pay providers appropriately and timely.
- Provide reports that can be utilized by member services, provider relations, utilization management and quality improvement departments of the managed care organization.
- Enable the MCO to identify liable third parties for services rendered to recipients, avoid payments where a third party is responsible as appropriate, and recover payments when a third party is subsequently identified.
- Enable the MCO to support data reporting requirements defined in the CHC contracts, and generate data necessary for financial and program evaluation, both at the MCO and Commonwealth level.
- Detect suspected instances of recipient and provider fraud and abuse.

Adequate and timely payment procedures for non-participating providers ensures appropriate use of Community HealthChoices program funds and assures enrollees and providers that appropriate services are accessible.

Community HealthChoices Contract Requirements

The MCO must provide DHS with accurate reports on provider payments and claims processing.

The Contractor must have appropriate procedures to pay for or deny provider claims. Claims reviewed and denied should be communicated appropriately to the health care provider with opportunity given to appeal denied claims within time frames established in the CHC contract.

The Contractor must have procedures and reporting mechanisms to accurately identify liable third parties, to avoid and recover costs as appropriate, and to make a payment where a third party has made a partial payment for a service.

The Contractor must have a strategy to detect and report recipient and health care provider fraud and abuse.

The contractor must have in effect written administrative policies and procedures that direct the receipt, update, and testing of on-line transfer of member data from DHS. The DHS will provide the MCO with enrollment information for its members including the beginning and ending effective dates of enrollment. The data provided will include new enrollments, disenrollments, and demographic changes. It is the responsibility of the MCO to take necessary administrative steps consistent with dates established by the DHS. It is the responsibility of the MCO to maintain a membership management system that includes accurate recipient information, including dates of MCO coverage and category of aid.

Compliance Requirements and Suggested Procedures

A. Compliance Requirement

The Contractor must have a claim processing system and MIS sufficient to support the provider payment and data reporting requirements specified in CHC A agreement, Section V.X.6. Management Information Systems and Section VII. Financial Requirements.

Suggested Procedures:

1. Obtain and review the application requirements defined in the CHC A agreement. Verify that specific requirements address the completeness, timeliness, and accuracy of claim data and standing reference (i.e.: diagnosis codes, pricing, effective dates, DHS assigned codes, HCPCS codes, etc.) data input for processing, the on-going control and maintenance of this data, and the payment of claims. Testing for completeness, timeliness, and accuracy of claims should include, but is not limited to, the following verifications:
 - a. Universe of CHC claims for the period of the engagement is complete.
 - b. Sample selected is representative of the Universe.
 - 1) A portion of the claims tested must be adjusted claims and manually entered claims. These adjusted claims should be further tested to determine that the adjusted claims contain the necessary information to link the adjusted claims with the original claims.
 - 2) In determining if the sample is representative, the IPA should consider whether the sample included each of the following types of claims: inpatient, nursing facility, HCBS waiver, pharmacy, dental, and vision. The IPA should also consider the extent to which each type of claim exists in the entire Universe.
 - c. Both the HIPAA standard data element code sets that are submitted on electronic claims and the data element code sets that are submitted on manual claims can be successfully cross walked to the codes that are acceptable on the DHS encounter records.
 - d. The claim reference information on the claim form can be linked with the Encounter

Claim Reference Number.

- e. The recipient identification number agrees with, or can be cross walked to, the DHS's Recipient CIS Number.
 - f. The recipient is eligible for service on the date(s) service is provided.
 - g. The recipient is eligible for the type of service provided.
 - h. If the claim does not indicate other insurance or Medicare as a third-party payer, ensure that the file does not include information that the recipient is covered by other insurance or Medicare on the date(s) service is provided. If the claim does indicate other insurance or Medicare as a third-party payer, ensure that the amount paid is calculated correctly.
 - i. The provider identification number agrees with, or can be cross walked to, the DHS's MA Provider Number.
 - j. The amount paid to the provider by the Contractor is in accordance with the Community HealthChoices contract and the provider agreement.
 - k. Where the claims information is manually input, the information on the system regarding the diagnosis code, type of service, procedure code, and revenue code, units of service and dates of service agrees with information on the input document.
2. Patient Protection and Affordable Care Act (PPACA) includes language to extend the federal rebate to drugs covered by the MCOs. The language requires the State to collect paid claims data from each MCO and invoice the manufacturers for the Federal Rebates. System Notice (#SYS-2010-030) outlines the requirements needed from the MCOs to process appropriate Drug Rebate information using MCO Encounter Data.
- a. Determine if the MCO has adequate policies and procedures in place to process appropriate Drug Rebate information using MCO Pharmacy Encounter Data.
 - b. Ensure the supplemental monthly file is accurately compiled.
 - c. Compare a sample of the Drug Rebate claims received by the MCO from the provider with the records submitted in the Pharmacy Encounter records to ensure all Drug Rebate claims are being reported completely and accurately to DHS.

B. Compliance Requirement

Under Section 1902(a) (25) of the Social Security Act, DHS is required to take all reasonable measures to identify legally liable third parties and treat verified Third Party Liability (TPL) as a resource of the MA recipient. Under the Community HealthChoices Program, TPL activities will be shared between DHS's TPL Section, and the Contractor as described in Section VII.F. of the Community HealthChoices Agreement.

Suggested Procedures:

1. Determine if adequate policies and procedures are in place for the payment of claims with health-related insurance (i.e.: cost avoidance through the identification of liable third parties).
2. Determine if adequate policies and procedures are in place for the payment of accident/injury claims (i.e.: the contractor is responsible for payment of accident/injury claims and reporting accident/injury claims to DHS for recovery of identified liable third parties).
3. Determine if adequate policies and procedures are in place for the recovery of claims

when health-related insurance is identified after a claim is paid (retroactive).

4. Determine if adequate policies and procedures are in place to supply the Department's TPL Division Third Party Resources identified by the MCO or its Subcontractors, which do not appear on the Department's TPL database, within two weeks of its receipt by the MCO in accordance with Section VII.F.5, Third Party Resource Identification of the Community HealthChoices Agreement.
5. Determine if adequate policies and procedures are in place to verify the validity of a resource in question supplied by the Department to the MCO timely as outlined and in accordance with Section VII.F.5, Third Party Resource Identification of the Community HealthChoices Agreement.
6. Determine if adequate policies and procedures are in place for providing, at the Department's request, information included in the Encounter Data submissions that may be necessary for the administration of TPL activity in accordance with the Community HealthChoices Agreement, Section VII.F.3, Requests for Additional Data.
7. Evaluate the policies and procedures for reporting COB/TPL Financial Reports (Report #8A-C) to DHS. The IPA should review the Agreement and FRR requirements for COB/TPL, then evaluate the MCO's policies and procedures to determine if they adequately address all TPL requirements. The IPA should then review the MCO's compliance with the Agreement and FRR requirements for reporting to DHS.
8. Determine if the policies and procedures ensure that the required information is reported timely and accurately to DHS. The IPA should ensure that there are policies and procedures in place to (1) submit Report #8 within the timeframes referenced in Section 1.0 of the FRR, (2) properly report all required TPL activity within the timeframe that it occurred, and (3) include the information required in Section 3.7 of the FRR.

C. Compliance Requirement

The MCO must establish written policies and procedures for the detection and prevention of fraud and abuse by health care providers, recipients, or MCO employees as described in the CHC Agreement, Section V.X.4, Fraud and Abuse.

1. Obtain the Contractor's compliance plan, policies, and procedures to prevent and detect fraud and abuse by members, providers, and employees in relation to the CHC Agreement requirements. Review the policies and procedures to ensure that they identify the specific controls in place for fraud and abuse detection, and the process for preventing, investigating, and reporting any fraud or abuse.
2. Ensure that there is a designated compliance officer, a regulatory compliance committee on the board of directors, and staff who have designated as part of their responsibilities the proactive detection, prevention, and elimination of instances or patterns of fraud and abuse. Verify that procedures have been developed and communicated to the appropriate personnel.

D. Compliance Requirement

The MCO must develop, implement, and maintain a provider complaint and appeals system which provides for informal settlement of provider complaints at the lowest level and formal appeals process for those which cannot be resolved informally (CHC Agreement, Section V.T. Provider Dispute Resolution System).

Suggested Procedures:

1. Evaluate the MCO's provider grievance and appeals policies and procedures. The policies should establish a provider complaint and appeals system which includes a written description of a process for informal settlement of provider complaints at the lowest level, and a written description of a formal appeals process for those which cannot be resolved informally. The system must, at a minimum:
 - a. Accept DHS's definitions of a complaint and an appeal (CHC Agreement, Exhibit G).
 - b. Delineate between a complaint and an appeal.
 - c. Include time frames to ensure prompt review of complaints and appeals.
 - d. Be equitable to all providers.
 - e. Ensure that all providers have access to all documentation pertaining to the resolution of the appeal.
 - f. Ensure that staff appropriately report and handle provider complaints and appeals.
 - g. Ensure the participation of individuals within the MCO with the authority, training, and expertise to address complaints, and appeals and to require corrective action.
 - h. Establish a committee to process formal appeals, which consists of at least one quarter provider/peer representation.
2. Review documentation that demonstrates that providers have been made aware of the existence of the complaint and appeals process, and of how a provider may file a complaint.
3. Examine a sample of provider complaints to determine whether the policies and procedures are being applied, and whether all complainants are being treated equitably.
4. Determine whether the Grievance Coordinator/Provider Services Manager is qualified to facilitate and manage provider complaints (CHC Agreement, Exhibit G).
5. Determine whether sufficient staff resources are committed to the function to ensure that complainants are afforded due process, and that the time frames delineated in the MCO's complaint and appeals processes are met.

E. Compliance Requirement

Report #3 (A) - Monthly Claims Processing

This monthly report should be accurately compiled in accordance with instructions included in the applicable FRR as required by the Community HealthChoices Agreement, Section VII.D. Claims Processing Standards, Monthly Reports and Penalties.

DHS utilizes the following definitions, which can be found in the 2021 FRR:

Clean Claim – A claim that can be processed without obtaining additional information from the provider of the service and/or from the DHS. Therefore, an unclean claim is one that is pended within the claims processing system, waiting for external provider information. A clean claim includes a claim with errors originating in the MCO's claim system. Claims under investigation for fraud, abuse, are not clean claims. The MCO should consider a claim is clean if delays/suspensions are caused by the MCO claims processing system, and not due to the need of obtaining additional information from the provider. A claim that needs clinical review without requiring provider records is clean. An out-of-network claim the MCO requires a single case agreement to process is clean.

Unclean Claim – A claim that is pended and requires additional information from the provider of the service and/or the Department before adjudication can occur. This can also include claims under investigation for fraud or abuse. An example of an unclean claim would be a claim that is pended waiting for the provider to submit a third-party insurer Explanation of Benefits (EOB). In this case, the MCO cannot process the claim until the necessary information is provided.

Rejected Claim – A claim with a provider that the MCO cannot identify. Also, a non-claim that has erroneously been assigned a unique identifier and is removed from the claims processing system prior to adjudication. In addition, the MCO may categorize as rejected, a claim where the recipient cannot be identified or was never a member of the MCO. Claims returned by a web-based clearinghouse that is not a contractor of the MCO are not considered as claims received and would be excluded from claims reports.

Denied Claim – An adjudicated claim that does not result in a payment obligation to a provider. Example: A claim containing a recipient who was not a plan member as of the date of service should be denied and the provider notified.

Report #3A provides data to DHS on key measures of claims processing timeliness. DHS requires the MCO to process and adjudicate provider claims within 30, 45, and 90- day compliance standards as required by the Community HealthChoices Agreement. This report provides information on claims received during the month, and subsequently processed by the MCO. The report serves as a monitoring tool to ensure MCO claim systems adjudicate claims to meet contractually required standards. This report is also analyzed to determine adjudication trends and aids in identification of problems being experienced by the MCO.

The Monthly Claims Processing Report #3A consists of 5 Excel worksheets (1 tab for each month). Each monthly report provides information on claims received during the month and each of the previous four months. For CHC illustrative purposes, the June 2018 monthly report submission is due to DHS on August 5, 2018, and is used to determine processing penalties for March 2018. The months included in the report would be February, March, April, May, and June.

The submission(s) to be examined will be determined by DHS and disclosed to the IPA when the confirmed schedules are forwarded by the Single Point of Contact. The IPA will be requested to perform sample testing on one monthly report, which contains 5 months of claims receipt and processing.

Report #3A – Provides information on claims identified as clean and, on all claims, as of the date the report is prepared. Each of the five tabs contains the following elements:

1. Inpatient Claims Processed by the MCO
 - a. Clean Claims (Part A)
 - b. All Claims (Part B)
2. Inpatient Claims Processed by Subcontractors
 - a. Clean Claims (Part A)
 - b. All Claims (Part B)
3. Nursing Facility Claims Processed by the MCO
 - a. Clean Claims (Part C)

- b. All Claims (Part D)
- 4. Nursing Facility Claims Processed by Subcontractors
 - a. Clean Claims (Part C)
 - b. All Claims (Part D)
- 5. HCBS Waiver Claims Processed by the MCO
 - a. Clean Claims (Part E)
 - b. All Claims (Part F)
- 6. HCBS Waiver Claims Processed by Subcontractors
 - a. Clean Claims (Part E)
 - b. All Claims (Part F)
- 7. Other than Inpatient, Nursing Facility, HCBS Waiver, or Pharmacy Claims Processed by the MCO
 - a. Clean Claims (Part G)
 - b. All Claims (Part H)
- 8. Other than Inpatient, Nursing Facility, HCBS Waiver, or Pharmacy Claims Processed by the Subcontractor (Subcontractor, Dental Subcontractor, Vision Subcontractor and Other Subcontractor)
 - a. Clean Claims (Part G)
 - b. All Claims (Part H)

Suggested Procedures

1. Confirm that the MCO/Subcontractor has established policies and procedures in place and are being performed to assure Report #3A is accurately compiled in accordance with the FRR. Specifically, policies and procedures are followed to assure:
 - a. Every claim entered into the claims processing/computer information system that is not a rejected claim is adjudicated.
 - b. An electronic file of rejected claims, including a reason or reason code for rejection, is maintained.
 - c. **The amount of time required to adjudicate a paid claim is computed by comparing the date the claim was received with the check date or the transmission date of an electronic payment. (The check/e-payment date MUST be used for this comparison.)** For provider negative balance situations, where a check may not be produced until a balance is cleared, provider paid notice date can be used in lieu of the check date.
 - d. The amount of time required to adjudicate a denied claim is computed by comparing the date the claim was received with the denial notice date or the transmission date of an electronic denial notice.
 - e. Checks are mailed no later than three workdays from the check date.
2. For the monthly report to be determined, ensure the completeness, accuracy, cutoff, and existence of the data included on Report #3A.
3. Ensure that the count of claims reported as received by the MCO is accurate.
4. Ensure reported Member month count is accurate.
5. Count figures, where appropriate, should be recalculated to assess the accuracy of figures included in Report #3A.
6. Ensure that claims held by the MCO's Special Investigation Unit are classified as Not Yet Adjudicated, and that adjudication occurred at a later time for these claims. The

MCO should provide in the comments box explanations for claims that are not yet adjudicated.

Clean Claims – Inpatient, Nursing Facility, HCBS Waiver and Other than Inpatient, Nursing Facility, HCBS Waiver, or Pharmacy

1. Design a sampling methodology for testing Clean Claims.
2. Sample testing should be designed to include, at the minimum, procedures to ensure:
 - a. For the monthly report selected for audit, the MCO provided accurate counts of all Clean Claims within the following categories:
 - 1) Claims Paid and Denied in 30 days or less
 - 2) Claims Paid and Denied in 31 to 45 days
 - 3) Claims Paid and Denied in 46 to 90 days
 - 4) Claims Paid and Denied in more than 90days
 - 5) Claims Rejected
 - b. Claims were properly classified as Clean Claim or Rejected Claim in accordance with the FRR.

All Claims - Inpatient, Nursing Facility, HCBS Waiver and Other than Inpatient, Nursing Facility, HCBS Waiver, or Pharmacy (Unclean Claims)

1. Determine the number of Unclean Claims for each adjudication period by calculating the difference between the All-Claims line and the Clean Claims line.
2. Design a sampling methodology for testing Unclean Claims.
3. Sample testing should be designed to include, at the minimum, procedures to ensure:
 - a. For the monthly report selected for audit, the MCO must have processed all Unclean Claims within the following categories:
 - 1) -Claims Paid and Denied in 30 days or less
 - 2) -Claims Paid and Denied in 31 to 45 days
 - 3) -Claims Paid and Denied in 46 to 90 days
 - 4) -Claims Paid and Denied in more than 90 days
 - 5) -Claims Not Adjudicated
 - b. Claims were properly classified as an Unclean Claim, in accordance with the FRR.

Reporting Requirement

This compliance requirement should be addressed in the Compliance Attestation Examination Report described in the Engagement Administration, Independent Accountants Report Section. Claims Processing Report #3A should be included in the contract report package as an attachment to the Management Assertion Letter.

Each Monthly Claims Processing Report #3A must include the five worksheets for individual months. The Single Point of Contact will forward all applicable required Report #3s to the IPA along with the confirmed financial schedules.

Management Information System (MIS)/Encounter Data Reporting

Objective

The MCO and MCO Subcontractor must have effective procedures to compile, analyze, evaluate, and report data critical to the operations of the Community HealthChoices program managed care product, including encounter data. Encounter data or other appropriate information can assist to determine how and when MCO services are being utilized, to set future rates, to determine program effectiveness, and to evaluate performance management.

MIS is a critical area for any MCO to understand and monitor the financing, delivery, and effectiveness of the health care. It is only through information collection, reporting, and analysis that a contractor will be able to determine, in a managed care environment, how services are being delivered, and whether adequate resources are available.

Compliance Requirements and Suggested Procedures

E. Compliance Requirement

The Contractor shall be responsible for maintaining appropriate systems and mechanisms to obtain all necessary data from its health care providers to ensure its ability to comply with the encounter data reporting requirements as required by CHC Agreement (Section V. Administration, Management Information Systems; Section VIII. System Reporting; Exhibit X). The failure of an MCO, MCO Subcontractor, third party administrator, or third-party processor to provide the MCO with necessary encounter data shall not excuse the MCO's compliance with this requirement.

Suggested Procedures:

1. Obtain and review the Contractor's procedures related to the input of claims and encounters data submitted (consider paper and/or electronic submissions) by the provider. Ensure the procedures address manual steps and/or electronic edits designed to ensure the complete and accurate input of the data. Specifically, identify the process for resolving missing, incomplete, or invalid claims and encounter data received from the health care provider.
2. Obtain and review the Contractor's procedures related to monitoring the continued completeness and accuracy of the claims and encounters data once input and residing on a standing data file. The procedures should address run-to-run balancing routines and programmer and user access restrictions to the data files. The Physical procedures should also address receiving, processing, and reconciling the U277 and NCPDP response files; and the ability to store and provide to DHS the PROMISe ICN associated with each processed Encounter Data record returned on the files.
3. Obtain a sample (representative of the Universe) of individual encounters as submitted by the Contractor to DHS throughout the period under review. A portion of the encounters tested must be adjusted encounters. Ensure that the Contractor's testing includes pharmacy, inpatient, nursing facility, professional, outpatient, dental, professional drug, outpatient drug, HCBS waiver, and voided encounters.
 - a. Ensure that the MCO's procedures related to converting the claim or encounter to the HIPAA like compliant transaction formats required by DHS are complete and accurate.

- b. Evaluate the length of time between the claim's date of MCO adjudication and the date of the encounter's receipt in PROMISE. Except for pharmacy encounters, all MCO approved encounters and those specified MCO denied encounters must be approved in PROMISE by the last day of the third month following the month of initial MCO adjudication. Pharmacy encounters must be submitted and approved in PROMISE within 30 days following the MCO adjudication.
 - c. Compare the sample encounter records to the claims and encounters submitted by health care providers to the MCO for accuracy of recipient identification, procedure coding including modifiers, diagnosis coding, revenue codes where applicable, place of service, amount paid, service date, units of service delivered, appropriate bill type when applicable, Provider ID, TPL/COB information, and date of adjudication by the MCO. The comparison should consider any differences in converting the HIPAA standard data element code sets that are submitted on electronic claims and the data element code sets that are submitted on manual claims to the DHS required codes for encounter reporting.
4. Determine whether the MCO has issued a data confidentiality policy to all employees with access to the various applications.

NOTE: Claims and encounters codes may have to be cross walked to the codes required by DHS for encounter reporting.

G. Compliance Requirement

DHS requires the Contractor to submit a separate record or "encounter" each time a member has an encounter with a provider.

Person-Level Record: The person level record must include, at a minimum, the data elements as required for a HIPAA compliant 837 transaction and NCPDP transactions as defined by the Department.

Suggested Procedures:

1. Compare a sample of the encounters data received by the Contractor from the provider with the records submitted in the Encounter file to ensure that the Contractors are reporting all encounters as person-level Encounter records.
2. Compare a sample of payments made to the providers for any payment agreements other than fee-for-service, i.e.: Alternative Payment Arrangement (APA) retainer, case rates, bundled case rates, etc., with the Financial APA records to ensure that all provider payments are being reported completely and accurately to DHS.

H. Compliance Requirement

Patient Protection and Affordable Care Act (PPACA) includes language to extend the federal rebate to drugs covered by the MCOs. The language requires the State to collect paid claims data from each MCO and invoice the manufacturers for the Federal Rebates. System Notice (#SYS-2010-030) outlines the requirements needed from the MCOs to process appropriate Drug Rebate information using MCO Encounter Data.

Suggested Procedures:

1. Determine if the MCO has adequate policies and procedures in place to process appropriate Drug Rebate information using MCO Pharmacy Encounter Data.
2. Ensure the supplemental monthly file is accurately compiled.
3. Compare a sample of the Drug Rebate claims received by the MCO from the provider with the records submitted in the pharmacy encounter records to ensure all Drug Rebate claims are being reported completely and accurately to DHS.

Health Service Delivery System/Provider Incentive Arrangements

Requirement Objective

One of the advantages offered by managed care is the opportunity that it affords MCOs and providers to enter into creative payment arrangements that provide an incentive for the MCO and provider alike to provide effectively managed, high-quality care. **Regardless of the arrangements, they must comply** with the federal regulations designed to discourage provider incentive arrangements or physician incentive plans (PIP) that may create an incentive for physicians to inappropriately limit or deny care.

A PIP is defined as “any compensation arrangement between an MCO and a physician or physician’s group that may directly or indirectly have the effect of reducing, or limiting services furnished to Medicaid recipients enrolled in the MCO.” The compensation arrangements negotiated between subcontractors of an MCO (i.e.: Physician-Hospital Organizations (PHOs), Individual Practice Associations) and a physician or group, are of particular importance given that the compensation arrangements with which a physician is most familiar will have the greatest potential to affect a physician’s referral behavior.

PIPs may not be designed to offer any payments (whether direct or indirect) to a physician or physician’s group that motivates them to limit or reduce medically necessary services to any individual enrollee who is covered under the MCO’s contract. Indirect payments include offerings of monetary value (i.e.: stock options or waivers of debt) measured in the present or future. Disallowance of specific payments should not be interpreted as a measure to preclude physicians from authorizing only those services that are medically necessary.

CHC Contract Requirements

The MCO must have in effect written policies and procedures for determining its compliance with the federal regulation governing physician incentive payments (42 CFR Section 422.208 and 422.210, which apply to MA managed care under 42 C.F.R. § 438.3(i)) and must be prepared to provide documentation verifying its compliance with this rule.

Policies and procedures must address all requirements of the federal regulation including determination of substantial financial risk (Compliance Requirement I), disclosure of contracting arrangements (Compliance Requirement J), maintenance of stop-loss protection (Compliance Requirement K), and completion of annual customer satisfaction surveys (Compliance Requirement L).

Compliance Requirements and Suggested Procedures

I. Compliance Requirement

The MCO agrees that its provider contracts and subcontracts comply with 42 CFR Section 422.208 and 422.210 regarding Physician Incentive Arrangements as outlined in the CHC Agreement, Section VII.

Provider or provider groups are subject to requirements outlined in the Final Rule if determined to be at Substantial Financial Risk (SFR). Providers or provider groups not at SFR or with member panels greater than 25,000 members are not subject to regulations requiring annual disclosure of contracting arrangements, maintenance of stop-loss protection, or annual customer satisfaction surveys.

If a physician or physician's group patient panel is greater than 25,000 patients, then PIP is not considered to put the group at SFR because the risk is spread over the large patient panel. The 25,000 patients may be a pool of Medicare, Medicaid, and commercial members across the MCOs that have contracted with the physician's group. However, the physician's group can only pool categories of patients for which the following criteria are true:

1. Referral risk must have been transferred in each of the physician incentive arrangements applicable to the pooled enrollees,
2. The incentive arrangements related to the compensation for those enrollees must be comparable with respect to the nature and extent of the risk born,
3. The payments for all pooled enrollees must be held in a common risk pool,
4. The distribution of payments from the risk pool must not be calculated separately by patient category or by MCO; and,
5. No provider contract can require that risk be segmented by MCO or patient category.

Suggested Procedures:

1. Assess the provider panel size (this is not the same as the patient panel size) of the MCO. If the provider panel size is greater than 25,000, then the MCO is determined not to place its physicians at SFR.
2. Review policies and procedures, which outline the process for determining SFR both with the providers of the MCO and its subcontracts.
3. Assess compliance of the policies and procedures with the requirements of 42 CFR 417.479, the federal regulation regarding physician incentive payments.
4. Review the MCO's process for determining SFR with its contracts and subcontracts and assess compliance with requirements of 42 CFR 417.479, the federal regulation regarding physician incentive payments.
5. Select a sample of contracts and subcontracts and test the validity and accuracy of the process to determine SFR. To determine the validity and accuracy of the SFR determination process, use the following steps.
 - a. Evaluate whether the provider or provider group is at SFR by reviewing the capitation arrangement (the contract between the provider and the MCO). The entity is at SFR if the difference between the maximum and minimum possible payment is more than 25% of the maximum possible payments, or if the capitation arrangement is not clearly explained in the provider/group's contract (e.g.: the minimum capitation payments – maximum payments = x. If x is greater

- than 25% of the maximum possible payment, then the group is at SFR).
- b. Evaluate whether the entity has any other arrangement that could hold it liable for more than 25% of potential payments. If yes, then the entity is at SFR.

I. Compliance Requirement

The MCO is responsible for monitoring disclosure requirements that apply to the MCO's direct contracting and subcontracting arrangements with providers. If a provider or provider group does not transfer SFR to its own employees or members, then disclosure requirements are limited to this fact only.

NOTE: The regulation differentiates between physician's groups and "intermediate entities", which contract between MCOs and physician's groups. Intermediate entities must disclose their incentive arrangements, regardless of the level of risk transferred in those arrangements. Examples of intermediate entities include Individual Practice Associations that contract only with an individual physician and not with physician's groups, are considered physician's groups under this rule.

NOTE: MCOs (contracting and subcontracting) must provide information indicating whether the MCO or any of its contractors or subcontracts uses PIP that may affect the use of referral services, the type of incentive arrangement(s) used, and whether stop-loss protection is provided to any Medicaid beneficiaries who request this information. Additionally, if the MCO is required to conduct a customer satisfaction survey, they must also provide beneficiary requesters with a summary of survey results.

Suggested Procedures:

1. Evaluate the MCO's policies and procedures regarding disclosure requirements to determine if provisions of these documents meet the federal regulations governing disclosure requirements.
2. Review actual documentation/incentive arrangements to determine if provider or provider groups disclose all required information.
3. Review dates of documentation submission to determine if provider or provider groups disclose the information in the appropriate time frames. Contracts must report capitation data by April 1 of the year following the contract's initial effective date. The April reporting date was suspended until further notice. All other requirements still remain in effect. Customer satisfaction survey results should be submitted to regulators within a reasonable period of time after conducting the survey (average length of time is four months).
4. Providers and provider groups are required to disclose the following information:
 - a. The physician or physician's group discloses whether referral services are covered by the PIP. If only services furnished by the physician or group are addressed by the PIP, then there is no need for disclosure of other aspects of the PIP.
 - b. The physician or physician's group discloses the type of physician incentive arrangements (i.e.: withhold, bonus, capitation).
 - c. The physician or physician's group discloses the percent of total income at risk for referrals.
 - d. The physician or physician's group discloses the amount and type of stop-loss insurance protection (See Compliance Requirement C).

- e. The physician or physician’s group discloses the panel size and whether enrollees were pooled in order to achieve the panel size.
- f. For capitated physicians or groups: The physician or physician’s group discloses the percentage data from the previous calendar year showing how capitation payments paid to primary care physicians were used to pay for primary care services, referral services to specialists, hospital services, and other types of providers.
- g. The physician or physician’s group discloses a summary of customer satisfaction results if the MCO is required by this regulation to conduct a survey (See Compliance Requirement D).
- h. The physician or physician’s group provides referral disclosure information to beneficiaries when requested specifically by the beneficiary.
- i. If required to conduct a customer satisfaction survey, the physician or physician’s group provides a summary of customer satisfaction results to beneficiaries when requested specifically by the beneficiary (See Compliance Requirement D).

K. Compliance Requirement

The MCO shall be responsible for monitoring the adequacy of stop-loss protection for physicians and/or physician’s groups at SFR.

Suggested Procedures:

1. Evaluate the MCO’s policies and procedures regarding monitoring the adequacy of stop-loss protection for physicians and/or physician’s groups who are at significant risk.
2. Review an appropriate sample of arrangements to determine the type of stop-loss protection acquired by physician or physician’s groups and measure compliance with adequacy of coverage using the grid provided below. Either aggregate or per patient stop-loss may be acquired. The rule specifies that if aggregate stop-loss is provided, it must cover 90% of the cost of referral services that exceeds 25% of potential payments. Physicians and physician’s groups can be held liable for only 10%. If per patient stop-loss is acquired, it must be determined based on the physician or physician’s group’s patient panel size and cover 90% of the referral costs that exceed the following per patient limits.

Patient Panel Size	Single Combined Limit	Separate Institutional Limit	Separate Professional Limit
1-1,000	\$ 6,000*	\$ 10,000*	\$ 3,000*
1,001-5,000	30,000	40,000	10,000
5,001-8,000	40,000	60,000	15,000
8,001-10,000	75,000	100,000	20,000
10,001-25,000	150,000	200,000	25,000
25,001+	none	none	none

*In these situations, stop-loss insurance would be impractical. Not only would the premiums be prohibitively expensive, but also the protections for patients would likely not be adequate for panels of fewer than 500 patients. MCOs and physician’s groups clearly should not be putting physicians at financial risk for panel sizes this small. It is our understanding that doing so is not common. For completeness, however, we do show what the limits would be in these circumstances.

L. Compliance Requirement

If the physician or physician's groups contracting or subcontracting with the MCO are found to be at substantial financial risk, the MCO must perform a customer satisfaction survey of its current Medicaid enrollees, as well as those who disenrolled in the last 12 months (for reasons other than loss of eligibility or relocation outside of the service area).

If a survey is required, it must be conducted within one year of the date on which the MCO is required to disclose referral withhold and bonus payments (as listed in the disclosure section of this document). It must be conducted annually thereafter for as long as the physician or physician's group is at SFR.

Suggested Procedures:

Evaluate compliance regarding the distribution of customer satisfaction surveys. This evaluation should include:

- a. A review of the content of the survey tool to determine if all required elements are included.
- b. A review of the structure and format of the survey tool to determine if the design meets generally accepted survey principles.
- c. A review of the distribution list to determine if the sample size was appropriate.
- d. A review of the results report to determine if surveys were distributed and reported according to time frame requirements.

Items one through six provided below can be used as a checklist when reviewing customer satisfaction documentation, survey tools, and results to determine compliance with the federal regulation governing provider or provider groups at SFR which require the distribution of customer satisfaction surveys and the reporting of results.

1. A physician or physician's group at SFR distributes customer satisfaction surveys.
2. A physician or physician's group at SFR discloses results in the required time frames or at the request of a beneficiary.
3. The survey is conducted on an adequate size of the sample population.
4. The survey is designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis.
5. The survey questions address enrollee/disenrollee satisfaction with access to services (including referral services).
6. The survey questions address enrollee/disenrollee satisfaction with quality of care.

Financial Management Compliance Reports

NOTE: A request to obtain a digital copy of the applicable CHC FRRs can be sent via email to RA-OBMCORvenue@pa.gov.

Requirement Objective

Each participating Contractor, at its expense, is required to provide to DHS an annual Community HealthChoices contract examination prepared by an IPA. This examination must include the specific financial schedules described in Table 1 below, along with accompanying

Notes to the Financial Schedules. These Notes must contain descriptions of methodologies regarding revenue and expense allocation used in preparing the financial schedules.

NOTE: The IPA should also see related guidance in the Notes to the Financial Schedules in Supplemental Guidance.

CHC – Table 1

<i>Report #</i>	<i>Name</i>	<i>Description</i>	<i>Required MCOs</i>
2	Related Party Transactions and Obligations	Provides a summary of transactions and obligations with related parties/affiliates	All
4 (A-H)	Lag Reports	Provides an analysis that assists in determining the accuracy of historical medical claims liability estimates, which is helpful in assessing the adequacy of current liabilities.	All
5 (A-G)	Income Statement	Provides an analysis of revenues and expenses completed for each rate cell.	All
5 (V and H)	Income Statement	Provides additional revenues and expenses, specific to COVID-19 Vaccine Non-Risk Arrangement.	All
6 (A)	Nursing Facility and Personal Assistance Statistics	Provides data on key measures of price and utilization for nursing facility and personal assistance services	All
6 (B)	Pharmaceutical Price and Utilization Statistics	Provides data on key measures of price and utilization for pharmaceutical services	All
8 (A, B, C)	Coordination of Benefits Reports	Captures MCO activities involving coordination of benefits utilizing third party resources	All
13 (A, B)	Subcapitation Data Summary and Data Detail Reports	Provides summary information on all MCO subcapitation payments made during the quarter	All
42	Medical Loss Ratio Reporting	Provides an analysis of revenue and costs that are specific to the CHC program	All

Contract Requirement

Each MCO will provide a Report on the Examination of Financial Schedules by June 30. This package should include a report of independent accountants on the financial schedules specified in Table 1 and include accompanying Notes to the Financial Schedules.

Compliance Requirements and Suggested Procedures

Compliance Requirement Report #2

Related Party Transactions and Obligations

This report should be accurately compiled in accordance with instructions included in the FRR.

NOTE: The FRR defines related parties as required for preparation of this report.

The objective of Report #2 is to assist the Commonwealth in understanding the nature and extent of transactions with related parties and obligations to or from related parties. This report is used to ensure that transactions with related parties reflect efficient business practices.

Suggested Procedures:

1. Test the completeness of Report #2 - Related Party Transactions and Obligations to ascertain that all related parties and affiliates are listed on the report by performing procedures such as a review of Board minutes, reviewing prior year engagement documentation for names of known related parties, reviewing filings with other regulatory/authoritative bodies, and inquiry of management. An additional source of information for determining completeness of related party transactions is Schedule Y of the MCO's annual statement submitted to the Insurance Department. Schedule Y is entitled "Summary of the Insurer's Transactions with Affiliates."
2. Detailed tests of transactions and balances should include steps to ascertain the completeness of the related party and affiliate transactions as defined in the CHC Agreement, Section IV.
3. The confirmation of related party balances should be supplemented with a review of accounting records for evidence of loan guarantees, large, unusual, and/or nonrecurring transactions with officers, directors, and affiliated companies. Attention to transactions recognized at, or near the end of the period (including loans receivable and payable), should be considered for confirmation.

Compliance Requirement Report #4

Parts A and B - Lag Reports For Nursing Facility Services

Parts C and D - Lag Report For Pharmaceutical Services

Parts E and F - Lag Report For Other Medical Services

Part G – Lag Report For Personal Assistance Services

Part H - Lag Report For Other HCBS Waiver Services

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #4 provides information on the relationship between reported expenses and paid claims. This helps the Commonwealth understand the adequacy of accruals reported for prior periods and provides information useful to evaluate the adequacy of expenses reported for current periods. Since this data provides a basis for incurred but not reported (IBNR) estimates, it is essential that the lag tables be developed properly.

Suggested Procedures:

1. Items included in the report should be tested to ensure that they are categorically accurate according to service group (i.e.: Nursing Facility, Pharmaceutical, Other Medical, Personal Assistance, and Other HCBS Waiver).
2. Claims payable aging should be tested and evaluated to ensure accuracy as included on the report.

3. Items included in the report should be tested to ensure that the amounts are net of any returns, recoveries, and/or rebates.
4. Claim files should be tested and agreed to detailed records and to the report to ensure completeness, accuracy, cutoff, and existence of information.
5. Detailed listings should be scanned for unusual items.
6. Determine that appropriate adjustments are made to the claims liability where there is a non-routine delay in the notification of claims, a significant volume of unprocessed claims, or a change in the date of closing records.
7. Review the results obtained from applying analytical procedures and consider their impact on substantive tests to be performed.
8. Amounts, where appropriate, should be recalculated to assess the accuracy of amounts included in the schedule.
9. Assess lag technique methodologies for reasonableness.
10. Consider the need for actuarial review to determine the calculations and methodologies involved in determining that the IBNR recorded on Line 43 are accurately stated.

Compliance Requirement Report #5

Parts A to G - Income Statement

Part V – Income Statement – COVID-19 Vaccine Non-Risk Arrangement

Part H – Income Statement Summary – Report #5 – Part G & V

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #5 Parts A through F provides a contract income statement for each rate cell. Report #5G provides a contract income statement for all rate cells combined. These reports are intended to provide an understanding of the amount of profit earned from the contract, along with components of administrative and service costs. Comparisons by Commonwealth staff between the costs reported by each contractor, and between costs that have been reported, and costs predicted by actuaries help provide an understanding of the contractors' financial performance. intended for the MCO to provide a separate summary of all revenue and expenses associated with coverage and administration of COVID- 19 vaccines as outlined in Appendix 3h of the CHC Agreement.

Report #5 Part H provides a contract income statement that includes the Report #5G summary, plus the addition of Report #5 Part V.

NOTE: It is imperative to the DHS's rate setting process that the totals of Nursing Facility, Pharmaceutical, Other Medical, Personal Assistance, and Other HCBS Waiver are correctly classified by service group and rate cell.

Suggested Procedures:

Income Statement (Report #5 A-G)

NOTE: A Medical Service Group Hierarchy Chart and an HCBS Waiver Service Chart has been included with the CHC FRR describing the service categories to be included on each service

expense line.

1. Ensure the completeness, accuracy and existence of data included on Report#5A-G.
2. Reporting of Revenue is accurate and properly classified by:
 - ♦ **Rate Region**
 - ♦ **Rate Cell, including break-out for NFCE participants residing in a nursing facility (defined as FAC population) from those enrolled in the CHC waiver and residing in the community (defined as WAV population)**
3. Capitation payments should be confirmed with Comptroller Operations, Bureau of Payable Services.
4. Design a sampling methodology for testing of Report #5A-G.
5. Claims files testing should be designed to include, at the minimum, procedures to ensure:
 - a. Claims files, as reported, agree to detailed records of claims.
 - b. Reporting of accrued cost amounts on Report #5A-G are accurately and appropriately reported using criteria established by DHS and provided in the Financial Reporting Requirements. The amounts should be accurately classified by:
 - ♦ **Rate Region**
 - ♦ **Rate Cell, including break-out for NFCE participants residing in a nursing facility (defined as FAC population) from those enrolled in the CHC waiver and residing in the community (defined as WAV population)**
 - ♦ **Service group**
 - c. Data included on report applies only to the Community HealthChoicescontract.
 - d. Data included on report is consistent with requirements of the Community HealthChoices contract.
6. Review the FRR instructions related to care management/service coordination costs. Obtain and review the Contractor's definition of care management/service coordination expenses policy and compare to the FRR instructions and provide Contractor explanation for any discrepancies.
7. Reporting of other non-benefit expenses (administrative expenses and activities that improve health care quality) on Report #5G is accurate and properly classified.
8. Design a sampling methodology to test that expenses reported as Health Care Quality Improvement (HCQI) meet the definition of the FRR instructions to be reported in Lines 46 through 51 of Report #5G.
9. Expense allocations, if any, used in preparing the report should be verified for reasonableness and accuracy, and disclosed in the footnotes. Amounts should be tested to appropriate supporting documentation, with recalculations performed where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the contract.
10. Corporate allocations and indirect administrative expense charges to the participating Contractor should be for expenses that are in support of the Community HealthChoices contract. Obtain and review the Contractor's corporate allocations and indirect administrative expenses included within Report #5G and provide a listing, with dollar amount, of charges associated with administrative functions not in support of the Community HealthChoices contract.
11. Care management/service coordination costs and other non-benefit expenses included within Report #5G should be for expenses that are in support of the Community

HealthChoices contract. Obtain and provide the dollar amount of all direct charges, indirect charges, and allocations for:

- a. Related party expenses/allocations/charges greater than actual cost.
 - b. Lobby expenses and membership expenses associated with lobbying.
 - c. Charitable donations and contributions.
 - d. Amortization of goodwill.
 - e. Organizational costs, proposal costs and other costs associated with contract or zone/rating region start-up
 - f. Bad debts.
 - g. Entertainment, non-commercial travel and/or alcoholic beverages.
 - h. Fines, penalties, damages, and other settlements not already reported in Lines 56 and/or 57 of Report #5G.
 - i. Any other expenses not in support of the Community HealthChoices contract.
 - j. If none of the items in a-i above are identified, include within the notes to the Financial Schedules (either a stand-alone note or included within one of the current notes as determined reasonable by the IPA) that: “Care management, administrative expenses, corporate allocations and indirect administrative expenses reported in the accompanying financial schedules do not include any expenses that require specific identification as outlined in the Compliance Requirement of Report #5.”**
12. Mathematical accuracy of report should be verified.
13. Amounts where appropriate should be recalculated to assess the accuracy of amounts included in the schedule.

Income Statement – COVID-19 Vaccine Non-Risk Arrangement (Report #5V)

1. Determine if policies and procedures are in place, and are utilized, to identify methods of accrual and accounting of the COVID-19 Vaccine dollars.
 - a. Revenue aligns with reported expenses, as non-risk arrangement requires all covered expenses for the covered population be reimbursed by the Department through separate invoice process after the end of the Arrangement Year.
 - b. Expenses must pertain to coverage and administration of COVID-19 vaccine payments to providers.
 - c. Expenses reported as ‘Pharmacy Administrative Costs’ must pertain to the administration of a COVID-19 vaccine and no other administrative costs.

Compliance Requirement Report #6

Part A – Nursing Facility and Personal Assistance Statistics

Part B - Pharmaceutical Price and Utilization Statistics

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #6 (A) provides data to DHS on key measures of price and utilization for nursing facility and personal assistance services. Additionally, these reports also provide data on costs by provider type. Report #6 will provide data available through the last day of the year under examination. Additionally, this report must show the Data Cutoff Date on each report and include data for which the MCO is both the primary and secondary payer. Each quarterly submission contains data for the current 4 service quarter as well as the three prior service quarters. The submission to be examined will be the 4th Quarter submission, which will cover the entire examination year.

Report #6 (B) provides DHS with data on key measures of price and utilization for pharmaceutical services. The submission to be examined will be the 4th quarter submission for the service period October through December of the examination year.

Nursing Facility and Personal Assistance Statistics (Report #6-A):

Suggested Procedures:

1. Design a sampling methodology for testing of Report #6 (A).
2. The sample items in support of Report #6 (A) should be tested to ensure that they are categorically accurate according to:
 - **Service group (i.e.: Nursing Facility and Personal Assistance)**
 - **Provider type (i.e.: Private vs. County Nursing Facility and Self-Directed vs. Agency Personal Assistance)**
3. Claim files should be tested and detailed records and to the report to ensure completeness, accuracy, cutoff, and existence of information for Report #6 (A).
4. Detailed listings should be scanned for unusual items.
5. Confirm that data included on report applies only to Community HealthChoices contract program.
6. Review the results obtained from applying analytical procedures and consider their impact on substantive tests to be performed.
7. Average Utilization and Cost figures, where appropriate, should be recalculated to assess the accuracy of figures included in Report #6 (A).

Pharmaceutical Price and Utilization Statistics (Report #6-B):

Suggested Procedures:

1. Design a sampling methodology for testing of Report #6 (B).
2. The sample items in support of Report #6 (B) should be tested to ensure that they are categorically accurate according to:
 - **Service group (Pharmaceutical)**
 - **Recipient group (i.e.: NFCE Non-Duals only)**
3. Claim files should be tested and agreed to detailed records and to the report to ensure completeness, accuracy, cutoff, and existence of information for Report #6 (B).
4. Detailed listings should be scanned for unusual items.
5. Confirm data included on report applies only to Community HealthChoices contract program.
6. Utilization figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Report #6 (B).
7. Costs, where appropriate, should be recalculated to assess the accuracy of amounts included in the Report #6 (B).
8. If the MCO was unable to utilize any of the recommended definitions stated in the FRR, ensure their methodology used is sufficiently explained in the methodology description,

including data field indicators and indicator descriptions.

Compliance Requirement Report #8

Coordination of Benefits Reports Part A – Claims Cost Avoided

Part B (1) – Provider Reported

Part B (2) – MCO Recovered

Part C – Vendor Recovered

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #8 (A-C) is used to capture MCO activities involving coordination of benefits with third party resources. Each report is separated into the type of claim that the service represents. These correspond to the report types used in the encounter data. Each report is also divided by resource type - Commercial and Medicare. On each report, there are fields for the **Commercial Total** and the **Medicare Total**. Within each resource type, the figures should equal the resource total. On each report, the final line is the combination of both the **Commercial** and **Medicare** totals for all claim types. The report is compiled using quarterly data. The reports are submitted quarterly, however, each report contains three months of accumulated history. The submission to be examined will include October, November, and December of the examination year.

Suggested Procedures:

Claims Cost Avoided (Report #8 (A)):

1. Ensure completeness, accuracy, cutoff, and existence of data included on this schedule.
2. Design a sampling methodology for testing of Report #8 (A).
3. The sample items in support of Report #8 (A) should be tested to ensure that they are categorically accurate according to:
 - **Type of Resource (i.e.: Commercial or Medicare)**
 - **Type of Claim (i.e.: Inpatient, Outpatient/Professional, Nursing Facility, Pharmacy, or HCBS Waiver)**
4. Confirm the **“Total Number of Claims with Coordination of Benefits Processed with a Known TPL Resource”** and associated **“Total Dollar Amount of Claims with Coordination of Benefits Processed with a Known TPL Resource”** reported for each category listed above.
5. Confirm the **“Total Number of Claims Denied Due to a Known TPL Resource without an Explanation of Benefits (EOB) attached”** and associated **“Total Dollar Amount of Claims Denied Due to a Known TPL Resource without an Explanation of Benefits (EOB) attached”** reported for Commercial Subtotal and Medicare Subtotal.
6. Confirm the **“Total Number of Active Members with a TPL Resource at the End of the Reporting Period (Commercial, Medicare, Total Commercial and Medicare)”** reported for Commercial Subtotal and Medicare Subtotal.
7. Figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Totals.

Provider Reported (Report #8 (B)(1)):

1. Ensure completeness, accuracy, cutoff, and existence of data included on this schedule.
2. Design a sampling methodology for testing of Report #8 (B)(1).
3. The sample items in support of Report #8 (B)(1) should be tested to ensure that they are categorically accurate according to:
 - **Type of Resource (i.e.: Commercial or Medicare)**
 - **Type of Claim (i.e.: Inpatient, Outpatient/Professional, Nursing Facility, Pharmacy, or HCBS Waiver)**
4. Confirm the “**Number of Claims**” reported for each category listed above.
5. Confirm the “**Allowed Amount**” reported for each category listed above.
6. Confirm the “**Amount Reported**” reported for each category listed above.
7. Figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Totals.

MCO Recovered (Report #8 (B)(2)):

1. Ensure completeness, accuracy, cutoff, and existence of data included on this schedule.
2. Design a sampling methodology for testing of Report #8 (B)(2).
3. The sample items in support of Report #8 (B)(2) should be tested to ensure that they are categorically accurate according to:
 - **Type of Resource (i.e.: Commercial or Medicare)**
 - **Type of Claim (i.e.: Inpatient, Outpatient/Professional, Nursing Facility, Pharmacy, or HCBS Waiver)**
4. Confirm the “**Number of Claims**” reported for each category listed above.
5. Confirm the “**Gross Amount Recovered**” reported for each category listed above.
6. Confirm the “**Net Dollar Amount Recovered by the CHC-MCO**” reported for each category listed above.
7. Figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Totals.

Vendor Recovered (Report #8 (C)):

1. Ensure completeness, accuracy, cutoff, and existence of data included on this schedule.
2. Design a sampling methodology for testing of Report #8 (C).
3. The sample items in support of Report #8 (C) should be tested to ensure that they are categorically accurate according to:
 - **Type of Resource (i.e.: Commercial or Medicare)**
 - **Type of Claim (i.e.: Inpatient, Outpatient/Professional, Nursing Facility, Pharmacy, or HCBS Waiver)**
4. Confirm the “**Number of Claims**” reported for each category listed above.
5. Confirm the “**Gross Amount Recovered**” reported for each category listed above.
6. Confirm the “**Net Dollar Amount Recovered by the Vendor**” reported for each category

listed above.

7. Figures, where appropriate, should be recalculated to assess the accuracy of figures included in the Totals.

Compliance Requirement Report #13

Part A – Sub-capitation Data Summary Report

Part B – Sub-capitation Data Detail Report

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #13 provides summary information on all Community HealthChoices MCO Sub-capitation payments made during the quarter. A quarterly Sub-capitation summary and detail reports are required to be submitted by each MCO.

The objective of these reports is to provide the Department with MCO costs associated with services being provided to their members through sub-capitation arrangements between the MCO and its providers.

Report #13 (A) will summarize all sub-capitation payment information that is being reported on Report #13 (B).

Report #13 Part (B) is a separate Sub-capitation Data Detail Report for each Category of Provider and Payment Method. The Category of Provider indicates the type of provider/subcontractor to whom the MCO paid the sub-capitation payment. The two types of Payment Methods are FFS-YES and FFS-NO.

The Report #13 to be examined is the 4th quarter submission, which is the period October through December of the examination year. Report #13 quarters 1-3 should not be included in the report package.

Sub-capitation Data Summary Report (Report #13-A):

Suggested Procedures:

1. Ensure the completeness, accuracy, and existence of data included on Report #13(A).
2. Compare the amounts listed by category of provider to their respective Report #4 – Lag Report by month.
3. Mathematical accuracy of Report #13 (A) should be verified.
4. Mathematical accuracy between Report #13 (A) and #13 (B) should be verified.

Sub-capitation Data Detail Report (Report #13-B):

Suggested Procedures:

1. Ensure completeness, accuracy, cutoff, and existence of data included on Report #13 (B).
2. Design a sampling methodology for testing of Report #13 (B).
3. The sample testing should be designed to include, at the minimum, procedures to ensure:
 - a. The MCO provided accurate counts by **rate cell** and amounts of **sub-capitation payments** within each of the following categories of provider:

- Nursing Facility
 - Pharmacy
 - Other Medical
 - Personal Assistance
 - Other HCBS Waiver
- b.** The MCO accurately classified payment methods as “FFS-YES” or “FSS-NO”.
4. On a sample basis, confirm “**Number of Providers Paid**” reported by month for the categories listed above is accurate.
 - a. Ensure all disbursements were made on or before June 30 of the subsequent calendar year.
 - b. Disbursements are only made for qualified members and eligible services. Disbursements are in compliance with the payment frequency noted for each measure with no duplication.
 - c. Claims documentation supports the pay-for-performance payment disbursed.
 5. If applicable, ensure payment of residual funds is in accordance with standards set forth with in the approved program.
 6. Verify the ending fund balance for the applicable program year is equal to zero.

Compliance Requirement Report #14
In-Lieu Of Services Summary Report

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #14 is used to capture services provided by the CHC-MCO that have been approved by the Department as medically appropriate, cost-effective substitutes to covered State Plan services.

Suggested Procedures:

1. Ensure completeness, accuracy, cutoff, and existence of data included on Report #14.
2. Design a sampling methodology for testing of Report #14.
3. Claims files testing should be designed to include, at the minimum, procedures to ensure:
 - a. Claims files, as reported, agree to detailed records of claims.
 - b. Reporting of accrued cost amounts on Report #14 are accurately and appropriately reported using criteria established by DHS and provided in the FRR. The amounts should be accurately classified by:
 - ◆ **Service name**
 - c. Data included on report applies only to the Community HealthChoice contract.
 - d. Data included on report is consistent with requirements of the Community HealthChoices contract.

Compliance Requirement Report #15
Expanded/Value-added Services
Summary Report

This report should be accurately compiled in accordance with instructions included in the FRR.

Report #15 is used to capture services offered by the CHC-MCO at no cost to the Department that do not directly replace another service outlined in the contract but may improve outcomes.

These services have been previously approved by the Department to encourage participant enrollment, encourage healthy lifestyles, or support other CHC program objectives.

Suggested Procedures:

1. Ensure completeness, accuracy, cutoff, and existence of data included on Report #15.
2. Design a sampling methodology for testing of Report #15.
3. Claims files testing should be designed to include, at the minimum, procedures to ensure:
 - a. Claims files, as reported, agree to detailed records of claims.
 - b. Reporting of accrued cost amounts on Report #15 are accurately and appropriately reported using criteria established by DHS and provided in the FRR. The amounts should be accurately classified by:
 - ♦ **Service name**
 - c. Data included on report applies only to the Community HealthChoice contract.
 - d. Data included on report is consistent with requirements of the Community HealthChoices contract.

Compliance Requirement Report #42

Report #42 Detail

Report #42 Summary

Report #42 Comments

This report should be accurately compiled in accordance with instructions included in the FRR.

NOTE: The reporting period for Report #42 is for the prior calendar year January 1, 2022 through December 31, 2022.

The report establishes requirements for the CHC-MCO'S to calculate and report their medical loss ratio (MLR) to the Department. The objective of Report #42 is to provide the Commonwealth with information regarding the revenue and costs that the MCOs report specific to the CHC program. A comparison of the financial amounts included in this report and what is reported in audited financials is required.

Suggested Procedures:

1. Ensure the completeness, accuracy and existence of data included on Report #42.
2. Confirm data included on the report applies only to the CHC program.
3. Revenue and expense allocations used in preparing this report should be verified for reasonableness, consistency, and accuracy.
4. Design a sampling methodology for testing of Report #42 revenue and costs.
5. Mathematical accuracy of report should be verified.
6. Amounts where appropriate should be recalculated to assess the accuracy of amounts included in the schedule.

GLOSSARY

AICPA	American Institute of Certified Public Accountants
APA	Alternative Payment Arrangement
ASO	Administrative Services Organization - an independent organization (e.g., private for-profit managed care organization, insurance carrier) under contract to provide administrative services for a managed care plan in exchange for a fee. ASO services may include claims processing, actuarial support, benefit plan design, financial advice, medical management, preparation of data for reports to governmental units and other administrative functions.
BH	Behavioral Health
BHRS	Behavioral Health Rehabilitation Services for Children and Adolescents (formerly referenced as EPSDT)
BPI	Bureau of Program Integrity
CFR	Code of Federal Regulations
CHC	Community HealthChoices
CIS	Client Information System
COB	Coordination of Benefits
CONTRACTOR	Entity that contracts directly with the Department of Human Services to administer the HealthChoices Behavioral Health Program in a County (see Attachments 2 and 3 to this Introduction). This term is synonymous with Primary Contractor.
CSR	Capitation Service Ratio
DDAP	Department of Drug and Alcohol Programs
DHS	Pennsylvania Department of Human Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment Program for persons under 21
FRR	Financial Reporting Requirements
GAGAS	Generally Accepted Gov't Auditing Standards (Yellow Book)

GLOSSARY (continued)

HCBS	Home and Community-Based Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HCQI	Health Care Quality Improvement
IBHS	Intensive Behavioral Health Services
IBNR	Incurred But Not Reported
IPA	Independent Public Accountant
MA	Medical Assistance or Medicaid
MCO	Managed Care Organization - An entity which manages the purchase and provision of physical or behavioral health services under the HealthChoices Program.
MCO SUBCONTRACTOR	A provider, practitioner, or vendor/supplier under subcontract with a County or an MCO pursuant to which services are provided under the HealthChoices Behavioral Health Program contract (see Attachments 2 and 3 to this Introduction).
MH/MR	Mental Health/Mental Retardation
MIS	Management Information System
MLR	Medical Loss Ratio
NCPDP	National Council for Prescription Drug Programs
OLTL	Office of Long-term Living
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Service
PMPM	Per Member Per Month
PROMISe	Provider Reimbursement and Operations Management Information System electronic
PSR	HealthChoices Program Standards and Requirements
RBUC	Received But Unpaid Claims

TPL

Third Party Liability