PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES
MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT CONTRACT

Section A. General Provisions

1. In Pennsylvania, the Department of Human Services (Department) is the State Medicaid Agency and provides benefits for those individuals eligible for Medicaid under the state's Medicaid Plan.

2. The Medicare Advantage (MA) Dual-Eligible Special Needs Plan (D-SNP) contracts with the Centers for Medicare & Medicaid Services (CMS) to arrange for the provision of Medicare services for individuals who are dually eligible for both Medicare and Medicaid benefits pursuant to Titles XVIII and XIX of the Social Security Act.

3. The Congress of the United States enacted the Medicare Improvements for Patients and Providers Act ("MIPPA") H.R. 6331 on July 15, 2008. MIPPA and its implementing regulations issued by CMS require a D-SNP to have a contract with the State Medicaid Agency in the state in which the D-SNP operates. Further, the Bipartisan Budget Act of 2018, requires D-SNPs meet certain integration requirements to continue to operate as a D-SNP, beginning in 2021. The purpose of this contract is to coordinate benefits and services for members of the D-SNP within the state and to provide, or arrange for the provision of, Medicaid benefits to its members. The Department and the D-SNP wish to enter into such a contract regarding the coordination of Medicare and Medicaid benefits by the D-SNP within the state in an effort to improve the integration and coordination of such benefits, improve the quality of care, and reduce the costs and administrative burdens associated with delivering such care.

4. This contract is between the Commonwealth of Pennsylvania, Department of Human Services, Office of Medical Assistance Programs, Health and Welfare Building, Room 515, P.O. Box 2675, Harrisburg, PA 17105-2675, Office of Long-Term Living, Forum Place, 6th Floor, P.O. Box 8025, Harrisburg, PA 17105-8025; and the Office of Mental Health and Substance Abuse Services, Commonwealth Tower, 12th Floor, P.O. Box 2675, Harrisburg, PA 17115, and <enter the D-SNP name and full address here>.

5. This agreement applies to (choose one):

   ☐ a companion D-SNP for <enter name of aligned Community HealthChoices Managed Care Organization (CHC-MCO)>; or

   ☐ a D-SNP that is not a companion D-SNP to a CHC-MCO.

   (Please note that Sections A through C apply to all D-SNPs. Section D applies only to companion D-SNPs.)

6. If any provision of this contract is rendered invalid or unenforceable by any local, state, or federal law, rules or regulations, or declared null and void by any court of competent jurisdiction, the remainder of this contract shall remain in full force and effect.

7. All notices required under this contract shall be in writing and sent by certified mail, return receipt requested, hand delivery or overnight delivery by a nationally recognized service to the following address unless otherwise directed by the Department:

   If to the D-SNP:

   _____

   _____

   _____

   _____

   If to the Department:

   Deputy Secretary Kevin Hancock
   Commonwealth of Pennsylvania
   Department of Human Services
   Office of Long-Term Living
   Forum Place, 6th Floor
   P.O. Box 8025
   Harrisburg, PA 17105-8025

8. This contract may be amended only in writing when signed by duly authorized representatives of each party. No provision of this contract may be modified, amended, or waived except by a written agreement signed by both of the parties to this contract. No course of dealing between the parties shall modify, amend, or waive any provision of this contract or any rights or obligations of any party under or by reason of this contract.

9. The Department reserves the right to inspect any records material to this contract.

10. The waiver of any breach or violation of any term or provision hereof shall not constitute a waiver of any subsequent breach or violation of the same or any other term or provision.

11. This contract shall be construed in accordance with and governed by the laws of the Commonwealth of Pennsylvania, except to the extent pre-empted by

federal law, in which case such federal law shall apply. The parties agree to comply with all relevant federal and state laws, including MIPPA.

12. This contract, its appendices, and its exhibits, supersedes any prior agreements among the parties in relation to the subject matter hereof, and no other agreements, understandings, or representations, verbal or otherwise, relative to the subject matter hereof exists among the parties at the time of the execution of this contract.

13. This contract may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same contract.

14. Appendix A, which contains definitions relating to contractual terms, is incorporated by reference into this contract.

15. In accordance with the Health Insurance Portability and Accountability Act (HIPAA), the D-SNP and its subcontractors agree to comply with the terms of the Commonwealth of Pennsylvania's Business Associate Agreement contained in Appendix B of this contract. Further, the Department agrees to comply with the terms contained in Appendix B of this contract. The Department further represents that it is a "Covered Entity" as that term is defined by HIPAA and its accompanying regulations. The Department agrees that it will comply with all regulations under HIPAA, its accompanying regulations and protect any Protected Health Information as the term is defined by HIPAA that the D-SNP sends pursuant to this contract.

Section B. The Eight Essential Elements Required By CMS

1. The D-SNP's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits

a. The D-SNP shall comply with CMS network adequacy guidelines for its provider network for its defined service area. Provider directories are due quarterly, in a format specified by the Department, broken down by Plan Benefit Package(s) (PBP).

b. The D-SNP shall have documented processes to coordinate payment between Medicaid and Medicare.

c. The D-SNP shall assign service coordinators as needed to coordinate the care and benefits of members who are eligible for both Medicare and Medicaid.

d. The D-SNP shall identify for its dual eligible members the benefits they may be eligible for under the state Medicaid Program that are not

covered services under the D-SNP. The current Medicaid covered benefits under the state's Medicaid Plan and Home and Community Based Services are described in Appendix C of this contract.

e. The D-SNP shall assist in the coordination and access to needed Medicaid services, and arrange for the provision of such Medicaid services, to its dual eligible members by identifying participating Medicaid providers, including long-term services and supports (LTSS) providers, in the D-SNP's provider network and within its approved service areas.

f. In order to ensure there is no gap or delay in services that causes discontinuity of care for a member, D-SNPs must inform providers when Medicare caps are reached so the providers may obtain Medicaid approval to continue similar services, when continuation of services is medically necessary.

g. As allowed by CMS guidance, D-SNPs shall provide deemed continued eligibility for 6 months to maintain continuous coverage when a member temporarily loses Medicaid eligibility.

h. The D-SNP must facilitate Medicaid eligibility redeterminations for members, including assisting with applications for medical assistance and conducting member education regarding maintenance of Medicaid eligibility.

i. Under CFR §422.562(a)(5), General provisions, D-SNPs must assist their members with filing grievance and appeals with Medicaid. The D-SNP must offer to provide the assistance described in the regulation whenever it becomes aware of a member's need for a Medicaid-covered service. Offering such assistance is not dependent on a member's request. The obligation to provide assistance under paragraph (a)(5)(i) of this regulatory section does not create an obligation for a D-SNP to represent an enrollee in a Medicaid appeal.

   According to the regulation, some examples of D-SNP assistance include:
   - Assisting the member in identifying their Medicaid managed care plan or fee-for-service point of contact;
   - Providing specific instructions for contacting the appropriate agency in a fee-for-service setting or for contacting the member's Medicaid MCO;
   - Assisting the member to make contact with their fee-for-service contact or Medicaid MCO;
   - Assisting the member in filing a Medicaid grievance or a Medicaid appeal; and

- Assisting the member to obtain documentation to support a request for authorization of Medicaid services or a Medicaid appeal.

For more information about this requirement, D-SNPs should refer to the regulation and the guidance issued by the Department in February 2020.

2. The categories of dual eligible beneficiaries to be enrolled under the D-SNP

a. Except for dual eligibles who are otherwise excluded under federal rules applicable to D-SNPs, the D-SNP shall accept all dual eligibles who select it and who meet the eligibility requirements of the D-SNP listed below in subsection b., without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, national origin, race, color, or religion, and shall not use any policy or practice that the D-SNP knows, or should know, has the effect of such discrimination.

b. Beneficiaries eligible for this D-SNP are specified below (choose i or ii, but not both). The Department intends to continue to allow D-SNPs to enroll partial dual eligibles, as is currently the case. However, since only full duals are eligible for CHC, D-SNPs who want to enroll partial dual eligibles must do so under a separate D-SNP that is not the companion D-SNP to an aligned CHC-MCO.

i. ☐ This is a companion D-SNP that is aligned with a CHC-MCO in the same region under the CHC program enrolling full dual eligibles 21 years and older who are eligible for enrollment in CHC.

ii. ☐ This is not a companion D-SNP. This D-SNP enrolls the following categories of duals (check all that apply) in Plan Benefit Package <enter PBP number> (please list all PBPs associated with this D-SNP operating in Pennsylvania separately):

☐ Qualified Disabled and Working Individual (QDWI)

☐ Qualified Medicare Beneficiary (QMB) Plus

☐ Qualified Medicare Beneficiary (QMB) Only

☐ Qualifying Individual (QI)

☐ Specified Low-Income Medicare Beneficiary (SLMB) Plus

☐ Specified Low-Income Medicare Beneficiary (SLMB) Only

☐ Other Full Dual Eligible (FDE)

3. The Medicaid benefits under the D-SNP

a. The D-SNP must coordinate Medicaid benefits as described above in Section B, subparagraph 1.

b. The D-SNP is responsible to coordinate payment, care and benefits of members who are eligible for both Medicare and Medicaid. The D-SNP will arrange for Medicaid benefits, either directly through providers in the aligned CHC-MCO's network or providers in other MCOs or through providers who have contractual arrangements with the Department to provide Medicaid services.

c. The D-SNP is not responsible to provide or pay for Medicaid benefits or Medicare cost sharing obligations where the Department or a CHC-MCO holds that obligation. CHC-MCOs are responsible to pay Medicare cost sharing obligations for CHC members. For non-CHC members, the Department will continue to process cost sharing obligations through the crossover claims process.

4. The cost-sharing protections covered under the D-SNP

a. In accordance with federal law, neither the D-SNP, its network providers, nor any of its subcontractors may impose Medicare cost sharing obligations on a QMB Plus or a QMB only member.

b. The D-SNP must notify its network providers and subcontractors (via a provider manual, provider bulletin, remittance advice or other contractual document) that they may not seek additional payments for Medicare cost sharing obligations from a QMB Plus or a QMB only member for Medicare A and B services rendered to members. D-SNP network providers are expected to bill the CHC plan for any Medicare cost sharing obligations. Network providers are prohibited from seeking payment directly from the Department for members enrolled in a CHC plan. The D-SNP must provide the Department with a copy of such written notice annually by May 1, or upon the Department's request.

5. The identification and sharing of information on Medicaid provider participation

a. The D-SNP shall identify its network providers to its members at least once a year and whenever requested by a member, and this shall

include providers who accept Medicare only and those who accept both Medicare and Medicaid. A hardcopy must be provided when requested by a member.

b. The D-SNP must perform at least monthly reviews of its provider directory and make any revisions necessary. The provider directory is subject to random monitoring by the Department to ensure complete and accurate entries.

c. The D-SNP shall provide written notice to affected members of any material change in the program, policies or procedures that is reasonably likely to impact an affected member's ability to access care or services from the D-SNP's provider network. Material changes include, but are not limited to, any instance when a network provider terminates its agreement with the D-SNP or the D-SNP initiates termination of a network provider.

d. The D-SNP shall provide the notice in writing at least 30 days prior to the effective date of these changes, or as soon as possible, if the network provider has not given the D-SNP 30 days' notice.

e. The Department shall provide a file of Medicaid providers to CHC-MCOs on a schedule and in a format determined by the Department. Companion D-SNPs shall obtain the file from their aligned CHC-MCOs. Non-companion D-SNPs will receive the file directly from the Department on a schedule and in a format determined by the Department.

f. D-SNPs shall use the Medicaid provider listing to identify for members those providers in its network who accept both Medicare and Medicaid.

6. The verification process of an enrollee's eligibility for both Medicare and Medicaid

a. To verify Medicaid eligibility of an individual member, the Department agrees to provide the D-SNP with access to the Pennsylvania Medicaid Program's eligibility verification system.

b. The D-SNP shall verify Medicare eligibility of individual members when requested by the Department.

c. To verify eligibility of all members in a D-SNP on a periodic basis, the Department and the D-SNP will exchange eligibility verification data files pursuant to a method agreed upon by both parties.

d. For companion D-SNPs, the D-SNP will verify ongoing Medicaid eligibility through the enrollment and disenrollment processes established for its aligned CHC-MCO.

7. Service Area

a. The service area is the geographic area in which members or potential members reside and for whom the D-SNP is approved to provide services by CMS. The service area (counties) covered by this D-SNP is specified in Table 1 in Appendix E and is broken out by PBP. ***(Please note that the service area for a companion D-SNP must include the service area of its aligned CHC-MCO.)***

b. The D-SNP must notify the Department in writing within 15 business days from the time the D-SNP decides to change the service area, whether it is an addition or deletion. Further, the D-SNP shall provide a copy of CMS' approval of such change within 15 business days of the receipt of CMS approval and the D-SNP shall provide the Department with a revised Table 1. Service Area.

8. The contracting period

a. This contract is effective January 1, 2021, through December 31, 2021, and shall be extended automatically for subsequent contract years in the absence of a notice by the Department or the D-SNP to terminate or amend the contract.

b. Termination of this contract is governed by the following:

1. By Mutual Agreement. This contract may be terminated by mutual agreement of the parties. Such agreement must be in writing.

2. Without Cause. Either party may terminate this contract for any reason effective at the close of the initial term or at the close of any renewal term upon providing the other party with prior written notice of termination at least 90 business days in advance of the close of the then-current term.

3. Termination for Cause. Either party may terminate this contract in the event the other party breaches any material provision of this contract and fails to cure such breach to the non-breaching party's satisfaction within 20 business days of receipt of written notice of such breach. Termination shall be effective 20 business days after the cure period expires, or such later date as determined by the party providing notice of termination.

4. Obligation Upon Termination. The Department shall not be liable for any costs of the D-SNP in any way associated or related to the termination, including those costs incurred both prior to and after the termination.

5. Termination Conditions. The effective dates of termination under Sections B.8.b.1-3 are subject to CMS regulations regarding notification to the dual eligible members.

6. Eligible Population or Service Area. A change in a companion D-SNP's service area or eligible population that makes the service area or eligible population different from that identified in the aligned CHC-MCO contract is grounds for termination.

Section C. Provisions for Enhanced Coordination and Health Care Outcomes

1. Service Coordination

a. Each D-SNP must attach to this contract its supplemental benefit(s) as approved by CMS and attach it as Appendix D upon execution of contract. In the event the D-SNP does not have a supplemental benefit(s) approved by CMS on the date this contract is executed, then the D-SNP shall forward the approved supplemental benefit(s) within 15 business days of CMS approval to the Department in accordance with the notice provisions of paragraph A.7., and the approved supplemental benefit(s) shall be incorporated into this contract as Appendix D. In the event the D-SNP changes the supplemental benefit(s) in subsequent years during which the contract automatically renews, then the D-SNP shall provide the amended supplemental benefit(s) within 15 business days of CMS approval of the amended supplemental benefit(s) to the Department in accordance with paragraph A.7., and the amended supplemental benefit(s) shall be incorporated into this contract as Appendix D.

b. The D-SNP shall educate its members about the full array of Medicare and Medicaid benefits available to them and assist members in accessing those benefits as needed.

c. The D-SNP shall coordinate Medicare and Medicaid benefits with both network and out of network providers for all of its members and this must be reflected in the D-SNP's care coordination policies.

d. The D-SNP shall assign service coordinators to dual eligible members as needed as determined by the D-SNP based upon their health needs to coordinate with the members' CHC-MCOs and with any other

services used by the members. This also includes the D-SNP sharing information and coordinating care with the member's Behavioral Health MCO regarding their need for, or receipt of, mental health or drug and alcohol services.

e. As permitted under federal regulation at 42 CFR 422.101(c), the D-SNP shall waive the Medicare three-day hospital stay requirement before Medicare skilled nursing facility coverage can begin.

f. To ensure coordination of inpatient discharge planning, the D-SNP shall link clinical management systems across all providers, including written protocols for accountability, referrals, information sharing, and tracking transfers between settings, such as from the hospital to the home, from the nursing facility to the home, or from the hospital to the nursing facility. The D-SNP must require that hospitals, nursing facilities, and skilled nursing facilities that contract with the D-SNP notify the D-SNP, including the member's D-SNP service coordinator, within 24 hours of visits and admissions of that member. The service coordinator must follow-up to address any care needs including skilled services covered by Medicare and LTSS services covered by Medicaid. To the extent possible, the Department would like these processes to be electronic and automated, but they may include fax, email, telephone and other forms of manual communication and coordination.

g. The D-SNP shall provide a toll-free dedicated hotline to respond to members' inquiries, issues and problems regarding eligibility, service coordination, provider access, and billing questions related to services that operates at least during normal business hours, 8:30 to 5:00, Monday through Friday. The D-SNP shall publicize the toll-free number to its members. Staff must be trained to address questions that relate to both Medicare and Medicaid. For companion D-SNPs, this function may be combined with an equivalent function offered by the aligned CHC-MCO.

h. The D-SNP shall provide a phone line for providers to inquire about a member's Medicare or Medicaid eligibility, service coordination, or billing that operates at least during normal business hours, 8:30 to 5:00, Monday through Friday. In addition, D-SNPs must have an after-hours phone line available to assist providers, including hospitals and nursing homes, to admit and discharge members during evenings and weekends.

i. In order to coordinate care for its full dual eligible members, the D-SNP shall develop written care coordination policies that will be used by the D-SNP to ensure notification within 48 hours to the extent possible of

the dual eligible member's CHC-MCO service coordination staff of the following: 1) planned or unplanned inpatient hospital and skilled nursing facility admissions and discharges, 2) emergency room visits, 3) high priority health concerns defined as a cardiac or orthopedic diagnosis requiring a procedure or an oncologic diagnosis requiring chemotherapy identified through the member's health assessment, 4) sharing of discharge planning documents, and 5) significant medication changes. Significant medication changes include: starting, stopping, reducing, or increasing medications by more than 25% (medication examples include antipsychotics, blood pressure, blood thinners, and diabetic medicines). This notification can be manual via telephone or electronic via an email, a data exchange, or through an HIE exchange between both parties. These policies must be submitted to the Department annually by May 15 and within 15 business days of any policy revision for review and approval, and if the Department determines changes are necessary, the D-SNP must revise the policies accordingly. The Department may request other elements be added to the care coordination policies throughout the course of the contract year or subsequent contract extensions.

j. If the D-SNP terminates this contract prior to the end of the contract term, if the D-SNP terminates its arrangement with its aligned CHC-MCO, or if counties are deleted from the service area, then the D-SNP agrees to coordinate benefits with any CHC-MCO or D-SNP that subsequently enrolls a dual eligible individual for whom the D-SNP was serving prior to these actions.

k. When dual eligible individuals change D-SNPs, both D-SNPs have the responsibility to work together to coordinate benefits including continuity of care regarding prior authorizations and sharing medical and case management records once member permission has been obtained.

l. For non-companion D-SNPs, the D-SNP shall coordinate benefits with the CHC-MCO to which the dual eligible member belongs, and this must be reflected in the D-SNP's care coordination policies.

m. If a member does not select a Primary Care Physician (PCP) within 14 business days of enrollment, or if a member has not selected a PCP through an aligned CHC-MCO, then the D-SNP must automatically assign a PCP, provided that the member may select and/or change the primary care provider within the plan without interference. The D-SNP shall take into consideration the following factors: current PCP, specific medical needs, physical disabilities of the member, language needs, area of residence and access to transportation.

n. If a member needs service coordination, then the D-SNP must assign a service coordinator within 14 business days of having identified the need. In assigning a service coordinator, the D-SNP shall take into consideration the following factors to the extent they are known: the current service coordinator, specific medical needs, physical disabilities of the member, language needs, area of residence and access to transportation. In cases of urgent need, it is expected that this timeframe will be reduced to meet the member's needs. If a D-SNP assigns a service coordinator after having identified a member's need, they must contact the member's CHC-MCO's service coordinator within seven business days.

2. Reporting Requirements

a. D-SNPs shall submit the following to the Department in the timeframes indicated, and in the manner and format specified by the Department. D-SNPs must also comply with Reporting Requirements Guidance issued by the Department, in addition to the terms of this contract.

1. Medicare grievances and appeals reports that are submitted to CMS annually by April 15 of the following calendar year at the PBP level for the D-SNP.

2. Medicare encounter data, at a frequency to be determined by the Department, in an 837 format.

3. Part D data, at a frequency to be determined by the Department, in a format specified by the Department.

4. D-SNP enrollment and disenrollment reports that are submitted to CMS at the PBP level for the D-SNP on a semi-annual basis by September 15 (covering the period January 1 – June 30) and April 30 (covering the period July 1 – December 31).

5. Frailty scores, if applicable, within 15 business days of receiving them from CMS.

6. Each D-SNP must submit the Monthly Membership Report (MMR) file received from CMS within 30 business days of receipt, including all fields, but only at the PBP level for the D-SNP members.

7. Significant changes to the terms of the Medicare contract with CMS, including D-SNP non-renewals, terminations, and service area reductions within 15 business days of approval by CMS.

8. Audit findings and corrective action plans, within 15 business days of either being notified by CMS or submitting them to CMS.

9. Any changes made to the use of projected Medicare savings and rebates within 15 business days of CMS approval of the changes.

10. Notices of non-compliance from CMS within 15 business days of the notification.

11. Sanctions of any kind imposed by CMS within 15 business days of the notification.

12. Performance information, including CMS warning letters, deficiency notices, and notices of Medicare star ratings less than 3.0, within 15 business days of the notification.

13. The Model of Care (MOC), within 15 business days of receipt of approval by CMS when initially approved. Thereafter, within 15 business days of receipt of approval by CMS when redline changes are made and have been accepted and approved by CMS.

14. On an annual basis, D-SNPs will submit to the Department their Chronic Condition Improvement Program (CCIP) Attestation, as it is submitted to CMS, by January 15.

15. All quality indicators reported to CMS or to the National Committee for Quality Assurance (NCQA), including HEDIS measures within 15 business days of being reported.

16. Member newsletters must be submitted to the Department for informational purposes only.

17. Each D-SNP will develop an Opioid Strategy Plan in accordance with Title 42, CFR 423.153- Drug utilization management, quality assurance, and medication therapy management programs (MTMPs), and submit the plan to the Department annually by December 31 for the following calendar year.

18. Each D-SNP must submit annually by January 31 a narrative report on care coordination. The report must include a retrospective review of care coordination activities undertaken in the prior calendar year including, but not limited to, activities performed under Sections C.1.c., C.1.d., C.1.f., C.1.i., C.1.k., C.1.l., and C.1.n. The report must also include a prospective

plan for care coordination improvements planned for the current calendar year.

19. The Department may request other reporting items throughout the course of the contract year, or subsequent contract extensions, as CMS guidance or regulations evolve over time; such as critical incident reports and mortality review reports.

b. If the D-SNP submits data/information in accordance with this contract which it believes contains confidential proprietary information or trade secrets, a signed written statement to this effect must be provided with the data submission in accordance with 65 P.S. Section 67.707(b) in order for the data to be considered exempt under 65 P.S. Section 67.708(b) (11). The data/information submitted will be treated as confidential and will not be disclosed to third parties except where required by law.

3. Supplemental Medicare Benefits

a. The D-SNP will offer at least one Supplemental Medicare Benefit that is designed to fill a gap in Medicaid services for which full duals are eligible. These may include, but are not limited to, gaps in hearing or vision services. D-SNPs may not impose any cost sharing to the Supplemental Medicare Benefits offered.

b. The D-SNP shall notify the Department within 15 business days from the time the D-SNP decides to change the Supplemental Medicare Benefit(s). Further, the D-SNP shall provide to the Department the final CMS approval of such change within 15 business days of the receipt of CMS approval.

c. The Department has no obligation to provide payment for any Supplemental Medicare Benefits provided by the D-SNP.

4. Marketing Provisions

a. Materials that contain reference to Pennsylvania Medical Assistance program benefits or the Pennsylvania Community HealthChoices program must be submitted for review to the Department 21 business days prior to submission to CMS for Department approval, including the marketing methods to be used.

b. Other communication materials according to CMS guidance and/or specified by the Department must be submitted to the Department for informational purposes within 15 business days of submission to CMS.

c. The D-SNP is prohibited from using the Medicaid provider listing as a resource for marketing purposes. Any attempt to use the Medicaid provider information without obtaining explicit written approval from the Department may result in termination of this contract.

5. Information Technology Systems

a. D-SNPs shall maintain information technology systems that interface with the Department's information technology systems. D-SNPs must demonstrate to the Department's satisfaction the capability to successfully send and receive interface files and encounter data. D-SNPs shall demonstrate to the Department's satisfaction the capability of interfacing with the state's Medicaid Program's eligibility verification system. The D-SNP may use a software vendor that provides interfacing capabilities with the Department's information technology systems.

b. D-SNPs are required to join a Health Information Exchange within the Commonwealth to enhance their capabilities to coordinate care for their members.

6. Training and Education

a. The D-SNP must educate members and network providers about Medicare and Medicaid benefit coordination related to dual eligible members. The Department may identify additional training requirements in the future.

b. The D-SNP shall distribute member newsletters that include policy changes, changes in benefits, and wellness information, at least twice a year to each member household. This must be available electronically and in hard copy for any member who requests one.

c. The D-SNP shall educate its provider network about the Community HealthChoices program annually. Materials to be used in the training must be submitted to the Department for review and approval at least 30 business days prior to use and may not be used until approved. The Department will provide guidance on material content.

Section D. Other Provisions That Only Apply to CHC Companion D-SNPs

The goal of the companion D-SNP is to provide a coordinated experience from the perspective of members who are also enrolled in the aligned CHC-MCO.

1. Companion D-SNP Service Area

The Companion D-SNP must include the service area of its aligned CHC-MCO.

2. Service Coordination

Companion D-SNPs shall provide information about both their aligned CHC-MCOs to their members, including the services covered and the service coordination available to those enrolled in both, and about how to request enrollment in their aligned CHC-MCO. The companion D-SNP and aligned CHC-MCO must provide a unified experience for members enrolled in both, which includes, but is not limited to, the following:

a. A Model of Care that is consistent with the service coordination requirements of its aligned CHC-MCO and supports the greatest possible coordination of Medicare and Medicaid services;

b. An integrated Medicare-Medicaid process across both the D-SNP and aligned CHC-MCO for screening, comprehensive needs assessment, and service coordination;

c. A single point of contact who addresses both Medicare and Medicaid-funded services, including primary, acute and LTSS services, and who oversees comprehensive assessments and development of person-centered service plans that meet the requirements in the aligned CHC-MCO's contract with the Department;

d. A service coordination information system that allows service coordinators to view all relevant information related to members, including Medicare and Medicaid encounters, assessments, eligibility status and the person-centered plan; and,

e. Access to a person-centered planning team that meets the standards in the aligned CHC-MCO's contract with the Department.

3. Enrollment

The Department intends to work with CMS and participating D-SNPs to facilitate enrollment of members in aligned Medicare and Medicaid plans. This will include but is not limited to the following.

a. When a member is already enrolled in a companion D-SNP of an aligned CHC-MCO, the Department will facilitate enrollment of the member into the D-SNP's aligned CHC-MCO as the default choice if the member does not actively choose a CHC-MCO within the timeframes provided to prospective CHC members.

b. To facilitate integration of Medicare and Medicaid for CHC-MCO members who become newly eligible for Medicare, D-SNPs shall obtain approval from CMS for default enrollment pursuant to 42 C.F.R. § 422.66(c). This applies to both individuals who become newly eligible for Medicare due to a disability and those who become eligible on their 65th birthday.

4. Administrative Streamlining

The D-SNP will cooperate fully with the Department and CMS in their ongoing efforts to streamline administration of the Medicare and Medicaid programs which may include, but is not limited to, coordinated readiness reviews, monitoring, enrollment, member materials and appeals processes.

a. In order to support better coordination of care, the Department encourages the D-SNP to accept and use the identification (ID) card issued to members enrolled in its aligned CHC-MCO for Medicare covered services to the extent possible. The Department recommends that the ID card have inclusive eligibility information of all plans to ease member access and reduce provider confusion.

b. The D-SNP's Member Handbook must reference and include a link to the Member Handbook for the aligned CHC-MCO so that members enrolled in both plans may easily reference both handbooks.

5. Marketing

a. In general, D-SNPs will be subject to the marketing restrictions included in the aligned CHC-MCO's contract with the Department to the extent they are not in conflict with CMS marketing guidance.

b. The D-SNP may market its approved, companion D-SNP product to its aligned CHC-MCO's full dual eligible members. Materials prepared and methods used for this purpose must meet all relevant federal Medicare requirements and must be submitted to the Department for approval within 30 business days prior to use.

6. Relationship Between Companion D-SNP and CHC-MCO

For this companion D-SNP, their parent organization, <enter the name of your parent organization>, or another entity owned and controlled by their parent organization, <enter the name of the entity owned and controlled by your parent organization >, has in place a Medicaid MCO that covers the Medicaid services outlined in Appendix C, except for behavioral health services. The name of this Medicaid MCO organization is <give the name of the aligned CHC MCO organization>. These Medicaid services include Personal

Assistant Services and Nursing Facility coverage. In Pennsylvania, behavioral health services are carved out and provided by the Behavioral Health MCOs (BH MCOs) to eligible Medicaid beneficiaries.

IN WITNESS WHEREOF, the parties hereto have caused this contract to be executed.

By the signing of this contract, the D-SNP certifies for itself and all of its subcontractors that as of the date of its execution of any Commonwealth contract, that neither the D-SNP, nor any subcontractors, nor any suppliers are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority. The D-SNP also certifies that as of the date of this contract's execution, it has no delinquent tax liabilities or other delinquent Commonwealth obligations.

D-SNP

Insert D-SNP Address

_____

_____

_____

By: _____
Typed Name:
_____
Title: _____
Date: _____

By: _____
Typed Name:
_____
Title: _____
Date: _____

By: _____
Typed Name:
_____
Title: _____
Date: _____

STATE AGENCY

Commonwealth of Pennsylvania
Department of Human Services
Office of Medical Assistance Programs
Health and Welfare Building, Room 515
P.O. Box 2675
Harrisburg, PA 17105-2675

By: _____
Typed Name: Sally Kozak
Title: Deputy Secretary and State Medicaid Director
Date: _____

Commonwealth of Pennsylvania
Department of Human Services
Office of Long-Term Living
Forum Place, 6th Floor
P.O. Box 8025
Harrisburg, PA 17105-8025

By: _____
Typed Name: Kevin Hancock
Title: Deputy Secretary
Date: _____

Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services
Commonwealth Tower, 12th Floor
P.O. Box 2675
Harrisburg, PA 17115

By:_____
Typed Name: Kristen Houser
Title: Deputy Secretary
Date:_____

Appendix A
Definitions
The following terms and phrases shall have the following meanings solely for the purpose of the Medicare Improvement for Patients and Providers Act Contract.

Activities of Daily Living (ADL). Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility and eating. The extent to which a person requires assistance to perform one or more ADLs is often a level of care criteria.

Aligned Community HealthChoices Managed Care Organization (Aligned CHC-MCO). A CHC-MCO operated by the same organization that also operates a Companion D-SNP for purposes of integrating services for members who are enrolled in both.

Behavioral Health Managed Care Organizations (BH-MCOs). An entity, operated by county government or licensed by the Commonwealth as a risk-bearing HMO, which manages the purchase and provision of Behavioral Health Services under an Agreement with the Department.

Centers for Medicare & Medicaid Services (CMS). The federal agency within the Department of Health and Human Services responsible for oversight of both the Medicare and Medicaid Programs.

Chronic Condition Improvement Program (CCIP). Initiative focused on clinical areas with the aim of improving health outcomes and beneficiary satisfaction, especially for those members with chronic conditions. The CCIP is part of the required QI Program.

Coinsurance. A percentage of costs normally paid by a D-SNP member for medical services provided by a D-SNP. Coinsurance amounts must comply with the terms of the D-SNP.

Community HealthChoices (CHC). The state's mandatory managed care program through which participants will receive Medicaid physical health services and LTSS.

Community HealthChoices Managed Care Organization (CHC-MCO). A Managed Care Organization (MCO) chosen through the competitive bid process and who has been awarded a contract by the Department and entered into such a contract with the Department to purchase and provide services through the CHC program.

Companion D-SNP. A D-SNP that is a plan of an MCO that also operates an Aligned CHC-MCO for purposes of integrating services for members who are enrolled in both programs.

Copayments. Fixed dollar amounts that a member of a D-SNP normally must pay for a medical service provided by a D-SNP. Copayment amounts must comply with the terms of the D-SNP plan.

Cost Sharing Obligations. Those financial payment obligations incurred by the state for dual eligible members in satisfaction of the coinsurance, copayments, deductibles, and premiums for the Medicare Part A and Part B programs.

Deductible. Fixed dollar amounts that a D-SNP member normally must pay out-of-pocket before the costs of services are covered by a D-SNP. Deductibles must comply with the terms of the D-SNP plan.

Department. The Pennsylvania Department of Human Services (DHS).

Dual Eligible. A Medicare beneficiary entitled to Medicare Part A and/or Part B who is also a Medicaid beneficiary, and for whom the Department has a responsibility for payment of cost sharing obligations or the Medicare Part A and/or Part B premiums under the Medicaid State Plan.

Dual Eligible Member. A dual eligible who is eligible to participate in, and is voluntarily enrolled in, the D-SNP. The categories of dual eligible members for D-SNPs include the following: QDWIs, QMB Only, QMB Plus, QI, SLMB Only, SLMB Plus, and Other FBDEs.

Dual Eligible Special Needs Plan (D-SNPs). A Medicare Advantage Plan that primarily or exclusively enrolls individuals who are entitled to both Medicare and Medicaid services.

Encounter Data (Medicare). A record of any covered service provided to a D-SNP member and includes encounters reimbursed through a capitation rate, Fee- for-Service, or other methods of compensation regardless of whether the payment is due or made.

Fee-for-Service (FFS). Payment to providers on a per-service basis for healthcare services provided to beneficiaries.

Full Dual Eligible. An individual, who is (i) entitled to Medicare Part A, enrolled in or eligible for Medicare Part B, and enrolled in or eligible to enroll in Part D and (ii) is eligible for full Medicaid services.

Independent Enrollment Broker (IEB). An independent and conflict-free entity contracted with the Department, which is responsible for providing choice counseling and enrollment services for the CHC program.

Instrumental Activities of Daily Living (IADL). Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items,

performing light or heavy housework, and communication. The extent to which a person requires assistance in performing IADLs is often assessed in conjunction with the evaluation of level of care.

Long-Term Services and Supports (LTSS). A broad range of services and supports designed to assist an individual with Activities of Daily Living and Instrumental Activities of Daily Living which can be provided in a home and community-based setting, a nursing facility, or other residential setting. LTSS may include but are not limited to: self-directed care; adult day health; personal emergency response systems; home modification and environmental accessibility options; home and personal care; home health; nursing services; specialized medical equipment and supplies; chore services; social work and counseling; nutritional consultation; home-delivered meals and alternative meal service; and nursing facility services.

Medicaid. The healthcare covered services, items, and supplies that are included under the Pennsylvania State Plan and authorized by Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, and 62 P.S. §441.1 et seq. and regulations at 55 PA Code Chapters 1101 et seq.

Medical Assistance. The name of Pennsylvania's Medicaid program.

Medicare. The healthcare covered services, items, and supplies that are authorized by Title XIX of the federal Social Security Act, 42 U.S.C. 1395 et seq., covering almost all individuals 65 years of age and older and certain individuals under 65 years of age who are disabled or have Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) or End Stage Renal Disease.

MIPPA Contract. A contract required under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 between a D-SNP and a State Medicaid Agency which documents roles and responsibilities with regard to dual eligible individuals and describes the D-SNP's responsibility to integrate and/or coordinate Medicare and Medicaid benefits.

National Committee for Quality Assurance. Not-for-profit organization dedicated to improving health care quality. In early 2008, CMS contracted with the NCQA to develop a strategy to evaluate the quality of care provided by D-SNPs.

Network Provider. A hospital, physician, or other health care practitioner or other organization which has a contractual relationship with the D-SNP, or its subcontractor, for the delivery of health services to the D-SNP's members.

Pennsylvania State Plan. The Commonwealth of Pennsylvania's plan for the Medicaid Program as submitted by the Department and approved by the Secretary of the U.S. Department of Health and Human Services under Title XIX of the Social Security Act, as modified or amended.

Primary Care Practitioner (PCP). A specific physician, physician group or a Certified Registered Nurse Practitioner (CRNP) or CRNP group operating under the scope of his/her licensure, who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services, and maintaining continuity of care on behalf of an individual.

Qualified Disabled and Working Individual (QDWI). An individual who lost Medicare Part A benefits due to returning to work, but who is eligible to enroll in the purchase of Medicare Part A. The individual must meet federal income and resource criteria and may not be otherwise eligible for Medicaid. A QDWI is eligible only for Medicaid payment of Part A premiums.

Qualified Medicare Beneficiary (QMB). An individual, who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and copayments (except for Medicare Part D) (collectively, these benefits are called "QMB Medicaid Benefits"). Categories of QMBs covered by this contract are:

a. QMB Plus – QMBs who also meet the financial criteria for full Medicaid coverage. QMB Plus individuals are entitled to QMB Medicaid Benefits, plus all benefits available under the Pennsylvania State Plan for fully eligible Medicaid beneficiaries.

b. QMB Only – QMBs who do not qualify for any additional QMB Medicaid Benefits.

Qualifying Individual (QI). An individual who is entitled to Medicare Part A, meets federal income and resource criteria, and who is not otherwise eligible for Medicaid. A QI is eligible only for Medicaid payment of Medicare Part B premiums.

Service Area. The counties in the state where the D-SNP is approved by CMS to offer services.

Service Coordination. Activities to identify, coordinate and assist members to gain access to needed covered and non-covered services such as social, housing, educational and other services and supports. Service Coordination includes the primary functions of providing information to members and facilitating access, locating, coordinating and monitoring needed services and supports for members.

Service Coordinator. An appropriately qualified professional who is the D-SNP's designated, accountable, point of contact for each member.

Specified Low-income Medicare Beneficiary (SLMB Only). A SLMB is an individual who is entitled to Medicare Part A, has income that exceeds 100% FPL but is less than120% FPL, and whose resources do not exceed twice the SSI limit. The only

Medicaid benefit a SLMB is eligible for is payment of Medicare Part B premiums. SLMBs who do not qualify for any additional Medicaid benefits are called SLMB only.

Specified Low-Income Medicare Beneficiary (SLMB Plus). A SLMB Plus is an individual who meets the standards for SLMB eligibility but who also meets the financial criteria for full Medicaid coverage. Such individuals are entitled to payment of Medicare Part B premiums, as well as all benefits available under the Pennsylvania State Plan to a fully eligible Medicaid recipient.

State. The Commonwealth of Pennsylvania.

Subcontract. Any contract between the D-SNP and an individual business or entity to perform part of or all of the D-SNP's responsibilities under this contract.

Subcontractor. An individual business or entity with which the D-SNP has a subcontract.

Supplemental Medicare Benefits. Extra Medicare benefits offered by D-SNPs to fill in gaps in Medicare coverage such as dental, hearing and vision services.

Appendix B
COMMONWEALTH OF PENNSYLVANIA
BUSINESS ASSOCIATE AGREEMENT

WHEREAS, the Pennsylvania Department of Human Services (Covered Entity) and <Insert Health Plan Name>. (Business Associate) intend to protect the privacy and security of certain Protected Health Information (PHI) to which Business Associate may have access in order to provide goods or services to or on behalf of Covered Entity, in accordance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, Public Law 104-191 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) and related regulations, the HIPAA Privacy Rule (Privacy Rule), 45 C.F.R. Parts 160 and 164, as amended, the HIPAA Security Rule (Security Rule), 45 C.F.R. Parts 160, 162 and 164,), as amended, 42 U.S.C. § 602(a)(1)(A)(iv), 42 U.S.C. § 1396a(a)(7), 35 P.S. § 7607, 50 Pa.C.S. § 7111, 71 P.S. § 1690.108(c), 62 P.S. § 404, 55 Pa. Code Chapter 105, 55 Pa. Code Chapter 5100, 42 C.F.R. §§ 431.301-431.302, 42 C.F.R. Part 2, 45 C.F.R. § 205.50, the Pennsylvania Breach of Personal Information Notification Act, 73 P.S. § 2301 et seq., and other relevant laws, including subsequently adopted provisions applicable to use and disclosure of confidential information, and applicable agency guidance.

WHEREAS, Business Associate may receive PHI from Covered Entity, or may create or obtain PHI from other parties for use on behalf of Covered Entity, which PHI may be used or disclosed only in accordance with this Agreement and the standards established by applicable laws and agency guidance.

WHEREAS, Business Associate may receive PHI from Covered Entity, or may create or obtain PHI from other parties for use on behalf of Covered Entity, which PHI must be handled in accordance with this Agreement and the standards established by HIPAA, the HITECH Act and related regulations, and other applicable laws and agency guidance.

NOW, THEREFORE, Covered Entity and Business Associate agree as follows:

1. **Definitions.**
   a. “Business Associate” shall have the meaning given to such term under HIPAA, the HITECH Act, applicable regulations and agency guidance.
   b. “Covered Entity” shall have the meaning given to such term under HIPAA, the HITECH Act and applicable regulations and agency guidance.
   c. “HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
   d. “HITECH Act” shall mean the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009).

e. “Privacy Rule” shall mean the standards for privacy of individually identifiable health information in 45 C.F.R. Parts 160 and 164, as amended, and related agency guidance.
f. “Protected Health Information” or “PHI” means any information, transmitted or recorded in any form or medium; (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA, the HITECH Act and related regulations and agency guidance. PHI also includes any and all information that can be used to identify a current or former applicant or recipient of benefits or services of Covered Entity (or Covered Entity’s contractors/business associates).
g. “Security Rule” shall mean the security standards in 45 C.F.R. Parts 160, 162 and 164, as amended, and related agency guidance.
h. “Unsecured PHI” shall mean PHI that is not secured through the use of a technology or methodology as specified in HITECH regulations and agency guidance or as otherwise defined in the HITECH Act.

2. Stated Purposes For Which Business Associate May Use Or Disclose PHI. The Parties hereby agree that the Business Associate shall be permitted to use and/or disclose PHI provided by or obtained on behalf of Covered Entity for the following stated purposes, except as otherwise stated in this Agreement: <Click here to enter text>.

No other disclosures of PHI or other information is permitted.

3. Business Associate Obligations.

a. **Limits on Use and Further Disclosure Established by Agreement and Law.** Business Associate hereby agrees that the PHI provided by, or created or obtained on behalf of Covered Entity shall not be further used or disclosed other than as permitted or required by this Agreement or as required by law and agency guidance.
b. **Appropriate Safeguards.** Business Associate shall establish and maintain appropriate safeguards to prevent any use or disclosure of PHI other than as provided for by this Agreement. Appropriate safeguards shall include implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that is created, received, maintained, or transmitted on behalf of the Covered Entity and limiting use and disclosure to applicable minimum necessary requirements as set forth in applicable federal and state statutory and regulatory requirements and agency guidance.
c. **Reports of Improper Use or Disclosure.** Business Associate hereby agrees that it shall report, within two business days of discovery, any use or

disclosure of PHI not provided for or allowed by this Agreement to the Office of Long-Term Living, via email to RA-PWPAMIPPA@pa.gov, Subject: MIPPA Reporting.

d. **Security Incidents.** In addition to following the breach notification requirements in Section 13402 of the HITECH Act and related regulations, agency guidance and other applicable federal and state laws, Business Associate shall report to the Office of Long-Term Living via email to RA-PWPAMIPPA@pa.gov, Subject: MIPPA Reporting, within two business days of discovery any security incident of which it becomes aware. At the sole expense of Business Associate, Business Associate shall comply with all applicable federal and state breach notification requirements. Business Associate shall indemnify the Covered Entity for costs associated with any incident involving the acquisition, access, use or disclosure of Unsecured PHI in a manner not permitted under federal or state law and agency guidance.
e. **Subcontractors and Agents.** Business Associate hereby agrees that any time PHI is provided or made available to any subcontractors or agents, Business Associate shall provide only the minimum necessary PHI for the purpose of the covered transaction and shall first enter into a subcontract or contract with the subcontractor or agent that contains the same terms, conditions and restrictions on the use and disclosure of PHI as contained in this Agreement.
f. **Right of Access to PHI.** Business Associate hereby agrees to allow an individual who is the subject of the PHI maintained in a designated record set, to have access to and copy that individual's own PHI within five business days of receiving a written request from the Covered Entity. Business Associate shall provide the PHI to the extent and in the manner required by 45 C.F.R. § 164.524 and other applicable federal and state law and agency guidance. If Business Associate maintains an electronic health record, Business Associate must provide the PHI in electronic format if requested. If any individual requests from Business Associate or its agents or subcontractors access to PHI, Business Associate shall notify Covered Entity of same within five business days. Business associate shall further conform with and meet all of the requirements of 45 C.F.R. §164.524 and other applicable laws, including the HITECH Act and related regulations, and agency guidance.
g. **Amendment and Incorporation of Amendments.** Within five business days of receiving a request from Covered Entity for an amendment of PHI maintained in a designated record set, Business Associate shall make the PHI available and incorporate the amendment to enable Covered Entity to comply with 45 C.F.R. §164.526, applicable federal and state law, including the HITECH Act and related regulations, and agency guidance. If any individual requests an amendment from Business Associate or its agents or subcontractors, Business Associate shall notify Covered Entity within five business days.
h. **Provide Accounting of Disclosures.** Business Associate agrees to maintain a record of all disclosures of PHI in accordance with 45 C.F.R.

§164.528 and other applicable laws and agency guidance, including the HITECH Act and related regulations. Such records shall include, for each disclosure, the date of the disclosure, the name and address of the recipient of the PHI, a description of the PHI disclosed, the name of the individual who is the subject of the PHI disclosed, and the purpose of the disclosure. Business Associate shall make such record available to the individual or the Covered Entity within five business days of a request for an accounting of disclosures.

i. **Requests for Restriction.** Business Associate shall comply with requests for restrictions on disclosures of PHI about an individual if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for treatment purposes), and the PHI pertains solely to a health care item or service for which the service involved was paid in full out-of-pocket. For other requests for restriction, Business Associate shall otherwise comply with the Privacy Rule, as amended, and other applicable statutory and regulatory requirements and agency guidance.

j. **Access to Books and Records.** Business Associate hereby agrees to make its internal practices, books, and records relating to the use or disclosure of PHI received from, or created or received by Business Associate on behalf of the Covered Entity, available to the Secretary of Health and Human Services or designee for purposes of determining compliance with applicable laws and agency guidance.

k. **Return or Destruction of PHI.** At termination of this Agreement, Business Associate hereby agrees to return or destroy all PHI provided by or obtained on behalf of Covered Entity. Business Associate agrees not to retain any copies of the PHI after termination of this Agreement. If return or destruction of the PHI is not feasible, Business Associate agrees to extend the protections of this Agreement to limit any further use or disclosure until such time as the PHI may be returned or destroyed. If Business Associate elects to destroy the PHI, it shall certify to Covered Entity that the PHI has been destroyed.

l. **Maintenance of PHI.** Notwithstanding Section 3(k) of this Agreement, Business Associate and its subcontractors or agents shall retain all PHI throughout the term of the Agreement and shall continue to maintain the information required under the various documentation requirements of this Agreement (such as those in §3(h)) for a period of six years after termination of the Agreement, unless Covered Entity and Business Associate agree otherwise.

m. **Mitigation Procedures.** Business Associate agrees to establish and to provide to Covered Entity upon request, procedures for mitigating, to the maximum extent practicable, any harmful effect from the use or disclosure of PHI in a manner contrary to this Agreement or the Privacy Rule, as amended. Business Associate further agrees to mitigate any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of this Agreement or applicable laws and agency guidance.

n. **Sanction Procedures.** Business Associate agrees that it shall develop and implement a system of sanctions for any employee, subcontractor or agent who violates this Agreement, applicable laws or agency guidance.
o. **Grounds for Breach.** Non-compliance by Business Associate with this Agreement or the Privacy or Security Rules, as amended, is a breach of the Agreement, if Business Associate knew or reasonably should have known of such non-compliance and failed to immediately take reasonable steps to cure the non-compliance.
p. **Termination by Commonwealth.** Business Associate authorizes termination of this Agreement by the Commonwealth if the Commonwealth determines, in its sole discretion that the Business Associate has violated a material term of this Agreement.
q. **Failure to Perform Obligations.** In the event Business Associate fails to perform its obligations under this Agreement, Covered Entity may immediately discontinue providing PHI to Business Associate. Covered Entity may also, at its option, require Business Associate to submit to a plan of compliance, including monitoring by Covered Entity and reporting by Business Associate, as Covered Entity in its sole discretion determines to be necessary to maintain compliance with this Agreement and applicable laws and agency guidance.
r. **Privacy Practices.** The Department will provide and Business Associate shall immediately begin using any applicable form, including but not limited to, any form used for Notice of Privacy Practices, Accounting for Disclosures, or Authorization, upon the effective date designated by the Program or Department. The Department retains the right to change the applicable privacy practices, documents, and forms. The Business Associate shall implement changes as soon as practicable, but not later than 45 business days from the date of notice of the change.

4. **Obligations of Covered Entity**

a. **Provision of Notice of Privacy Practices.** Covered Entity shall provide Business Associate with the notice of privacy practices that the Covered Entity produces in accordance with applicable law and agency guidance, as well as changes to such notice.
b. **Permissions.** Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by individual to use or disclose PHI of which Covered Entity is aware, if such changes affect Business Associate's permitted or required uses and disclosures.
c. **Restrictions.** Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 C.F.R. §164.522 and other applicable laws and applicable agency guidance, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

Appendix C
Pennsylvania's Current Medicaid State Plan Benefits and Home and Community Based Services

Adult Benefit Package*	
Services	**Adult Benefit Package**
Category 1: Ambulatory Services	
Primary Care Provider	No limits
Physician Services and Medical and Surgical Services provided by a Dentist	No limits
Certified Registered Nurse Practitioner	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Care Services as described below
Independent Clinic	No limits
Outpatient Hospital Clinic	No limits
Podiatrist Services	No limits
Chiropractor Services	No limits
Optometrist Services	2 visits (exams) per calendar year
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of 5 consecutive days in a 60-day certification period.
Radiology (For example: X-Rays, MRIs, and CTs)	No limits
Dental Care Services	Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation. **Key Limitations:** Dentures - 1 upper arch (complete or partial) and 1 lower arch (complete or partial) per lifetime. Denture relines - either full or partial, limited to 1 arch every 2 calendar years. Oral exams - 1 per 180 days Dental prophylaxis - 1per 180 days Panoramic maxilla or mandible single film is limited to 1 per 5 calendar years.

	Crowns, Periodontics and Endodontics only via approved benefit limit exception.
Outpatient Hospital Short Procedure Unit (SPU)	No limits
Outpatient Ambulatory Surgical Center (ASC)	No limits
Non-Emergency Medical Transport	Only to and from Medicaid covered services.
Family Planning Clinic, Services and Supplies	No limits
Renal Dialysis	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.
Category 2: Emergency Services	
Emergency Room	No limits
Ambulance	No limits
Category 3: Hospitalization	
Inpatient Acute Hospital	No limits
Inpatient Rehab Hospital	No limits
Inpatient Psychiatric Hospital	No limits
Inpatient Drug & Alcohol	No limits
Category 4: Maternity and Newborn	
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits
Category 5: Mental Health and Substance Abuse (Behavioral Health)	
Outpatient Psychiatric Clinic	No limits
Mobile Mental Health Treatment	No limits
Outpatient Drug and Alcohol Treatment	No limits
Methadone Maintenance	No limits
Clozapine	No limits
Psychiatric Partial Hospital	No limits
Peer Support	No limits
Crisis	No limits
Targeted Case Management – other than Behavioral Health	Limited to individuals identified in the target group (No limits).
Targeted Case Management – Behavioral Health Only	Limited to individuals with Serious Mental Illness (SMI) only (No limits).
Category 6: Prescription Drugs	
Prescription Drugs	No limits
Nutritional Supplements	No limits
Category 7: Rehabilitation and Habilitation Services and Devices	

Skilled Nursing Facility	365 days per calendar year
Home Health Care includes nursing, aide and therapy services.	Unlimited for first 28 days; limited to 15 days every month thereafter.
ICF/IID and ICF/ORC	Requires an institutional level of care (No limits).
Durable Medical Equipment	No limits
Prosthetics and Orthotics	Orthopedic Shoes and Hearing Aids are not covered. Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications. Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or splint. Coverage for low vision aids and eye protheses is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.
Eyeglass Lenses	Limited to individuals diagnosed with aphakia - 4 lenses per calendar year.
Eyeglass Frames	Limited to individuals diagnosed with aphakia - 2 frames per calendar year. Deluxe frames not included.
Contact Lenses	Limited to individuals diagnosed with aphakia - 4 lenses per calendar year.
Medical Supplies	No limits
Therapy (physical, occupational, speech) – Rehabilitative	Only when provided by a hospital, outpatient clinic, or home health provider.
Therapy (physical, occupational, speech) – Habilitative	Only when provided by a hospital, outpatient clinic, or home health provider.
Category 8: Laboratory Services	
Laboratory	No limits
Category 9: Preventative/Wellness Services and Chronic Care	
Tobacco Cessation**	70, 15-minute units per calendar year

All units of service, age, gender, diagnosis, and other procedure code related limits still apply as indicated on the Medical Assistance Fee Schedule.

***Children's benefit plan will include all medically necessary services without limitation.**

****Tobacco cessation is one of the preventative services as recommended by the US Preventative Services Task Force. For a full listing of preventative services beyond tobacco cessation, please contact your MCO.**

Home and Community-Based Services (HCBS)	
Services	**Limits**
Adult Daily Living Services Assistive Technology Behavior Therapy Benefits Counseling Career Assessment Cognitive Rehabilitation Therapy Community Integration Community Transition Services Counseling Employment Skills Development Home Adaptations Home Delivered Meals Home Health Aide Home Health – Nursing Home Health – Occupational Therapy Home Health – Physical Therapy Home Health – Speech and Language Therapy	Under Community Integration: Each distinct goal may not be more than twenty-six (26) weeks. No more than 32 units per week for one goal will be approved. If the participant has multiple goals, no more than 48 units per week will be approved. However, the Office of Long Term Living retains the discretion to authorize more than 48 units (12 hours) of Community Integration in one week for up to 21 hours per week and for periods longer than 26 weeks. Community Transition Services are limited to an aggregate of $4,000 per participant, per lifetime, as pre-authorized by the State Medicaid Agency program office. Total combined hours for Employment Skills Development, or Job Coaching services are limited to 50 hours in a calendar week. A participant whose needs exceed 50 hours a week must obtain prior approval. Under Specialized Medical Equipment and Supplies non-covered items include:

Job Coaching Job Finding Non-Medical Transportation Nutritional Counseling Participant-Directed Community Supports Participant-Directed Goods and Services Personal Assistance Services Personal Emergency Response System (PERS) Pest Eradication Residential Habilitation Respite Service Coordination Specialized Medical Equipment and Supplies Structured Day Habilitation TeleCare Vehicle Modifications	All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream) Items covered under third party payer liability Items that do not provide direct medical or remedial benefit to the participant and/or are not directly related to a participant's disability Food, food supplements, food substitutes (including formulas), and thickening agents Eyeglasses, frames, and lenses Dentures Any item labeled as experimental that has been denied by Medicare and/or Medicaid Recreational or exercise equipment and adaptive devices for such

For all HCBS services that are also offered under the State Plan, the State Plan benefit must be exhausted before HCBS services can be accessed. Additionally, Medicare and other third party resources such as private insurance limitations must also have been exhausted. Lastly, some HCBS services may not be accessed at the same time.

Appendix D
D-SNP Supplemental Benefits

(Each D-SNP will attach their CMS approved Supplemental Benefits, see Section C.1.a)

Appendix E
D-SNP Service Area

(Each D-SNP will attach their CMS approved Service Area, see Section B.7.a)

Table 1. Service Area				
CMS Contract Code	**Contract Name**	**Plan Benefit Package**	**Plan Name**	**Counties Served**