Introduction

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

The CHIP Eligibility Handbook serves to provide contractors with a comprehensive guide that will ensure proper implementation of statutory requirements, pursuant to Title XXI of the Social Security Act, the Children’s Health Care Act, and the Patient Protection and Affordable Care Act (PPACA or more commonly referred to as ACA).

The Procedure’s Handbook is divided into 3 parts:

Part 1: Application Processing Procedures

Part 2: Quality Management and Administrative Requirements

Part 3: Marketing and Outreach
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ACRONYMS

ACR – Awaiting Contractor Response (premium payment).

ADD – Administrative Due Date

APTC – Advance Premium Tax Credits

CAO – County Assistance Office

CEU – Central Eligibility Unit

CHAMPUS/TRICARE – Civilian Health and Medical Program of the Uniformed Services/TRICARE is the health care program serving Uniformed Service members, retirees and their families worldwide.

CHAMPVA – The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries.

CHIP – Children’s Health Insurance Program.

CIS – Client Information System

CMS – Centers for Medicare and Medicaid Service.

COBRA – Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272)

COMPASS – Commonwealth of Pennsylvania Application for Social Services.

CYF – Office of Children, Youth, and Families


DX – Data Exchanges

EHC – Enrollment Health Center

ERP – Eligibility Review Process

FDSH - Federal Data Services Hub

FFM – Federally Facilitated Marketplace
FPL – Federal Poverty Level

HIPAA – Health Insurance Portability and Accountability Act

HMS – Health Management System

INA – Immigration and Nationality Act

IRC – Internal Revenue Code

MA – Medical Assistance or Medicaid

MAGI – Modified Adjusted Gross Income.

MCI – Master Client Index

MEC – Minimum Essential Coverage

MNO – Medically Needy Only

PCP – Primary Care Provider

RDD – Renewal Due Date

REMIC – Real Estate Mortgage Investment Conduits

SAVE – Systematic Alien Verification for Entitlements.

SNAP – Supplemental Nutrition Assistance Program

SSI – Supplemental Security Income

TANF – Temporary Assistance for Needy Families

TPL – Third Party Liability

USCIS – United States Citizenship and Immigration Services
APPENDIX 1-A: DEFINITIONS

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

**Administrative Due Date (ADD)** – Date on the renewal notice informing the family that this is the date by which the renewal must be completed. The Administrative Due Date (ADD) equals 45 days prior to the Renewal Due Date (RDD).

**Annual Tax Household Gross Income** – Income used for determination of eligibility is defined for the purposes of this eligibility handbook tax household (See Modified Adjusted Gross Income).

**Applicant** – An applicant is defined as a child who wants his/her eligibility for CHIP determined. The adult (custodial parent or legal guardian) with whom the child lives will be the applicant on the behalf of the child.

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

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

**Children’s Health Insurance Program (CHIP)** – The name of the program that provides Free- and Low-Cost or Full-Cost health care services in accordance with Act 2006-136.

**CHIP Application Processing System** – The various software applications that manage CHIP applications and renewals for the Commonwealth of Pennsylvania.

**Client Information System (CIS)** – The Pennsylvania Department of Human Service’s online database which contains information needed to authorize cash, Medicaid and food stamp programs.

**Citizen** – An applicant or enrollee whose United States citizenship has been verified.

**Commonwealth Of Pennsylvania Application for Social Services (COMPASS)** – Pennsylvania’s online portal for applying for and renewing health and human services benefits.

**Contracted Service Area** – The geographic area for which a contractor is contracted by CHIP to provide health insurance.

**Contractor** – An insurer awarded a contract to provide health care services.

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

**County Assistance Office (CAO)** – The Pennsylvania Department of Human Service’s offices located in each county where Medicaid eligibility is determined.

**County of PCP** – County where the enrollee’s Primary Care Provider is located.
**County of Residence** – County of the enrollee’s principle residence.

**County of Service** – County where the CHIP-eligible service was provided.

**Creditable Health Insurance** – Health insurance coverage that meets a minimum set of qualifications established by ACA.

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

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

**Department** – Refers to the Department of Human Services and specifically to the CHIP Office.

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

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

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

**Federal Poverty Level (FPL)** - The Federal Poverty Level is a scale to judge whether or not a family’s income meets the financial needs for the basic necessities of life. New guidelines are issued every year in late January or early February to account for fiscal changes such as higher utility costs, inflation, and minimum wage levels.

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

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

**Full-Cost CHIP** - Allows families with income greater than 314% of the FPL to purchase CHIP insurance by paying the full premium.

**HEDIS®** – Healthcare Effectiveness Data and Information Set

**Health Insurance Portability and Accountability Act (HIPAA)** – For purposes of this handbook, HIPAA means the Federal standards for privacy and security of individual identifiable

**Insurer** – A health insurance entity licensed in this Commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under Act 2006-136 or any of the following:

- The Act of May 18, 1976 (P.L. 123, No. 54), known as the “Individual Accident and Sickness Insurance Minimum Standards Act.”
- 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

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

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

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

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

**Medicaid (MA)** – Federal medical assistance program established under Title XIX of the Social Security Act.

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

**Minimum Essential Coverage (MEC)** – Coverage required to meet the individual responsibility requirement under the Affordable Care Act.

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

**Newborn** – An infant from birth to 1 month of age.
Out-of-Pocket Cost Sharing – Includes premiums and point-of-service co-payments paid by families to contractors or providers on behalf of children enrolled in a Low- or Full-Cost category of CHIP for CHIP covered benefits and services only.

Parent – A natural parent, stepparent, adoptive parent, legal guardian or legal custodian of a child, unless otherwise noted in policy.

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

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

Premium Lock-out Period – A period up to 90 days in which a family has to pay overdue premiums to have the child reinstated back to the termination date without having to reapply for coverage.

Primary Care Provider (PCP) – A health care provider, who within the scope of the provider’s practice supervises, coordinates, prescribes, or otherwise provides or proposes to provide health care services to a enrollee; initiates enrollee referral for specialist care; and maintains continuity of enrollee care.

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

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

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

Reassessment – The process of changing a child’s eligibility status during the enrollment period, at the request of the parent or guardian, as a consequence of a reported change in family size and/or household income.

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

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

Renewal Due Date (RDD) – Date renewal of coverage must be completed to remain enrolled in CHIP.
Residency – A resident of Pennsylvania is someone who is living and intends to reside in Pennsylvania, with or without a fixed or permanent address.

Resource – Real or personal property.

Supplemental Security Income (SSI) – Monthly cash payments made to the aged, blind, or disabled under the authority of Title XVI of the Social Security Act, as amended, Section 1616 (A) of the Social Security Act, or Section 212 (A) of Pub. L. 93-66. (The SSI income is not included in an eligibility determination).

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

Tax household – The group of persons and their income used to determine a child’s CHIP eligibility based upon the rules.

Termination – Discontinuance of CHIP coverage for a child who had been previously enrolled and has severed his/her relationship with an approved CHIP contractor for one of the reasons enumerated in the CHIP Eligibility Handbook.

Third Party Liability (TPL) file – A DHS file that ensures the enrollee is not covered by private insurance.

United States Citizenship and Immigration Services (USCIS) – The governmental agency that oversees lawful immigration into the United States.
Part 1: APPLICATION PROCEDURES

CHAPTER 1: APPLICATION SUBMISSION

1.1 GENERAL REQUIREMENTS

Title XXI of the Social Security Act requires that a child be placed in the health care coverage program for which he or she is financially eligible. The two programs for which eligibility must be determined are CHIP and Medicaid. With the implementation of the Affordable Care Act, we are not determining eligibility for Advanced Premium Tax Credits (APTC), but will pass applications back and forth with the Federally Facilitated Marketplace (FFM).

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

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

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

If a family applies for insurance through the FFM and is determined eligible for APTC, the children cannot be enrolled in the APTC coverage unless it is determined that they are not eligible for Medicaid and CHIP first. The family can still enroll in a Qualified Health Plan through the FFM as a family if they are not asking for a premium subsidy.

1.2 SUBMISSION OF APPLICATION

The CHIP application process begins when a parent submits an application for healthcare on behalf of a child. Applications may be submitted electronically through COMPASS (www.compass.pa.us), via a telephone call, or submitted in paper form to any of the insurance contractors. Applications may also be sent to a contractor as referrals from the CAO or from the FFM. The contractor must process any application received and “Submit” it in the CHIP Application Processing System within 15 calendar days of the receipt of such application. If the 15th calendar day falls on a non-working day, the contractor is allowed until the close of business on the next working day to “Submit” the application.
In order to provide the family the maximum period to supply any missing information, the contractor shall reach out to the family during this 15 day period to obtain the missing information. However, missing information will not delay the application submission beyond the allowable 15 day window.

1.2.1 ELECTRONIC APPLICATIONS

1.2.1.1 REAL-TIME ELIGIBILITY

Real-time eligibility determinations are available for applications submitted through COMPASS that meet set criteria.

- Create a “My COMPASS Account”
- MCI clearance performed and MCI numbers assigned if necessary
- CIS and CHIP Application Processing System clearance performed
- Complete Remote Identity Proofing through Experian via the FDSH
- Calls to the FDSH via the EDX to gather additional verification details
- COMPASS calls existing CORTICON eligibility services and receives an eligibility determination
- If eligible, COMPASS routes application to CHIP Application Processing System for auto open

If unable to pass all specified gateposts or if the applicant(s) are determined ineligible, the application is routed to CHIP Application Processing System for manual processing.

1.2.1.2 CONTRACTOR SELECTION

The application received date is the date CHIP Application Processing System received the application from any good source. Applicants may submit their application directly to any contractor they choose.

An electronic application submitted through COMPASS allows the applicant to select one CHIP contractor providing service in his/her county. If a contractor is not chosen by the applicant, COMPASS will assign a contractor. If electronic verifications were incomplete, COMPASS provides instructions for submitting additional information and the selected contractor’s address for the applicant to submit the required information.

AUTOMATIC ASSIGNMENT

Any applicant who does not select an MCO at application and is enrolled into the CHIP Program will be subject to the auto-assignment process as described below. The auto-
assignment process does not negate the enrollee’s option to change his/her MCO at any time.

Enrollees in a family unit will be assigned together to one MCO.
An eligible enrollee who has not made a MCO selection and who has a case that also includes another active enrollee in the case will be assigned to that same MCO.
All remaining eligible enrollees, who have not voluntarily selected a MCO, will be equally auto-assigned to the active MCOs in their county. For example, if there are five MCOs in the county, each MCO would receive 20%.

Once an enrollee is open in an MCO, they may transfer to a different active MCO in their county of residence. The transfer will become effective the first day of the following month, based on MCO dating rules.

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

1.2.1.3 E-SIGNATURES

Applications submitted via COMPASS may be electronically signed by using the last four digits of the applicant’s social security number. If an applicant chooses to submit an e-signed COMPASS application, the applicant is not required to submit a signed signature page to the contractor. During user review of the CHIP Application Processing System Application Detail Screen, the user will notice in Section VII that the signature flag field will be automatically populated with a “yes” for e-signed applications. Additionally, the signature date will be populated with the date the e-signature was completed. If the applicant chooses not to provide an electronic signature, the application will go incomplete. The contractor will send a signature page along with the incomplete letter for the applicant’s signature.

1.2.2 TELEPHONE APPLICATIONS

The applicant for a child may submit an application via telephone. The application received date is the date of the call. If the application is submitted through the Commonwealth’s call center, the signature must follow telephone signature procedures.

1.2.2.1 TELEPHONE SIGNATURE PROCEDURES

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

1.2.3 PAPER APPLICATIONS

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

The applicant for a child shall submit the signed application to the CHIP contractor of their choosing. The timeframe for processing an application begins on the date the application is received by the CHIP contractor. The contractor is responsible for date stamping the application promptly with the date on which it is received.

1.3 COMPLETE APPLICATIONS

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

- All questions are answered and all information requested on the application form is provided;
- The application is signed and dated (or e-signed in COMPASS) by the applicant for the child (faxed signatures are acceptable);
- Verification of family income is received through the Federal Data Services Hub (FDSH), is provided by the family and/or verified by the CEU using Data Exchange (DX) matches;
- Verification of other eligibility factors is provided as requested by the contractor.

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

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

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

Case comments of any oral communication with the family are immediately recorded in the case file and in CHIP Application Processing System. In the case of written communication, the contractor must promptly place a “hard copy” of the notification in the case file or maintain an electronic record of the notification and its text.

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

The contractor will make a determination of ineligibility if the applicant fails to provide the information by the date requested.

A notice of eligibility or ineligibility with an appropriate explanation for denial must be sent to the applicant.

(See Chapter 6 – Notices)

1.5 DATA ENTRY

When a contractor receives a CHIP application or renewal, or receives notification that a change has occurred along with documentation, the contractor must data enter all information that appears on the application, renewal, or notification of change into CHIP Application Processing System promptly.

If mandatory data elements are missing the contractor must attempt to obtain the missing information and enter the data into CHIP Application Processing System. Failure to enter mandatory data elements into CHIP Application Processing System will result in applications and electronic referrals being delayed or denied.

MANDATORY DATA ELEMENTS

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

- Last Name;
- First Name;
- Date of Birth;
- Gender;
- Citizenship.

**EMPLOYER NAME**

If an individual indicates that they have wages, and the wages have been verified, the name of the employer is a mandatory data field in CHIP Application Processing System. Contractors will be unable to proceed without the data entry of an employer’s name.

**NOTE**: Contractors should enter the Federal Employer Identification Number (FEIN) when available and exact name of the employer (ABC Enterprises instead of McDonald's) in order to prevent duplicate income entries from TALX.

**1.6 AUTOMATED REFERRALS (E-REFERRALS) FROM A COUNTY ASSISTANCE OFFICE (CAO)**

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

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

When an application for health care coverage is filed with the CAO using an MA application form or through COMPASS and the child is determined to be ineligible for MA, the CAO will forward the information electronically to the appropriate CHIP contractor in that county.

**1.6.1 MA FAILURE REASONS**

The CAO will only refer children who are not eligible for MA due to high income.

DHS will not refer a child if the family did not provide all information to DHS for a full eligibility determination or if the child has private insurance.

**1.6.2 CAO REFERRAL REPORT**

Referrals from the CAO will come into “Suspended Applications” in the section of the CHIP Application Processing System named “Received via CAO” or the “Awaiting Fax from CAO”.
Contractors may receive referrals from the CAO before the MA record is actually closed.

- The MA close date will be displayed on the “CAO Referral Report” and on the eligibility details screen in the CHIP Application Processing System. The CHIP Application Processing System will use the MA close date to automatically determine the correct effective date for eligibility enrollment. **There should be no lapse in coverage.**

- If the MA close date on the CAO referral report is **blank**, the referral is from a **REJECTED MA APPLICATION**. Normally, no retroactivity will be authorized.

All electronic CHIP referrals from MA will be marked as signed in the CHIP Application Processing System.

### 1.6.3 PROCESSING A CAO REFERRAL

- Contractors will be able to process all referrals as complete, except for instances when income is not processed in the MA Client Information System (CIS).

- If income screens are **processed in CIS**, the income verification code in CIS will be displayed. The referral is directed to the “Received via CAO” section of “Suspended Applications” in CHIP Application Processing System. The contractor can process the application immediately.

- If the income was not verified, the application will become incomplete for income verification.

- Some applications in the “Received via CAO” section may have no income. In this instance, an error has been made. We should never receive a CHIP application with zero income as verified. In this instance, the contractor must contact the CAO to determine how or why the application was forwarded to CHIP. The contractor must reach out to its MA contact at the CAO within 2-days to determine the basis for the income discrepancy.

- If the income screens were not processed in CIS, the income is not considered verified and the resulting referral may be directed to the “Awaiting Fax from CAO” section of “Suspended Applications” in CHIP Application Processing System.
- CAO’s are not required to fax notification (See Appendix 1-C for the Fax: e-Referral form) documenting the income the CAO collected; however, if a notification is received the contractor must match this income documentation to the application.

- Whether an eReferral lands on the Received via CAO or Awaiting Fax from CAO tab and it has no income listed or has $0 income verified, the contractor must contact the CAO within 2 business days to obtain the income or determine if it was an incorrect eReferral. The CAO should be given 2 business days to respond.
  - If a correct eReferral and the income was verified by the CAO within the past 60 days, enter the income into CAPS and process the application.
  - If the CAO states it was an incorrect eReferral (family failed to provide documentation, failed to renew, intercounty transfer, foster/adoption assistance ended and the child aged out of the program, etc.) or the child/ren was reopened in MA, the eReferral should be deleted.
  - If the contractor is not able to obtain income from the CAO, the contractor must enter “not provided” in the Employer Name and process the application.

NOTE: An MA End Date present in the referral has no bearing on this process.

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

1.6.4 ELIGIBILITY REVIEW PROCESS

If the CHIP applicant disagrees with the eligibility decision made, based on information provided by the CAO, they may request an Eligibility Review.
(See Chapter 8 - Eligibility Review Process)

EXAMPLE 1: CHILD NOT ELIGIBLE FOR MEDICAID ENROLLMENT

Sammy B. was referred to CHIP from the CAO on August 4. The CAO completes an electronic referral to CHIP. The referral shows the family income is within the CHIP guidelines. Sammy meets all the eligibility factors and is enrolled in CHIP effective September 1.
EXAMPLE 2: CHILD’S ELIGIBILITY FOR MEDICAID TERMINATED (HEALTH CHOICES)

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

EXAMPLE 3: CHILD’S ELIGIBILITY FOR MEDICAID TERMINATED (FEE-FOR-SERVICE)

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

EXAMPLE 4: REFERRAL FROM CAO--CHILD ELIGIBLE FOR LOW-COST OR FULL-COST CHIP

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

EXAMPLE 5: CHILD’S ELIGIBILITY FOR MEDICAID TERMINATED (HEALTH CHOICES) -- CHILD ELIGIBLE FOR LOW-COST OR FULL-COST CHIP

Richard Q. is enrolled in Medicaid in a Health Choices county. The family’s income has increased and the Medicaid eligibility will be terminated April 15, but healthcare coverage will continue until April 30. An electronic referral from the CAO is received on April 8 that shows the new family income to be within the Low-Cost CHIP guidelines. Eligibility determination will be for month of May. Richard is placed in ACR status in Low-Cost CHIP and a request for the May premium is sent to the family for enrollment in Low-Cost CHIP. If the premium is not received, the child will be denied enrollment in CHIP.

EXAMPLE 6: CHILD’S ELIGIBILITY FOR MEDICAID TERMINATED (FEE-FOR-SERVICE) - CHILD ELIGIBLE FOR LOW-COST OR FULL-COST CHIP
Jeffrey is enrolled in Medicaid fee-for-service. The family's income has increased and the Medicaid coverage will be terminated effective July 23. An electronic referral from the CAO is received showing the new family income to be within the Low-Cost CHIP guidelines. Contact is made with the family, preferably by phone, to explain that Jeffrey is eligible for Low-Cost CHIP. The parent is given a choice of a retroactive enrollment to July 1 to avoid a gap in health care coverage or enrollment on the next enrollment date August 1. Once the parent chooses an enrollment date, Jeffrey is placed in ACR status in Low-Cost CHIP and a request for premium is sent to the family for enrollment in Low-Cost CHIP. If the premium payment is not received, the child's CHIP coverage is denied.

EXAMPLE 7: CHILD ELIGIBLE FOR FULL-COST CHIP

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

EXAMPLE 8: CONTRACTOR RECEIVES A CHIP REFERRAL FROM THE CAO BUT INCOME HAS NOT BEEN VERIFIED

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

1.7 AUTOMATED REFERRALS TO THE CAO

When an application for health care coverage is filed with the CHIP contractor, the CHIP Application Processing System will run eligibility first, screening for MA eligibility using MA eligibility rules for monthly income calculation and household size. If the child is determined to be ineligible for CHIP due to income being too low, or the child reaches age 19, the CHIP Application Processing System will forward the information electronically to the appropriate CAO.
Manual referrals will not be acceptable, unless specific situations are identified where an electronic referral was not able to be sent to the CAO.

1.7.1 INCOME

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

The CHIP Application Processing System will determine the individual ineligible for CHIP if the annual tax household income is below the CHIP income limit.

(See Chapter 6 – Notices)

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

1.8 TRANSFERS TO ANOTHER CONTRACTOR

The contractor may receive an application for a child from another CHIP contractor.

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

When an address change is entered in CHIP Application Processing System that is outside the current contractor’s coverage area, an application transfer is initiated by the system via an Autoshare alert, which will terminate the child in the existing UCI and generate a new UCI for the receiving contractor.

The information entered in CHIP Application Processing System by the original contractor, including the tax household’s income and size will be electronically forwarded to the appropriate or requested contractor within 24 hours of the request.

The original contractor is responsible for verification of all information on the application, whereas the receiving contractor is responsible for verifying any information that seems erroneous or has not been verified according to policy guidelines.
An effective enrollment date should be indicated to the new contractor with this transfer to avoid any lapse or delay in coverage. The original application in hard copy form and all supporting documentation must be retained by the contractor initiating the transfer.

The receiving contractor will take action on the transfer within 48 hours of receiving the transfer.

Once the transfer is complete the receiving contractor will:

- Send a notice informing the applicant of their eligibility;
- Request PCP selection, if appropriate;
- Request payment for coverage if applicable. Coverage will be denied or terminated if the payment is not received within 30 days.

1.9 TRANSFERS FROM THE FFM

The FFM will forward applications for children to CHIP from families who applied for insurance through the FFM and applied for APTC, but determined the children may qualify for CHIP.

Transfers from the FFM will come into “Suspected Applications” in the section of the CHIP Application Processing System named “Received via FFM”.

Contractors will review the FFM application to ensure that all information on the application is verified. If no additional verification is required, the contractor must run clearance and submit the application. If there is missing or unverified information, the application will be incomplete and the applicable verifications must be requested.

As referenced in Section 1.2, the contractor must process any application received and “Submit” it in the CHIP Application Processing System within 15 calendar days of the receipt of such application.
APPENDIX 1-B COUNTY ASSISTANCE OFFICE INFORMATION

The Department of Human Services periodically updates information regarding the County Assistance Offices. The updates are posted at: [http://www.dhs.pa.gov/citizens/findfacilsandlocs/countyassistanceofficecontactinformation/index.htm](http://www.dhs.pa.gov/citizens/findfacilsandlocs/countyassistanceofficecontactinformation/index.htm)

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<tr>
<td>Adams</td>
<td>Adams County Assistance Office</td>
<td>Toll Free: 1-800-638-6816 Phone: 717-334-6241 FAX: 717-334-4104</td>
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<tr>
<td></td>
<td>225 South Franklin Street P.O. Box 4446</td>
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<tr>
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<td>Phone: 412-565-2146 FAX: 412-565-3660</td>
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<tr>
<td></td>
<td>Piatt Place 301 5th Avenue, Suite 470</td>
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<td></td>
<td>Low Income Home Energy Assistance Program (LIHEAP)</td>
<td>Phone: 412-562-0330 FAX: 412-565-0107</td>
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<tr>
<td></td>
<td>5947 Penn Avenue, 4th Floor</td>
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<td></td>
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<tr>
<td>Institution-Related Eligibility District (ISED)</td>
<td>301 5th Avenue, Suite 420 Pittsburgh, PA 15222</td>
<td>Phone: 412-565-5604 FAX: 412-565-5074</td>
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<tr>
<td>Liberty District</td>
<td>332 5th Avenue, Suite 300 Pittsburgh, PA 15222</td>
<td>Phone: 412-565-2652 FAX: 412-565-5088</td>
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<td>Three Rivers District</td>
<td>Warner Center 332 Fifth Avenue, 2nd Floor Pittsburgh, PA 15222</td>
<td>Phone: 412-565-7755 FAX: 412-565-5198 or 5075</td>
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<tr>
<td>Southeast District</td>
<td>220 Sixth Street McKeesport, PA 15132-2720</td>
<td>Phone: 412-664-6800 or 6801 FAX: 412-664-5218</td>
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### APPENDIX 1-C CAO REFERRAL FAX SHEET

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If you have additional income sources please add to an additional sheet.

**Comments:**

**cc:**
CHAPTER 2: CENTRAL ELIGIBILITY UNIT VERIFICATION PROCESSES

2.1 CENTRAL ELIGIBILITY UNIT (CEU)

The CHIP Office’s Central Eligibility Unit (CEU) is responsible for completing the following:

- Assisting the contractor in obtaining citizenship and identity verification for children whose citizenship and identity cannot be verified electronically;

- Verifying income through data matches with the DX and FDSH;

- Determining eligibility for all new applications except for CAO referrals with verified income and COMPASS applications that meet Real Time Eligibility criteria; and,

- Processing retroactivity requests from insurers when the retroactive period exceeds 6 months.

2.2 ELECTRONIC VERIFICATION OF CITIZENSHIP AND IDENTITY

Once an application goes through the clearance process, a request will be sent to SSA to electronically confirm citizenship and identity.

Note: If an SSN is not provided by the family, an attempt will be made to obtain an SSN electronically from SSA. If the SSN is obtained from SSA, another request will be generated to SSA to validate citizenship and identity. If an SSN is not acquired from SSA, the CEU will attempt to obtain the SSN from the family. If unsuccessful, the application will go incomplete until the SSN is provided.

Once an SSN is obtained, the child’s information is again sent to SSA to validate citizenship and identity of the child. If SSA confirms citizenship and identity for a CHIP child, the verification code will be updated in CHIP Application Processing System automatically. The contractor is not required to take further action.

An alert will be created in CHIP Application Processing System to identify children whose citizenship and identity cannot be verified electronically. The CEU worker will take action on this alert.

2.3 CONDITIONAL ENROLLMENT
A child will be entered into a Conditional Enrollment Period of 90 days if an inconsistency exists between information in CHIP Application Processing System and information on file with the SSA and citizenship and identity cannot be verified electronically. (See Eligibility Handbook, Chapter 3 – Citizenship/Alien, Section 3.5 – Citizenship and Identity Cannot be Confirmed by SSA).

The family will receive letters 90, 60 and 30 days prior to coverage ending advising the enrollee that CHIP coverage will terminate if the inconsistency between data in CHIP Application Processing System and data in SSA files cannot be corrected or proof of citizenship and identity is not provided. A U.S. Citizenship and Identity Guide will be included with all letters.

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

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

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

**NOTE:** An explanation of “90-day conditional eligibility” will be displayed on the Eligibility Detail Screen in CHIP Application Processing System.

### 2.4 CEU REVIEW OF CHIP APPLICATION PROCESSING SYSTEM

An alert will be generated in CHIP Application Processing System for the CEU for any child whose citizenship and identity could not be electronically verified.

The CEU worker will attempt to contact the family by telephone to correct any information in CHIP Application Processing System or obtain any missing verification needed to complete the eligibility process.

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

If there is an error in CHIP Application Processing System, the CEU will correct CHIP Application Processing System.
Any change in CHIP Application Processing System demographics (name, SSN, Date of Birth, and Gender) will initiate another citizenship and identity match with SSA.

If, after contacting the family, the CEU worker determines the information in CHIP Application Processing System is correct, the CEU worker will advise the family to provide the contractor with citizenship and identity documentation. (See Section 2.2 of this chapter). The CEU worker will also suggest the family contact their local SSA office to update the information SSA has on file for the child.

The CEU worker will also assist individuals in acquiring birth certificates, if needed, by directing them to the following web sites, or advising them where to send a request and what must be included with that request if they do not have access to the internet.

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

For individuals born in PA needing to obtain a birth certificate: www.health.pa.gov. Individuals may click on the Birth Certificates link for detailed instructions.

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

If the CEU worker is unable to make contact with the family, the child will remain conditionally enrolled in CHIP for 90-days pending the receipt of citizenship and identity documentation by the contractor. (See Section 2.2 of this Chapter)

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

2.5 CITIZENSHIP AND IDENTITY DOCUMENTATION RECEIVED BY THE CONTRACTOR

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

2.5.1 ACCEPTABLE CITIZENSHIP AND IDENTITY DOCUMENTATION

Once the contractor receives acceptable citizenship and identity documentation, the contractor will verify all demographic information in CHIP Application Processing System and update the appropriate fields to “Document in Record”. If
changes are made to the demographics, CHIP Application Processing System will initiate another match with the SSA.

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

2.5.2 VERIFICATION OF UNDOCUMENTED IMMIGRANTS
If the contractor or the CEU receives verified information that the applicant does not meet the citizenship requirements, the applicant will be retro-terminated to the original enrollment date (See Eligibility Handbook Chapter 9, Section 9.3).

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

2.6 TERMINATION FOR FAILURE TO PROVIDE CITIZENSHIP AND IDENTITY DOCUMENTATION
If the CEU worker cannot resolve any discrepancy, and/or the enrollee does not provide the verification documentation to the contractor within the 90-day verification period, a 30-day advance notice to close will be issued.

In the event the individual provides the required information to the contractor during this 30-day period, the benefits will continue.

2.7 DATA EXCHANGES (DX)
The CEU worker will use the DX in an effort to acquire income verification for an applicant, enrollee and household members on an ongoing basis.

The DX details can only be accessed by Commonwealth employees (i.e. the CEU workers).

Details from the DX will be updated in CHIP Application Processing System by the CEU worker.

The CEU worker will enter case comments for all actions taken (or not taken because the DX caused the application to go incomplete) as a result of DX matches. For example:

- If the CEU worker determines that there is a discrepancy relating to wages, Unemployment Compensation or Social Security benefits, but there will be no
change in eligibility or the enrollment level (information provided is reasonably compatible), the CEU worker will continue the eligibility process.

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

A system generated letter will be issued advising the applicant that additional income verification is needed. The letter will advise the applicant to provide this additional income verification to the contractor.

If the CEU worker discovers a deceased person’s match, the CEU worker will contact the contractor to request that they contact the family to validate information before initiating a closure.

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

2.8 VERIFICATION OF LAWFUL PRESENCE (VLP)

VLP replaces the SAVE process the CEU used in the past to verify immigration status of non-citizen applicants. The CEU is able to access the VLP service through CHIP Application Processing System from the Citizenship screen.

- The CEU worker enters information provided by the applicant into CHIP Application Processing System;
  - Alien Number,
  - Date of Entry into the U.S,
  - Document Type,
  - I-94 Number,
  - Passport Number, etc.
- The CEU worker checks the “Verify Lawful Presence Box” on the Citizenship Screen;
- A call is electronically initiated to the VLP service.
- The VLP service then sends back a “VLP Response” which identifies the individual’s immigration status:
  - Verified
  - Not verified
If the status comes back as verified, the CEU worker enters “Document in Record” under the “Citizenship Verification” field and no further documentation is required.

If the status comes back as not verified, the CEU leaves the “Citizenship Verification” field as “Client Statement” and the application will go “Incomplete”. A letter is sent requesting that the family provide verification documents to the insurance contractor.

[SISTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE) PROCESS (Obsolete) – This process can still be used, but the VLP is more efficient.

The CEU will submit a SAVE request on all lawfully residing aliens. The following information is required to submit a SAVE request;

- Name
- DOB
- Alien registration number (A#)
- Card Number is required for certain types of documents

Documentation to verify the status of a lawfully residing alien is only required if the individual fails the 1st step in the SAVE verification process. If an individual fails the 1st step, a legible front and back copy of their immigration documentation is required.]

2.9 CASE COMMENTS

Case comments must be updated for all actions taken by either the contractor or the CEU regarding citizenship and identity and DX.
CHAPTER 3: INCOME AND TAX DEDUCTION VERIFICATION

3.1 GENERAL REQUIREMENTS

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

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

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

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

Income must be attached to the individual for whom the income is intended. For example, Jane, the parent, receives child support and Social Security Disability benefits for Johnny. Jane, the head of household, also receives alimony. The Social Security Disability and child support will be entered in CHIP Application Processing System under Johnny, not Jane. The alimony will be entered under Jane.
3.1.1 INCOME THAT IS COUNTED INCLUDES BUT IS NOT LIMITED TO:

- Salaries, wages, compensation as an officer in an S Corporation, overtime, shift differentials, allowances, commissions, incentives, bonuses, etc.;
- Interest (both Lines 8a and 8b on the Form 1040 or 1040A);
- Dividends (only Line 9a on Form 1040 or 1040A);
- Taxable refunds, credits or offsets of state and local income taxes (Line 10 on Form 1040);
- Alimony, court ordered (Line 11 on Form 1040);
- Net profit/loss from a sole proprietorship (Line 31 from each Schedule C);
- Capital Gain/Loss (Line 13 on Form 1040 or Line 10 on Form 1040A);
- Other Gain/Loss (Line 14 on Form 1040);
- IRA Distributions (gross amount or Line 15b on Form 1040 or Line 11b on Form 1040A);
- Pensions and annuities (gross amount or Line 16b on Form 1040 or Line 12b on Form 1040A);
- Net profit/net loss from rental property, royalty, partnership, the tax liability of an S Corporation, trust, estate and REMIC (Schedule E);
- Farm income/loss (Schedule F, line 34);
- Unemployment Compensation (UC) *
- Social Security (OASDI – old age (retirement), survivors & disability insurance) (Gross amount);
  - Parent’s is always counted
  - If the child/tax dependent has other income (not counting the Social Security benefit) which would require the child/tax dependent to file a tax return
  - If the child/tax dependent is in a household without a parent (biological, adoptive, or step).
- Other income/loss (Line 21 on Form 1040);
- Workers’ Compensation (WC) IF the person receiving it also receives a Social Security Disability benefit;
- Housing allowances if included on Schedule C or in wages;
- Foreign Earned Income;
- Stipends used for living expenses;
- Scholarships, grants and loans used for living expenses; and,
- TAA benefits (Trade or NAFTA Transitional Adjustment Assistance).

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

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

3.1.2 INCOME THAT IS NOT COUNTED INCLUDES BUT IS NOT LIMITED TO:

- Child support and arrears;
- WC if the person is not receiving Social Security Disability;
- Social Security benefits of a child/tax dependent if the child/tax dependent lives in a household with a parent (biological, adoptive, or step) and the child/tax dependent is not required to file a tax return;
- Supplemental Security Income (SSI);
- Alaska Native Claims payments;
- German Reparation payments; and,
- Earnings of a child or tax dependent that is not required to file a tax return.

3.1.3 DEDUCTIONS ARE LIMITED TO THE FOLLOWING:

<table>
<thead>
<tr>
<th>Tax Deductions</th>
<th>2016 Form 1040, Line:</th>
<th>2016 Form 1040A, Line:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educator expenses</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Certain business expenses of reservists, performing artists, and fee-basis government officials</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Health savings account deduction</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Moving expenses</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Deductible part of self-employment tax</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Self-employed SEP, SIMPLE and qualified plans</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Self-employed health insurance deduction</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Penalty on early withdrawal of savings</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Alimony paid</td>
<td>31a</td>
<td></td>
</tr>
<tr>
<td>IRA deduction</td>
<td>32</td>
<td>17</td>
</tr>
<tr>
<td>Student loan interest deduction</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>Tuition and fees</td>
<td>34</td>
<td>19</td>
</tr>
<tr>
<td>Domestic production activities deduction</td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>
3.2 VERIFICATION REQUIREMENTS

Income and deductions must be verified prior to enrollment and prior to renewal with the exception listed below. Income verification should reflect the household’s reasonably expected income over the 12-month enrollment period. Deduction verifications should reflect the household’s reasonably expected deductions on next year’s federal individual tax return. At intake, the CEU will determine if deduction verification is needed. A comparison will be performed between no deductions being taken and the deductions a family expects to take on next year’s tax return. If the deductions do not change the eligibility determination, verification will not be required. Only in cases where the expected deductions would result in a different eligibility determination will verification be required.

**NOTE:** If verification of income deductions is the only reason for an application or renewal to go incomplete resulting in the denial or termination of a child’s CHIP coverage, the insurance contractor can ignore the deductions and process the application as if they were not claimed. This will allow eligibility to be run and an outcome to be determined.

Verification of changes to the household income and deductions are not required during the 12-month enrollment period. Household income and deductions do not need to be reviewed until the next renewal unless the family requests a reassessment (See Chapter 10 Reassessment) of verified income or deductions and provides current supporting documentation.

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

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

3.2.1 ACCEPTABLE INCOME VERIFICATION DOCUMENTATION
Electronic means will be utilized to verify income where possible. Several electronic sources are available to verify household income. The Social Security Administration (SSA) Composite system provides current Social Security Benefit (SSB) amounts. The Federal Data Services Hub (FDSH) allows limited access to payroll information through its TALX Interface. In cases where no electronic means are available or when electronic means do not support the income being reported, paper documentation will be required. Additionally, all income reported as verified by CAO is considered acceptable verification.

**SALARIES, WAGES, COMMISSIONS, BONUSES**

1. **Electronic Sources of Income - Preferred**

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

2. **Paystubs – alternative to electronic source**

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

   When reviewing the paystub for the gross pay amount, be sure to look at the number of hours worked for that pay period and all items listed under the paystub’s earnings/wage column and year-to-date (YTD) column for other types of income being earned in prior pay periods. The number of hours worked listed on the application/renewal should reflect the number of hours on the paystub. If not, the hours listed on the application are likely not representative of their income. Additional paystubs may be requested; however, the **contractor may use the one paystub submitted to calculate the average gross pay using the year-to-date earnings**. This will aid in more efficient processing of the application/renewal rather than waiting for additional paystubs to be submitted.
To calculate the YTD average gross pay, divide the total gross YTD figure listed on the most recent paystub by the number of pays received by the actual Pay Date on the most recent paystub. DO NOT use the number of pay periods worked as of the Pay Date. This serves as a comparison to the gross wage for the individual pay period. This is a double check to determine if other income occurs. Be sure to count only the number of pays received during the employment period within the calendar year and not the number of Pay Dates from the beginning of the calendar year. For example, if a person’s start date was 4/10/16, and you are averaging a paystub dated 9/23/16, you would only count the number of Pay Dates received during that timeframe.

If the YTD average calculation is the same or higher than the gross earnings shown on the most recent paystub received, then all income listed on the paystub will be included. The higher amount is to be used in the eligibility determination. If the person disagrees with the determination caused by using the higher amount, they may request an eligibility review as described in CHIP (See Chapter 8 – Eligibility Review Process).

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

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

On most paystubs, all of the different types of income (regular earnings, overtime, shift differentials, allowances, commissions, bonuses, etc.) are totaled individually. For individuals that receive quarterly or annual bonuses, individual calculations may be performed and added to the eligibility determination.
NOTE: As long as paystubs are dated within 60 days of the date of the signature on the application or renewal, it can continue to be accepted, and updated verification is not required regardless of when eligibility is determined.

(See Chapter 4, Section 4.2 - Income Calculation Illustrations for more detailed information and examples).

3. **Letter from the Employer** - Alternative to paystubs

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

If an applicant states that additional pay, such as overtime, is seasonal, the employer is to provide the year-to-date earnings as stated in the above paragraph. The letter is to further state the dates through which the overtime is worked, such as through the winter only, and provide the gross amount of the overtime that is included in the overall year-to-date earnings.

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

4. **Business Records** – Alternative to Letter from the Employer

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

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

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

Specific to Form W-2, boxes 1, 3, 5, 16, and 18 contain the wage, tip, and other determination. Note that one full year of income is then used in the determination of eligibility instead of 48 weeks (See Chapter 4 - Determining Financial Eligibility).

BUSINESS INCOME
The most current federal individual income tax return and related schedules are to be submitted for the eligibility determination. The net profit/net loss is used in the eligibility determination. For an individual with multiple sources of self-employment income, the cumulative losses will reduce the cumulative profits. In short, counting self-employment income would be equivalent to counting the amount of profit/loss appearing on the Form 1040 Line(s) 12 and/or 17. However, when entering these types of income in CHIP Application Processing System, the net profit/net loss should be entered for each business or source of income. For example, if an individual has 2 partnerships, 3 ‘S’ Corporations, 1 sole proprietorship and 15 rental properties, then 8 entries should be made in CHIP Application Processing System -- one for each of the 6 businesses and 2 for the rental property. Specific to the 2 separate entries for rental property, the Employer Name in CHIP Application Processing System should contain the number of rental properties having net profits and net losses.

Acceptable Tax Returns

When a new calendar year starts, a tax return from the previous year may not have been completed at the time of application or renewal. For example, when 2017 begins, the tax returns for 2016 may not be finalized and filed. If this is the case, the following should be done:

January 1 – Tax deadline day mid-April:

The latest filed yearly tax return will be accepted as proof of income. For example, in 2017 a yearly tax return from 2015 or a copy of the last quarterly tax filing from 2016 will be accepted until mid-April, if the 2016 tax return has not been finalized. If a quarterly return is used, the net profit shown must be annualized.
A year-to-date profit & loss statement may be accepted for the current year for each source of business income. The profit & loss statement should list the business name, type of business entity (sole proprietor, partnership, S Corporation), the time period covered by the profit & loss statement, gross income earned in that period, a line item list of expenses for the period, and a net profit/loss figure for the period.

Be careful reviewing the profit & loss statements. If the individual receives profit, the wages must be added to the eligibility determination.

Mid-April – End of Year:

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

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

Be careful reviewing the profit & loss statements. If the individual receives wages from the business, it will appear as a business expense and lower the net profit. The wages must be added to the eligibility determination.

Types of Business Income -

Self-Employment (Royalties, Rental Properties, Sole Proprietors, and Partnerships) and S Corporations

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

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

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

If a YTD profit & loss is used and “wages” were deducted as a business expense, the contractor will have to reach out to the enrollee/applicant to inquire as to whom the wages were paid. Sole proprietors may have employees on their payroll. The contractor must confirm that the “wage” business expense does not include wages for the sole proprietor. If the response is that the sole proprietor received the “wages”, the contractor will have to add this amount back into the net profit.

2. Self-employment royalties and rental properties

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

A separate entry should be made in CHIP Application Processing System for each source of royalty. For multiple rental properties, 2 separate entries should be made in CHIP Application Processing System—one for the cumulative net profit and one for the cumulative net loss. The Employer Name in CHIP Application Processing System should contain the number of rental properties having net profits and net losses. For instance if someone has 17 rental units and 15 had profits and 2 had losses, an entry should be made for “15 rental profits” and the amount of the cumulative profits and an entry should be made for “2 rental losses” and the amount of cumulative losses. Only if all properties each had a profit or each had a loss, should you have 1 entry in CHIP Application Processing System.

3. Self-employment partnerships

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

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

- Line 28 A – non-passive income $30,000, Section 179 expense $2,300;
- Line 28B – non-passive income $5,000 and;
- Line 28C – non-passive income $17,500, unreimbursed partner expense $150, Section 179 expense of $1,800

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

- Line 28A - $27,700 ($30,000 - $2,300)
- Line 28B - $5,000
- Line 28C - $15,550 ($17,500 - $150 - $1,800)

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

4. S Corporations

An S Corporation is a regular Corporation that has between 1 and 100 shareholders.

There are 2 types of shareholders:

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

The IRS requires a shareholder-employee to be paid a reasonable salary from the S Corporation; however, not all S Corporations practice this. The S Corporation passes through net income and losses to the shareholders via special tax status with the Internal Revenue Service (IRS). This allows the Corporation to not be a separate taxable entity. The S Corporations can retain its net profits as operating capital.
All profits are considered as if they were distributed to shareholders. Thus, a shareholder might be taxed on income they never received because the shareholder is liable for paying tax (tax liability) on his/her shares of the S Corporation’s aggregate income whether or not income was actually received by the shareholder.

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

Specific only to S Corporations, the listed amount on Schedule E, line 28, identified as “S” represents tax liability and under the new rules of MAGI methodology, is counted in the eligibility determination. Section 179 expense deductions and/or unreimbursed expenses are of relevance and should be removed from the tax liability just as explained above in Section 3 Self-Employment Partnerships.

Compensation as an Officer (i.e., wages for which the shareholder-employee will receive a Form W2 and that will be reported on Form 1040 line 7).

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

A separate entry should be made in CHIP Application Processing System for each ‘S’ Corporation. The Employer Name in CHIP Application Processing System should identify “S Corp” after the name of the business. For instance, if the business is called Creative Consultants, the Employer Name should be “Creative Consultants S Corp”.

**UNEMPLOYMENT COMPENSATION**

1. Award Letters—Preferred

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

2. Electronic Records – Alternative to Award Letters

A print out from the internet that shows the gross payment is an acceptable form of documentation. Please keep in mind that federal income tax that is deducted from the gross payment must be included as part of the income used in the eligibility determination.
A print out from the internet of the Claim Status and Additional Benefit Payment History screens may be submitted. The Claim Status shows the UC begin date, the number of weeks awarded and the balance remaining on the claim.

**Note:** Only the number of remaining weeks that Unemployment Compensation (UC) income will be received is used in situations where a job is lost. (See Section 3.1.1 of this chapter.

For seasonal workers, the annual amount of UC is to be counted in the eligibility determination. Refer to “Seasonal Workers”.

Be careful in your calculations for situations where the worker is collecting partial unemployment due to reduced hours and may then collect full unemployment for some weeks.

**SEASONAL WORKERS**

For the purposes of CHIP, a “seasonal worker” is an individual whose ability to work directly relates to the weather or to the season. For example, people who work in landscaping, construction, grounds maintenance or individuals that pick fruit at an orchard would all work as the weather or season permits. Many of these jobs are performed for only a part of a year. The other part of the year the employee is unemployed or laid off.

When an applicant or enrollee indicates seasonal employment, contractors should ask additional questions of the applicant or enrollee. For renewals where an enrollee was a seasonal employee during the last renewal process, CHIP Application Processing System history should be searched to ascertain a pattern for the enrollee.

Questions could be:

- What are the dates that the individual worked i.e., to determine the number of weeks worked?
- If UC was collected by the individual last year, will it be collected this year?
- Does the individual have a UC award letter that shows the benefit amount?
- Has the individual been given a date that they should expect to return to work, i.e., to determine the number of weeks of UC to be used in income calculations?
- Can the individual provide copies of the latest UC award letter or a copy of their federal tax return that shows the amount of UC paid to them last year?
Many times an applicant or enrollee may not know the amount of their new UC benefit. In these instances, the award letter from last year or 1099-MISC form from last year could be accepted to determine a clear picture of an individual's income.

**WORKERS’ COMPENSATION PAYMENTS**

Workers’ Compensation is excluded income under MAGI unless the individual receives WC and Social Security Disability payments. If the person receives Social Security Disability benefits, the gross benefit amount indicated on the SSA award letter or obtained through the SSA electronic verification includes the WC portion of the benefit. For example, the gross award on the SSA letter is $2,000 monthly and it shows reductions for Medicare Part B of $104.90 and a WC offset of $500. It is the $2,000 amount that will be provided through the SSA electronic verification or should be used from the copy of the SSA award letter. One entry will appear in CHIP Application Processing System for the Social Security benefit which would encompass both the SS benefit and the WC benefit.

1. Electronic Verification - Preferred

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

2. Award Letters - Alternate

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

**SOCIAL SECURITY BENEFITS**

If the person receives Workers’ Compensation benefits, the gross benefit amount indicated on the SSA award letter, Form 1099-SSA or obtained through the SSA electronic verification will include the WC portion of the benefit. For example, the gross award on the SSA letter is $2,000 monthly and it shows reductions for Medicare Part B of $104.90 and WC offset of $500. It is the $2,000 amount that will be provided through the SSA electronic verification and is what should be used from the copy of the SSA award letter.
If the SSA award letter or the SSA electronic verification is used in the determination, there will be only 1 entry in CHIP Application Processing System for the Social Security benefit.

1. Electronic Verification - Preferred

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

2. Award Letters - Alternate

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

Award letters for the upcoming calendar year are mailed to the recipient in October/November of the current calendar year. For example, if an applicant is applying in January 2017, the 2016 award letter is preferred. The applicant should have received that letter in October/November 2016. If the applicant states they do not have the 2016 award letter, the applicant needs to request a copy.

If an applicant does not have a copy of their proof of income letter, instructions to receive a copy are available online at https://secure.ssa.gov/apps6z/BEVE/main.html. Each beneficiary must request his/her own letter. According to the website, a letter may take four to six weeks, so it is suggested that an applicant print it electronically for immediate verification.

3. SSA-1099 Form or Form 1040 or 1040A - Alternative to Award Letter

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

Additionally, the annual amount must be increased to account for any Cost of Living Adjustment. For example, if a 2015 SSA-1099 is submitted, it is possible there was no Cost of Living Adjustment (COLA) for 2016. However, future years must be reviewed for the COLA amount.

MONTHLY RETIREMENT BENEFITS
1. Award Letters - Preferred

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

2. IRS Form 1099-R – Alternative to Award Letters

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

3. Bank Statement – Alternative to IRS Form 1099-R

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

ALIMONY PAYMENTS

Alimony refers to a court order for monetary support from one spouse to the other for a specified length of time. Alimony is considered taxable income to the recipient and a tax deduction to the payer. Alimony is countable income and tax deduction for each person and is to be included in the eligibility determination.

1. Decree of Divorce, Separation Maintenance or a written instrument to that decree - Preferred

A written separation agreement or a decree of any type of court order requiring a spouse to make payments for the support or maintenance of the other spouse. This includes a temporary decree, a ‘not final’ decree, and a decree of alimony pendente lite.

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

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

2. 12-month Electronic Payment History—Alternate

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

Payment history for the past 12-months is to be requested. The history will show the amount and frequency of payments. In many cases, payments may be inconsistent: the payer might pay ahead several months of alimony or might make infrequent payments. This needs to be taken into account when determining income eligibility. The recipient may not get alimony payments every month but that may be due to the fact that the payer paid ahead or only pays occasionally. If payments are sporadic, annualize the past 12 month history figure to obtain a monthly average and use this in the eligibility calculation.

EXAMPLE 1:

Wife’s court ordered monthly support is $350. This means $350 is to be received every month and is to be used in the eligibility determination.

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Payment</th>
<th>Date</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/2/15</td>
<td>$350</td>
<td>9/2/15</td>
<td>$350</td>
</tr>
<tr>
<td>6/2/15</td>
<td>$350</td>
<td>10/2/15</td>
<td>$350</td>
</tr>
<tr>
<td>7/2/15</td>
<td>$350</td>
<td>11/2/15</td>
<td>$350</td>
</tr>
<tr>
<td>8/2/15</td>
<td>$350</td>
<td>12/2/15</td>
<td>$1,750</td>
</tr>
</tbody>
</table>

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

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

**EXAMPLE 2:**

Husband’s court ordered monthly alimony is $1,100. This means $1,100 is to be received every month and is to be used in the eligibility determination.

On 3/30/16, dad contacts the CHIP contractor and states he hasn’t received an alimony payment since 1/13/15. He further states that he cannot count on the alimony and believes the mother will not pay any future alimony. Because CHIP policy states that income is not to be removed without documentation to support it, dad is asked to submit a 12-month payment history to support his claim. The payment history is received. It is dated 3/2/16 and shows transactions from 1/1/15 to 3/2/16. It shows the total arrears currently owed are $37,456.07 and that the following payments have been applied to dad’s account:

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/2/15</td>
<td>$6,092</td>
</tr>
<tr>
<td>9/13/15</td>
<td>$4,953</td>
</tr>
<tr>
<td>10/5/15</td>
<td>$273.73</td>
</tr>
<tr>
<td>10/12/15</td>
<td>$4,953.35</td>
</tr>
<tr>
<td>11/12/15</td>
<td>$4,953.35</td>
</tr>
<tr>
<td>12/13/15</td>
<td>$4,953.35</td>
</tr>
<tr>
<td>1/13/16</td>
<td>$4,953.35</td>
</tr>
</tbody>
</table>

The payment history shows that dad has been receiving payments. Although he has not received a payment within the past 60 days, this does not mean that the income is to be
disregarded*. In this case, the contractor should annualize the income. The payment received on 2/2/15 can be ignored because it was received prior to the past 12 months. $25,040.48 total alimony payments received divided by 12 months = $2,086.71 average monthly alimony received. This amount should be used in the eligibility determination.

*This could be disregarded if dad supplies a signed court order modification showing the alimony termination date. A letter from ex-wife stating she is no longer paying alimony is NOT acceptable in this situation because this alimony order was issued by a court of law.

INTEREST and DIVIDENDS

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

Interest

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

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

Dividend

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

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

Statement from Financial Institution

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

CAPITAL GAINS/LOSSES and OTHER GAINS/LOSSES

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

The most recent individual federal income tax return –
Form 1040a – use Line 10
Form 1040 – use Line 13.

Specific to an individual who flips houses, because house flipping is a source of self-employment, the capital gain/loss will be counted. For an individual who sold a home NOT as a source of generating income, for example, a family that sold its home and bought a new one, the capital gain/loss attributable to that sale should be excluded.

For someone who sells stocks or mutual fund investments every year, the capital gain/loss will be counted. If an individual reports that this income should not be counted, they should be asked if the selling of investments is something they do each year regardless of consistency or routine. If so, it is counted. If they state they fell on hard times and needed money to pay bills, then it can be treated as a one-time event lump sum as long as the contractor does not have information to the contrary. For instance, if on their 2014 and 2015 tax returns they had capital gains and in 2016 they report that the selling of stocks/funds is an unusual occurrence for them, in this particular case, the income should be counted because the insurer has documentation showing they have continued to sell. Only if the family should report that they have no other stocks/funds to sell would this income be removed in this example.

TAA (Trade or NAFTA Transitional Adjustment Assistance) BENEFITS

1. Award Letters—Preferred

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

2. Form 1099-G – Alternative to Award Letters

3. Check Stubs – Alternative to Form 1099-G

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

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

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

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

3.2.2 ACCEPTABLE DEDUCTION VERIFICATION DOCUMENTATION

For tax deductions appearing under section 3.1.3 of this chapter, the most recent tax return may be used for all deductions with the exception of Moving Expenses.

The Moving Expense deduction is deductible if the employee incurs the job-related expense for which the employer will not provide reimbursement and it meets the federal tax law criteria to be claimed on the individual’s tax return. The expense must be incurred in the same year for which eligibility is being determined. For example, an application is received February 2017 indicating a moving expense will be claimed as a tax deduction on next year’s tax return. If the expense was incurred on January 1, 2017, up to the date eligibility is determined, the deduction will be allowed. If the expense incurred prior to January 1, 2017, it will not be allowed. If an applicant indicates on the February 2017 application an expected moving expense later in the year, the deduction is not allowed. Once the deduction is incurred, the individual may submit the applicable IRS document to verify the deduction and may request a reassessment.

For an individual who does not have a recent tax return or for those who expect their tax deduction on next year’s tax return to be higher or lower than the most recent tax return, they may complete the necessary IRS federal income tax schedule/form/worksheet specific to the deduction * with any necessary modification.

Note: All deductions listed here are for reference only in determining CHIP eligibility and ultimately limited based on all applicable IRS Guidelines.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Educator expenses</td>
<td>23</td>
<td>16</td>
<td>N/A</td>
<td>$250 per educator</td>
</tr>
<tr>
<td>Certain business expenses of reservists, performing artists, and fee-basis</td>
<td>24</td>
<td></td>
<td>Form 2106, line 10 or 2106EZ, line 6 --- *Just the portion which will carry over to the Form 1040</td>
<td>None. Maximum limit is determined by IRS calculation</td>
</tr>
<tr>
<td>government officials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health savings account deduction</td>
<td>25</td>
<td></td>
<td>Form 8889, line 13</td>
<td>None</td>
</tr>
<tr>
<td>Moving expenses (job related only)</td>
<td>26</td>
<td></td>
<td>Form 3903, line 5</td>
<td>None</td>
</tr>
<tr>
<td>Deductible part of self-employment tax</td>
<td>27</td>
<td></td>
<td>Schedule SE, line 6</td>
<td>None</td>
</tr>
<tr>
<td>Self-employed SEP, SIMPLE and qualified plans</td>
<td>28</td>
<td></td>
<td>Publication 560, Worksheet for Self Employed, Step 21--*Just the amount which will carry over to the Form 1040</td>
<td>None. Maximum limit is determined by IRS calculation</td>
</tr>
<tr>
<td>Self-employed health insurance deduction</td>
<td>29</td>
<td></td>
<td>Form 1040 Instructions, Line 29, Self-employed Health Insurance Deduction Worksheet, line 3 or Publication 535, Self Employed Health Insurance Worksheet-6A, line 14</td>
<td>None</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Penalty on early withdrawal of savings</td>
<td>30</td>
<td></td>
<td>Form 1099-INT, Box 2 or Form 1099-OID, Box 3 or end of year statement from financial institution</td>
<td>None</td>
</tr>
<tr>
<td>Alimony paid</td>
<td>31a</td>
<td></td>
<td>A fully executed copy of Decree of Divorce or Separation Maintenance or a written instrument incident to that decree; A written separation agreement, or a decree of any type of court order requiring a spouse to make payments for the support or maintenance of the other spouse. This includes a temporary decree, a ‘not final’ decree and a decree of alimony pendente lite.</td>
<td>None</td>
</tr>
<tr>
<td>IRA deduction</td>
<td>32</td>
<td>17</td>
<td>Form 1040 Instruction Booklet, Line 32, IRA Deduction Worksheet, lines 12a and 12b (or 1040A Booklet, Line 17, IRA Deduction)</td>
<td>$5,500 if under age 50 at end of tax year; $6,500 if age 50 or older but under 70 1/2 at end of tax year, per tax filer</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Worksheet, lines 10a and 10b)</td>
<td></td>
</tr>
<tr>
<td>Student loan interest deduction</td>
<td>33</td>
<td>18</td>
<td>Form 1040 Instruction Booklet, Line 33, (or 1040A, Line 18) Student Loan Interest Deduction Worksheet, line 9 or if the individual files Form 2555, 2555EZ or 4563 or excludes income from Puerto Rico, use Publication 970, Worksheet 4-1, line 16</td>
<td>$2,500 per annual tax filing</td>
</tr>
<tr>
<td>Tuition and fees</td>
<td>34</td>
<td>19</td>
<td>Form 8917, line 6 This will be either $2,000 or $4,000</td>
<td>$4,000 per annual tax filing</td>
</tr>
<tr>
<td>Domestic production activities deduction</td>
<td>35</td>
<td></td>
<td>Form 8903, line 25</td>
<td>None</td>
</tr>
</tbody>
</table>

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

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

EXAMPLE 1:

A federal income tax return with one Schedule C for the past calendar year is provided. Schedule C, line 31 shows John Smith Painting had a net profit of $19,000. Form 1040 Line 12 shows a business loss of $(1,000). The two lines do not match. This indicates all income from sole proprietorships is not all accounted for. The contractor reaches out to the family to obtain all missing Schedule C’s to complete the tax return. The missing Schedule C is received. It shows self-employment sole proprietor income for John Smith Computer Services with a net loss of $(20,000). Now Lines 31 from both Schedule C’s match with Form1040, Line 12. John’s income is his net profit from John Smith’s Painting, $19,000 + the net loss from John Smith’s Computer Services of $(20,000) = an overall net loss of $(1,000) to be used in the eligibility determination.

SELF EMPLOYMENT PARTNERSHIP ’S’ CORPORATION

EXAMPLE 2:

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

OTHER NET LOSS

EXAMPLE 3:

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

**NOTE:** The business type (Self-employment) and business name should be entered into CHIP Application Processing System Income screen.

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

**TAX DEDUCTIONS**

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

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

Pay attention to the limitations allowed for tax deductions. Refer to the Tax Deduction Verification chart on the preceding pages. Be sure when entering the amount in the CHIP Application Processing System that it is entered only for the applicable person. The CHIP Application Processing System will not prevent you from entering the tax deduction for more than one person. Caution should be exercised to ensure the correct amount is entered not to exceed the limitation, if applicable.

**EXAMPLE 4:**

A family completes an application indicating the expected tax deductions on next year’s tax return are:

- Educator expenses $500
- Student loan interest $3,000
- Tuition and fees $6,250
- IRA deduction $12,000
- SEP Simple Plan $10,000
The family is asked to provide the most recently filed tax return as verification of the tax deductions. The family does promptly provide last year’s Form 1040 which shows the following:

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

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

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

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

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

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

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

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

**IRA Deduction** $5,500 – per tax filer with age limits
The application indicates the tax filer expects to claim a $12,000 deduction because the one tax filer contributes $1,000 monthly to an IRA. The other tax filer does not. Because the last year’s federal income tax return shows $5,500, the deduction should be entered under the tax filer’s name for the amount appearing on the tax return. Should the tax filer contact the contractor and state that the IRA deduction on last year’s return represents a smaller contributed monthly amount or does not represent 12 months of contributions, the tax filer should be asked to submit the applicable IRS document listed in the Tax Deductions Verification table below.

SEP (Simplified Employee Pension) Simple Plan $12,500 – per tax filing. The application indicates the tax filer expects to claim a $10,000 deduction because the one tax filer contributes $833 monthly to his retirement plan through his business. Because the last year’s federal income tax return shows $8,200, the deduction should be entered under the tax filer’s name for the amount appearing on the tax return. Should the tax filer contact the contractor and state that the SEP deduction on last year’s return represents a smaller contributed monthly amount or does not represent 12 months of contributions, the tax filer should be asked to submit the applicable IRS document listed in the Tax Deductions Verification table below.

**NOTE:** If both tax filers are self-employed and both contribute to their own SEP, the limit that can be taken is for the tax filing itself, not per tax filer.
CHAPTER 4: DETERMINING FINANCIAL ELIGIBILITY

4.1 GENERAL REQUIREMENTS

Financial eligibility is prospectively determined on the basis of the tax household’s reasonably expected income, including a net loss, to be received during the 12-month enrollment period based upon current documentation and the tax deductions the tax filer expects to take on next year’s federal individual income tax return.

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

A contractor shall not remove income without verification of the change. For instance, if Mrs. X reports that her husband lost his job, she should be asked if there is replacement income, such as unemployment or starting a new job. The parent should then be asked to provide the documentation to support this, such as a copy of the Notice of Financial Determination provided by the Department of Labor and Industry or the letter of employment for the new job. If no documentation is received, the income must not be updated.

This also applies to removing income that appears in CHIP Application Processing System but is not listed on the application/renewal form. The contractor shall reach out to the applicant to verify if this “missing” income is still being received, if there is replacement income, and obtain the appropriate documentation.

If an applicant/enrollee reports that a spouse/parent is now deceased and there is no indication of a survivor/death benefit being received by the surviving spouse or child(ren), the contractor shall reach out to the applicant to verify if any survivor/death benefit is being received and obtain the appropriate documentation.

Annual income is calculated based on:

- 48 pays, if paid weekly;
- 24* pays, if paid biweekly or bimonthly;
- 12 pays, if paid monthly.

*22 pays for employees of school districts who only receive earned income during the 10-month school year (September to June). If the employee is a teacher who has elected to receive the 10-month salary during the full calendar year, then 24 biweekly pays would apply.
When annual income is being calculated, consideration is given to fluctuations in the period of time or the amount of income that is expected to be received during the 12-month enrollment period. The following income categories should be particularly noted:

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

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

4.2 INCOME CALCULATION ILLUSTRATIONS

Note: All illustrations are based on the January 25, 2016, Federal Income Guidelines.

PAYSTUB REVIEW AND AVERAGING

The illustrations provided underscore various scenarios that may occur when reviewing paystubs and provide the contractor with insight on what to look for to determine if and when a YTD average should be used. The contractor is expected to use the method that is best able to determine the reasonably representative income of a person over the upcoming 12 month enrollment period, based on valid supporting documentation regardless of what category of CHIP will result from the use of this method.

How to recognize fluctuating income and when to use a YTD average:

One Paystub Received

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

Comparison
YTD Average: The most recent paystub dated 6/3/11 (his 11th pay of the year) shows the total YTD gross income is $11,862.52. $11,862.52 / 13 pays received = $1,078.41 average biweekly pay.
Individual Paystub: The individual paystub he submitted shows his gross biweekly pay is $1,165.28.

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

EXAMPLE 1B:
Scenario
A parent completes the app/renewal form stating that his gross pay is $1,600 bimonthly and that it does not fluctuate. He provides his current paystub for Pay Date 8/15/16 showing the gross pay amount of $1,600 and the YTD gross earnings are $24,000. There are no other earning types appearing on the paystub.

Comparison
YTD Average: The most recent paystub dated 8/15/16 (his 15th pay of the year) the total YTD gross income is $24,000. $24,000 / 15 pays received = $1,600 average biweekly pay. Individual Paystub - The individual paystub he submitted shows his gross biweekly pay is $1,600. $1,600 x 15 pays = $24,000.

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

EXAMPLE 1C:
Scenario
A father reports he receives a biweekly gross pay of $1,600 and that his income does not fluctuate.

He submits 1 biweekly paystub containing earning types of Regular Pay, OT Pay, and Bonus. Paystub for Pay Date 6/11/16 is $1,730, YTD gross $22,814. The earnings for the 6/11/16 pay are comprised of $1,600 Regular Pay (80 Regular Hours x $20 hourly rate) and a $130 Bonus. The YTD gross earnings from OT and Bonuses are not totaled separately. It is all combined into one YTD Gross Pay.

Comparison
YTD Average: The paystub dated 6/11/16 (his 12th pay of the year) the total YTD gross income is $22,814. $22,814 / 12 pays received = $1,901.17 average biweekly pay.
Individual Paystub: The individual paystub he submitted shows his gross biweekly pay is $1,730.

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

EXAMPLE 1D:
Scenario
A mother submits 1 paystub for pay period ending 5/31/16, Pay Date 5/31/16 showing her rate of $2,253.34 and a current gross earnings this period of $1,525.34 and a YTD gross of $10,161.70. Her paystub does not provide a pay period begin date to determine if this is a monthly pay as she indicated on the renewal form nor is the gross amount of the pay the same as she indicated.

Comparison
The CHIP Application Processing System Income History screen shows no prior employer by this name for the 2015 renewal. There is no correlating flat voluntary deduction or flat tax from her earnings to determine how many pays she has received as of the Pay Date 5/31/16.

Conclusion
The contractor could contact mom and request that she submit the 6/30/16 paystub as soon as she receives it. Alternatively, because the YTD amount shows a different monthly
average than the 5/31/16 pay amount, the contractor may use the information mom provided on the renewal form of a $2,253.34 gross pay rate as a monthly pay rate.

1. YTD Gross Average vs. Averaging Individual Gross Pay Amounts

Multiple Paystubs Received

EXAMPLE 2A:

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

Comparison
YTD Average: The gross annual income based on averaging the gross YTD income of $6,235 / 23 pays received = $271.09 average gross weekly.
Multiple Paystub Average: The weekly gross pay amounts of $260 + 240 + 300 + 280 = $1,080. $1,080 ÷ 4 pays = $270 average weekly gross pay.

Conclusion
Because the paystubs confirm that the income does fluctuate—regardless of what was stated on the application—averaging the YTD earnings would best represent the income reasonably expected to be received over the 12 month enrollment period. In this example, the YTD average amount of $271.09 would be used in the eligibility determination.

EXAMPLE 2B:

Scenario
A parent completes the application attesting that he works 80 hours per biweekly pay and that his income does not fluctuate.
The parent submits 4 biweekly paystubs containing earning types of Hourly Regular Rate, Overtime, Holiday Pay and Vacation Hourly Rate for the following Pay Dates: 5/6/13, $1,192.62, YTD gross $9,550.41; 5/20/13, $1,146.83, YTD gross $10,697.24; 6/3/13, $1,165.28, YTD gross $11,862.52 and 6/17/13, $892.71, YTD gross $12,755.23. Of the 4 paystubs, only the most recent pay date has no overtime or vacation pay. The YTD Overtime on the most recent pay is $2,898.12 and Vacation is $160. The number of hours worked on each biweekly pay varies from 107 hours to 87 hours.

Comparison
YTD Average: On the most recent paystub (Pay Date 6/17/13 which is his 12\textsuperscript{th} pay of the year), the total YTD gross income is $12,755.23. $12,755.23 / 12 pays received = $1,062.94 average gross biweekly pay.

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

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

Scenario Legend

= Child
= Parent

= Married, Filing Jointly
= Not Married
= Married, Not Filing Jointly
= Not Living Together

NOTE: All illustrations are based on the January 25, 2016, Federal Income Guidelines.
The following scenarios are formatted with background information, followed by building the household size for each applicant child, then determining whose income gets counted and the result.

**EXAMPLE 1 – MARY LEWIS & FAMILY**

**BACKGROUND**
Mary Lewis is a working grandmother who claims her daughter Samantha, age 20 and a full-time student, and granddaughter Joy (Samantha’s daughter), age 2, as tax dependents.

Mary earns $2,250 bimonthly for a projected annual taxable income of $54,000
Samantha earns $75 weekly for a projected annual taxable income of $3,900
Joy receives $600 monthly child support for an annual projected amount of $7200
There are no other sources of income

**CONSTRUCT HOUSEHOLD SIZE FOR EACH APPLYING CHILD**

**JOY’S HOUSEHOLD**
Joy is claimed as a tax dependent, so we consider whether any of the exceptions under Box 1 of the MAGI Household Composition Chart (HCC) apply:

-Is this child the tax dependent of someone other than a spouse or a biological, adopted, or step parent? Yes. Joy is being claimed by her grandmother.
- Is this child (age <19) who lives with both parents, but both parents do not expect to file taxes jointly, and only 1 parent expects to claim child as his/her tax dependent? No.
- Is this child (age <19) expected to be claimed as a tax dependent to a non-custodial parent? No.

- Is this child the tax dependent of someone other than a spouse or a biological, adopted, or step parent? Yes. Joy is being claimed by her grandmother.
- Is this child (age <19) who lives with both parents, but both parents do not expect to file taxes jointly, and only 1 parent expects to claim child as his/her tax dependent? No.
- Is this child (age <19) expected to be claimed as a tax dependent to a non-custodial parent? No.

Because Joy meets 1 of the 3 exceptions, look to the rules for non-filers in Box 2 of the MAGI HCC to determine Joy’s household. The non-filer rules include the child plus the child’s:
- Biological, adoptive or step parent(s). Yes - mother, Samantha.
- Biological, adoptive or step sibling(s). None.
- Spouse. None

JOY’S HOUSEHOLD SIZE = Samantha (child’s mother) + Joy (applying child)

DETERMINE HOUSEHOLD INCOME FOR EACH APPLYING CHILD

JOY’S INCOME DETERMINATION
Joy’s Household = Samantha (child’s mother) + Joy (applying child)

Sources of income:
Samantha earns $75 a week
Joy receives $600 monthly child support

Samantha’s income = $75 weekly × 48 weeks = $3,600
Joy’s income = $600 monthly × 12 months = $7,200
Joy’s child support is not counted under MAGI methodology

Household income for eligibility is $3,600

RESULT
The minimum income limit in CHIP for a child age 1 through 5 years is $24,697.01 (>157%FPL).

Joy appears to be MA eligible and will be referred to the CAO.

EXAMPLE 2 – MARY LEWIS & FAMILY, CHILD CLAIMED BY NONCUSTODIAL PARENT

BACKGROUND
This example builds from Example 1 except the granddaughter, Joy, is claimed as a tax dependent by her father, Ben, who lives out of the household and is not married to Joy’s mother.

Mary earns $2,250 bimonthly for a projected annual taxable income of 54,000
Samantha earns $75 weekly for a projected annual taxable income of $3,900
Joy receives $600 monthly child support for a projected annual amount of $7200
There are no other sources of income
CONSTRUCT A CHIP HOUSEHOLD FOR EACH APPLYING CHILD

JOY’S HOUSEHOLD
Joy is claimed as a tax dependent by her father who is out of the household, so we consider whether any of the exceptions in Box 1 of the MAGI HCC apply:

- Is this child the tax dependent of someone other than a spouse or a biological, adopted, or step parent? No.
- Is this child (age <19) who lives with both parents, but both parents do not expect to file taxes jointly, and only 1 parent expects to claim the child as his/her tax dependent? No.
- Is this child (age <19) who expects to be claimed as a tax dependent to a non-custodial parent? Yes.

Because Joy falls into 1 of the 3 exceptions, look to the rules for non-filers in Box 2 of the MAGI HCC to determine Joy’s household. Non-filer rules include the child plus the child’s:
- Biological, adoptive or step parent(s). Yes – mother, Samantha
- Biological, adoptive or step sibling(s). None
- Spouse. None.

JOY’S HOUSEHOLD SIZE = Samantha (child’s mother) + Joy (applying child)

DETERMINE HOUSEHOLD INCOME FOR EACH APPLYING CHILD
Because non-filer rules are still applied in this case, the household composition and income remains the same.

RESULT
Because non-filer rules are still applied in this case, the outcome of Joy’s eligibility determination is the same as in Example 1.

The minimum income limit in CHIP for a child age 1 through 5 years is $24,697.01 (>157%FPL).
EXAMPLE 3 – MARCIA’S FAMILY

BACKGROUND
Marcia is a 50 year old woman, applying for coverage for her 17 year old daughter Julie, Julie’s 18 year old husband Frank, and their 1 year old Abigail. Marcia claims Julie as a tax dependent, and Frank claims Abigail as a tax dependent. They all live together.

Marcia earns $2,500 monthly for a projected annual taxable income of $30,000
Marcia gets about $20 a year in interest
Frank earns $1,300 biweekly for a projected annual taxable income of $33,800
Julie and Abigail have no income
There are no other sources of income.

CONSTRUCT A HOUSEHOLD FOR EACH APPLYING CHILD

JULIE’S HOUSEHOLD
Julie is claimed as a tax dependent by her mother (Marcia), so we consider whether any of the exceptions in Box 1 of the MAGI HCC apply:
- Is this child the tax dependent of someone other than a spouse or a biological, adopted, or step parent? No
- Is this child living with both parents, but the parents do not expect to file a joint tax return, and only 1 parent expects to claim the child as his/her tax dependent? No
- Is this child expected to be claimed by a non-custodial parent? No

Because none of the exceptions apply, Julie’s household is the same as her tax filer’s household which is the tax filer plus the tax filer’s:
- Spouse. None.
- Tax dependents. Yes – daughter, Julie.
- Tax dependent’s spouse living in the HH. Yes – daughter Julie’s husband, Frank.

JULIE’S HOUSEHOLD SIZE = Marcia (tax filer) + Julie (tax dependent) + Frank (spouse of tax dependent). Because tax filer rules from Box 1 of MAGI HCC are followed, Julie and Frank’s child, Abigail, is not included in Julie’s household because Abigail is not a tax dependent of Marcia. However, because Julie is married and living with her spouse, her household size also includes her spouse, Frank.

FRANK’S HOUSEHOLD. Frank is expected to file a tax return and he is not claimed as a tax dependent of someone else. Using the MAGI HCC chart, because Frank is a tax filer Box 1 should be reviewed first to consider whether any of the exceptions apply:
- Is this child the tax dependent of someone other than a spouse or a biological, adopted, or step parent? No.
- Is this child (age <19) who lives with both parents, but both parents do not expect to file taxes jointly, and only 1 parent expects to claim the child as his/her tax dependent? No.
- Is this child (age <19) who expects to be claimed as a tax dependent to a non-custodial parent? No.

Because Frank does not meet any of the 3 exceptions, Frank’s household will be determined by following tax filer rules in Box 1 of the MAGI HCC, which includes the tax filer plus the tax filer’s:
- Spouse. Yes - his spouse, Julie.
- Tax dependents. Yes - his daughter, Abigail.
- Tax dependent's spouse living in the HH. None.

FRANK’S HOUSEHOLD SIZE = Frank (tax filer) + Julie (tax filer's spouse) + Abigail (tax dependent). Frank does not file jointly with his wife, Julie, nor claim her as a tax dependent, but because they are married and living in the same household Frank’s household size also includes his spouse, Julie.

ABIGAIL’S HOUSEHOLD
Abigail is claimed as a tax dependent of her father, Frank, so we consider whether any of the exceptions in Box 1 of the MAGI HCC apply:
- Is this child a tax dependent of someone other than a spouse or a biological, adopted, or step parent? No
- Is this child living with both parents, but the parents do not expect to file a joint tax return, and only 1 parent expects to claim the child as his/her tax dependent? Yes
- Is this child expected to be claimed by a non-custodial parent? No

Because Abigail meets 1 of the 3 exceptions, we look to the rules for non-filers in Box 2 of the MAGI HCC to determine Abigail’s household. Non-filer rules include the child plus the child’s:
- Biological, adoptive or step parent(s). Yes – mother, Julie and father, Frank.
- Biological, adoptive or step sibling(s). None.
- Spouse. None.

ABIGAIL’S HOUSEHOLD SIZE = Abigail (applying child) + Julie (mom) + Frank (dad)

DETERMINE HOUSEHOLD INCOME FOR EACH APPLYING CHILD
JULIE’S HOUSEHOLD = Marcia (tax filer mom) + Julie (applying child) +
Frank (child’s spouse)

Sources of income:
Marcia earns $2,500 gross monthly x 12 months = $30,000
Marcia gets about $20 a year in interest
Frank earns $1325 biweekly x 24 pays = $31,800
Julie has no income
HH income for eligibility is $61,820 ($31,800 + 31,200 +$20)

RESULT
CHIP Income Guideline = $58,061.01 – $63,303 (<288% - <=314%FPL).

FRANK AND ABIGAIL’S HOUSEHOLD = Frank (tax filer/dad) + Julie (tax filer’s spouse/mom) + Abigail (applying child)

Sources of income:
Frank earns $1,300 biweekly x 24 pays = $31,200
Julie and Abigail have no income
HH income for eligibility is $31,800
Note: Although Julie is a tax dependent of her mother (Marcia), Marcia is not included in Frank and Abigail’s household, so if Julie had any income it would count regardless of whether or not she had a tax filing requirement.

RESULT
CHIP Income Guidelines = $31,652.01 - $41,933 (>157% - <=215%) and $26,318.01 – $41,933 (>157% - <=215%).

ABIGAIL: With a child age 1 through 5 years, the income appears to be Free CHIP at first glance. Because this is an intersection of MA and CHIP income

Julie is eligible for Low Cost 3 CHIP.

Frank appears to be eligible for Free CHIP.
Abigail appears to be MA eligible and will be referred to the CAO.
EXAMPLE 4 – ALICE AND JASON

BACKGROUND
Alice is a 66 year old grandmother applying for coverage for her 12 year old grandson, Jason, who lives with her. Alice does not plan to claim Jason as a tax dependent. Jason receives Social Security Survivors benefits. Jason does not file taxes.

Alice currently earns $2,250 biweekly for a projected annual taxable income of $54,000. Jason receives $1,400 monthly Social Security Survivors benefit for an annual total of $16,800. There are no other sources of income.

CONSTRUCT A HOUSEHOLD FOR EACH APPLYING CHILD

JASON’S HOUSEHOLD
Jason is neither a tax payer, nor is he claimed as a tax dependent, so his household will be based on Box 2 of the MAGI HCC, non-filer rules. Non-filer rules include the child plus the child’s:
- Biological, adoptive or step parent(s). None.
- Biological, adoptive or step sibling(s). None.
- Spouse. None.

JASON’S HOUSEHOLD SIZE = Jason (applying child)

Jason is a household size of 1.
DETERMINE HOUSEHOLD INCOME FOR EACH HOUSEHOLD

JASON'S HOUSEHOLD
Sources of income:
Jason receives $1,400 monthly x 12 months = $16,800.

To determine if the child or tax dependent's income is included in this determination –
- Is any household member (1) the child or expected tax dependent of another member of the household? No
  If no, the income of all household members is counted in the determination.
  IMPORTANT! Although Jason is a child, his income does count because there is no parent (biological, adoptive or step) included in his household.

HH income for eligibility is $16,800

RESULT
The minimum CHIP income limit for a child age 6 through 18 years is
$15,522.01 - $24,274 (>133% - <=208%)

NOTE: If the grandmother, Alice, would claim Jason as a tax dependent, his household size and income determination would remain the same because he would meet exception 1 in Box 1 of the MAGI HCC and would default to Box 2 for non-filer rules.

Jason appears to be eligible for Free CHIP.
EXAMPLE 5: BETH AND STANLEY’S FAMILY

BACKGROUND
Beth is applying for coverage for her 15 year old son Isaac, her partner Stanley’s, 14 year old son Trent, and Beth and Stanley’s 2 year old son, Jacob. Beth claims Isaac as a tax dependent. Stanley claims Trent and Jacob as tax dependents.

CONSTRUCT A HOUSEHOLD FOR EACH APPLYING CHILD

ISSAC is claimed as a tax dependent of his mother, Beth, so we consider whether any of the exceptions in Box 1 of the MAGI HCC apply:
- Is this child a tax dependent of someone other than a spouse or a biological, adopted, or step parent? No
- Is this child living with both parents, but the parents do not expect to file a joint tax return, and only 1 parent expects to claim the child as his/her tax dependent? No
- Is this child expected to be claimed by a non-custodial parent? No
Because none of the exceptions apply, Isaac’s household is the same as his tax filer’s household which is the same as his tax filer’s:
- Spouse, None.
- Tax dependents. One—Isaac.
- Tax dependent’s spouse living in the HH. None.

Issac is a household size of 2
TRENT is claimed as a tax dependent of his father, Stanley, so we consider whether any of the exceptions in Box 1 of the MAGI HCC apply:
- Is this child a tax dependent of someone other than a spouse or a biological, adopted, or step parent? No
- Is this child living with both parents, but the parents do not expect to file a joint tax return, and only 1 parent expects to claim the child as his/her tax dependent? No
- Is this child expected to be claimed by a non-custodial parent? No
Because none of the exceptions apply, Trent’s household is the same as his tax filer’s household which is the tax filer plus the tax filer’s:
- Spouse. None.
- Tax dependents. Two – Jacob and Trent.
- Tax dependent’s spouse living in the HH. None.

JACOB is claimed as a tax dependent by his father, Stanley, so we consider whether any of the exceptions in Box 1 of the MAGI HCC apply:
- Is this child a tax dependent of someone other than a spouse or a biological, adopted, or step parent? No
- Is this child living with both parents, but the parents do not expect to file a joint tax return, and only 1 parent expects to claim the child as his/her tax dependent? Yes
- Is this child expected to be claimed by a non-custodial parent? No
Because Jacob meets 1 of the 3 exceptions, look to the non-filer rules in Box 2 of the MAGI HCC. Non-filer rules includes the applying child plus the child’s:
- Biological, adoptive or step parent(s). Yes – mother, Beth and father, Stanley.
- Biological, adoptive or step sibling(s). Yes – biological siblings, Isaac and Trent.

Trent is a household size of 3
- Spouse. None.

**DETERMINE HOUSEHOLD INCOME FOR EACH HOUSEHOLD**

**ISAAC** = Beth (tax filer) + Isaac (applying child)
Sources of income:
Beth currently earns $1,200 biweekly x 24 pays = $28,800
Beth receives $800 monthly court ordered alimony x 12 months = $9,600
Isaac receives $300 monthly child support x 12 months = $3,600
Child support is not counted under MAGI methodology.
HH income for eligibility is $38,400 ($28,800 + $9,600)

**RESULT**
CHIP Income Guidelines = $33,322.01 - $41,973 (>208% - =<262%)

**TRENT** = Stanley (tax filer) + Jacob (tax dependent sibling) + Trent (applying child)
Sources of income:
Stanley currently earns $3,500 per month x 12 pays = $42,000.
Trent receives $530 monthly S.S. Survivor’s benefit x 12 months = $6,360

To determine if the child or tax dependent’s income is included in this determination –
Is any household member (1) the child or expected tax dependent of another member of the household? Yes. Trent and Jacob are the children and tax dependents of Stanley.
If no, the income of all household members is counted in the determination.
If yes, is the individual (2) expected to file a tax return? No. Neither Trent
nor Jacob is required to file a tax return.
   If no, this individual’s income is not counted.
   If yes, this individual’s income is counted.

HH income for eligibility is $42,000

RESULT
CHIP Income Guidelines = $341,933.01 - $52,820 (>208% - <=262%)    Trent is eligible for Low Cost 1 CHIP

JACOB = Stanley (tax filer) + Beth (mom) + Isaac (tax dependent sibling) +Trent (tax dependent sibling) +Jacob (applying child)

Sources of income:
Stanley currently earns $3,500 per month x 12 pays = $42,000.
Beth currently earns $1,200 biweekly x 24 pays = $28,800
Beth receives $800 monthly court ordered alimony x 12 months = $9,600
Isaac receives $300 monthly child support x 12 months = $3,600
Trent receives $530 monthly SS Survivor’s benefit x 12 months = $6,360
Child support is not counted under MAGI methodology.

To determine if the child or tax dependent’s income is included in this determination –
   Is any household member (1) the child or expected tax dependent of another member of the household? Yes. All children are either a child or tax dependent of Beth or Stanley
   If no, the income of all household members is counted in the determination.
   If yes, is the individual (2) expected to file a tax return? No. None of the
children are required to file a tax return.
  If no, this individual’s income is not counted.
  If yes, this individual’s income is counted.

HH income for eligibility is $80,400 (42,000 + $28,800 + $9,600)

RESULT
CHIP Income Guidelines = $81,908.01 – $89,302 (>288% - <=314%)
CHIP
Jacob is eligible for Low Cost 3
CHAPTER 5: ENROLLMENT PROCEDURE

5.1 GENERAL REQUIREMENTS
The contractor must enter the application into the CHIP Application Processing System within 15 calendar days of the date stamp so that an eligibility determination can be made. If the 15th calendar day falls on a non-working day, the determination must be completed by close of business on the next working day. A notice of eligibility or ineligibility (with an appropriate explanation and reason code for denial) must be sent to the parent or guardian.

(See Eligibility Handbook, Chapter 9 - Enrollment Guidelines)

The contractor should not hold the application waiting for additional information (especially income) for those applications that will move to “Pending CEU Review”. There is a strong possibility that the CEU will be able to verify income or complete other portions of the application without waiting for paper verification from the applicant. Therefore, the contractor should enter all available information into the CHIP Application Processing System and hit the “SUBMIT” button.

5.2 COMPLETE APPLICATION – ELIGIBLE FOR FREE CHIP

Once all the information is entered into the CHIP Application Processing System, eligibility is determined. If all of the eligibility requirements have been met and the child is Free CHIP eligible, an electronic cross check with MA is performed automatically to ensure that the applicant is not enrolled in MA. The child is enrolled for the enrollment date currently being processed.

EXAMPLE:

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

5.3 COMPLETE APPLICATION - ELIGIBLE FOR LOW-COST OR FULL-COST CHIP

Once all the information is entered into CHIP Application Processing System, eligibility is determined. If all of the eligibility requirements have been met and the child is Low-Cost or Full-Cost eligible, the child is placed in pending status check for the enrollment date currently being processed.
An electronic cross check with MA is performed automatically to ensure that the applicant is not enrolled in MA. An additional check is made with a third party liability vendor to verify if there is private health insurance.

**EXAMPLE:**

Determination of Eligibility made April 15  
Effective Date of Coverage – Optimum May 1, premium request sent April 16, premium received April 30, and child is enrolled May 1, if possible  
Effective Date of Coverage – Optimum May 1, premium request sent April 16, premium received May 5, child is enrolled June 1  
Effective Date of Coverage – alternate June 1, premium request sent April 16, premium received before May 17, child is enrolled June 1.

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

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

Once all the information is entered into CHIP Application Processing System, eligibility is determined. When the income is below the CHIP income eligibility guidelines; an electronic referral to MA is forwarded to the appropriate CAO for a determination of eligibility for MA.

(See Chapter 1 - Application Submission, Section 1.7 - Automated Referrals to the CAO)
CHAPTER 6: NOTICES

6.1 GENERAL REQUIREMENTS

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

The Department has developed standardized notices that must be used by the contractor. If the contractor wishes to deviate from the standardized notice provided by the Department, it must submit a draft of its amended notice to the Department, per the standard approval office, for review and approval prior to use.

6.2 NOTICES TO APPLICANT FAMILY ELIGIBLE FOR CHIP

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

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

Note: If a PCP has not been designated by the family, the notification letter must inform the applicant of the necessity to select a PCP within 10 days or one will automatically be selected.

(For 90-day conditional enrollment pending citizenship and identity confirmation, See Central Eligibility Unit Verification Processes, Section 2.3 – Conditional Enrollment.)

6.3 NOTICE TO APPLICANT FAMILY OF ELIGIBILITY FOR LOW-COST OR FULL-COST CHIP

The applicant for a child must receive notification of enrollment in Low-Cost or Full-Cost CHIP. A copy of the dated notice must be retained by the contractor. The following information must be contained in the notice:

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

Note: If a PCP has not been designated by the family, the notification letter must inform the applicant of the necessity to select a PCP within 10 days or one will automatically be selected.

6.4 PREMIUM REQUEST NOTIFICATION

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

- The child is eligible
- Income the eligibility decision was based on
- Amount of monthly premium required
- Premium bill and due date
- 90-day premium lock out period if premiums are not paid
- The telephone number to be used if the applicant has any questions
- ERP language
6.5 NOTICE TO APPLICANT FAMILY OF POTENTIAL ELIGIBILITY FOR MA

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

- The child is potentially eligible for MA;
- The reasons why the child may be potentially eligible for MA and why the child is not eligible for CHIP (tax household size and income upon which the eligibility decision was based);
- A list of the CAO address and phone numbers within the contractor’s coverage area;
- Instructions to call the appropriate CAO if the CAO does not contact the family within 30 days.

6.6 NOTICE TO APPLICANT FAMILY OF INELIGIBILITY FOR CHIP

The applicant for a child must receive notification that the applicant child is ineligible for CHIP. A copy of the dated notice must be retained by the contractor.

The following information must be contained in the notice:

- The child is ineligible for CHIP;
- The complete list of all reasons that the child is ineligible (e.g. private insurance, citizenship/alien status issues, or Full-Cost eligibility factors not met);
- The applicant may reapply if the circumstances change;
- The telephone number to be used if the applicant has any questions;
- ERP language;
- Termination.
CHAPTER 7: CHANGES AFFECTING ELIGIBILITY DURING INTAKE OR RENEWAL

It is important to differentiate between changes made during the time that eligibility is being determined (i.e., prior to enrollment period) from changes during the enrollment period. Any change affecting the eligibility determination or process must be handled through the Eligibility Review Process (See Chapter 8). Any change occurring after eligibility has been determined is handled through reassessment (See Chapter 10 – Reassessment).

Should the Department and/or its contractors discover through employers, financial sources or other third parties information that was not provided or that differs from information on the application, eligibility may be redetermined.

7.1 CHANGES MADE/FOUND IMPACTING THE ELIGIBILITY DETERMINATION

If the change impacts the eligibility determination, the 12-month continuous enrollment period defined in the definitions and discussed throughout this manual becomes null and void. Any changes affecting intake must be handled through the Eligibility Review Process and not through reassessment.

EXAMPLE 1: Change occurs prior to start of enrollment period. Mary is determined eligible for Free CHIP effective March 1 based on her application completed January 27. On February 15, dad ends unemployment and starts a job paying $32,000 per year. Added to the income previously reported, Mary is now eligible for Low-Cost CHIP. Eligibility must be redetermined and Mary must be enrolled in the proper CHIP program because the change occurred prior to the start of the enrollment period (March 1). If there is an appeal, it must be handled through the Eligibility Review Process (See Chapter 8).

EXAMPLE 2: Misinformation was provided at application or renewal that would have resulted in a different eligibility decision had accurate or complete information been provided. Johnny is enrolled in Free CHIP effective July 1. On September 4, it is reported and verified that Johnny’s mother had a part time job since before July 1 that was not included on the original application. Eligibility is redetermined. If the child is found eligible for low-cost CHIP, the change is made back to July 1 and the family is required to make any back premium payments or be retro-terminated. (See Chapter 10 regarding premium payments or non-payment of premiums).
EXAMPLE 3: Misinformation was provided at application or renewal that would have resulted in a different eligibility decision had accurate or complete information been provided. Mary is enrolled in Free CHIP with an effective date of July 1. It is discovered on November 3 that she has had private insurance through her father’s employer since before July 1. Mary’s CHIP coverage must be retro-terminated to July 1 as CHIP is for the uninsured.

EXAMPLE 4: Change in income between renewal date and renewal due date. Renewal Due Date is April 1. Renewal application is received and processed on February 25. Based on reported income, the child is found eligible for low-cost CHIP. On March 15, the father loses his job and files for unemployment. The family appeals the CHIP eligibility decision. This should be reviewed through the Eligibility Review Process per Chapter 8.
CHAPTER 8: ELIGIBILITY REVIEW PROCESS

8.1 GENERAL REQUIREMENTS

An impartial eligibility review may be requested when a determination made at application or renewal results in:

- An applicant is denied coverage;
- An enrollee’s coverage is to be terminated;
- An enrollee’s coverage is to change from Free CHIP to Low-Cost or Full-Cost CHIP;
- An enrollee’s cost changes – goes from low cost to higher cost or decreases, but applicant disagrees with the amount (may think it should be even lower);
- An applicant with income over 314% of the FPL disagrees with the determination of availability or affordability of private insurance;
- There is a failure to make a timely determination of eligibility.

At application and renewal, the applicant must be provided with information concerning the impartial eligibility review process. If an applicant requests help in filing a request for a review, assistance should be provided promptly.

The applicant for an enrollee may submit a written request for a review within 30 days of the date of the notice for which the review is being requested.

A request for a review must be sent by the applicant directly to the appropriate contractor to resolve any disputes related to eligibility.

8.2 NOTICE OF INELIGIBILITY TO APPLICANTS AND ENROLLEES

The contractor is required to send a notice of denial to applicants or a notice of termination to enrollees in accordance with, Chapter 6 - Notices and Chapter 11 - Renewal Procedures. The notice must inform the applicant of the reason(s) for ineligibility, the right to request an impartial review of the decision of ineligibility and how to file a request for an impartial review.

8.3 FILING A REQUEST FOR AN IMPARTIAL REVIEW

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

The Department has provided a sample format that may be used by the applicant to file a request for review. See Appendix 8 - A for the sample format that may be used in filing a request for review. The use of this format is not required, but is recommended. If a different format is used, it should contain all of the information, and be at least as easy to understand, as the sample format. If the applicant requests assistance in filing a written request, the contractor, or Department should help in whatever way is determined necessary.

If an applicant files an oral request for review (e.g., by telephone, in person), they must be informed by the contractor or the Department that the request must be reduced to written form. A record of the oral request will be entered into CHIP Application Processing System comments at the time the request is made. The date of the oral communication will be considered the date of filing for the purpose of determining that the request is or is not filed in a timely fashion. However, if no written request is received, the review interview will not be held.

8.4 REQUESTS FOR AN IMPARTIAL REVIEW RECEIVED BY THE CONTRACTOR

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

- Log in the request for review and note its receipt being sure to update the contractor’s monthly ERP log sheet;
- Inform the applicant that the request for review was received;
- Determine the need for expedited review (i.e., the applicant has indicated that the child has an immediate need for medical attention);
- Inform the Department’s Review Officer that a request for review has been received, if contractor cannot resolve within 2 business days;
- Continue coverage or reinstate the enrollee, if appropriate (excludes terminations due to MA, private insurance, state employees and late renewals), until the review process has been concluded;
- Offers coverage for an applicant if a decision is made in favor of the applicant. Coverage will begin after the review process is concluded.

8.5 CONTINUATION OF COVERAGE FOR ENROLLEES IN FREE CHIP

Coverage of a child enrolled in Free CHIP should continue uninterrupted pending the outcome of the eligibility review. In the event that a contractor has terminated
an enrollee’s coverage prior to the timely receipt of a request for a review, coverage should be reinstated to the date of termination.

### 8.6 CONTINUATION OF COVERAGE FOR ENROLLEES IN LOW-COST OR FULL-COST CHIP COVERAGE

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

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

If the applicant elects to continue paying the premium, coverage will continue.

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

### 8.7 MANAGEMENT REVIEW BY THE CONTRACTOR

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

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

- Prepare a written record of the management review and,

- Forward the results of the management review along with the complete eligibility file to the Department’s Review Officer,

- Inform the applicant in writing of:

  - The right to review records maintained by the contractor regarding the eligibility determination;
  - The right to receive a copy of the relevant portions of the CHIP Procedures Manual and State or Federal law upon which the decision of ineligibility was based;
• The right to have a representative during the interview;
• The opportunity for continuation of coverage for an enrolled child as long as premium payments are made (when appropriate); and,
• Update the monthly ERP log sheet.

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

• Inform the applicant and review officer in writing that an error occurred and the child is eligible;
• Enrolls the applicant child retroactively to the date that the child should have been enrolled;
• Reinstates an enrollee who has been terminated retroactively to the date the child was terminated; and,
• Update the monthly ERP log sheet.

8.8 REQUEST FOR REVIEW WITHDRAWN

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

8.9 CONDUCTING THE ELIGIBILITY REVIEW

If the management review results in a determination that the decision was appropriate, the Department’s Review Officer will conduct an interview with the applicant and the contractor’s representative.

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

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

The review officer will:

• Schedule a review interview (to be held by telephone unless a face-to-face review is requested due to special circumstances);
• Inform the applicant in writing of:
  • The date, time and location of the interview;
  • The right to have appropriate interpretative service available during the interview if needed; and,

• Inform the contractor of the date, time, and location of the interview.

The actual interview will be recorded for reference purposes. Specifics on income documentation used, calculations, deductions applied and family size should be given by the contractor during the interview. Additional documents that may have an impact on the outcome may be submitted by the applicant or their representative. The review officer may ask either or both parties for additional documentation, as needed.

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

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

The contractor will implement the decision of the review officer upon receipt of the letter.

8.10 RECONSIDERATION

An applicant or the representative may request reconsideration of the decision of the review officer if they are dissatisfied with the outcome of the review. The letter from the review officer containing the decision will include information describing how an applicant may request reconsideration.

An applicant or the representative must submit a written request for reconsideration with the Secretary of Human Services, postmarked within 15 calendar days from the date of the review officer’s decision. The request for reconsideration must describe the reason(s) the request is being made. Requests for reconsideration will stay the action proposed in the decision of the review officer (e.g., that coverage should be terminated).
The Secretary may affirm, amend, or reverse the decision of the review officer. The Secretary of Human Services decision will be provided in writing. A copy of the reconsideration decision will be sent to: the applicant, the representative (if applicable), and to the contractor.

8.11 APPEALS TO COMMONWEALTH COURT

An applicant or the representative may appeal the decision of the Department of Human Services to Commonwealth Court within 30 days from the date that the Secretary of Human Services issues the reconsideration decision.
APPENDIX 8-A REQUEST FOR A REVIEW OF AN ELIGIBILITY DECISION (SAMPLE FORMAT)

I am requesting a complete review of the eligibility decision concerning the child(ren) listed below:

Name and birth date of child or children:
Address:
City, State, Zip:
Phone number where I can be reached during the day:

I disagree with the decision because:

______________________________________________
Signature & Date

Send this form to:

Contractor Name
Contractor Address
Contractor Phone Number
Contractor Fax Number
CHAPTER 9: CHANGES DURING THE ENROLLMENT PERIOD

9.1 GENERAL REQUIREMENTS

The applicant of an enrolled child is required to report changes in the family’s circumstances during a child’s 12-month enrollment period. When a change is reported, the information will be recorded in the child’s record. Comments relevant to the reported change are to be added in CHIP Application Processing System. If a change is reported that could affect eligibility, it will be deemed as a request for a reassessment by the parent of the enrollee.

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

Should the Office of CHIP and/or its contractors discover, through employers, financial sources, or other third parties, information that was not provided or that differs from information on the application that would have impacted eligibility, eligibility must be redetermined as defined in Chapter 7 above.

Except for the situations listed in Section 9.2 of this Chapter - Changes that Require Termination, no change in eligibility status during the enrollment period is required.

9.2 CHANGES THAT REQUIRE TERMINATION

A child is no longer eligible for CHIP when any of the circumstances listed below is reported or occurs:

- The child moves out of state;
- The child becomes 19 years of age – this child will be screened for potential MA eligibility. See Eligibility Handbook Chapter 1 - Age, Section 1.3 – Aging Out of CHIP (regarding Referrals to MA) and, Chapter 1 - Application Submission, Section 1.7 - Automated Referrals to the CAO;
- Private health insurance is obtained or the child becomes eligible for or is enrolled in MA. See Eligibility Handbook Chapter 5 – Other Sources of Health Insurance Coverage and Chapter 12 - Termination Procedures for an Ineligible Child, Section 12.3 - Private Insurance, Retroactive Termination;
- The child becomes an inmate of a public institution or a patient in a public institution for mental diseases;
• Notification is received that the child is deceased;
• A voluntary request for termination is received;
• Information was omitted or misinformation was provided at the time of the application or renewal that would have resulted in a different eligibility determination had the correct information been provided;
• Special Needs child is referred to MA, but the family or physician does not provide required information for an eligibility determination. See Eligibility Handbook Chapter 5 – Other Sources of Health Insurance and Section 9.7 of this Chapter - CHIP Enrollees who Appear to be Eligible for MA (PH-95) due to a Special Need;
• The child is eligible for coverage through a state health benefit plan based on a parent’s or a court-appointed legal guardian’s or legal custodian's employment with a state/ public agency. See Eligibility Handbook Chapter 5 – Other Sources of Health Insurance, Section 5.2.1 – State Health Benefits for Government Employees;
• Nonpayment of the required monthly premium payment for Low-Cost and Full-Cost CHIP. See Chapter 12 – Termination Procedures for Ineligible Child, Section 12.2 – Nonpayment of Premium for Low-Cost or Full-Cost Program.

9.3 ENROLLING A CHILD WHEN ANOTHER CHILD IS ALREADY ENROLLED

If a child is enrolled in CHIP, an applicant may request that another child in the household be added for coverage.

An abbreviated application developed by the contractor may be used to acquire information regarding the child to be added for coverage. At a minimum, the contractor must obtain the child’s:
• Full name;
• Date of birth;
• Gender;
• Citizenship, and
• Social security number (if the child is older than 90 days)
• Existing health insurance and date of termination.

The child being added must be screened for and referred to MA if potentially eligible for MA. See Eligibility Handbook Chapter 5 – Other Sources of Health Insurance, Section 5.1 – General Requirements and in this handbook Chapter 1 - Application Submission, Section 1.7, Automated Referrals to the CAO.
Age, residency, and citizenship requirements are applicable.

The child being added must have his/her renewal due date aligned with the existing child. Under the added child system logic, the sibling should automatically be aligned with the existing child unless the child is “Managed” to enrolled. In each case, the contractor must double-check to ensure RDDs match to the existing child to ensure that all children in the household are able to renew at the same time.

**EXAMPLE 1:** An applicant calls on January 15 to report the recent adoption of a child. The adoption was finalized on January 3. The insurer gathers the information required above and adds the child to the current application. When eligibility is run, it is determined that by adding the child, the tax household is now eligible for Free CHIP. The insurance contractor should reassess the other child(ren). The adopted child can be enrolled with an effective date of January 1 based on newborn rules (reported within 30 days of birth/adoption) if the child cannot be covered under the tax filer’s insurance for the first 30 days. Otherwise the child along with the other children will be enrolled in Free CHIP effective February 1.

**EXAMPLE 2:** The insurance contractor receives an e-referral from the county assistance office that would add a child to an existing household; however, the income provided with the referral is greater than the income shown in CHIP Application Processing System. The income shows as verified through the new hire database, as well as the DX. The insurance contractor will add the child to the existing UFI, but must use the updated income information and determine eligibility using the most recent information available. In the case of this example, the child will be enrolled in a higher category of CHIP than his siblings based upon the new income. The other children need not be reassessed because the income increased after their 12-month eligibility period began (example: tax filer acquired new job). If this were not the case and it was due to omitted income, then all the children would be managed to the correct category of CHIP and premiums would need to be collected for the period of time the children were enrolled in the incorrect category.

### 9.4 REPORTED CHANGE OF ADDRESS

#### 9.4.1 WITHIN CONTRACTOR’S CONTRACTED SERVICE AREA

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

9.4.2 OUTSIDE OF CONTRACTOR’S CONTRACTED SERVICE AREA

If a parent reports a change of address and the family is now located in a county for which a contractor does not have a contract to provide CHIP service, the child’s record will be promptly updated. The contractor must inform the parent that the contractor does not provide coverage at the new location. The contractor will inform the parent of the available contractors in the area and explain the process of selecting a new contractor.

The losing contractor will terminate the child using a future close date that is at least 30 days after the reported change, unless an earlier start date can be arranged with the gaining contractor.

EXAMPLE:

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

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

During this time, the family will be required to select a new contractor and PCP.

Additional action is required when a transfer involves a child enrolled in Low-Cost or Full-Cost CHIP. The following actions are required:

- If the parent has pre-paid for the following month of coverage, the enrollee will not be further invoiced by the current contractor.
- The contractor receiving the transfer must send written instructions to the parent regarding the invoice process.
- The enrollee will be required to pay the premium(s) according to the rules of the newly selected contractor.

The newly selected contractor must send out a premium notice to the parent. If the parent of the enrollee does not pay the premium, coverage may be terminated in accordance with the newly selected contractor’s rules.
The new contractor will receive the application through the “Received via Contractors” tab and must manage the child to an enrolled status promptly and action must be taken within 48 hours.

9.4.3 MOVE OUT OF STATE

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

9.5 REQUEST VOLUNTARY TRANSFER TO ANOTHER CONTRACTOR

If an applicant requests that their child be transferred to another CHIP contractor, the source contractor will initiate the transfer within 24 hours using the online process. The application should be in a complete status and not missing any information.

Contractors must work out a mutually acceptable effective date, and ensure there is no lapse in coverage or access. The source contractor will also send a notice to the family advising that a transfer will be initiated.

The gaining contractor will receive a transaction advising that a transfer has been initiated and must activate benefits without any lapse in coverage. Action must be taken within 48 hours. An informational packet must be sent to the child’s applicant by the gaining contractor.

Additional action is required when a transfer involves a child enrolled in Low-Cost or Full-Cost CHIP. The following actions are required:

- If the applicant has pre-paid for the following month of coverage, the enrollee will not be further invoiced during the last 30 days of coverage with the source contractor;
- The gaining contractor must send written instructions to the applicant regarding the invoice process. The enrollee will be required to pay the premium(s) according to the rules of the gaining contractor.

9.5.1 TRANSFER REQUEST WHILE AN INPATIENT

If a CHIP enrollee transfers to another CHIP contractor while admitted for inpatient treatment, the source contractor is responsible for the inpatient facility bill.
The gaining contractor will be responsible for all other covered services not included in the inpatient facility bill, starting with the enrollment begin date with the gaining contractor.

This procedure applies to voluntary transfers as well as a move to another service area.

9.6 PREGNANT ENROLLEES AND NEWBORN CHILDREN

Pregnancy is covered by MA where, using adjusted eligibility criteria, the pregnant woman meets financial eligibility criteria.

Pregnancy, because it initiates financial rather than non-financial eligibility criteria, is not one of the non-financial exceptions to the 12-month continuous eligibility policy.

9.6.1 NEWBORN BORN TO A CHIP ENROLLEE

A child born to a CHIP enrollee is guaranteed one year of coverage through either CHIP or MA. See Eligibility handbook Chapter 9 – Enrollment Guidelines, Section 9.4 – Pregnant Enrollees and Newborn Children.

The newborn is presumed eligible for either CHIP or MA, as appropriate, until age 1, without a separate application being filed on the newborn’s behalf and without an eligibility determination for the newborn (as stated below, CHIP will screen for MA eligibility).

Applications for newborns must be moved to the front of the queue for processing.

Upon notification of the birth, the CHIP contractor must enter the appropriate information into CHIP Application Processing System using the identification number of the newborn’s mother.

The newborn will be temporarily enrolled in CHIP with an effective date of the first day of the month following birth.
During this application process, the newborn will immediately be screened for MA eligibility using the appropriate information on income and family size contained on the mother’s application.

The appropriate information to be used must be directly related to the newborn and the newborn’s parent(s) and siblings and their associated income only.

The new grandparents and the new mother’s siblings and their incomes are not to be counted for the newborn’s eligibility determination.

In the majority of cases, the outcome will be that the newborn is potentially eligible for MA.

The contractor must e-mail the receiving CAO contact person to inform them that an automated newborn referral is being made. The CAO will have 5 days to process eligibility for the newborn.

The child will be terminated from CHIP when the monthly cross match with DHS is completed.

If not eligible for MA during the MA screening process, the newborn will be screened to determine in which category of CHIP the newborn is placed.

The newborn is guaranteed 1 year of eligibility.

The normal renewal process will remain in effect for the new mother. After 1 year, the newborn’s renewal due date will be synchronized with the new mother’s renewal due date. At the next renewal due date, the normal renewal process will be followed.

NOTE: Newborns born to a CHIP enrollee or MA recipient are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States and will not be required to further document citizenship or identity at any subsequent MA or CHIP eligibility redetermination.

EXAMPLE:

Mary is 17 years old and is enrolled in CHIP. She lives with her mother, father, and 15-year old brother. Mom and dad have an adjusted income of $44,238 per year. Mary’s renewal due date is in July.
On October 15, the CHIP contractor is notified that Mary is two months pregnant.

The CHIP contractor will reassess (See Chapter 10 Reassessment) Mary’s eligibility by adding an additional enrollee to the household. The current income with a household size of five would make Mary potentially eligible for MA (215% of poverty for a family size of five is $61,146.01).

Mary could remain in CHIP, but be moved to Free CHIP, effective the first of the month following notification of the pregnancy.

On May 13, Mary delivers a healthy baby boy. The family notifies the contractor of the birth on May 22 and requests coverage.

The contractor adds the pertinent information into CHIP Application Processing System and runs eligibility on the newborn using Mary’s UCI number.

Mary has no income so the child is determined potentially eligible for MA. The child is referred to MA for an eligibility determination.

In the meantime, the newborn is temporarily enrolled in CHIP.

If the child is eligible for MA, the child will remain in MA until May 12 of the next year when a redetermination will be conducted.

Mary will remain in CHIP until July when her renewal is due.

9.6.2 NEWBORN BORN TO A FAMILY WITH OTHER CHILDREN ENROLLED IN CHIP (MOTHER IS NOT A CHIP ENROLLEE HERSELF)

If it is determined that the mother of a CHIP child is pregnant and requests benefits for herself, the CHIP contractor will run MA eligibility screening for potential referral of the mother to MA (screening would include adding the unborn as an additional family enrollee and would be at 215% of the FPL; this results in all Free CHIP moms being eligible for MA as well as many of the Low-Cost mothers).

If potentially eligible for MA, the mother should be referred to the local CAO for an eligibility determination.

If the child is born to a mother covered under MA, the child is then guaranteed 1 year of MA eligibility.
If the mother is not eligible for MA or is not screened for MA eligibility when the child is born, the child is covered by the mother's private insurance, if any, for 31 days.

Upon notification of the birth, the CHIP contractor will run MA screening for the child.

If the child is potentially eligible for MA, the child is referred to the local CAO. (See, Chapter 1 - Application Submission, Section 1.7 - Automated Referrals to MA).

The contractor must e-mail the receiving CAO contact person to inform them that an automated newborn referral has been made.

If the child is not potentially eligible for MA, the child is added to the current CHIP children’s file. (See Chapter 9 - Changes during the Enrollment Period, Section 9.3 - Enrolling a Child When Another is Already Enrolled).

If the applicant informs the CHIP contractor within 30 days of the birth of the child and the mother has private insurance, the contractor shall enroll the child with an effective date of the first of the month following the month of birth (e.g., born on February 27, notified of birth on March 12, enrolled effective March 1). This provides for no gap in coverage.

The CHIP contractor remains the payer of last resort and should not be responsible for any claims prior to the date following the last date of the coverage under the mother's insurance (in the example, March 30).

**NOTE:** The newborn’s renewal due date is the same as the other children on the file.

If the child is eligible for one of the Low-Cost categories or Full-Cost CHIP, the parent may pay the premium to have the child retro-enrolled in CHIP to the first of the month following the month of birth. Otherwise, the child shall be enrolled in CHIP the first of the month following the receipt of payment if the payment meets the timelines provided by the contractor.

If the mother is uninsured at the time of the birth of the child and an application for coverage is received within 30 days of the date of birth, the child shall be retro-enrolled to the 1st of the month of birth. No claims may be paid for services
provided prior to the date of birth. This retroactivity does not include the birth itself, but any claims that are attributable directly to the child following the birth.

9.6.3 NEWBORNS BORN TO FAMILIES WITH NO OTHER CHILD ENROLLED IN CHIP

If a completed application is received by a CHIP contractor prior to the 30th day following birth of the child, and the mother has private insurance, eligibility should be determined for the first day of the month following the month of birth. If there is an overlap of coverage in any of the scenarios below, CHIP remains the payer of last resort.

If the child is potentially eligible for MA, the child will be referred to the local CAO. See Chapter 1 - Application Submission, Section 1.7 - Automated Referrals to the CAO.

The contractor must e-mail the receiving CAO contact person to inform them that an automated newborn referral is being made to their office.

If the child is eligible for one of the Low-Cost categories or Full-Cost CHIP, the parent may pay the premium in order to have the child retro-enrolled in CHIP to the first of the month following the month of birth. Otherwise, the child must be enrolled in CHIP the first of the month following the receipt of payment, if the payment meets the timelines provided by the contractor.

If the mother is uninsured at the time of the birth of the child and an application for coverage is received within 30 days of the date of birth, the child shall be retro-enrolled to the 1st of the month of birth. No claims may be paid for services provided prior to the date of birth. This retroactivity does not include the birth itself, but any claims that are attributable directly to the child following the birth.

If an application is received by the CHIP contractor after the 30th day following the birth of the child, the application should be processed as a normal application and will follow all the eligibility rules for a normal application. In most cases, retroactivity will not be permitted. See Eligibility Handbook, Chapter 9 – Enrollment Guidelines, Section 9.2 – Enrollment Begin Dates.

9.7 CHIP ENROLLEES WHO MAY BE ELIGIBLE FOR MEDICAL ASSISTANCE DUE TO A SPECIAL NEED (PH-95 REFERRAL)
The Department of Human Services (DHS) has a program for children under the age of 18 with special needs who meet the Social Security Administration’s (SSA) definition of a disability.

The SSA’s definition of a disability for a child is:

- A physical or mental condition or a combination of conditions, that results in “marked and severe functional limitations”. This means that the condition(s) must very seriously limit the child’s activities.
- The child’s condition(s) must be permanent or have lasted or be expected to last at least 12 months; or must be expected to result in death.


9.7.1 MA REFERRAL PROCESS

NOTE: This referral process may take 30 to 45 days. A child who is in urgent need of MA coverage should be referred directly to the Executive Director of CHIP.

CHIP contractors are required to review history from medical claims management information to identify children enrolled in CHIP who may potentially be eligible for MA based on the child’s disability. All PH-95 Referrals will be tracked in CHIP Application Processing System by the contractor.

Once a contractor identifies a potential special needs child by reviewing history from medical claims information, the contractor will take the following steps to manually refer the child to DHS:

- Confirm the child is currently enrolled in CHIP; the child will remain in CHIP during the referral process.
- Contact the family by telephone or otherwise orally (with up to three attempts), using the Talking Points (Appendix 9-A).
- Follow up by mailing the family the Referral Notice (Appendix 9-B) for possible MA eligibility; also include the Medical Release Form (Appendix 9-C) that has been populated with information specific to the child.
- Contact the key physician by telephone. Fax or mail the partially completed Physician Certification Form (Appendix 9-D) with a copy of the Letter addressed to Physician from the Department (Appendix 9-E) which explains why the CHIP contractor is collecting the information for the CHIP PH-95 Referral and the importance of the need to verify the child’s level of disability.
- Make two follow-up telephone calls to the medical provider within the next 20 days from the day the Physician Certification Form is sent. If the
completed and signed *Physician Certification Form* is received, no further follow-up is necessary.

**NOTE:** If the *Physician Certification Form* indicates the child is not disabled, the child will remain enrolled in CHIP.

Once the contractor has a signed *Medical Release Form* from the family and the signed *Physician Certification Form* indicating the child is or will be disabled for at least 12 months, the contractor will print a CHIP Application Processing System consolidated application, complete the *Referral Coversheet* (Appendix 9-F) and send the entire CHIP-to-MA referral packet to the DHS Central Unit (CU) at the address below:

Administrator  
OIM Central Unit  
6th Floor Forum Place  
555 Walnut Street  
Harrisburg, PA 17101  
Telephone: 717-772-2592  
FAX: 717-346-0363

**9.7.2 REFERRAL PROCESS FOR INCOMPLETE SCENARIOS**

**Incomplete Medical Release Form** – If the family did not cooperate and the CHIP contractor has not received a signed *Medical Release Form*, the following procedures apply:

- If the CHIP contractor has received a completed *Physician Certification* from the key physician indicating a disability of at least 12 months and;
- 20 days have elapsed after the CHIP contractor has sent the *Referral Notice* and the partially completed *Medical Release Form* to the family and at least three attempts have been made in total to reach the family other than by mail.

The CHIP contractor will send the balance of the CHIP-to-MA referral packet to DHS’s CU even if the CHIP contractor has not received a signed *Medical Release Form* from the family. Since there is a Health Insurance and Portability and Accountability Act (HIPAA) exception for eligibility and there is a state law exception for DHS receiving ‘sensitive information’ for eligibility, there is no legal reason that a CHIP contractor may not forward the CHIP-to-MA packet to DHS’s CU even though the family has not signed and returned the *Medical Release Form*. 
Example: The Physician Certification Form is completed and returned indicating that Mary has a disability of at least 12 months. After twenty days from sending the Medical Release Form and three telephone attempts requesting the signed release, Mary’s family did not cooperate. The CHIP contractor will document by entering a Comment in CHIP Application Processing System and send the incomplete referral packet to DHS’s CU.

Incomplete Physician Certification Form – If the CHIP contractor has not received a signed Physician Certification Form, the CHIP contractor will forward the balance of the CHIP-to-MA referral packet to DHS’s CU, as long as:

- The CHIP contractor has received the signed Medical Release Form from the family;
- At least 20 days have passed since the Physician Certification Form was sent to the physician and two attempts have been made to contact the physician;
- The CHIP contractor has credible claims, case management, or other information indicating the child could meet the SSA’s definition of a disability.

A CHIP contractor may allow or encourage a physician or other health care provider to complete and send the Physician Certification Form directly to DHS’s CU for CHIP-to-MA referrals rather than have the provider send the form to the CHIP contractor, as long as the CHIP contractor monitors whether each health care provider actually has sent the Physician Certification Form to DHS.

Example: Through a review of her history of medical claims information, Susie has been identified as possibly having a disability. The contractor contacts the family and Susie’s physician explaining the need to complete the referral process. Susie’s family returned the signed Medical Release Form to the contractor but after twenty days from sending the Physician Certification Form and two attempts were made to contact the physician, the physician fails to return the signed Physician Certification Form to the contractor. The CHIP contractor will document by entering a Comment in CHIP Application Processing System and forward the balance of the CHIP to MA referral packet to DHS’s CU without the signed Physician Certification Form.

Incomplete Medical Release Form and Physician Certification Form - Neither the signed Medical Release Form from the family nor the Physician Certification
Form has been received. The contractor will complete the Referral Coversheet and print a CHIP Application Processing System consolidated application, and send to DHS’s Central Unit (CU), as long as:

- The CHIP contractor has credible claims, case management or other information indicating the child could meet the SSA’s definition of a disability.
- At least 20 days have passed since the Physician Certification Form was sent to the physician and two attempts have been made to contact the physician;
- 20 days have elapsed after the CHIP contractor sent the standard CHIP-to-MA notice to a family.
- At least three attempts have been made in total to reach the family other than by mail.

Example: The CHIP contractor has credible claims indicating Billy may have a disability of at least 12 months. The family fails to return the signed Medical Release Form to the contractor. The Physician Certification Form is also not returned. However, because there is no legal reason that a CHIP contractor may not forward the CHIP-to-MA packet to DHS’s CU even though the family and the physician did not cooperate, the CHIP contractor will document by entering a Comment in CHIP Application Processing System and send the incomplete referral packet to DHS’s CU.

9.7.3 REVOCATION OF CONSENT

If a family returned the signed Medical Release Form to the contractor then decides to revoke their consent to release medical information, the request must be relayed to both The Office of CHIP and DHS CU. DHS CU is responsible for maintaining all revocations.

Example: The Physician Certification Form is completed and returned indicating that Johnny has a disability of at least 12 months. The family returned the signed Medical Release Form to the contractor. After a change of heart, the family decides to revoke their consent by writing to the CHIP Office, the CHIP contractor and/or DHS CU. However, because there is no legal reason that a CHIP contractor may not forward the CHIP-to-MA packet to DHS’s CU even though the family has revoked the Medical Release Form, the CHIP contractor will send the referral packet to DHS’s CU regardless. Johnny will remain in CHIP until the Referral Coversheet is returned from DHS stating the PH-95 referral was approved and he
has been enrolled in MA. Johnny will be terminated from CHIP without a lapse in coverage between CHIP and MA.

9.7.4 MA ELIGIBILITY

Once the Referral Coversheet is received from DHS stating the child has been enrolled in MA, the child will be terminated from CHIP, ensuring there is no lapse in coverage between CHIP and MA.

If the Referral Coversheet indicates the child is not disabled, the child will remain enrolled in CHIP.

9.7.5 FAILURE TO FURNISH REQUIRED INFORMATION (REASON CODE 042)

If either the family or physician fails to cooperate with the PH-95 referral verification process by not furnishing the required information, the contractor must terminate CHIP coverage noting reason code 042. This implements the Federal requirement that a child who is eligible for MA is not eligible for CHIP: the child may not be considered for CHIP until it is determined that the child is not eligible for MA.

(See Chapter 12 – Termination Procedures, and Chapter 6 – Notices, Section 6.6 – Notice to Applicant Family of Ineligibility for CHIP).
APPENDIX 9-A TALKING POINTS

Talking Points
CHIP to Medical Assistance Transition for PH-95

- We are calling to let you know that your child might be eligible for Medical Assistance. There is a special category of Medical Assistance for children with special health care needs. Looking at your child’s use of health care services, we think he or she may be eligible for Medical Assistance.

- You may already know about Medical Assistance. Have you ever even applied for Medical Assistance based on your child’s special health care needs?

- Medical Assistance often covers more medical and mental health services than CHIP.

- The rules for CHIP and Medical Assistance are clear. If your child can get Medical Assistance through the children with special health care needs program, he or she cannot be enrolled in CHIP. We want to work with you to be sure your child gets the health coverage he/she needs without interruption. However, we will need your help.

- Here’s what will happen next: We will send you a form to sign. The form will let us send your child’s health information to Medical Assistance. It will also give your child’s doctor permission to give us information about his/her health. It’s important that you sign and return the form. If you don’t get the form in the next ten days or lose it, give us a call at <telephone number of contact person at CHIP insurance contractor>.

- Your child may lose health coverage if the form isn’t signed and returned on time.

- We will also send a letter to your child’s doctor(s). That letter will ask him/her/them to tell us if they believe your child will fit the rules for the special health care needs program.

- The Medical Assistance office will look at all the information from us and your child’s doctors. They will decide whether your child should be switched from CHIP to Medical Assistance. Once they make a decision, they will contact you by mail.
While CHIP and Medical Assistance work together to make sure your child is in the most beneficial program, your child will continue to be covered by CHIP. You can still take him or her to the doctor, fill prescriptions and get any other health services. Nothing will change until Medical Assistance makes a decision.

If Medical Assistance decides that your child is eligible for Medical Assistance, you will receive a letter saying when your child’s Medical Assistance will start and a new card for your child. Your child’s CHIP will stop once Medical Assistance begins.

If Medical Assistance decides that your child is not eligible for Medical Assistance, your child will continue to be enrolled in CHIP, and no changes will be made.

We understand this may be confusing. We are here to help you and your child. You may also hear from a caseworker at Medical Assistance. If you have questions you can call <name of contact person at CHIP insurance contractor> at <telephone number of contact person>.

Our goal is to give your child the best health care benefits we can.
APPENDIX 9-B REFERRAL NOTICE

CHIP Contractor Name
Address
Address

Important Information Regarding Your Child’s CHIP Enrollment

To the Parent or Guardian of <CHIP enrollee’s name>:

<CHIP enrollee’s name> may be eligible for Medical Assistance. We will forward your child’s information to the Department of Human Services (DHS) Central Unit. DHS will use this information to determine if your child is eligible for Medical Assistance.

Why might my child’s coverage change?

Under Federal and state rules, parents do not have a choice between CHIP and Medical Assistance. A child will be enrolled in Medical Assistance or CHIP based on the rules for these programs. If your child is eligible for Medical Assistance, he/she is ineligible for CHIP. We reviewed the information CHIP has regarding your child’s health and the services he or she has used. It appears that <insert child’s name> may be eligible for Medical Assistance for children with disabilities. This program provides more health care benefits and services for <insert child’s name> than CHIP can.

What is best for my child?

Medical Assistance provides extensive coverage of medical and mental health services that may be limited or not available through CHIP. Medical Assistance covers all medically necessary services.

What do I have to do?

You must fill out the form that came with this letter. Return it to us in the self-addressed, stamped envelope right away. This form will allow your child’s doctor and other health care providers to provide medical record information necessary for the final decision of whether your child is eligible for Medical Assistance. Your child’s doctor and other health care providers can provide most needed medical record information in this situation without your signed release. However, signing this release will speed up the process and it will allow your child’s doctor and other health care providers to provide all needed information.

What will happen next?

DHS will send you a letter. The letter may inform you that your child is eligible for Medical Assistance or it may ask you to provide more information. If you are asked for more information, it is very important that you send the information to DHS. If you do not send
the information, your child cannot receive Medical Assistance and your child’s CHIP will also end.

If the CAO determines that your child is eligible for Medical Assistance, you will receive more information in the mail and be issued PA ACCESS card.

If the CAO decides that your child is not eligible for Medical Assistance, your child will continue to be covered by CHIP as long as you cooperate with this process (or unless the benefits would terminate for some other reason.

How will my child receive health care during the referral process?

Until a PA ACCESS card is issued, you may continue to use your child’s CHIP card, fill prescriptions, and schedule other services your child needs that are covered by CHIP. Once you receive your PA ACCESS card, you should begin using it right away and destroy the old CHIP card.

What if I have questions?

We are here to help! Call us at "toll-free number", "days and times". TTY users please call "TTY number".

What if I don’t agree with this change?

If you do not agree with this change, you may request a review. You must make the request in writing within 30 days from the date on this letter. Send the letter to the address listed above.

You can also get help from the Pennsylvania Health Law Project at 800-274-3258.

Sincerely,

<Contractor Name/info>

Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros del "contractor name" al "contractor's phone number". Estos servicios están disponibles de lunes a viernes, de "contractor's Monday-Friday hours", y los sábados de "contractor's Saturday hours, if applicable". Usuarios del sistema TTY deberán llamar al "contractor's TTY phone number".
APPENDIX 9-C MEDICAL RELEASE FORM

Commonwealth of Pennsylvania
Department of Human Services

Authorization for Use or Disclosure of Protected Health Information

Please complete and return this form. This form has three parts:

Part A
General Information: should be filled out and signed for each child.

Part B
Special Categories of Medical Information: should be filled out and signed if your child’s health records include information about:

- The use of drugs or alcohol
- Mental Health
- HIV/AIDS

And

Part C
Signature Page: Signing this form will allow CHIP and your child’s doctors to share your child’s health information with Medical Assistance and the Department of Human Services (DHS) Central Unit. DHS will use the information to determine if your child is eligible for Medical Assistance.
PART A

General Information

I, (Parent/Legal Guardian), authorize any and all health care providers who have treated my child to share the medical records of my child to the Pennsylvania Department of Human Services (the “Department”) and <the CHIP contractor> from the records of:

Name: _______________________________ Date of Birth: _____________________
Address: ______________________________ City: ______________________________
State: ___________________ Zip: _________ Telephone: ______________________
Social Security Number: _____________ Health Insurance ID number: _____________

These medical records will be shared so that the Department may review them to see children currently enrolled in CHIP may qualify for Medical Assistance. I understand that:

- My child’s medical records will be shared so that the Department may review them to determine if he/she may qualify for Medicaid. Medical records disclosed should be those related to [insert description of child’s condition here]
- This authorization may be revoked at any time by writing to the CHIP Office, <the CHIP contractor> or the Department, except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- Signing this form may be required in order for my child to continue enrollment in CHIP.
- Information (except drug and alcohol information) disclosed pursuant to this authorization may be subject to re-disclosure by the individual/organization identified in this Part A and if so, would no longer be protected by federal privacy regulations.
- CHIP Office, <the CHIP contractor>, the Department, its programs, services, employees, officers and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Tell us your relationship to the child: _______________________________________
____________________________________________________________________

Signature of Parent/Legal Guardian    Date

(This authorization ends three (3) months from the date it is signed)

PART B
Special Categories of Medical Information

Drug and Alcohol Information

If my child’s medical record includes drug and alcohol information, I want that information shared with the Department and <the CHIP contractor>:

________ Yes  ________ No

This information will be disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Mental Health Information

If my child's medical record includes mental health information, I want that information shared with the Department and <the CHIP contractor>:

________ Yes  ________ No

HIV/AIDS Information

If my medical record includes HIV/Aids information, I want that information shared with the Department and <the CHIP contractor>:

________ Yes  ________ No

This information will be disclosed from records protected by Pennsylvania law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

For mental health information, a child age 14 or older can sign this consent.

PART C

Signature Page
Signature of Child age 14 or older       Date
(for mental health consent only)

Signature of Parent/Legal Guardian       Date
(for mental health, HIV, and/or drug and alcohol consent)

Tell us your relationship to the child: ____________________________________________

Signature of Witness       Date
(Necessary for release of mental health and drug and alcohol information)

If individual is physically unable to sign, signature of second witness:

Signature of Witness       Date
APPENDIX 9-D PHYSICIAN CERTIFICATION FORM AND INSTRUCTIONS FOR CHILD WITH SPECIAL NEEDS

General instructions

The information on this form and any attachments must be complete and legible. The inability to read this material will require the form be returned to your office and will delay the application process.

Section I  DISABILITY VERIFICATION

1. Choose only one (1) level of disability
2. If indicated, enter the date the disability is expected to end.

Section II  ASSESSMENT INFORMATION

1. This assessment must be completed by a psychologist, physician or medical professional under the physician’s supervision and authority, e.g. physician assistant or certified nurse practitioner. Information from a chiropractor is not acceptable documentation.
2. Check all assessment tools that apply.

Section III  EXAMINATION RESULTS

1. Include the date of diagnosis
2. Include the name of each diagnosis and include the ICD 9 code and description
3. Be specific and include:
   a. Functional limitations and their impact
   b. Duration expected
   c. Symptoms
   d. Complete findings
4. Documentation sufficient to support your decision must be available for further review if required.

Section IV  SIGNATURE

1. Only the individual who performed the assessment may sign this form
2. The signature must be original or the form will be invalidated
3. Signature or clinic stamps, labels and other facsimiles are not acceptable.

<table>
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<th>Name of Child</th>
<th>Child's Date of Birth</th>
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The above named individual has been identified as a child with special needs.

In Pennsylvania a child with a permanent or temporary disability may be eligible for Medical Assistance.
The definition of disability in a child under 18 is:
A medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Section I - Disability Verification

Please verify the child's level of disability below. (Check Only One)

1. ____ PERMANENTLY DISABLED - Has a physical or mental disability which results in permanent marked and severe functional limitations. The patient may be a candidate for SSI benefits.

2. ____ TEMPORARILY DISABLED - 12 MONTHS OR MORE - Is currently disabled due to a temporary condition as a result of an injury or an acute condition. The temporary disability began and is expected to last until_______________. The patient may be a candidate for SSI benefits.

3. ____ TEMPORARILY DISABLED – LESS THAN 12 MONTHS - Is currently disabled due to a temporary condition as a result of an injury or an acute condition. The temporary disability began and is expected to last until _____________.

4. ____ NOT DISABLED - The patient's physical and/or mental condition is such that he or she does not have an impairment that results in marked and severe functional limitations.

BOTH OF THE FOLLOWING SECTIONS MUST BE COMPLETED IF #1 OR #2 ABOVE IS CHECKED

Section II - Assessment Information

ASSESSMENT BASED UPON: (Check all that apply)
A. ____ PHYSICAL EXAMINATION
B. ____ REVIEW OF MEDICAL RECORDS
C. ____ CLINICAL HISTORY
D. ____ APPROPRIATE TESTS AND DIAGNOSTIC PROCEDURES
E. ____ OTHER (Specify) ___________________________________

Section III - Examination Results

DATE OF DIAGNOSIS: ______________________________

DIAGNOSIS(Primary and Secondary):
PRIMARY:
_________________________________________________

SECONDARY:
_________________________________________________

FUNCTIONAL LIMITATIONS:
_________________________________________________________________________________
## Section IV - Signature

AS A LICENSED MEDICAL PROVIDER, I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY PROFESSIONAL KNOWLEDGE. I FURTHER CERTIFY THAT MY DIAGNOSIS AND ASSESSMENT ARE BASED SOLELY ON THE PATIENT'S CONDITION AS DETERMINED BY MY EXAMINATION. I UNDERSTAND AND AGREE THAT MY DIAGNOSIS AND SUPPORTING DOCUMENTATION MAY BE SUBJECT TO REVIEW BY THE DEPARTMENT OF PUBLIC WELFARE.

<table>
<thead>
<tr>
<th>Physician (Print Name)</th>
<th>Medical Assistance Provider No. (Optional)</th>
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Dear Physician or Licensed Health Care Provider:

There is a special category of Medical Assistance for children with special health care needs. Our CHIP insurance plan has reviewed the submitted claims data of your patient, whose information is noted on the attached document. The insurance plan has found that, based on your patient’s use of health care services, he or she may be eligible for Medical Assistance, which covers more medical and mental health services than CHIP.

The rules for CHIP and Medical Assistance are clear. If a child is eligible for the Medical Assistance special health care needs program, he or she cannot stay enrolled in CHIP. To that end, we ask that you work with us to ensure that this child gets the health insurance coverage he or she needs without interruption.

Attached you will find a Physician Certification Form for Child with Special Needs. We ask that you fill out this form and return it to the child’s insurance plan as soon as possible. If you have any questions about this process, please contact the CHIP insurance plan at the phone number listed on the attached FAX or letter that accompanies this letter. This will assist us in determining whether your patient is eligible for increased benefits through Medical Assistance.

Please note that the CHIP insurance plan’s Special Needs case management unit is or will be contacting your patient’s parent or guardian to educate and engage them in this process.

Sincerely,
Executive Director

Office of Children’s Health Insurance Program
1142 Strawberry Square | Harrisburg, PA 17120
Phone: 717.705.0009 | www.chipcoverspakids.com
# APPENDIX 9-F REFERRAL COVERSHEET

## CHIP PH-95 Referral Coversheet

**TO:** DHS/OIM/CENTRAL UNIT
**FAX:** [717] 346-0363

**FROM:** ___________________________  **DATE:** ____________

**ORGANIZATION:** _________________________________________________________

**TELEPHONE:** _______________  **ORGANIZATION FAX:** _______________

**CHIP CONTRACTOR - MA PROVIDER NO.:** _______________________

**COMMENTS:**

---

**Child’s Name:**

**Parent or Guardian:**

**Address:**

**County:**

**Child’s UCI:**  **Date Family Notified:**

**Primary DX:**

**Secondary DX:**

**Other Key Provider - names/telephone/address/NPIs**

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### FOR DHS USE ONLY

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CHAPTER 10: REASSESSMENT

10.1 GENERAL

The process of changing a child’s eligibility status during the enrollment period is known as reassessment. Except as noted in Chapter 9 - Changes during the Enrollment Period, Section 9.2 - Changes That Require Termination, reassessment is completed when requested by the family. A change in eligibility status that results from a reassessment requires agreement by the parent and will remain in effect until the next renewal is completed, or until another change is reported and another re-assessment is requested.

A reassessment also occurs during renewal. Prior to the initial renewal notice being sent to the household, electronic sources are checked for income verification. If income matches are found, the income is prepopulated on the renewal form, and the system performs a reassessment of the case. This may result in a lower category for the 3 final months of the child’s current enrollment period.

Reassessment does not extend the enrollment period or affect the renewal date.

10.2 CHANGE IN TAX HOUSEHOLD OR INCOME

When a change in tax household size or income is reported, the contractor updates the child’s record. In addition to informing the parent of the impact, comments relevant to the reported change are to be added in the CHIP Application Processing System. The information will be retained online until the time of the next renewal. Changes in tax household or income will not result in a change to the child’s eligibility status during the enrollment period unless there is a request for a reassessment by the child’s parent.

A parent may ask the contractor to determine if the reported change has an impact on the child’s eligibility status. The contractor has the capability of completing an online inquiry to determine the effect that the reported change may have. Examples of the potential impact of a reported change in tax household or income are:

- A reported increase in household income or decrease in household size may result in a child who is enrolled in Free CHIP going to Low-Cost or Full-Cost CHIP;
• A reported decrease in household income or increase in household size may result in a child who is enrolled in Low-Cost or Full-Cost CHIP becoming eligible for Free CHIP or MA;

Note: If a child goes from Low-Cost or Full-Cost CHIP to an MA referral, the child should be enrolled in Free CHIP prior to completing the referral process.

• A reported increase in household size or decrease in household income may result in a child that is enrolled in Free CHIP becoming eligible for MA.

The contractor is responsible for informing the parent of the impact that the reported change may have on the child’s eligibility. Once informed, the parent has the choice of allowing the child’s eligibility status to continue unchanged until the end of the enrollment period, or, alternatively, requesting that the child’s enrollment status be changed.

EXAMPLE 1:

A child is enrolled in Low-Cost CHIP. The parent reports on February 3 that there has been a decrease in the household’s income and asks how the decrease affects the child’s eligibility. The contractor updates the child’s record. An online inquiry is completed which shows that the child qualifies for Free CHIP, and the contractor so informs the parent. The parent requests that the child’s eligibility status be changed to Free CHIP. The contractor will request verification of new income. Once the contractor receives the new income verification, the contractor will complete the reassessment by enrolling the child in Free CHIP. The contractor will notify the parent in writing that the child’s status will change effective March 1. The renewal date remains unchanged.

EXAMPLE 2:

A child is enrolled in Low-Cost CHIP. The parent reports on March 1 that there has been a decrease in the household’s income and asks how the decrease affects the child’s eligibility. An online inquiry is completed which shows that the child may qualify for MA. With permission from the parent, the contractor transfers the application to MA (after enrolling the child in Free CHIP) where it is determined that the family income is too high to qualify for MA. Based upon the contractor’s income determination, the family is given the option of enrolling the child in Free CHIP. The parent requests the child be enrolled in Free CHIP and the contractor enrolls the child in Free CHIP. The contractor will notify the parent in writing that
the child’s status will change effective April 1. The renewal date remains unchanged.

**EXAMPLE 3:**

A child is enrolled in Low-Cost CHIP. The parent reports that there has been a decrease in the household’s income and asks how the decrease affects the child’s eligibility. An online inquiry is completed which shows that the child may qualify for MA. The contractor informs the parent and the parent requests that the child’s application NOT be transferred to MA. No change is made to the child’s enrollment status until renewal and the parent must continue to pay the Low-Cost CHIP premiums.

**EXAMPLE 4:**

A child is enrolled in Free CHIP. The family reports an increase in the household’s income. The contractor updates the child’s record. An online inquiry is completed which shows that the child is now eligible for Low-Cost CHIP. The child remains enrolled in Free CHIP until the renewal due date when eligibility is redetermined and the child is then placed into the program for which the child is eligible.

**EXAMPLE 5:**

A child’s 12-month enrollment in Free CHIP began March 1. The parent reports on April 15 that there has been an increase in the household; the child’s father has moved back into the home and he earns $38,000 a year. The parents will file next year’s federal income tax return as ‘married filing jointly’. The parent asks how the increase affects the child’s eligibility. An online inquiry is completed which shows the child may now qualify for Low Cost 3. The insurer informs the parent of the choice to be placed in Low Cost 3 CHIP by adding the individual and his income (verification documents to be obtained from the individual) or remain in Free CHIP until renewal.

**EXAMPLE 6:**

A child’s 12-month enrollment in Low Cost 1 began March 1. The parent reports on April 15 that there has been an increase in the household; the child’s father has moved back into the home and has no income. The parents will file next year’s federal income tax return as ‘married filing jointly’. The parent asks how the change affects the child’s eligibility. An online inquiry is completed which shows the child
may now qualify for MA. The contractor informs the parent and the parent requests that the child’s application NOT be transferred to MA. No change is made to the child’s enrollment status until renewal. This means the child remains enrolled in Low Cost 1.
CHAPTER 11: RENEWAL PROCEDURES

11.1 RENEWAL OF COVERAGE

Renewal of CHIP coverage must occur prior to the end of the 12-month period of enrollment. See Eligibility Handbook Chapter 8 - Enrollment Guidelines, Section 9.2 - Enrollment Begin Dates. In order for renewal to occur, eligibility for continued coverage must be reviewed.

- There is no limit on the number of times that a child’s CHIP coverage may be renewed;
- A child’s coverage may be renewed, if eligible, every 12 months until the child reaches the age of 19.

11.2 FACTORS TO BE REVIEWED

The only factors requiring review by the CHIP contractors at the time of renewal are those family circumstances that are likely to change. Those factors include:

- Tax household income;
- Age of child (especially important for a child nearing their 19th birthday);
- Number of tax household members (additions and deletions);
- Medicaid eligibility and/or enrollment;
- Private health insurance;
- Missing SSN of existing enrollee.

If a new child has become part of the tax household since the time of application or last renewal (e.g., birth of a child, reuniting with the family, adoption), the applicant will be offered the opportunity to apply for benefits for the child. Although this is an application for coverage for the new child, the contractor may exercise discretion in developing procedures for determining eligibility of the applicant when another child from the same family is already enrolled. For example, an abbreviated application developed by the contractor may be used to acquire information regarding the child to be added for coverage.

11.3 FACTORS TO BE VERIFIED

The only factor of eligibility requiring verification at time of renewal is family income. However, the contractor should request verification of other factors if there is a reason to question information provided on the renewal form.
If a new child is added to the renewal application, citizenship and identity for the new applicant child must also be verified (see Chapter 2 – Central Eligibility Unit Verification Processes and Chapter 9.6.1 – Newborn Born to a CHIP Enrollee).

11.4 RENEWAL NOTIFICATION

At intervals of 90 and 60 calendar days prior to expiration of the 12-month enrollment period, the contractor must send notification to the parent informing them of the need for renewal. A pre-populated renewal form and a postage-paid envelope of sufficient size are to be enclosed with the renewal notification to allow for the return of the renewal form along with all required verification documents.

During renewal:
Prior to generating the 90-day CFF, the CHIP Application Processing System will request updated income information from the TALX interface. If TALX identifies income has been received within the past three months from point in time, the income will be imported to the Income screen in the CHIP Application Processing System. If the TALX data matches the FEIN or exact name of an existing employer in the CHIP Application Processing System, the income information will be updated. If the FEINs or employer names do not match, the TALX match will be entered into the CHIP Application Processing System as new income. The income will be identified as verified by FDSH – Equifax. This income will be pre-populated in the renewal form. However, once the renewal is initiated in the CHIP Application Processing System, the TALX information will revert to “unverified” status and must be re-verified once the renewal is returned.

The notification of renewal must contain at least the following information:

- The date that coverage will be terminated if renewal is not completed – Renewal Due Date (RDD);
- An explanation of the factors to be reviewed and verification required;
- The date by which the renewal form and verification must be submitted by the parent to the contractor (Administrative Due Date (ADD) – 45 days prior to the RDD);
- The web address for COMPASS and instructions for online renewal;
- The contractor’s customer service number if the parent has questions about the notice of renewal or the renewal process.
NOTE: The 60-day renewal notification will serve as the intent to terminate. A termination notice will be sent at RDD if the renewal is not completed. See Section 11.10.2 Eligibility Notices for other possible outcomes.

EXAMPLES:

Renewal received prior to ADD

The child’s RDD is May 31. On February 23, a letter is generated to alert the family to renew coverage by April 16 (ADD) or the child’s coverage will end on June 1. The family completes the prepopulated renewal form and returns it on March 12. The contractor determines eligibility for the child within the 15 day window and determines the child is eligible for Low-Cost 1 CHIP. The appropriate letter is generated and the family is provided adequate notice of required premiums. Payment is received by the contractor on May 28 and the child is enrolled in Low-cost CHIP effective June 1.

Renewal received after ADD, but prior to RDD

The child’s RDD is May 31. On February 23, a letter is generated to alert the family to renew coverage by April 16 (ADD) or the child’s coverage will end on June 1. On March 23, the 60-day notice is generated as a reminder to renew and intent to terminate if the renewal form is not completed by June 1. The family completes the prepopulated renewal form and returns it on May 12. On May 25, the contractor determines eligibility and the child is found eligible for Low-Cost 1 CHIP. The appropriate letter is generated; however, due to the lateness of the renewal, the family is no longer given adequate notice of required premiums. CHIP Application Processing System puts the child in Enrolled ACR status on May 25. If payment is not received by May 31, the child is terminated May 31, effective June 1 (See 11.8.1 Renewals Completed after 90 Days).

Examples for payments received after the RDD.

Administrative Renewal

The child’s RDD is May 31. On February 23, a letter is generated to alert the family to renew coverage by April 16 (ADD) or the child’s coverage will end on June 1. On March 23, the 60-day notice is generated as a reminder to renew and intent to terminate if the renewal form is not completed by June 1. The family reviews the prepopulated renewal form, determines no changes are needed, signs the
renewal, and returns it on May 12. On May 25, the contractor verifies the household income using the TALX-FDSH tab in CHIP Application Processing System, and determines eligibility.

11.5 RENEWAL OPTIONS

Renewals may be initiated in any one of three ways:

- By completing an online renewal through COMPASS and submitting required income documentation and signature page, if required;
- By completing a telephonic renewal, if the contractor wishes to take renewal applications over the phone, and submitting required income documentation and signature page, if required;
- By returning the completed renewal form sent from the contractor and submitting required income documentation.

11.6 RENEWAL OF ELIGIBILITY FOR CHILDREN UNDER THE CARE AND CONTROL OF A COUNTY CHILDREN AND YOUTH ORGANIZATION

Foster children are under the care and control of the County through The Office of Children Youth and Families (CYF) and not the foster parents with whom they reside. The foster parents are excluded from the foster child’s household composition.

Contractors must accept a signed statement from a County Children and Youth organization that indicates that a child remains in CYF custody. This should be received along with the child’s annual income verification documents. The statement, along with the updated income information, will constitute a signed renewal application for these children. No other application or verification documentation will be required.

11.7 DETERMINATION OF ELIGIBILITY OR INELIGIBILITY FOR RENEWAL-COMPLETE APPLICATION

The contractor must make a determination of a child’s eligibility for renewal within 15 calendar days of the receipt of a complete renewal application. If the 15th calendar day falls on a non-working day, the determination must be completed by close of business on the next working day. In no event may a processing delay attributable to a contractor result in the disruption of coverage for a child. A notice of eligibility or ineligibility must be sent to the parent.
11.8 DETERMINATION OF ELIGIBILITY OR INELIGIBILITY FOR RENEWAL-INCOMPLETE APPLICATION

When a renewal application is incomplete, the parent must be given the opportunity to submit the missing information or verification. The contractor must inform the parent either orally (e.g., by telephone) or in writing (e.g., by letter, fax, secure e-mail) of the additional information or verification required and the date by which it should be received. The time frame established for the submission of the missing information should, if at all possible, avoid a disruption of coverage.

A narrative of any oral communication with the parent must be recorded in the “Comments” section of the CHIP Application Processing System. In the case of written communication, the contractor will place a “hard copy” of the notification in the case file or maintain an electronic record of the notification and its text.

11.8.1 RENEWALS RECEIVED UP TO 90 DAYS AFTER THE RENEWAL DUE DATE

Completed renewal within 90 days after the RDD - If a child is terminated for failure to renew and the parent submits a completed renewal within 90 days of the original renewal due date, and if the child is found eligible, the child must be reinstated retroactively to the renewal due date if premiums are paid by the family.

Incomplete renewal - When a child is terminated for failure to renew and the parent submits an incomplete renewal within 90 days of the original renewal due date, the incomplete application process in Section 11.8 of this chapter will be followed. Any pending information needed to complete the renewal can delay the eligibility process not more than 90 days beyond the renewal due date.

- If the parent submits the completed renewal within 90 days of the original renewal due date, and if the child is found eligible, the child will be reinstated retroactively to the renewal due date. There will be no lapse in coverage so long as premiums are paid.
• If the parent fails to provide any pending information or verification within 90 days of the renewal due date, the contractor will make a determination of ineligibility.

EXAMPLES:

CHIP to Medical Assistance

Termination date is April 1, 2016, and a completed renewal form and required verification is received April 20, 2016. It is determined the child is potentially eligible for Medical Assistance. The reinstatement functionality of CHIP Application Processing System is used to process eligibility for the child for CHIP. The child is not reinstated in CHIP because the child is not eligible for CHIP if potentially eligible for MA. If the child is found ineligible for MA due to high income, the child may be reinstated in CHIP effective the date of termination to allow for no gap in coverage.

Free CHIP to Free CHIP or Low-Cost/Full-Cost to Free CHIP

Termination date is April 1, 2016, and a completed renewal form and required verification is received April 20, 2016. Again, reinstatement functionality is used to determine eligibility for CHIP. If the child remains eligible or is determined eligible for Free CHIP, the child should be retro-enrolled to April 1, 2016. If the renewal form is not received until July 2, 2016 (more than 90 days past the Renewal Due Date, continued coverage will be denied and a new application will be required. The current process for processing applications remains in effect.

Free CHIP to Low-Cost CHIP or Full-Cost CHIP

Termination date is April 1, 2015, and a completed renewal form and required verification is received April 20, 2015. The child is determined to be eligible for Low-Cost CHIP. The family must pay the premiums beginning April 1, 2015, to be reinstated. If they are unwilling to pay the premiums beginning April 1, 2015, or if the renewal form is received more than 90 days from the renewal due date, the family may reapply for coverage. Contractors will follow current policy for eligibility determination and start dates.

Low-Cost or Full-Cost CHIP to Low-Cost or Full-Cost CHIP

Termination date is April 1, 2016, and a completed renewal form and required verification is received April 20, 2016. The child is determined to be eligible for
Low-Cost or Full-Cost CHIP. The family must pay the premiums payments for the new enrollment period that will begin April 1, 2016, in order for the child to remain eligible for CHIP. If the family is unwilling to pay the premiums for the new enrollment period that will begin April 1, 2016, or if the renewal form is received more than 90 days from the renewal due date, the family may reapply for coverage. Contractors will follow current policy for eligibility determination and start dates.

11.8.2 RENEWALS RECEIVED MORE THAN 90 DAYS AFTER RDD

If a child is terminated for failure to renew and the parent submits the completed renewal and required verification, but more than 90 days have passed since the renewal due date, the renewal form is treated as a new application. There will be a lapse in coverage.

EXAMPLE:

Free CHIP to Free CHIP or Low-Cost/Full-Cost to Free CHIP
Termination date is April 1, 2016, and a completed renewal form and required verification is received July 2, 2016, continued coverage will be denied and a new application will be required. The current process for processing applications remains in effect, resulting in a new effective date and a new renewal due date.

11.9 EFFECTIVE DATE OF RENEWAL

The effective date of renewal will be as follows:

11.9.1 FREE CHIP

The effective date of renewal is the first day of the calendar month following the renewal due date (RDD).

11.9.2 FREE TO LOW OR FULL-COST CHIP

The date the enrollee begins in the new program (Low-Cost or Full-Cost) is dependent on the time the individual renews and premium is received in relation to their RDD. If the premium is paid prior to RDD, the effective date of the renewal is the first day of the calendar month following the RDD.

If payment is received after RDD, but within the 60 days immediately following RDD and the child has been terminated, the contractor will require premiums to be paid in full, resulting in no gap in coverage. If payment is not received within the 60 days immediately following RDD, the child must reapply and a gap in coverage will result.
11.10 ELIGIBILITY NOTICE

The contractor must send the parent a notice of the eligibility determination within 15 calendar days from the renewal receipt date. If the 15th calendar day falls on a non-working day, the determination must be completed by close of business on the next working day. At a minimum, the notice must contain the following information:

11.10.1 FOR A CHILD ELIGIBLE FOR RENEWAL

- That the child is eligible for renewal;
- The new enrollment period;
- The contractor’s customer service telephone number to call in the event that the parent has questions;
- That additional information or materials will be sent by separate cover, if applicable (e.g., new ID card);
- Notice regarding availability of enrollee handbook (i.e. whether it will be sent under separate cover, or directions on where to find it on the website and how to obtain it if the family does not have internet access); Cost sharing limit, if applicable;
- Premium payment amount and due date, if applicable;
- Consequences for not paying the premium payment;
- The right to an Eligibility Review. (See Chapter 8 - Eligibility Review Process).

11.10.2 FOR A CHILD INELIGIBLE FOR RENEWAL

- That the child is ineligible for renewal;
- Date CHIP coverage ends;
- All of the reasons that the child is ineligible for renewal (e.g., income too low, failure to submit information necessary to determine continuing eligibility, failure to submit the application for renewal);
  - If applicable, that the application has been forwarded to the local CAO when a child is ineligible because the family income is within the Medicaid eligibility range. The list of CAO’s must be attached.

NOTE: If a child is going from Low-Cost or Full-Cost CHIP to a Medical Assistance referral, prior to terminating for a CAO referral, the child must be enrolled in Free CHIP. See Chapter 1 - Application Submission, Section 1.7 - Automated Referrals to the CAO and Appendix 1-A CAO Information.
The contractor’s customer service telephone number to call in the event the applicant has questions;

- The right to an Eligibility Review. (See Chapter 8 - Eligibility Review Process).

**NOTE:** The eligibility review process is not applicable if termination is due to low income and a referral to MA is completed.

- That the applicant may reapply if family circumstances change.
CHAPTER 12: TERMINATION PROCEDURES FOR INELIGIBLE CHILD

12.1 TERMINATION - CHILD NO LONGER ELIGIBLE FOR FREE CHIP

A child is no longer eligible for Free CHIP if at the time of renewal:

- Tax household income exceeds 208% of the FPL annual income limit for Free CHIP;
- Tax household income is less than the minimum income requirements for CHIP (e.g., eligible for Medicaid, (See CHIP Eligibility Handbook, Chapter 5 – Other Sources of Health Insurance);
- The child is covered by other health insurance, (See Eligibility Handbook, Chapter 5 – Other Sources of Health Insurance) and Section 12.3 of this Chapter;
- The applicant fails to complete the renewal process (e.g., fails to respond to the notice of renewal, fails to provide required information or verification);
- The child is eligible for coverage through a state health benefit plan based on a parent, legal guardian, or legal custodian’s employment with a state/public agency (See Eligibility Handbook, Chapter 5 – Other Sources of Health Insurance and Section 5.2.1 – State Health Benefits for Government Employees).

Normally termination is effective the last day of the 12th calendar month of the period of enrollment. A notice of termination must be sent to the parent at least 30 calendar days prior to termination.

12.2 NON-PAYMENT OF PREMIUM FOR LOW-COST OR FULL-COST PROGRAM

Failure to pay the premium for the Low-Cost or Full-Cost program will result in termination. Within 7 days of the start of the 30-day grace period, a notice of proposed termination must be sent to the parent at least 30 calendar days in advance of the effective date of termination. For example, a family’s premium is due September 30 for the new coverage period beginning October 1. If the premium is not received by September 30, the contractor must send a notice to the family no later than October 8 (no later than seven days after the first day of the coverage period) stating that payment must be received by October 30 or coverage will be terminated effective September 30.

The notice must include at least the following information:
The effective date of termination;

The reason for termination (i.e., non-payment);

What corrective measures the parent may take to prevent termination from occurring;

The contractor's customer service telephone number a parent may call if they have questions or wish to resolve the situation;

That the 90 day lock-out period will be imposed if they reapply.

12.3 PRIVATE INSURANCE – RETROACTIVE TERMINATION

CHIP is by law the payer of last resort. The contractor shall not pay any claim unless all other Federal, State, local or private resources available to the child are utilized first. If a child has obtained private insurance, the contractor must do the following:

- Terminate CHIP retroactively to the 1st day of the month following the month that private insurance was obtained;
- There is no limit to how far back the termination can occur, whether that date is months prior or years prior to the discovery of private insurance. Contractors must contact the CEU for assistance in terminating any coverage in excess of 6 months;
- A 30-day termination notice is not required but a termination notice must be sent in a timely fashion;
- All premiums will be refunded and any claims that have been paid should be submitted to the private insurance for reimbursement;
- Enrollees terminated in this situation may request an Eligibility Review. (See Chapter 8 – Eligibility Review Process).

MA coverage is not private insurance: therefore, retroactive terminations do not apply if the child is enrolled in MA. CHIP will be terminated the end of the month in which the contractor is notified of the MA enrollment.

EXAMPLE 1:

Richard T. is enrolled in CHIP May 1. On August 20 a letter is received at the contractor requesting termination of the CHIP coverage effective September 1 because other insurance has been procured in August. Richard’s eligibility period runs from May 1 through August 31.

EXAMPLE 2:
Susie S. was enrolled in CHIP on November 1. Information is received on March 13 that Susie is active in Medicaid. Her CHIP eligibility period runs from November 1 through March 31.

**EXAMPLE 3:**

Kathy K. was enrolled in CHIP on January 1. In September, the contractor learned that Kathy has had private insurance coverage since February 4. The contractor will terminate CHIP effective March 1.

12.4 **VOLUNTARY TERMINATION**

The tax filer may request termination. Such a request is a “voluntary termination.”

A request may be made either orally or in writing. A file note of any oral request by the tax filer should be recorded in the case file.

Coverage should end the last day of the month requested by the tax filer, if the request is in accordance with policy. A notice of termination must be sent to the tax filer advising of the date on which coverage will end, and confirming that this action has been taken in accordance with their request. In all cases, the contractor must send a written confirmation of all requests.

**EXAMPLE:** Mom contacts the contractor in May to request her child’s CHIP coverage be terminated in August due to upcoming move out of state. The contractor should complete a future termination in the CHIP Application Processing System for an August 31 termination with a September 1 effective date.

12.5 **SPECIAL CIRCUMSTANCES – 30-DAY TERMINATION REQUIREMENT**

The requirement to send a written 30-day termination notice prior to action being taken may be waived only if:

- The tax filer requests, either orally or in writing, that their child’s coverage be terminated as soon as possible and they have a compelling reason for the request;
- The tax household moved out of state;
- The child has obtained private insurance or is enrolled in Medicaid;
• The child turns 19 years of age;

• A child is terminated for providing misinformation or omitting information on an application or at renewal;

• The child is eligible for coverage through a state health benefit plan based on a parent, legal guardian, or legal custodian’s employment with a state/public agency.

In the above circumstances a contractor may terminate coverage without providing notice at least 30 days before the action is taken.

Coverage should be terminated effective the last day of the month in which the change occurs.

Case comments should document the circumstances and the reason the exception to the 30-day notice procedure occurred. In all cases a letter must be sent to the applicant identifying the date on which coverage will be terminated.

12.6 RETURNED MAIL “ADDRESS UNKNOWN”

Mail returned to the contractor by the U.S. Postal Service that is marked “address unknown” may provide cause for termination. It is recommended that the contractor make an attempt to contact the applicant by telephone or other means to establish that the family is no longer at the address previously provided. Information about this attempt should be narrated in the case file.

Termination should be effective with the first of the calendar month for which a processing deadline can be met.
PART 2 – QUALITY MANAGEMENT AND ADMINISTRATIVE REQUIREMENTS

CHAPTER 13: DIVISION OF QUALITY ASSURANCE

13.1 GENERAL REQUIREMENT

Both state and federal law require that the Department conduct monitoring and oversight of contractors. It is the responsibility of the Division of Quality Assurance to ensure that children are enrolled properly, that services being provided by each contractor are consistent with the requirements set forth in the RFA, and that funds appropriated for the program are properly expended.

13.2 PROGRAM MONITORING

Program monitoring will be conducted by Quality Assurance staff who will work directly with the contractor on operational and programmatic issues. Areas of specific responsibility include, but are not limited to:

- Reviewing and compiling monthly, quarterly and annual reports submitted by contractors;
- Monitoring eligibility and enrollment application processing, including transfers between CHIP and Medical Assistance;
- Conducting random sample reviews;
- Reviewing consumer service and enforcement issues;
- Coordinating audit reviews, i.e. contractor A-133 independent single audits, PERM related, and coordination of other audits initiated by federal and state agencies;
- Coordinating and implementing corrective action plans;
- Detecting fraud and abuse;
- On-site monitoring and readiness reviews;
- Participating in ongoing CHIP Application Processing System (CAPS) development and redesign;
- Compliance with the ACA, HIPAA; and
- Overall contract compliance.

13.3 MEDICAL SERVICES ANALYST

1 Detailed instructions on the eligibility and enrollment monitoring process will be distributed to contractors via official departmental transmittal.
The Medical Services Analyst oversees utilization of services and directs Quality Improvement initiatives as described in the RFA and the CHIP Procedures Manual. The Medical Services Analyst is not specifically assigned to any particular Contractor, but serves in an overall capacity. Areas of specific responsibility include, but are not limited to:

- HEDIS®/CAHPS annual reviews;
- Performance improvement projects (PIPs);
- Provider network issues;
- Oversight of EQRO contract;
- Participation in the oversight of Data Warehouse claims and encounter data systems;
- Participation in on-site monitoring and readiness reviews;
- Development and implementation of corrective actions;
- Review and compilation of monthly, quarterly, and annual reports;
- Consumer and legislative inquiries and correspondence;
- Coordination of ad hoc data requests; and
- General contract compliance.

### 13.4 EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1902(a), 1932 (c), and 1903(a). States are required to obtain an independent, external review of the quality of services furnished under state contracts with Managed Care Organizations, including the evaluation of quality outcomes, timeliness, and access to services. The requirements for EQR were further outlined in 42 CFR Parts 433 and 438; External Quality Review of Medicaid Managed Care Organizations; Final Rule issued on May 6, 2016. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Enrollees. “Quality”, as it pertains to EQR, means the degree to which a MCO maintains or improves the health outcomes of its Enrollees through its structural and operational characteristics and through the provision of services. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight.
The Department currently contracts with an EQRO vendor that also contracts with Pennsylvania’s Medical Assistance Program. Similar quality measurement tools were developed for the CHIP Program in order to more fully align both programs.

These core products and services include quality measurement and improvement surveys and studies, utilization and diagnosis related groups (DRG) management, encounter data validation, quality assurance, and health care process design and measurement activities. Additionally, the EQRO vendor is licensed by the National Committee for Quality Assurance (NCQA) to conduct Healthcare Effectiveness Data and Information Set (HEDIS®) Audits.

Responsibilities of the EQRO:

- Preparing the HEDIS® reports, including a measure result comparison table with weighted averages for each measure.
  - Creating the annual HEDIS® reports, displaying data and rate comparison tables that are helpful for ongoing monitoring and performance improvement. The tables provide MCO and national benchmark comparative information (when available and appropriate).

- Implementing selected Pennsylvania specific performance measures and preparing Pennsylvania performance measure comparison tables.
  - Selected Pennsylvania specific performance measures used by the Department of Human Services (DHS) or Medicaid managed care enrollees are implemented for the CHIP population (including HMO and PPO enrollees), as appropriate to the populations age range.

- Preparing Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results and comparison tables.
  - Create an annual CAHPS data comparison tables that will provide MCO and national benchmark comparative information (when available and appropriate).

- Developing “report cards” to display HEDIS®, CAHPS, and Pennsylvania performance measure results.
  - Develop an annual report card similar to MA’s “A Consumer’s Guide to the HealthChoices Health Plans.” The annual report card displays each MCO’s rates for selected CAHPS survey results, HEDIS® measures, and Pennsylvania performance measures. These rates are compared to the statewide average using graphics.

- Validating performance improvement projects (PIPs) per MCO per calendar year.
• Validate performance improvement projects per calendar year per MCO in the CHIP Program. CHIP requests that each MCO develop projects to improve performance based on the HEDIS® measures. The EQRO vendor will use the same validation methodology currently used for the Medicaid MCO PIPs that are based on HEDIS® measures.

• Providing technical assistance in the development of a quality-monitoring program.
  • Provide technical assistance in the development of a state quality-monitoring program for CHIP to include strategic planning.

• Proposing a pay-for-performance methodology using the HEDIS® measures.

• Acting as a technical resource for Data Warehouse issues.

Responsibilities of the MCO:

• Accurately, completely and within the required timeframe identify eligible Enrollees to the EQRO.

• Correctly identify and report the numerator and denominator for each measure.

• Actively encourage and require Providers, including subcontractors, to provide complete and accurate Provider medical records within the timeframe specified by the EQRO.

• Demonstrate how the results of the EQR are incorporated into the Plan's overall Quality Improvement Plan and demonstrate progressive improvements during the term of the contract.

• Improve Encounter Data in an effort to decrease the need for extensive Provider medical record reviews.

• Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.
• Ensure that data, clinical records and workspace located at the MCO’s work site are available to the independent review team and to the Department, upon request.

• Participate in Performance Improvement Projects whose target areas are dictated by the Department to address key quality areas of focus for improvements. The MCO will comply with the timelines as prescribed by the EQRO.
CHAPTER 14: QUALITY MANAGEMENT: ROUTINE REPORTS

14.1 GENERAL REQUIREMENTS

These reports are required to enable the Department to assess the quality of care and the cost of services. These reports may also be used to spot-check potential problem areas for which the Department may provide technical assistance and develop corrective action plans.

Report templates will be emailed to the contractors with the most current instructions and data collection tools. This chapter's appendices include the most current set of instructions (when applicable) as well as representations of the report template in table form. All collected data should be emailed back to the individual noted unless the contractors have been instructed otherwise by official Departmental Transmittal. Reports are to be securely emailed individually with the report name noted in the email’s subject line.

14.2 POTENTIAL PRECLUDED PROVIDER REPORT

14.2.1 CONTENT

Providers identified by the Office of Inspector General (OIG) or the Department of Human Services (DHS), as excluded or precluded providers may not receive payments from government-funded health care programs. Because of this restriction, these providers may not furnish items or services, nor may they direct or prescribe care for any CHIP enrollee. In addition, businesses owned by these providers, and any staff employed by them are restricted from providing services for any CHIP enrollee.

On a quarterly basis, each contractor’s network is compared against both the OIG List of Excluded Individuals & Entities (LEIE) and the DHS Medicheck databases to determine if there are any potentially precluded providers in their current network. A Precluded Provider cross match report for each contractor is then published in the CAPS System Report Repository documenting the results for each contractor.

This report documents the contractor’s investigation into the providers identified in the cross match and indicates whether the providers found on LEIE or Medicheck are in fact the same providers operating within their network.
If the provider in the contractor’s network is determined to be a precluded entity, this report also documents whether the provider has been actively rendering services to enrollees, the amount of any payments made to the provider, and the recovery of these funds.

14.2.2 FREQUENCY

The precluded provider cross match report will be available in the CAPS Report Repository as follows:
Quarter 1 (January, February, March) – April 15th
Quarter 2 (April, May, June) – July 15th
Quarter 3 (July, August, September) – October 15th
Quarter 4 (October, November, December) – January 15th

The response report is due to the Department as follows:
Quarter 1 – May 15th
Quarter 2 – August 15th
Quarter 3 – November 15th
Quarter 4 – February 15th

If the due date of the report (either for the cross match or the response portion) falls on a weekend or holiday, the next business day following the weekend or holiday will become the date the report is published or due.

NOTE: This report is to be submitted to:

Medical Facility Records Examiner
Bureau of Children’s Health Insurance Program (CHIP)
1142 Strawberry Square
P.O. Box 2675
Harrisburg, PA 17105-2675
14.2.3 FORMAT

An example of the report format template is given below. Templates will be sent to the Contractors via email.

**No alternative format will be accepted.**

### Potential Precluded Provider Response Report

<table>
<thead>
<tr>
<th>Contractor:</th>
<th>Quarter: ___ 1st ___ 2nd ___ 3rd ___ 4th</th>
<th>Year: ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>In Network?</td>
<td>Any CHIP Claims?</td>
</tr>
</tbody>
</table>

**Instructions:**

After researching the providers identified on the Potential Precluded Provider cross match, please complete the attached template.

The Provider Name field should have the Provider Name as specified on the cross match generated by Deloitte.

Answer the “In Network” field with a Yes, No, No*, or UTD.

If the answer is “yes” then the purple fields must be completed as well as a description of the actions taken in the green field.

If this field is answered as a “No” there is no need to answer any of the purple fields and only a note in the green “Actions Taken and Other Comments” is required explaining why the provider identified is not actually in your network (i.e. not the same provider, previously terminated, etc.).

Utilize “No*” in situations when the provider is still technically in the greater commercial network but protocols have been put in place to prevent CHIP enrollees from seeing them. This information would then be documented in the Actions Taken and Other Comments field.

UTD, Unable to Determine, should only be utilized if there is not enough information available via OIG or Medicheck in order to verify whether the provider identified on the
precluded list is the same individual as the provider in your network. What information you have discovered in your research should be documented in the Actions Taken and Other Comments field. The CHIP Office will attempt to obtain the necessary missing information required to continue the investigation and will forward any additional information under separate cover.

It is understood that it may not always be possible to recover claims within the same quarter as they are identified. It is expected that the MCO will continue to document this provider until all claims are recovered and will be reported on this document in the quarter it is received, regardless of when the initial identification of the provider occurred. Claims recovery processes that are ongoing (i.e. the provider will be paying the contractor $30/month for the next 10 years for example) should be explained in the “Actions Taken and Other Comments” section. Any costs paid out may not be included in the utilization costs used for the purposes of establishing rates for the CHIP Program.
1. On the PPP Report, if CHIP enrollees are not able to receive services from a precluded provider due to internal monitoring, how do we mark the “In Network?” section?

If CHIP enrollees are not able to receive services from the provider due to internal monitoring, you may mark “No” and then explain in the “Actions Taken and Other Comments” section that the provider is present in the contractor’s greater network, but that protocols have been put in place to prevent CHIP enrollees from seeing them. This documentation will assist in explaining why the provider continues to show up on the Deloitte cross match that is generated based on the monthly data warehouse provider files.

2. What do we do with providers in cases where after thoroughly researching the entity there simply is not enough information to determine whether the contractor’s provider is the same individual as the precluded provider?

In the “In Network?” section, document UTD (unable to be determined), and document any information that you have in the “Actions Taken and Other Comments” section. The CHIP Office will attempt to assist by providing additional information if possible.

3. What do we do if we cannot find the precluded provider listed on the cross match in Medicheck or on the OIG list?

Changes have been made to the cross match report to try to eliminate this from occurring. Since OIG updates the list on their website monthly, the providers identified on the current OIG list may not correspond with the providers that were published on the list at the time the cross match was run. If you are having trouble locating a provider on the Medicheck list, please email CHIP’s Medical Facility Record’s Examiner and the discrepancy will be researched. The Medicheck website can be accessed at www.dhs.pa.gov/publications/medichecksearch/. The OIG website can be accessed at http://exclusions.oig.hhs.gov/.

4. Can you specify the provider type of the precluded provider?

Details such as provider type or specialty will be determined by the contractor as they research the cross match.

5. What is the actual cross match finding based on?

On the cross match report, a column with burgundy print identifies the “origin” of the cross match. At least one entry for the provider in question will indicate the contractor’s
name. The line on the spreadsheet that lists the contractor as the “origin” indicates that the data listed for that specific entry has been drawn from the monthly data warehouse provider file that Deloitte receives from the contractor. The Department of Human Services (DHS), formerly DPW, indicates that a cross match for the provider in question occurred when the contractor’s provider database was run against DHS’s Medicheck database. OIG indicates that the cross match for the provider in question occurred when the contractor’s provider database was run against the Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE).

Fields, in which the font is green, indicate the fields that indicated a possible match. Matches are generated based on a combination of the first name, last name, county and zip, or NPI and county. Different methodologies of cross matching are used for the different databases as the LEIE and Medicheck do not document entries using the same identification criteria.

6. Does it matter what the provider is sanctioned for?

No. Regardless of the reason, if the provider is showing up on either the Medicheck or the LEIE, they should not be providing services to CHIP enrollees.

7. If a provider is only on the Medicheck list and has been removed from OIG’s LEIE because the term of sanction documented on the LEIE has passed, should they still be considered precluded?

Yes. Even if a provider is only found on the Medicheck list, they should be considered precluded. PA state law requires that providers must officially request reinstatement prior to being removed from the Medicheck list. Until a provider takes this step, DHS cannot remove them from the Medicheck list and they will remain in precluded status.

NOTE: See the below clarification on this matter directly from DHS:

Per MA General Regulations §1101.77(e) (3) the Department issues the Medicheck list containing the names of all providers who have been terminated from the Program. Per §1101.82(a) the provider must send a written request to OMAP which includes statements giving factual evidence why they believe the violations leading to the termination will not be repeated as well as reasons why they should be re-enrolled. Per §1101.82 (b) criteria for provider re-enrollment are defined. A provider cannot be removed from Medicheck until they have met all reinstatement requirements.

8. Can we contact our providers and request that they apply to DHS for reinstatement if they are showing up only on the Medicheck list?
Certainly. There is nothing preventing your Provider Relations staff from discussing the issue with providers and explaining the importance of them following through with the necessary paperwork to seek reinstatement.

9. Why would a business or entire office show up on our list? Do we have to research these and should they be precluded?

A terminated provider may not receive direct or indirect payments from the Department in the form of salary, equity, dividend, shared fees, contracts, kickbacks, or rebates from or through a participating provider or related entity. (Refer to 55 Pa. Code § 1101.77 (c.).)

These businesses may be showing up on your report because their owner is a precluded provider. It is expected that research is done to determine if the business listed within your network is owned or operated by a precluded provider. If so, the entity should be considered precluded.

10. What if the DHS or the OIG list states “Only Professional Corp is Excluded”?  

In this case, a provider has been determined for whatever reason to be allowed to continue to provide services while acting in their capacity as a healthcare provider, but is not allowed to collect monies associated with a business they might own or operate.

11. What does it mean if there isn’t a Potential Precluded Provider Cross Match Report for the contractor in the CHIP Application Processing System Report Repository?

If no report is present for the quarter in question, it means that none of the providers in the file you sent to Deloitte ended up cross matching to the providers listed in the Medicheck and LEIE databases. When this happens, it means there were no providers identified in your network that appeared to require further research.

12. We have already researched this precluded provider and taken the necessary steps to make sure our enrollees are not receiving services from them. Can’t you keep them from appearing on our report every quarter?

No. As long as the precluded provider is still listed in the data files you are sending Deloitte each month as being a part of your network, the provider will continue to show up on your report. You can indicate on the response report the previous actions you have put in place to ensure that enrollees do not receive services from this provider, but it is still expected that you will run the necessary reports to determine that no monies were paid out to the provider in question over the previous quarter.

13. We have already researched this provider and determined that the precluded provider listed on the cross match is not the same provider in our network. Can’t you keep them from appearing on our report every quarter?
No. As long as the provider that resulted in the original cross match is still listed in the data files you are sending Deloitte each month as being a part of your network and the entity that it matched against is still precluded, the provider will continue to show up on your report. In these cases, simply continue to document the initial research that you performed that indicates that your provider is not the same individual as the precluded provider in the “Actions Taken and Other Comments” section of the response report.

14. What if the precluded provider is in our greater network, but we know CHIP enrollees cannot receive services from them because they only provide non-covered services?

Answer the “In Network?” field as “No**” and explain the circumstances in the “Actions Taken and Other Comments” section of the response report. Reports should still be run to determine that no payments were rendered to this provider, however, just on the off chance that something slipped through the cracks and a claim was paid in error for whatever reason.

15. What if we find conflicting information and we think there might be a mistake in the LEIE, Medicheck, or Deloitte databases?

Mistakes do happen. If you find information that appears to indicate there is a problem with one of the databases or other concern, please contact CHIP’s Medical Facility Record’s Examiner and the CHIP Office will look into the matter. As an FYI, errors on the Medicheck database take a couple of weeks to correct, so if you do identify a problem, please understand it may take a little while before the public database reflects the correction.

16. What if due to various circumstances, monies for paid claims cannot be immediately collected?

If at all possible, an attempt should be made to collect the monies paid – whether by means of offsetting future payments or by recouping the funds directly. Whatever actions the contractor is taking to meet this expectation should be documented on the response report. It is understood that in certain circumstances this can be a challenging endeavor and at times delayed due to legal proceedings the provider may be involved in. Obstacles to the recovery of funds should be documented in the “Actions Taken and Other Comments” section of the response report.

17. Isn’t checking the LEIE database sufficient to determine which provider should be precluded?

No. Medicheck is a more restrictive database than LEIE, and it is the current policy of CHIP to consider providers that are precluded from Pennsylvania’s MA Program to be precluded from receiving CHIP funds as well. This policy is consistent with recent healthcare reform legislation passed at the federal level relating to termination of
providers from networks based on the preclusion of the providers in the networks of other government-funded programs.

18. If the contractor recoups money from a precluded provider for services rendered to a CHIP enrollee, can the provider attempt to collect money from the enrollee?

No.
14.3 ABORTION SERVICES REPORT

16.3.1 CONTENT

This report provides documentation that all abortion services paid for by the CHIP Program are compliant with the requirements set forth in 18 Pa. C.S.A. § 3204-3206 and 35 P.S. §§ 10101, 10103-10105.

14.3.2 FREQUENCY

This report is due annually by January 31st of the following year.

If the due date of the report falls on a weekend or holiday, the next business day following the weekend or holiday will become the date the report is published or due.

NOTE: This report is to be submitted via secure email to CHIP’s Medical Facility Record’s Examiner.

14.3.3 FORMAT

An example of the report format template is given below. Templates will be sent to the Contractors via email.

No alternative format will be accepted.
Abortion Services Report

<table>
<thead>
<tr>
<th>Contractor:</th>
<th>CHIP Program</th>
<th>Year: _______</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>UCI Number</th>
<th>Date of Service</th>
<th>Claim Paid?</th>
<th>Amount Paid</th>
<th>Documentation of Compliance Available?</th>
<th>Actions Taken, Funds Recovered, &amp; Other Comments</th>
</tr>
</thead>
<tbody>
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**Instructions:**

Use the current ICD-9 or ICD-10 codes, CPT, and HCPCS associated with abortions to identify all abortion services that have occurred over the previous calendar year:

Legally Induced, Illegally Induced, and Unspecified Abortions

**Exclude abortions that are performed as a result of an ectopic or molar pregnancy.**

Refer to Transmittal 2009-12, dated 12/30/2009, for existing CHIP certification requirements for abortion services consistent with federal and state laws.

For each abortion service, document the following:

The enrollee’s UCI number. If an enrollee has received more than one abortion within the calendar year, they should be listed more than once.

The date the service was rendered according to the claim is the date that should be documented for this field.

Document whether the claim has been paid or not. This should be populated with a “Y” for yes or an “N” for no. If the answer is “N”, no further documentation regarding that enrollee’s service is necessary. If the answer is “Y” then information relating to the next four columns must be documented.

The amount paid for the abortion service should document only the cost of the abortion procedure itself and not include any other services associated with the claim in question.

The next column should document whether the contractor possesses information that documents that the enrollee’s circumstances met the necessary statutory requirements in order for the abortion to be a covered service. A “Y” for yes or an “N” for no should be used to populate this field. It is not necessary to specify the type of the documentation or send it at this time. The question is simply looking to verify that should the CHIP Office request proof of compliance, that you are satisfied that you can provide sufficient documentation to verify that the abortion met the necessary criteria to be considered a covered service.
If sufficient documentation is not available, the MCO must attempt and document recovery of funds. Information relating to the recovery of funds and any other actions or comments should be documented in the “Actions Taken, Funds Recovered, & Other Comments” column.
ABORTION SERVICES REPORT

Abortion Services Report Q & A

1. Is there a specific statute or new regulation that requires the use of the Enrollee and Physician statements?

No. The forms parallel those used by the Department of Human Services and are therefore intended to streamline your processes between the two programs. These forms reflect state law, as read in conjunction with the federal law articulated in the State Medicaid Letter of February 12, 1998. The carry-over paragraph in particular focuses on the reporting requirement and requirement for a waiver provision.


2. Do we have to use the forms distributed with the abortion transmittals?

No. The Physician Certification for an Abortion Form and the Enrollee Statement Form are examples of forms that, when properly filled out, serve to document compliance with the law. Other types of documentation which sufficiently establish compliance with the law are acceptable.

3. Are Contractors expected to recoup funds paid out to providers for abortion services that do not have documentation establishing compliance associated with the service?

Yes. All possible attempts should be made to recoup funds paid for abortions if the Contractor determines that the abortion should not have been a covered service. If the funds cannot be recovered, documentation as to why funds are not recovered should be provided to the CHIP Office. Any costs paid out may not be included in the utilization costs used for the purposes of establishing rates for the CHIP Program.

4. Do the abortion services have to be prior authorized?

No, this is not required by CHIP. Administration of the benefit is up to the Contractor as long as it determines that its policies and procedures will ensure compliance with the law. Prior authorization has proven to be an effective way of monitoring these services. Each Contractor may develop its own policies to ensure compliance based on its current business practices if it is determined that it is not feasible to use a prior authorization policy.
5. May we use claims data such as modifiers to establish compliance with the law?

There may be occasions where there is sufficient documentation via claims data to establish compliance. Discussions with the Contractor’s legal counsel will assist in determining the Contractor’s policy regarding what data is required to establish adequate documentation that meets the law’s requirements.

6. Are Contractors allowed to pay for any services rendered at the time of the abortion if it is determined that the abortion does not meet the legal criteria to be a covered service?

Yes. Only the payment for the abortion itself would be disallowed. Blood work, pregnancy tests, ultrasounds, etc. are generally covered services.

7. Are Contractors allowed to pay for any services that are required as a result of complications resulting from an abortion if it is determined that the abortion does not meet the legal criteria to be a covered service?

Yes. Only the payment for the abortion itself would be disallowed. Medical services to remedy complications are generally covered services.

8. Our providers might not know at the time of the service that they are working with a CHIP enrollee. How are we supposed to make sure the right documentation is gathered at the time of the service?

The CHIP office allows contractors to determine the best means of administering the CHIP program in compliance with all applicable laws and this policy manual using the most effective methods in regard to the MCO’s current business practices.
CHAPTER 15: QUALITY MANAGEMENT INTERMITTENT REPORTS

15.1 AD HOC REPORTING

15.1.1 CONTENT

The Department may request contractors to submit ad hoc reports to meet a specific reporting need. These requests may result from federal or state legislative/gubernatorial data calls, requests from other state agencies, or requests from public sector entities.

15.1.2 FREQUENCY

The frequency of ad hoc report requests cannot be predetermined.

15.1.3 FORMAT

The request for an ad hoc report will be made to contractors in written form (e.g., email, letter, or fax). The written request will provide:

- A description of the nature and purpose of the report
- The format of the report (e.g., a template may be included to submit data)
- The means of transmission (e.g., fax or regular mail, email or secure email) for all reports containing HIPAA information
- The person to whom the report should be submitted
- The due date for submission

15.2 CONSTITUENT LEGISLATIVE CORRESPONDENCE

15.2.1 CONTENT

The Office of CHIP receives constituent correspondence/telephone calls and inquiries for investigation and resolution from various sources such as the Governor's Office, legislators, and other state agencies or authorities. In order to respond to these inquiries, CHIP staff will contact the appropriate contractor to obtain additional information as necessary. All correspondence/telephone call inquiries that require investigation are logged in. While this is an internal tracking system to manage inquiries, the log will also be used to track performance in conjunction with program monitoring activities. The log will also be used to determine areas of the program which might require further explanation in the form of a policy clarification.
15.2.2 FREQUENCY

Contractors will be contacted as needed by telephone, email, or fax. Due dates and a control number will be assigned to each inquiry, also known as a Blue Sheet, by CHIP support staff. Due dates for internal CHIP staff normally fall within two weeks of the origination date. Contractors are required to respond to any inquiry submitted to their attention within five (5) business days in order for CHIP staff to respond by the assigned, internal due date.

15.2.3 FORMAT

No specific format is required. Responses can be submitted by telephone, email, fax, or regular mail to the originating CHIP staff member.
CHAPTER 16: INTERNAL AND EXTERNAL AUDITS

16.1 GENERAL REQUIREMENTS

Both state and federal law require that the Department conduct monitoring and oversight of contractors. It is the responsibility of the Department to ensure that children are enrolled properly, that services being provided by each contractor are consistent with the requirements set forth in the RFA, and that funds appropriated for the program are properly expended.

Each contractor, at its own expense, is required to make all records available for audit, review, or evaluation by the Commonwealth and/or its designated representatives or Federal Agencies. Access shall be provided as directed by the Department either on-site, during normal business hours, or through the mail. During the contract and record retention period, these records shall be available at each contractor’s chosen location, subject to approval of the Commonwealth. Each contractor must fully cooperate with any and all reviews and/or audits by the Commonwealth and its designated representatives, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail must be sent in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity.

Each contractor shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity as well as to all required programmatic activity and data pursuant to this Agreement. Records may be kept in an original paper state or preserved on micro media or electronic format. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period and ten years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed. The Department has the ability to inspect physical facilities at any times during this period as well.

Each contractor shall include in all risk sharing subcontract agreements clauses, which reflect the above provisions.

If circumstances arise in which the Commonwealth or the contractor invoke the contractual termination clause or determine the contract will cease, the audit for the period ending with the termination date or the last date the contractor is responsible to provide benefits to CHIP enrollees shall be submitted to the
Commonwealth within 180 days after the contract termination date or the last date the contractor is responsible to provide such benefits.

16.2 OFFICE OF MANAGEMENT AND BUDGET (OMB) CIRCULAR A-133 AUDITS OF STATES, LOCAL GOVERNMENTS, AND NON-PROFIT AND COMMONWEALTH POLICY (“SINGLE AUDITS”)

16.2.1 CONTENT

Non-Profit entities that expend total federal awards of $750,000 or more during a fiscal year received either directly from the federal government or indirectly from a recipient of federal funds, are required to have an audit performed in accordance with the provision of Uniform Guidance. The Uniform Guidance can be accessed at [http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl)

For-Profit entities that expend total federal awards of $750,000 or more during a fiscal year have two options: 1) a financial related audit (as defined in the Government Auditing Standards) of a particular award in accordance with Government Auditing Standards, in those cases where the sub recipient receives awards under only one HHS program (i.e. a CHIP audit; or if awards are received under multiple HHS programs, a financial related audit of all HHS awards in accordance with Government Auditing Standards; or 2) a Single Audit performed in accordance with the Uniform Guidance (45 CFR § 75.501(i)).

Expenditures for single audits are the responsibility of the CHIP Provider.

16.2.2 FREQUENCY

Audits are to cover the fiscal year practiced by the individual Contractor. The audit must be electronically submitted to the Commonwealth’s Office of Budget, Bureau of Audits, 9 months after the end of the fiscal year.

16.2.3 FORMAT

Reports are to be submitted in the format deemed appropriate by the state or federal entity requiring the report.

All CHIP contractors who are submitting a single audit in accordance with OMB Circular A-133 or 2 CFR Part 200, Subpart F, as appropriate, are also required to include in their single audit reporting package a supplemental schedule. (See Appendix 16-A).
16.3 HEALTH CARE EFFECTIVENESS DATA INFORMATION SET AND CONSUMER ASSESSMENT HEALTH PLAN SURVEY (HEDIS®/CAHPS)

16.3.1 Content (HEDIS®)

Contractors are required to report CHIP-specific data for the measures listed below based on the latest version of HEDIS®. Measures may change from year-to-year. The Department will notify contractors annually, by official Department transmittal, of any changes to measures or permissible rotations. All contractors will follow HEDIS® Medicaid product line technical specifications, including Medicaid continuous enrollment requirements per NCQA’s specifications.

Contractors are required to have HEDIS® results audited and validated by an NCQA licensed compliance vendor. The MCO may utilize these validation results for other purposes such as pursuit of accreditation.

The Department currently contracts with an external quality review organization (EQRO) to collect and analyze data unless otherwise advised via official Departmental transmittal. The EQRO will also be responsible for developing an official report and report card which will be publicly reported.

It is important to refer to the most recent HEDIS® and CAHPS transmittal to determine the most current measures the Department is requiring CHIP contractors to collect. The following HEDIS® measures are currently required by the Department specifically for the CHIP population for the calendar year 2016 (these measures are subject to change):

1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): This measure assesses the percentage of children/adolescents 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. Three rates are reported:
   - BMI (body mass index) Percentile Documentation
   - Counseling for nutrition
   - Counseling for physical activity

2. Childhood Immunization Status (CIS): The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu)
vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

3. Immunizations for Adolescents (IMA): The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

4. Human Papillomavirus Vaccine for Female Adolescents (HPV): The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

5. Lead Screening in Children (LSC): The percentage of children two years of age who had one or more capillary or venous lead blood test(s) for lead poisoning by their second birthday.

6. Chlamydia Screening in Women (CHL): The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.
   - Age stratifications for CHIP: 16-19 years

NOTE: The 16-19 age stratification range differs from HEDIS® 2016 technical specifications.

7. Appropriate Testing for Children with Pharyngitis (CWP): The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

8. Appropriate Treatment for Children with Upper Respiratory Infection (URI): The percentage of children 3 months-18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. The measure is reported as an inverted rate \[1 - \left(\frac{\text{numerator}}{\text{eligible population}}\right)\]. A higher rate indicates appropriate treatment of children with URI, (i.e., the proportion for whom antibiotics were not prescribed).

9. Medication Management for People With Asthma (MMA): The percentage of enrollees 5-85 years of age during the measurement year who were identified as having persistent asthma and who were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported
   - The percentage of enrollees who remained on an asthma controller medication for at least 50% of their treatment period.
   - The percentage of enrollees who remained on an asthma control medication for at least 75% of their treatment period.
NOTE: The CHIP age range of 5-19 differs from HEDIS® 2016 technical specifications.

10. Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder Medication (ADD): The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:
   • Initiation Phase. The percentage of enrollees 6-12 years of age as of the IPSD with an ambulatory dispensed ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
   • Continuation and Maintenance (C&M) Phase. The percentage of enrollees 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

11. Follow-Up after Hospitalization for Mental Illness (FUH): The percentage of discharges for enrollees 6 years of age and older who were hospitalized for treatment of selected mental health diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental practitioner. Two rates are reported:
   • The percentage of discharges for which the enrollee received follow-up within 30 days of discharge.
   • The percentage of discharges for which the enrollee received follow-up within 7 days of discharge.

12. Children and Adolescents' Access to Primary Care Practitioners (CAP): The percentage of enrollees 12 months-19 years of age who had a visit with a primary care practitioner (PCP). The organization reports four separate rates for each product line.
   • Children 12-24 months and 25 months-6 years who had a visit with a PCP during the measurement year.
   • Children 7-11 years and adolescents 12-19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

13. Annual Dental Visit (ADV): The percentage of enrollees 2-21 years of age who had at least one dental visit during the measurement year.
   • Age stratifications for CHIP: 2-19 years
NOTE: The 16-19 age stratification range differs from HEDIS® 2016 technical specifications.
14. Well-Child Visits in the First 15 Months of Life (W15): The percentage of enrollees who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:
   - No (0) well-child visits, one well-child visit, two well-child visits, three well-child visits, four well-child visits, five well-child visits, or six or more well-child visits.

15. Well-Child Visits in 3rd, 4th, 5th and 6th Years of Life (W34): The percentage of enrollees 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.

16. Adolescent Well-Care Visits (AWC): The percentage of enrolled enrollees 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
   - Age stratifications for CHIP: 12-19 years.

NOTE: The 12-19 age stratification range differs from HEDIS® 2016 technical specifications.

17. Ambulatory Care (AMB): This measure summarizes utilization of ambulatory care in the following service categories:
   - Outpatient Visits
   - Emergency Department (ED) visits
   - Age stratifications for CHIP: <1 year, 1-9 years, 10-19 years, and Total.

18. Inpatient Utilization: General Hospital/Acute Care (IPU): This measure summarizes utilization of acute inpatient care and services in the following categories:
   - Total Inpatient
   - Medicine
   - Surgery
   - Maternity
   - Age stratifications for CHIP: < 1 year, 1-9 years, 10-19 years, and Total.

19. Identification of Alcohol and Other Drug Services (IAD): This measure summarizes the number and percentage of enrollees with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year.
   - Any service
   - Inpatient
   - Intensive outpatient or partial hospitalization
   - Outpatient or ED
   - Age/gender stratifications for CHIP: 0-12 years, 13-17 years, 18-19 years; Each for Male, Female and Total.
NOTE: The 18-19 age stratification range differs from HEDIS® 2016 technical specifications.

20. Mental Health Utilization - Percentage of Enrollees Receiving Inpatient and Intermediate Care and Ambulatory Services (MPT): This measure summarizes the number and percentage of enrollees receiving the following mental health services during the measurement year.
   - Any service
   - Inpatient
   - Intensive outpatient or partial hospitalization
   - Outpatient or ED
   - Age/gender stratifications for CHIP: 0-12 years, 13-17 years, 18-19 years; Each for Male, Female, and Total.

NOTE: The 18-19 age stratification range differs from HEDIS® 2016 technical specifications.

16.3.2 FREQUENCY (HEDIS®)

This is an annual audit. The deadline for submission of CHIP data to NCQA is June 15th or otherwise specified by the official HEDIS submission timeline. If the 15th falls on a weekend, it will be due the following Monday or next business day.

16.3.3 FORMAT (HEDIS®)

Contractors are required to submit their data through NCQA’s Interactive Data Submission System’s (IDSS) web-based tool. Contractors will contact NCQA for direction regarding the HEDIS® IDSS submission process.

16.3.4 CONTENT (CAHPS)

Contractors are required to complete a CHIP-specific CAHPS Survey (CPC). All contractors will follow NCQA’s Specifications for Survey Measures “General Guidelines for Data Collection and Reporting” chapter using the Medicaid product line specifications except for additional questions added to the survey by the Department for the purposes of evaluating PA CHIP. Contractors must contract with a certified vendor to administer the CAHPS survey.

Current (2016) Additional Child CAHPS Mental Health Questions These may change over time.

M1. If you were concerned about your child’s mental health, which provider would you be most likely to contact?
- My child’s primary care provider
- A mental health provider

M2. In the last 12 months, how often did your family get the help you wanted for your child’s mental health from any provider?

- Never
- Sometimes
- Usually
- Always
- My child did not require any help for mental health related conditions.

M3. If your child received service from a professional mental health provider in the last 12 months, how often was it easy to get the counseling or treatment you thought your child needed?

- Never
- Sometimes
- Usually
- Always
- My child did not require any help for mental health related conditions.

16.3.5 FREQUENCY (CAHPS)

This is an annual survey. CAHPS data will be submitted to the Department’s EQRO, by July 15th, but may be submitted prior to this deadline. Detailed instructions regarding submission to the EQRO will be provided to the contractors each year.

16.3.6 FORMAT (CAHPS)

Detailed format and submission instructions provided by the EQRO each year.

16.4 CHIP PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

16.4.1 GENERAL REQUIREMENT

The Department’s EQRO performs the validation of CHIP MCO PIPs. The PIP process and timeline, as well as EQRO’s validation, are conducted according to the Centers for Medicare and Medicaid (CMS) protocols. As outlined in these protocols, the PIP cycle spans several years and includes multiple steps. CHIP MCOs must document all PIP activities on the on the PIP Submission Form.

Each year the EQRO validates progress on the PIP during the measurement year (i.e., a "snapshot" of activities during one year of the cycle).

16.4.2 CONTENT
Topic Selection:

- The overall PIP topic will be selected by the Department.
- The MCO must do a root cause or similar analysis to determine the reasons for over/under-utilization in the CHIP population.
- The reason why the topic is relevant to the MCO’s CHIP population must be clearly stated.
- The MCO can choose an entire population for the topic or a subset of this population for MCO developed measures. However, MCOs are reminded that smaller populations may introduce increased variability of results and potentially more error.
- In general, topic selection is based upon continuous data collection, analysis and monitoring of all aspects of patient care and service delivery, and should consider the prevalence of a condition, enrollee need for a specified service, enrollee demographics and the interests of consumers and providers.
- Clinical focus areas should include prevention and care of acute and chronic conditions, high-volume services, and/or high-risk services.

Study Indicators:

- The indicators selected by the MCO should be consistent with current clinical standards and health services research.
- MCO developed indicators should be evidenced-based, use recognized clinical guidelines, or be accompanied by a consensus among expert practitioners.
- The PIP should describe the event being assessed or the enrollees who are eligible for the service or care. Indicate whether all events or eligible enrollees are included, or whether the denominator is a sample.
- Indicators should relate directly to the project topic and type of indicator.

Study Design:

The study design must:

- Clearly specify the data to be collected,
- Specify the sources of data,
- Specify a systematic method of collecting valid and reliable data that represents the entire population to which the study’s indicators apply, and
- Prospectively specify a data analysis plan.

Baseline Measurement:

CHIP MCOs will use data from the specified period (service dates) as baseline data for the first year of the measure. The data can be obtained through retrospective review of administrative data or medical records. As noted, MCOs
will submit data collection methodology, rates and barrier analyses – via the PIP Submission Form.

**Intervention Cycle:**

It is expected that interventions associated with improvement on CHIP quality indicators will be: 1) system interventions, or affect a wide range of participants; 2) timely, most typically having been implemented after measurement or early in the next measurement period; 3) targeted at the indicator and the population studied. The MCO should be able to demonstrate that its data have been corrected for any major confounding variables with an obvious impact on the outcomes, and that interventions that are developed or continued are the result of analysis of these data.

While MCOs may conduct continuous, ongoing interventions, validation of PIPs focus on examining interventions at two points in time: interventions that occur after baseline and subsequent interventions that occur after the first re-measurement.

The second measurement (calendar) year will be dedicated to the development of interventions after baseline to control for the effects of barriers to quality care. Documentation of Intervention Activities will be submitted to the EQRO in November of the second project year. No rates will be documented in the second submission.

**Re-measurement:**

CHIP MCOs will use data (service dates) from the second measurement year as re-measurement to determine if there is improvement over baseline. This will take into account the impact of interventions enacted in the second measurement year. Additionally, MCOs will use measurement year two for subsequent interventions, in which they will implement new interventions or continue existing ones. Re-measurement data and subsequent interventions will be submitted to the EQRO in November of year three.

**Sustained Improvement:**

Sustained improvement is re-measurement #2. It is measured as improvement relative to baseline and should be demonstrated based on performance in the year following the re-measurement year. Data for sustained improvement will be submitted to the EQRO in November of year four.

Contractors must submit a corrective action plan, as determined by the Department, and within timeframes established by the Department to resolve any
performance or quality of care deficiencies identified either by an independent assessor and/or by the Department.

**Schedule of PIP Submissions – Emergency Department Utilization (Current PIP)**

The EQRO will review each PIP using a standard scoring tool and will provide feedback to the Office of CHIP and the MCO. Findings from this review will be included in the annual CHIP Report.

**16.4.3 FREQUENCY**

This report is due annually in March.

NOTE: This report should be submitted via email to the EQRO.

**16.4.4 FORMAT**

Detailed format and submission instructions provided by the EQRO each year.

**Schedule of PIP Submissions – Lead Screening in Children (Current PIP)**

The EQRO reviews each PIP using a standard scoring tool and will provide feedback to the Office of CHIP and the MCO. Findings from this review will be included in the annual CHIP Report.

**16.4.5 FREQUENCY**

This report is due annually in November.

NOTE: This report should be submitted via email to the EQRO.

**16.4.6 FORMAT**

Detailed format and submission instructions provided by the EQRO each year.

**16.5 PERFORMANCE MEASURES**

**16.5.1 GENERAL REQUIREMENTS**

Selected Pennsylvania specific performance measures are implemented for the CHIP population. The performance measures allow CHIP to monitor particular clinical areas of interest to the Office of CHIP, DHS, or CHIP Advocates. These performance measures may reflect changes in the Child Core Set, CMS initiatives, and DOH projects. Four Pennsylvania performance measures are currently collected for CHIP.
16.5.2 CONTENT/PROCESS OVERVIEW

A list of required Performance Measures will be provided annually by the EQRO.

Process Overview:

An overview of the validation process for Performance Measures follows:

- Enrollee level detail file (Data file) and Source Code validation is conducted by the EQRO for all Performance Measures.
- Contractors will submit Source Code and a data file for each Performance Measure for review and validation each year prior to or on the specified due date.
- All files containing protected health information (PHI) will be submitted via secure ftp.
- The EQRO will review Source Code to ensure that the appropriate eligible populations are selected for each performance measure and that the appropriate enrollees are selected as numerator positives for each measure.
- The EQRO will review each data file to confirm that all data elements are present in the specified position.
- As appropriate, contractors are permitted to provide corrective action to pass validation (i.e., correcting the cause of the discrepancy and re-submitting both the Source Code and data files).
- If the errors are not resolvable, the contractor receives a “Not Report” for the measure(s).
- At the completion of validation, the EQRO will submit the final rate sheet to Contractors for each measure.
- Contractors will review, sign, and return a copy of the final rate sheet to the EQRO to signify agreement with the final rates.

16.5.3 FREQUENCY

Each measure is due in August of each year.

16.6 ACCREDITATION VERIFICATION

16.6.1 CONTENT

The Medical Services Analyst will contact the Bureau of Managed Care, (DOH) yearly, during the month of January, to verify that the contractors have maintained their accreditation with the NCQA. Contractors must have NCQA accreditation and
must inform the Commonwealth of accreditation status annually. Contractors must also authorize private independent accrediting entities to provide status, results, and expiration date to the Commonwealth. DOH will also let CHIP's QA Department know of any changes that they need to be aware of.

16.7 PAYMENT ERROR RATE MEASUREMENT (PERM)

16.7.1 GENERAL REQUIREMENTS

The Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act (IPERA), requires federal agencies to annually review programs, which are identified by the Office of Management and Budget (OMB) as at risk for improper payments, e.g. CHIP. Improper payments are any payments that have been made in error, including payments that should not have been made, payments that were made in the incorrect amount, and inappropriate denials of payment or services. PERM was created by CMS to aid in compliance with IPIA by measuring improper payments and procedures error rates. Per IPIA the final estimates are submitted to Congress and used by CHIP to reduce the improper payments.

16.7.2 CONTENT

Under PERM, reviews will be conducted in three areas: (1) fee-for-service (FFS), (2) managed care, and (3) program eligibility for both the Medicaid and SCHIP Programs. Detailed information can be found at www.cms.hhs.gov/PERM.

16.7.3 FREQUENCY

Each year PERM will review payment error rates for a rotating subset of one-third of all states, or about 17 states each year. Pennsylvania was selected to participate in Cycle 1.

16.7.4 FORMAT

Contractors will be contacted on specifications regarding information to be submitted and a timeline.

16.8 MEDICAL LOSS RATIO (MLR)

The MCO must calculate the Medical Loss Ratio (MLR) for each MLR Reporting Year in accordance with the calculation standards in 42 CFR §457.1203(c) in reference to 42 CFR §438.8 and report the MLR experience to the Department with the information specified in 42 CFR §438.8(k) within twelve (12) months of the close of the MLR Reporting Year. The MCO will owe a remittance to the Department if a MLR of at least 85 percent is not achieved for the MLR Reporting
Year. See Appendix 16-B for the Medical Loss Ratio Template that the Department will use to track MLR for each MCO.
APPENDIX 16-A: RECONCILIATION SUPPLEMENT FINANCIAL SCHEDULE

Reporting

RECONCILIATION SUPPLEMENTAL FINANCIAL SCHEDULE
ATTENTION: The information contained below is for Government Operated, Non-profit, and For-profit Children’s Health Insurance Program (CHIP) contractors that contract directly with the Department of Human Services (DHS) and are submitting a single audit in accordance with OMB Circular A-133, 2 CFR Part 200, Subpart F, or Title 45, CFR 75.501(i), as appropriate.

RECONCILIATION SUPPLEMENTAL FINANCIAL SCHEDULE

Introduction

NOTE: The submission of information related to Appendix II is not affected by the Single Audit Amendments of 1996, the latest OMB Circular A-133 Revision, or the issuance of 2 CFR Part 200, Subpart F. Please review the Audit Exhibit contained in the CHIP contract to determine whether a Single Audit or Program Specific (Yellow-book) audit is required.

All CHIP contractors who are submitting a single audit in accordance with OMB Circular A-133 or 2 CFR Part 200, Subpart F, as appropriate, are also required to include in their single audit reporting package a supplemental schedule, which is to be subjected to an Agreed-Upon Procedures engagement. The schedule, for which an example is included in this Appendix, is a reconciliation of the expenditures listed on the Schedule of Expenditures of Federal Awards (SEFA) to the Federal award income received from the Pennsylvania Department of Human Services (DHS), as noted in the revenue confirmation received from the Commonwealth of Pennsylvania. The procedures to be performed on the reconciliation schedule are as follows:

(a) Agree the expenditure amounts listed on the reconciliation schedule under the “Federal Expenditures per the SEFA” column C to the audited Schedule of Expenditures of Federal Awards (SEFA).

(b) Agree the receipt amounts listed on the reconciliation schedule under the “Federal Awards Received per the audit confirmation reply from Pennsylvania” column D to the subrecipient Federal amounts that were reflected in the audit confirmation reply from the Office of Budget, Comptroller Operations.

(c) Recalculate the amounts listed under the “Difference” column E and the “% Difference” column F.

(d) Agree the amounts listed under the “Difference” column E to the audited books and records of the CHIP Office.
(e) Agree the “Detailed Explanation of the Differences” to the audited books and records of the CHIP Office.

(f) Based on the procedures detailed in paragraphs (a) through (e) above, disclose any adjustments and/or findings which have not been reflected on the corresponding schedules (List each separately.)

As is the case with other financial statements, management (the auditee) is responsible for the preparation of the required supplemental financial schedules. The auditor is asked to perform certain procedures on these schedules and incorporate all such schedules into the Audit package using the Independent Accountant’s Report on Applying Agreed-Upon Procedures.

Technical Assistance
Questions regarding this Audit Guide, DHS audit policy, and specific programs funded either directly or indirectly through DHS should be directed to:

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Financial Operations
Division of Audit and Review
Audit Resolution Section
3 Ginko Drive
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
RA-pwauditresolution@pa.gov
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Instructions for MLR Report

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**Introduction**

These instructions are for the Excel-based MLR Reporting. The Excel workbook is designed to collect all information needed for MLRs as required by the Office of CHIP.

This report is to be completed and submitted to the Department by November 30<sup>th</sup> of the year following the MLR reporting year. For example, for CY 2017 rates, this MLR report for reporting year CY 2017 would be due to the Department on November 30<sup>th</sup>, 2018.

Throughout these instructions there will be references to the 2016 Medicaid/CHIP Managed Care Final Rule and other regulations. The text of the regulations cited are included in this document. All regulations are parts of 42 CFR unless cited otherwise.

The information requested by the report follow regulation § 438.8(k):

1. The State, through its contracts, must require each MCO, PIHP, or PAHP to submit a report to the State that includes at least the following information for each MLR reporting year:
   1. Total incurred claims.
   2. Expenditures on quality improving activities.
   3. Expenditures related to activities compliant with § 438.608(a)(1) through (5), (7), (8) and (b).
   4. Non-claims costs.
   5. Premium revenue.
   6. Taxes, licensing and regulatory fees.
   7. Methodology(ies) for allocation of expenditures.
   8. Any credibility adjustment applied.
   9. The calculated MLR.
   10. Any remittance owed to the State, if applicable.
   11. A comparison of the information reported in this paragraph with the audited financial report required under § 438.3(m).
   12. A description of the aggregation method used under paragraph (i) of this section.
   13. The number of member months.

2. A MCO, PIHP, or PAHP must submit the report required in paragraph (k)(1) of this section in a timeframe and manner determined by the State, which must be within 12 months of the end of the MLR reporting year.

3. MCOs, PIHPs, or PAHPs must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that MCO, PIHP, or PAHP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCO, PIHP, or PAHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.
1. **Plan Information**
Please fill out the contact information of your MCO.

2. **Numerator**
This worksheet collects information for items that are included or deducted from the numerator. Note that incurred claims by one MCO that is later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

Detail for each line can be found here:

**Line 1.1** Incurred claims, including unpaid claim liabilities for the MLR reporting year: Note that this amount should be net of all fraud recoveries, including what is reported in or out of the claims system. See §§ 438.8(e)(2)(i)(A) and 438.8(e)(2)(i)(B):

(A) Direct claims that the MCO, PIHP, or PAHP paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and services meeting the requirements of § 438.3(e) provided to enrollees.

(B) Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

§ 438.3(e) Services that may be covered by an MCO, PIHP, or PAHP:
(1) An MCO, PIHP, or PAHP may cover, for enrollees, services that are in addition to those covered under the State plan as follows:
   (i) Any services that the MCO, PIHP or PAHP voluntarily agree to provide, although the cost of these services cannot be included when determining the payment rates under paragraph (c) of this section.
   (ii) Any services necessary for compliance by the MCO, PIHP, or PAHP with the requirements of subpart K of this part and only to the extent such services are necessary for the MCO, PIHP, or PAHP to comply with § 438.910.

(2) An MCO, PIHP, or PAHP may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan as follows:
   (i) The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;
   (ii) The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting;
   (iii) The approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP; and
   (iv) The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.
Line 1.2 IBNR for claims incurred in the period expected to be paid in months after the known runout: See § 438.8(e)(2)(i)(F)
Incur but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

Line 1.3 Withholds from payments made to network providers: See § 438.8(e)(2)(i)(C)
Withholds from payments made to network providers.

Line 1.4 Amount of incentive and bonus payments made, or expected to be made, to network providers: See § 438.8(e)(2)(iii)(A)
The amount of incentive and bonus payments made, or expected to be made, to network providers.

Line 1.5 Changes in other claims-related reserves: See § 438.8(e)(2)(i)(G)
Changes in other claims-related reserves.

Line 1.6 Reserves for contingent benefits and the medical claim portion of lawsuits: See § 438.8(e)(2)(i)(H)
Reserves for contingent benefits and the medical claim portion of lawsuits.

Line 1.7 Net payment or receipts related to state-mandated solvency funds: See § 438.8(e)(2)(iv)
Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

Line 1.8a Amount spent on fraud reduction: See § 438.8(e)(2)(iii)(B)
The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph (e)(4) of this section.

§ 438.8(e)(4):
Fraud prevention activities. MCO, PIHP, or PAHP expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section.

Note that the private market at this time has not adopted fraud prevention, so amounts for fraud prevention should not be any part of this MLR report.

Line 1.8b Amount of claims payments recovered through fraud reduction: Note that Line 1.1 should be net of all fraud recoveries, including what is reported in and out of the claims system. That same recoveries amount is then reported here as a positive amount. Also, see Line 1.8a.
Line 1.9 Claims that are recoverable for anticipated coordination of benefits: See § 438.8(e)(2)(i)(D)
Claims that are recoverable for anticipated coordination of benefits.

Line 1.10 Claims payments recoveries received as a result of subrogation: See § 438.8(e)(2)(i)(E)
Claims payments recoveries received as a result of subrogation.

Line 1.11 Overpayment recoveries received from network providers: The Department expects this to include any anticipated settlements for claims incurred during the MLR reporting year, including those outside of the claims system. See § 438.8(e)(2)(ii)(A)
Overpayment recoveries received from network providers.

Line 1.12 Prescription drug rebates received and accrued: See § 438.8(e)(2)(ii)(B)
Prescription drug rebates received and accrued.

Line 2.1 PH-MCO activity that meets 45 CFR § 158.150(b) and is NOT EXCLUDED under 45 CFR § 158.150(c): See § 438.8(e)(3)(i)
An MCO, PIHP, or PAHP activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150(c).

45 CFR § 158.150 – Activities that improve health care quality
(b) Activity requirements. Activities conducted by an issuer to improve quality must meet the following requirements:
(1) The activity must be designed to:
   (i) Improve health quality.
   (ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
   (iii) Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.
   (iv) Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.
(2) The activity must be primarily designed to:
   (i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
(A) Examples include the direct interaction of the issuer (including those services delegated by contract for which the issuer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
(1) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3502 of the Affordable Care Act.
(2) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
(3) Quality reporting and documentation of care in non-electronic format.
(4) Health information technology to support these activities.
(5) Accreditation fees directly related to quality of care activities.
(6) Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD-10 as the standard medical data code set, implementing ICD-10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.

(B) [Reserved]

(ii) Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:
(A) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
(B) Patient-centered education and counseling.
(C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.
(D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
(E) Health information technology to support these activities.

(iii) Improve patient safety; reduce medical errors, and lower infection and mortality rates.
(A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:
(1) The appropriate identification and use of best clinical practices to avoid harm.
(2) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.
(3) Activities to lower the risk of facility-acquired infections.
(4) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions.
(5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.
(6) Health information technology to support these activities.
(B) [Reserved]

(iv) Implement, promote, and increase wellness and health activities:
(A) Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include -
(1) Wellness assessments;
(2) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
(3) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
(4) Public health education campaigns that are performed in conjunction with State or local health departments;
(5) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS Act;
(6) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
(7) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and
(8) Health information technology to support these activities.
(B) [Reserved]
(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with § 158.151 of this subpart.
(c) Exclusions. Expenditures and activities that must not be included in quality improving activities are:
(1) Those that are designed primarily to control or contain costs;
(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;
(3) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;
(4) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.
(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
(7) All retrospective and concurrent utilization review;
(8) Fraud prevention activities;
(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
(10) Provider Credentialing;
(11) Marketing expense
(12) Cost associated with calculating and administering individual enrollee or employee incentives;
(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and
(14) Any function or activity not expressly included in paragraph (a) or (b) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this part or otherwise support monitoring, measuring or reporting health care quality improvement.

**Line 2.2** MCO activity related to any EQR-related activity as described in §§ 438.358(b) and 438.358(c): See § 438.8(e)(3)(ii)

An MCO, PIHP, or PAHP activity related to any EQR-related activity as described in § 438.358(b) and (c)

§ 438.358 – Activities related to external quality review

(b) Mandatory activities.

(1) For each MCO, PIHP, or PAHP the following EQR-related activities must be performed:

   (i) Validation of performance improvement projects required in accordance with § 438.330(b)(1) that were underway during the preceding 12 months.

   (ii) Validation of MCO, PIHP, or PAHP performance measures required in accordance with § 438.330(b)(2) or MCO, PIHP, or PAHP performance measures calculated by the State during the preceding 12 months.

   (iii) A review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D of this part and the quality assessment and performance improvement requirements described in § 438.330.

   (iv) Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in § 438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, § 438.14(b)(1).

(2) For each PCCM entity (described in § 438.310(c)(2)), the EQR-related activities in paragraphs (b)(1)(ii) and (iii) of this section must be performed.

(c) Optional activities. For each MCO, PIHP, PAHP, and PCCM entity (described in § 438.310(c)(2)), the following activities may be performed by using information derived during the preceding 12 months:

   (1) Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)).

   (2) Administration or validation of consumer or provider surveys of quality of care.

   (3) Calculation of performance measures in addition to those reported by an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) and validated by an EQRO in accordance with (b)(2) of this section.

   (4) Conduct of performance improvement projects in addition to those conducted by an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) and validated by an EQRO in accordance with (b)(1) of this section.

   (5) Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

   (6) Assist with the quality rating of MCOs, PIHPs, and PAHPs consistent with § 438.334.

**Line 2.3** MCO expenditure that is related to Health Information Technology and meaningful use: See § 438.8(e)(3)(iii)
Any MCO, PIHP, or PAHP expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in paragraph (e)(2) of this section.

45 CFR § 158.151
(a) General requirements. An issuer may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in § 158.150 of this subpart and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

(1) Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their “meaningful use” as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in § 158.140 of this subpart;

(2) Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;

(3) Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

(4) Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS® measures and costs for public reporting mandated or encouraged by law.

(5) Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.

(6) Advancing the ability of enrollees, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient’s medical history and to support care management.

(7) Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.

(8) Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

(b) [Reserved]
3. Excluded Amounts
This worksheet collects information for items excluded from the numerator, but is required to be reported. Note that incurred claims by one MCO that is later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

**Line 3.1** Amounts paid to third party vendors for secondary network savings: See § 438.8(e)(2)(v)(A)(1)
Amounts paid to third party vendors for secondary network savings.

**Line 3.2** Amounts paid to third party vendors for network development, admin fees, claims processing, and utilization management: See § 438.8(e)(2)(v)(A)(2)
Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

**Line 3.3** Amounts paid to a provider for professional or administrative services outside of providing services to enrollees: See § 438.8(e)(2)(v)(A)(3)
Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

§ 438.3(e): See Line 1.1

**Line 3.4** Fines and penalties assessed by regulatory authorities: See § 438.8(e)(2)(v)(A)(4)
Fines and penalties assessed by regulatory authorities.

**Line 3.5** Amounts paid to the Department as remittance for prior MLR experience: See § 438.8(e)(2)(v)(B)
Amounts paid to the State as remittance under paragraph (j) of this section.

§ 438.8(j): Remittance to the State if specific MLR is not met. If required by the State, a MCO, PIHP, or PAHP must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher if set by the State as described in paragraph (c) of this section.

**Line 3.6** Amounts for pass-through payments under § 438.6(d): See § 438.8(e)(2)(v)(C)
Amounts paid to network providers under to § 438.6(d).

§ 438.6: Special contract provisions related to payment
(a) Definitions. As used in this part, the following terms have the indicated meanings:

*Pass-through payment* is any amount required by the State to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the
MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of this section for services and enrollees covered under the contract; a sub capitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments.

(d) Pass-through payments under MCO, PIHP, and PAHP contracts.

1) States may require MCOs, PIHPs, and PAHPs to make pass-through payments (as defined in paragraph (a) of this section) to network providers that are hospitals, physicians, and nursing facilities under the contract subject to the requirements of this paragraph (d). States may not require MCOs, PIHPs, and PAHPs to make pass-through payments other than those permitted under this paragraph.

2) Calculation of the base amount. The base amount of pass-through payments is the sum of the results of paragraphs (d)(2)(i) and (ii) of this section.

(i) For inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under MCO, PIHP, or PAHP contracts two years prior to the rating period, the State must determine reasonable estimates of the aggregate difference between:

(A) The amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under the MCO, PIHP, or PAHP contracts for the 12-month period immediately two years prior to the rating period that will include pass-through payments; and

(B) The amount the MCOs, PIHPs, or PAHPs paid (not including pass through payments) for those inpatient and outpatient hospital services utilized by the eligible populations under MCO, PIHP, or PAHP contracts for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

(ii) For inpatient and outpatient hospital services that will be provided to eligible populations through the MCO, PIHP, or PAHP contracts for the rating period that includes pass-through payments and that were provided to the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period, the State must determine reasonable estimates of the aggregate difference between:

(A) The amount Medicare FFS would have paid for those inpatient and outpatient hospital services utilized by the eligible populations under Medicaid FFS for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments; and

(B) The amount the State paid under Medicaid FFS (not including pass through payments) for those inpatient and outpatient hospital services utilized by the eligible populations for the 12-month period immediately 2 years prior to the rating period that will include pass-through payments.

(iii) The base amount must be calculated on an annual basis and is recalculated annually.
(iv) States may calculate reasonable estimates of the aggregate differences in paragraphs (d)(2)(i) and (ii) of this section in accordance with the upper payment limit requirements in 42 CFR part 447.

(3) Schedule for the reduction of the base amount of pass-through payments for hospitals under the MCO, PIHP, or PAHP contract. Pass-through payments for hospitals may be required under the contract but must be phased out no longer than on the 10-year schedule, beginning with contracts that start on or after July 1, 2017. Pass-through payments may not exceed a percentage of the base amount, beginning with 100 percent for contracts starting on or after July 1, 2017, and decreasing by 10 percentage points each successive year. For contracts beginning on or after July 1, 2027, the State cannot require pass-through payments for hospitals under a MCO, PIHP, or PAHP contract.

(4) Documentation of the base amount for pass-through payments to hospitals. All contract arrangements that direct pass-through payments under the MCO’s, PIHP’s or PAHP’s contract for hospitals must document the calculation of the base amount in the rate certification required in § 438.7. The documentation must include the following:
   (i) The data, methodologies, and assumptions used to calculate the base amount;
   (ii) The aggregate amounts calculated for paragraphs (d)(2)(i)(A), (d)(2)(i)(B), (d)(2)(ii)(A), (d)(2)(ii)(B) of this section; and
   (iii) The calculation of the applicable percentage of the base amount available for pass-through payments under the schedule in paragraph (d)(3) of this section.

(5) Pass-through payments to physicians or nursing facilities. For contracts starting on or after July 1, 2017 through contracts beginning on or after July 1, 2021, the State may require pass-through payments to physicians and nursing facilities under the MCO, PIHP, or PAHP contract. For contracts beginning on or after July 1, 2022, the State cannot require pass-through payments for physicians or nursing facilities under a MCO, PIHP, or PAHP contract.

4. Denominator
This worksheet collects information for the denominator. Note that the total amount of the denominator for a MCO, which is later assumed by another entity, must be reported by the assuming MCO for the entire MLR reporting year, and no amount for that year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

**Line 4.1 State capitation payments, including adjustments, excluding pass-through payments:** See § 438.8(f)(2)(i)

State capitation payments, developed in accordance with § 438.4, to the MCO, PIHP, or PAHP for all enrollees under a risk contract approved under § 438.3(a), excluding payments made under to § 438.6(d).

**§ 438.4 Actuarial Soundness:**
(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms
of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.

(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

(1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices.

(2) Be appropriate for the populations to be covered and the services to be furnished under the contract.

(3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§ 438.206, 438.207, and 438.208.

(4) Be specific to payments under the contract.

(5) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).

(6) Meet any applicable special contract provisions as specified in § 438.6.

(7) Be provided to CMS in a format and within a timeframe that meets requirements in § 438.7.

(8) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under § 438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

§ 438.3(a) Standard Contract Requirements:
CMS review. The CMS must review and approve all MCO, PIHP, and PAHP contracts, including those risk and non-risk contracts that, on the basis of their value, are not subject to the prior approval requirement in § 438.806. Proposed final contracts must be submitted in the form and manner established by CMS. For States seeking approval of contracts prior to a specific effective date, proposed final contracts must be submitted to CMS for review no later than 90 days prior to the effective date of the contract.

§ 438.6(d): See Line 3.6

Line 4.2 State developed one time payments for specific life events of enrollees: See § 438.8(f)(2)(ii)
State-developed one time payments, for specific life events of enrollees.

Line 4.3 Earned premium withholds approved under § 438.6(b)(3): See § 438.8(f)(2)(iii)
Other payments to the MCO, PIHP, or PAHP approved under § 438.6(b)(3)

§ 438.6(b)(3):
Contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the MCO's, PIHP's or PAHP's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's, PIHP's or PAHP's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required under § 438.7(b)(6). For all withhold arrangements, the contract must provide that the arrangement is:

(i) For a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied.

(ii) Not to be renewed automatically.

(iii) Made available to both public and private contractors under the same terms of performance.

(iv) Does not condition MCO, PIHP, or PAHP participation in the withhold arrangement on the MCO, PIHP, or PAHP entering into or adhering to intergovernmental transfer agreements.

(v) Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy under § 438.340.

§ 438.6(a)

*Withhold arrangement* means any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

**Line 4.4** Unpaid cost-sharing amount that the health plan could have collected from enrollees under the contract: See § 438.8(f)(2)(iv)

Unpaid cost-sharing amounts that the MCO, PIHP, or PAHP could have collected from enrollees under the contract, except those amounts the MCO, PIHP, or PAHP can show it made a reasonable, but unsuccessful, effort to collect.

**Line 4.5** All changes to unearned premium reserves: See § 438.8(f)(2)(v)

All changes to unearned premium reserves.

**Line 4.6** Net payments/receipts related to risk sharing mechanisms: The risk-sharing mechanisms referenced in § 438.5 and § 438.6 are risk adjustment, risk corridors, reinsurance, and stop loss limits: See § 438.8(f)(2)(vi)
Net payments or receipts related to risk sharing mechanisms developed in accordance with § 438.5 or § 438.6.

§ 438.5(a) and (g): Rate Development Standards
(a) Definitions. As used in this section and § 438.7(b), the following terms have the indicated meanings:

*Budget neutral* means a standard for any risk sharing mechanism that recognizes both higher and lower expected costs among contracted MCOs, PIHPs, or PAHPs under a managed care program and does not create a net aggregate gain or loss across all payments under that managed care program.

*Prospective risk adjustment* means a methodology to account for anticipated variation in risk levels among contracted MCOs, PIHPs, or PAHPs that is derived from historical experience of the contracted MCOs, PIHPs, or PAHPs and applied to rates for the rating period for which the certification is submitted.

*Retrospective risk adjustment* means a methodology to account for variation in risk levels among contracted MCOs, PIHPs, or PAHPs that is derived from experience concurrent with the rating period of the contracted MCOs, PIHPs, or PAHPs subject to the adjustment and calculated at the expiration of the rating period.

*Risk adjustment* is a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs, PIHPs, or PAHPs contracted with the State.

(g) Risk adjustment. Prospective or retrospective risk adjustment methodologies must be developed in a budget neutral manner consistent with generally accepted actuarial principles and practices.

§ 438.6(a) and (b)(1): Special contract provisions related to payment
(a) Definitions. As used in this part, the following terms have the indicated meanings:

*Risk corridor* means a risk sharing mechanism in which States and MCOs, PIHPs, or PAHPs may share in profits and losses under the contract outside of a predetermined threshold amount.

(b) Basic requirements.
(1) If used in the payment arrangement between the State and the MCO, PIHP, or PAHP, all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be described in the contract, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices.
Line 5.1 Statutory assessments to defray the operating expense of any state or federal department: See § 438.8(f)(3)(i)
Statutory assessments to defray the operating expenses of any State or Federal department.

Line 5.2 Examination fees in lieu of premium taxes as specified by state law: See § 438.8(f)(3)(ii)
Examination fees in lieu of premium taxes as specified by State law.

Line 5.3 Federal taxes and assessments allocated to MCOs: See § 438.8(f)(3)(iii)
Federal taxes and assessments allocated to MCOs, PIHPs, and PAHPs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

Line 5.4 State and local taxes and assessments: See § 438.8(f)(3)(iv)
(iv) State and local taxes and assessments including:
(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
(B) Guaranty fund assessments.
(C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
(D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
(E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

Line 5.5 Amounts otherwise exempt from Federal income taxes for community benefit expenditures: See § 438.8(f)(3)(v)
(v) Payments made by an MCO, PIHP, or PAHP that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:
(A) Three percent of earned premium; or
(B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the MCO's, PIHP's, or PAHP's earned premium in the State.

45 CFR § 158.162(c)
(c) Community benefit expenditures. Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes any of the following activities that:
(1) Are available broadly to the public and serve low-income consumers;
(2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);
(3) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
(4) Leverage or enhance public health department activities such as childhood immunization efforts; and
(5) Otherwise would become the responsibility of government or another tax-exempt organization.

5. MLR Calculation
This worksheet takes the prior amounts and summarizes them into subtotals and calculates the unadjusted MLR. There are also inputs for member months and credibility adjustments if applicable.

If the unadjusted MLR is above the minimum of 85.00%, and a credibility adjustment is not applicable or declined by a partially-credibly MCO above the minimum MLR, still include the number of member months tied to the claims and premium used to calculate the MLR.

If the unadjusted MLR is below the minimum of 85.00%, and member months indicate the MCO’s size is eligible as partially-credible, then report the applicable credibility adjustment.

Please fill in the cells that are formatted with blue font.

6. Expense Allocation
Certain expenses may not be attributable to one line of business. Describe methods used to allocate these expenses and how they factor into the MLR calculated for this report. A description can be included in the workbook or a reference can be made to an attached document: See § 438.8(g)

§ 438.8(g)
(g) Allocation of expense -
(1) General requirements.
   (i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.
   (ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.
(2) Methods used to allocate expenses.
   (i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.
   (ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
(iii) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

7. Remittance Calculation
If the credibility-adjusted MLR is below the minimum MLR threshold, than a remittance to the Department is required. Include the calculation of the remittance here, or reference an attached document that shows and describes the calculation.

8. Financial Comparison
Per § 438.8(k)(1)(xi) (see intro for text), a comparison of the financial amounts included in this report and what is reported in audited financials is required. Show the comparison in this worksheet or reference an attached document with the comparison.

9. Aggregation Method
The Department requires the MCO’s MLR and MLR report is to be calculated as one aggregate value representing all of the MCOs counties of coverage. The Department reserves the right to modify this requirement and obtain MLR information on a county specific basis.

A description can be included in the workbook or a reference can be made to an attached document to explain the aggregation method.

10. MLR Report Summary
This worksheet summarizes the information requested by the Agreement and meets § 438.8(k) (see intro for regulation text)

11. Attestation
An attestation to the accuracy of this MLR report is required per § 438.8(n), § 438.604(a)(3), and § 438.606.
§ 438.8(n):
Attestation. MCOs, PIHPs, and PAHPs must attest to the accuracy of the calculation of the MLR in accordance with requirements of this section when submitting the report required under paragraph (k) of this section.

§ 438.604(a)(3) Data, information, and documentation that must be submitted.
Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in § 438.8.

§ 438.606 Source, content, and timing of certification:
(a) Source of certification. For the data, documentation, or information specified in § 438.604, the State must require that the data, documentation or information the MCO, PIHP, PAHP, PCCM or PCCM entity submits to the State be certified by either the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

(b) Content of certification. The certification provided by the individual in paragraph (a) of this section must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in § 438.604 is accurate, complete, and truthful.

(c) Timing of certification. The State must require the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in § 438.604(a) and (b).

Please contact the Department if there are any questions about the requirements for this MLR report.
## Plan Information

<table>
<thead>
<tr>
<th>Plan Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Managed Care Plan</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Contract / MLR Reporting Year</strong></td>
<td>12-month period starting</td>
</tr>
<tr>
<td><strong>Mailing Address</strong></td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td></td>
</tr>
<tr>
<td>City, State</td>
<td></td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td><strong>Contact Person</strong></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Fax Number</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td><strong>Chief Executive Officer (CEO)</strong></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Fax Number</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td><strong>Chief Financial Officer (CFO)</strong></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Fax Number</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
</tbody>
</table>
### Numerator Line Description

<table>
<thead>
<tr>
<th>Numerator Line Description</th>
<th>All Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Incurred Claims</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Incurred claims, including unpaid claim liabilities for the MLR reporting year</td>
<td>$</td>
</tr>
<tr>
<td>1.2 IBNR for claims incurred in the period expected to be paid in months after the known runoff</td>
<td>$</td>
</tr>
<tr>
<td>1.3 Withholds from payments made to network providers</td>
<td>$</td>
</tr>
<tr>
<td>1.4 Amount of incentive and bonus payments made, or expected to be made to network providers</td>
<td>$</td>
</tr>
<tr>
<td>1.5 Changes in other claims-related reserves</td>
<td>$</td>
</tr>
<tr>
<td>1.6 Reserves for contingent benefits and the medical claim portion of lawsuits</td>
<td>$</td>
</tr>
<tr>
<td>1.7 Net payment or receipts related to state-mandated solvency funds</td>
<td>$</td>
</tr>
<tr>
<td>1.8a Amount spent on fraud reduction</td>
<td>$</td>
</tr>
<tr>
<td>1.8b Amount of claims payments recovered through fraud reduction</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total INCLUDED Incurred Claims</strong></td>
<td></td>
</tr>
<tr>
<td>((1.1 + 1.2 + 1.3 + 1.4 + 1.5 + 1.6 + 1.7 + \text{minimum}(1.8a + 1.8b)))</td>
<td>$</td>
</tr>
<tr>
<td>1.9 Claims that are recoverable for anticipated coordination of benefits (report a positive value to reduce the numerator)</td>
<td>$</td>
</tr>
<tr>
<td>1.10 Claims payments recoveries received as a result of subrogation (report a positive value to reduce the numerator)</td>
<td>$</td>
</tr>
<tr>
<td>1.11 Overpayment recoveries received from network providers (report a positive value to reduce the numerator)</td>
<td>$</td>
</tr>
<tr>
<td>1.12 Prescription drug rebates received and accrued (report a positive value to reduce the numerator)</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total DEDUCTED Incurred Claims</strong></td>
<td></td>
</tr>
<tr>
<td>((1.9 + 1.10 + 1.11 + 1.12))</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total Incurred Claims</strong></td>
<td></td>
</tr>
<tr>
<td>((\text{Included Incurred Claims} - \text{Deducted Incurred Claims}))</td>
<td>$</td>
</tr>
<tr>
<td><strong>2. Included Activities that Improve Health Care Quality</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 MCO activity that meets 45 CFR §158.150(b) and is NOT EXCLUDED under 45 CFR §158.150(c)</td>
<td>$</td>
</tr>
<tr>
<td>2.2 MCO activity related to any EOR-related activity as described in §438.355(b) and (c)</td>
<td>$</td>
</tr>
<tr>
<td>2.3 MCO expenditure that is related to Health Information Technology and meaningful use, under 45 CFR §158.151</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total Activities that Improve Health Care Quality</strong></td>
<td></td>
</tr>
<tr>
<td>((2.1 + 2.2 + 2.3))</td>
<td>$</td>
</tr>
<tr>
<td><strong>Numerator Total</strong></td>
<td></td>
</tr>
<tr>
<td>((\text{Total Incurred Claims} + \text{Activities that Improve Health Care Quality}))</td>
<td>$</td>
</tr>
</tbody>
</table>

### Excluded Amounts Line Description

<table>
<thead>
<tr>
<th>Excluded Amounts Line Description</th>
<th>All Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. Excluded Non-claim Costs</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 Amounts paid to third party vendors for secondary network savings</td>
<td>$</td>
</tr>
<tr>
<td>3.2 Amounts paid to third party vendors for network development, admin fees, claims processing, and utilization management</td>
<td>$</td>
</tr>
<tr>
<td>3.3 Amounts paid to a provider for professional or administrative services outside of providing services to enrollees</td>
<td>$</td>
</tr>
<tr>
<td>3.4 Fines and penalties assessed by regulatory authorities</td>
<td>$</td>
</tr>
<tr>
<td>3.5 Amounts paid to the Department as remittance for prior MLR experience</td>
<td>$</td>
</tr>
<tr>
<td>3.6 Amounts for pass-through payments under §438.6(d)</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total Non-claim Costs</strong></td>
<td></td>
</tr>
<tr>
<td>((3.1 + 3.2 + 3.3 + 3.4 + 3.5 + 3.6))</td>
<td>$</td>
</tr>
</tbody>
</table>
### Denominator Line Description

<table>
<thead>
<tr>
<th>Description</th>
<th>All Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Premium Revenue</td>
<td></td>
</tr>
<tr>
<td>4.1 State capitation payments, including adjustments, excluding pass-through payments</td>
<td>$ -</td>
</tr>
<tr>
<td>4.2 State developed one time payments for specific life events of enrollees</td>
<td>$ -</td>
</tr>
<tr>
<td>4.3 Earned premium withholding approved under § 438.60(b)(3)</td>
<td>$ -</td>
</tr>
<tr>
<td>4.4 Unpaid cost-sharing amount that the health plan could have collected from enrollees under the contract</td>
<td>$ -</td>
</tr>
<tr>
<td>4.5 All changes to unearned premium reserves</td>
<td>$ -</td>
</tr>
<tr>
<td>4.6 Net payments/receipts related to risk sharing mechanisms</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>Total Premium Revenue</strong></td>
<td>(4.1 + 4.2 + 4.3 + 4.4 + 4.5 + 4.6) $ -</td>
</tr>
</tbody>
</table>

| 5. Federal, State, and Local Taxes                                         |              |
| 5.1 Statutory assessments to defray the operating expense of any state or federal department (report a positive value to reduce the denominator) | $ -         |
| 5.2 Examination fees in lieu of premium taxes as specified by state law (report a positive value to reduce the denominator) | $ -         |
| 5.3 Federal taxes and assessments allocated to MCOs (report a positive value to reduce the denominator) | $ -         |
| 5.4 State and local taxes and assessments (report a positive value to reduce the denominator) | $ -         |
| 5.5 Amounts otherwise exempt from Federal income taxes for community benefit expenditures (report a positive value to reduce the denominator) | $ -         |
| **Total Federal, State and Local Taxes**                                   | (5.1 + 5.2 + 5.3 + 5.4 + 5.5) $ - |
| **Denominator Total**                                                       | (Total Premium Revenue - Total Federal, State, and Local Taxes) $ - |

### MLR Calculation

#### Numerator Subtotals
- Incurred Claims: $ -
- Activities that Improve Health Care Quality: $ -
- Total Numerator: $ -

#### Denominator Subtotals
- Premium Revenue: $ -
- Less, Federal, State, and Local Taxes: $ -
- Total Denominator: $ -

#### MLR Calculation

0.00%

- Member Months (all counties): 0
- Credibility Adjustment (0.00% if none): 0.00%
- Credibility-adjusted MLR: 0.00%
## MLR Report Summary

<table>
<thead>
<tr>
<th>MLR Report Summary</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total incurred claims</td>
<td>$</td>
</tr>
<tr>
<td>Expenditures on quality improving activities</td>
<td>$</td>
</tr>
<tr>
<td>Recoveries through fraud reduction</td>
<td>$</td>
</tr>
<tr>
<td>Expenditures on fraud reduction</td>
<td>$</td>
</tr>
<tr>
<td>Non-claim costs</td>
<td>$</td>
</tr>
<tr>
<td>Premium revenue</td>
<td>$</td>
</tr>
<tr>
<td>Premium related taxes, licensing, and regulatory fees</td>
<td>$</td>
</tr>
<tr>
<td>MLR Numerator</td>
<td>$</td>
</tr>
<tr>
<td>MLR Denominator</td>
<td>$</td>
</tr>
<tr>
<td>The calculated MLR (unadjusted)</td>
<td>0.00%</td>
</tr>
<tr>
<td>Any credibility adjustment applied</td>
<td>0.00%</td>
</tr>
<tr>
<td>Credibility-adjusted MLR</td>
<td>0.00%</td>
</tr>
<tr>
<td>The number of member months</td>
<td>0</td>
</tr>
<tr>
<td>Methodologies for allocation of expenditures</td>
<td>Refer to [Expense Allocation]</td>
</tr>
<tr>
<td>Any remittance potentially owed to the Department</td>
<td>Refer to [Remittance Calculation]</td>
</tr>
<tr>
<td>A comparison of the MLR report information to the MCO’s audited financial report(s)</td>
<td>Refer to [Financial Comparison]</td>
</tr>
<tr>
<td>A description of the aggregation method used to aggregate data for all CHIP eligibility groups</td>
<td>Refer to [Aggregation Method]</td>
</tr>
</tbody>
</table>

## Attestation Statement

Consistent with 42 CFR §438.8(n) and 42 CFR §438.606, the officers of this reporting issuer being duly sworn, each attests that he/she is the described officer of the reporting issuer, and that this MLR Report, the Company/Issuer Associations, and any supplemental submission that the issuer includes are full and true statements of all the elements included therein for the MLR reporting year, and that the MLR Report has been completed in accordance with the Department’s reporting instructions, according to the best of his/her information, knowledge and belief.

Chief Executive Officer (or delegate with authority to sign for the CEO)  
Date

or

Chief Financial Officer (or delegate with authority to sign for the CFO)  
Date
CHAPTER 17: DATA WAREHOUSE and MMIS

17.1 GENERAL REQUIREMENTS

Each contractor is required to electronically transmit enrollee claims and encounter level data to the Department, including any data gathered through subcontractors. The reported data will be held via the data warehouse. The Department has developed unique file formats to communicate the necessary information to satisfy ad hoc reporting and requirements for the CHIP Application Processing System Data Warehouse. Use of ASC X12N 5010 837 and NCPDP D.0 file formats for health care claim transactions are mandated by HIPAA Transactions and Code Sets regulations when electronically communicating claim information. File specifications and/or any upgrades will be provided to contractors as the project progresses.

17.2 PROVIDER FILE

17.2.1 CONTENT

This is a proprietary file format that contains a list of all the active providers (individuals, groups, and facilities) in the contractor’s CHIP Provider Network in Pennsylvania.

17.2.2 FREQUENCY

This file is due monthly by the 20th of the month.

17.2.3 FORMAT

The details of the content are provided in the CHIP Application Processing System Provider File Specifications.

17.3 837 INSTITUTIONAL FILE

17.3.1 CONTENT

This file contains the institutional claims and/or encounters filed in the prior month for CHIP enrollees and follows the HIPAA 5010 837 Institutional mandated guidelines.

17.3.2 FREQUENCY

This file is due monthly by the 20th of the month.

17.3.3 FORMAT
The details of the content are provided in the CHIP Application Processing System 837 Institutional Companion Guide.

17.4 837 PROFESSIONAL FILE

17.4.1 CONTENT

This file contains the professional claims and/or encounters filed in the prior month for CHIP enrollees and follows the HIPAA 5010 837 Professional mandated guidelines.

17.4.2 FREQUENCY

The details of the content are provided in the CHIP Application Processing System 837 Professional Companion Guide.

17.5 837 DENTAL FILE

17.5.1 CONTENT

This file contains the dental claims and/or encounters filed in the prior month for CHIP enrollees and follows the HIPAA 5010 837 Dental mandated guidelines.

17.5.2 FREQUENCY

This file is due monthly by the 20th of the month.

17.5.3 FORMAT

The details of the content are provided in the CHIP Application Processing System 837 Dental Companion Guide.

17.6 NCPDP FILE (NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAM)

17.6.1 CONTENT

This file contains the pharmacy claims and/or encounters filed in the prior month for CHIP enrollees and follows NCPDP D.0 guidelines.

17.6.2 FREQUENCY
This file is due monthly by the 20\textsuperscript{th} of the month.

17.6.3 FORMAT

The details of the content are provided in the CHIP Application Processing System NCPDP Companion Guide.

17.7 DATA SUPPORT FOR MCO’s

Each MCO will be required to connect to the Department’s network for the purpose of on-line inquiries and file transfers. Specifications and limited technical assistance will be made available. No information made available to the MCO is to be used for any purpose other than supporting their program under CHIP. Access to the Department’s network will continue for the functions not included under MMIS.

The MCO’s will be required to adhere to Department requirements and HIPAA transactions. Each MCO will need to be certified through MMIS prior to implementing any data exchange. The Department will provide training on the use and interpretation of information found on the system.

17.7.1 DHS INQUIRY ACCESS:

1. Client Information System (CIS)

   The Department will make available to each MCO access to the Department’s CIS database. This database provides eligibility history, demographic information, and enrollment information to support the MCO in meeting their obligations.

2. DHS Internet

   Each MCO will have access to the Department’s Internet at www.dhs.pa.gov.

DATA FILES:

Following are the descriptions of the data files that will be provided to the MCO by the Department and the data files that the MCO will be required to submit to the Department. Additional files may be made available upon request.
### FILES AND REPORTS PROVIDED TO THE MCO:

<table>
<thead>
<tr>
<th>NAME</th>
<th>PURPOSE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>834 Daily Membership File</td>
<td>HIPAA compliant file of any change affecting a Enrollee’s demographic, eligibility and enrollment data.</td>
<td>Daily</td>
</tr>
<tr>
<td>834 Monthly Membership File</td>
<td>HIPAA compliant file containing one record for each recipient who eligible.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Weekly Enrollment/Alert Reconciliation file</td>
<td>File of the disposition of each record submitted on the Weekly Enrollment File.</td>
<td>Weekly</td>
</tr>
<tr>
<td>820 Capitation Payment File</td>
<td>HIPAA compliant file reflecting Capitation payments and adjustments processed for eligible Enrollees.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Response to PCP File</td>
<td>Report of records returned by MMIS due to error.</td>
<td>Weekly</td>
</tr>
<tr>
<td>Procedure Code Extract</td>
<td>The Procedure Code File contains five files within the zip file: Modifier Max Fee, Procedure Code, Provider Type, Restricted and Related.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Diagnosis Code File</td>
<td>Diagnosis Code file to assist in the coding of Claims and Encounter Data.</td>
<td>Monthly</td>
</tr>
<tr>
<td>MCO Provider Error Report (PRM640)</td>
<td>Report of MCO Provider records returned by DHS due to error.</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

### FILES PROVIDED BY THE MCO:

<table>
<thead>
<tr>
<th>NAME</th>
<th>PURPOSE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Network Provider file (PRV640)</td>
<td>File provided listing all Providers within the Network to serve Enrollees.</td>
<td>Monthly</td>
</tr>
<tr>
<td>File Type</td>
<td>Description</td>
<td>Frequency</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>PCP File</td>
<td>File provides the PCP assignments for all Enrollees.</td>
<td>Weekly</td>
</tr>
<tr>
<td>837P, 837I, 837D, NCPDP</td>
<td>HIPAA compliant file submitted by the MCO providing the Department with Encounter Data for all MCO Enrollees.</td>
<td>As Scheduled</td>
</tr>
<tr>
<td>NCPDP Supplemental File</td>
<td>A file containing supplemental data for NCPDP transactions used for the purpose of drug rebate dispute resolution.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Automated Provider Directory File</td>
<td>File contains information on all Providers in the Network for the MCO. The information will be used by the EAP contractor for their Electronic (Online) Provider Directory.</td>
<td>Weekly</td>
</tr>
<tr>
<td>PH Pharmacy File</td>
<td>Pharmacy data</td>
<td>Submission based on schedule developed by the MCO (at least twice per month.)</td>
</tr>
</tbody>
</table>

**17.8 MMIS REQUIREMENTS**

The submission of timely and accurate encounter data is critical to the Commonwealth’s ability to establish and maintain cost effective and quality managed care programs. Consequently, the requirements for submission and metrics for measuring the value of the data for achieving these goals are crucial.

- **CERTIFICATION REQUIREMENT**
  
  All MCOs must be certified through MMIS prior to the submission of live encounter data. The certification process is detailed at: [https://dpwintra.dpw.state.pa.us/CHIP/custom/program/encounter/promise/documents/encounter_updated_certification_process_for_promise_v1.0_to_dpwintra_dpw_state_pa_us CHIP/Custom/Program/Encounter/Promise/Documents/Encounter_Udated_Certification_Process_for_Promise_v1.0_to_dpwintra_dpw_state_pa_us](https://dpwintra.dpw.state.pa.us/CHIP/custom/program/encounter/promise/documents/encounter_updated_certification_process_for_promise_v1.0_to_dpwintra_dpw_state_pa_us CHIP/Custom/Program/Encounter/Promise/Documents/Encounter_Udated_Certification_Process_for_Promise_v1.0_to_dpwintra_dpw_state_pa_us)
**SUBMISSION REQUIREMENTS**

**Timeliness:**

With the exception of pharmacy encounters, all MCO approved encounters and those specified MCO denied encounters must be approved in MMIS by the last day of the third month following the month of initial MCO adjudication. Pharmacy encounters must be submitted and approved in MMIS within 30 days following the MCO adjudication.

**Metric:** During the sixth months following the month of the initial PROMISE adjudication, the encounters will be analyzed for timely submission of encounters.

- Failure to achieve MMIS approved/paid status for 98% of all MCO paid/approved and specified MCO denied encounters by the last day of the third month following initial MCO adjudication may result in a penalty.
- Any encounter corrected or initially submitted after the last day of the third month following initial MCO adjudication may be subject to a penalty.

**Accuracy and Completeness:**

Accuracy and completeness are based on the consistency between encounter information submitted to the Commonwealth and information for the same service maintained by the MCO in their claims/service history data base.

**Metric:** Accuracy and completeness will be determined through a series of analyses applied to MCO claims history data and encounters received and processed through MMIS. This analysis will be done at least yearly but no more than twice a year and consist of making a comparison between an encounter sample and what is found in MCO claims history. A sample may also be drawn from the MCO service history and compared against encounters processed through MMIS.

Samples will be drawn proportionally based on the MCO financial expenditures for each transaction type submitted during the review period. Each annual or semi-annual analysis will be based on a statistically valid sample of no less than 200 records.

**PENALTY PROVISION**

**Timeliness**

- Failure to comply with timeliness requirements will result in a sanction of up to $10,000 for each program month.

**Completeness and Accuracy**

- Errors in accuracy or completeness that are identified by the Department in an annual or semi-annual analysis will result in sanctions as follows. An error in accuracy or completeness or both, in one sample record, counts as one error.

<table>
<thead>
<tr>
<th>Percentage of the sample that includes an error</th>
<th>Sanction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage Range</td>
<td>Payment Amount</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Less than 1.0 percent</td>
<td>None</td>
</tr>
<tr>
<td>1.0 – 1.4 percent</td>
<td>$4,000</td>
</tr>
<tr>
<td>1.5 – 2.0 percent</td>
<td>$10,000</td>
</tr>
<tr>
<td>2.1 - 3.0 percent</td>
<td>$16,000</td>
</tr>
<tr>
<td>3.1 – 4.0 percent</td>
<td>$22,000</td>
</tr>
<tr>
<td>4.1 – 5.0 percent</td>
<td>$28,000</td>
</tr>
<tr>
<td>5.1 – 6.0 percent</td>
<td>$34,000</td>
</tr>
<tr>
<td>6.1 – 7.0 percent</td>
<td>$40,000</td>
</tr>
<tr>
<td>7.1 – 8.0 percent</td>
<td>$46,000</td>
</tr>
<tr>
<td>8.1 – 9.0 percent</td>
<td>$52,000</td>
</tr>
<tr>
<td>9.1 – 10.0 percent</td>
<td>$58,000</td>
</tr>
<tr>
<td>10.1 percent and higher</td>
<td>$100,000</td>
</tr>
</tbody>
</table>
CHAPTER 18: FRAUD AND ABUSE

18.1 GENERAL REQUIREMENTS

Contractors are required to report to the Department any act by Providers/Recipients/ Employees that may affect the integrity of the CHIP Program. Specifically, if the Contractor suspects that either Fraud Abuse or Waste may have occurred, the contractor must report the issue to the OOC’s Quality Assurance Division. The contractor must have a process to notify the department of any adverse actions and/or provider disclosures taken during the credentialing/re-credentialing process. Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review or suspend payments to avoid unnecessary expenditures during the review process.

Contractors are also required to report quality issues to the department for further investigation. Quality issues are those which, on an individual basis, affect the enrollee’s health (e.g. poor quality services, inappropriate treatment, aberrant and/or abusive prescribing patterns, and withholding of necessary services from an enrollee).

All Fraud, Abuse, Waste, or quality referrals must be made within thirty (30) days of the identification of the problem/issue. The contractor must send all relevant documentation collected to support the referral.

Failure to comply will result in sanctions and/or corrective action. The Department must suspend all Medicaid payments to a provider after a determination that there is a credible allegation of fraud for which an investigation is pending against an individual or entity unless the Department has good cause not to suspend payments or to suspend payments.

Contractors are required to maintain written policies and procedures for the detection and prevention of fraud and abuse. The contractor and its employees must cooperate fully with centralized oversight agencies responsible for fraud and abuse detection and prosecution activities. Such agencies include, but are not limited to, the Department, the Governor’s Office of the Budget, Bureau of Audits, the Office of the Auditor General, and the Centers for Medicaid and Medicare.

18.1.1 DUTY TO NOTIFY

1. Department’s Responsibility
The Department will provide the MCO with immediate notice via electronic transmission or access to Medicheck listings or upon request if a Provider with whom the MCO has entered into a Provider Agreement is subsequently suspended or terminated from participation in the MA or Medicare Programs. Upon notification from the Department that a Network Provider is suspended or terminated from participation in the MA or Medicare Programs, the MCO must immediately act to terminate the Provider from its Network. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

The MCO is required to check the SSADM, and NPPES at the time of initial enrollment and re-enrollment as well as providers, owners, agents, and managing employees against the HHS-OIG LEIE, the EPLS on the SAM, and the PA Medicheck list on a monthly basis as required in 42 CFR §455.436.

2. MCO’s Responsibility

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

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

- An individual who is an Affiliate of a person described above.

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

- A director, officer, or partner of the MCO.

- A person with beneficial ownership of five percent (5%) or more of the MCO’s equity.

- A person with an employment, consulting or other arrangement for the provision of items and services that are significant and material to the MCO’s obligations under this Agreement with the Department.
The MCO must immediately notify the Department, in writing, if a Network Provider or subcontractor is subsequently suspended, terminated or voluntarily withdraws from participation in the CHIP program as a result of suspected or confirmed Fraud, Waste or Abuse. The MCO must also immediately notify the Department, in writing, if it terminates or suspends an employee as a result of suspected or confirmed Fraud or Abuse. The MCO must inform the Department, in writing, of the specific underlying conduct that lead to the suspension, termination, or voluntary withdrawal. Provider Agreements must carry notification of the prohibition and sanctions for submission of false Claims and statements. MCOs who fail to report such information are subject to sanctions, penalties, or other actions. The Department’s enforcement guidelines are outlined below.

The MCO must also notify the Department in writing and receive approval from Department before it recovers overpayments or improper payments related to Fraud, Abuse or Waste of CHIP funds from non-administrative overpayments or improper payments made to Network Providers, or otherwise takes an adverse action against a Network Provider, e.g. restricting the Enrollees or services of a PCP. The MCO must report to the Commonwealth any overpayments under the contract within 60 days of identification by the MCO.

### 18.1.2 SANCTIONS

The Department recognizes its responsibility to administer the CHIP Program and ensure that the public funds which pay for this program are properly spent.

To maintain the integrity of the CHIP Program and to ensure that contractors comply with pertinent contract provisions and related state and federal policies, including rules and regulations involving Fraud, Waste and Abuse issues, the Department will impose sanctions as deemed appropriate where there is evidence of violations involving Fraud, Waste and Abuse issues in the CHIP Program. To that end, monetary penalties will be assessed and will be payable to the department for the contractor’s program integrity deficiencies. Below are some general guidelines that the department intends to use when imposing sanctions. Note that the department also retains discretion to impose additional remedies available to it under applicable law and regulations.

Fraud, Waste, and Abuse issues, which may result in sanctions, include, but are not limited to, the following:

A. Failure to implement, develop, monitor, continue, and/or maintain the required policies and procedures directly related to the detection,
prevention, investigation, referral, or sanction of Fraud, Waste, and Abuse by provider, caregivers, enrollees or employees.

B. Failure to cooperate with reviews conducted by the Department or its designees, Office of Attorney General, Office of Inspector General of the U.S. DHHS, other state or federal agencies and auditors under contract to CMS or the Department. (42 CFR 438.3 (h))

C. Failure to adhere to applicable state and federal laws and regulations.

D. Failure to adhere to the terms of the contract related to Fraud, Waste, and Abuse issues.

E. Failing, as an MCO, to provide, upon written request, encounter/claims data, payment methodology, policies, and/or other data contractually required to document the services and items delivered by or through the contractor to CHIP program recipients. (42 CFR 438.604)

F. Engaging in actions that indicate a pattern of wrongful denial or payment for a health-care benefit, service or item that the organization is required to provide under its contract;

G. Failing to provide to recipient enrollee a health-care benefit, service or item that the organization is required to provide under its contract with DHS.

H. Engaging in actions that indicate a pattern of wrongful delay of at least 45 days or a longer period specified in the contract with DHS (not to exceed 60 days,) in making payment for a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency.

I. Discriminating against enrollees or prospective enrollees on any basis, including, without limitation, age, gender, ethnic origin or health status; (42 CFR 438.3 (d) (3- 4))

The range of sanctions that will be imposed by the Department include, but are not limited to, the following:

A. Requiring a Corrective Action Plan

B. Imposing Monetary Penalties

C. Restricting Enrollment of Enrollees

D. Withholding of Capitation Payments
E. Termination of Contract

It is the Department's intent to maintain an effective, reasonable, and consistent sanctioning process as deemed necessary to protect the integrity of the CHIP Program. The assessment for each violation is calculated using each line item detail and/or occurrence identified on a claim, cost report, or other document resulting in or supporting fraudulent or abusive billing.

18.2 FRAUD AND ABUSE REPORTING

18.2.1 CONTENT

For purposes of gathering information for this report, fraud and abuse shall have the following meanings:

Fraud – A false representation of a matter of fact which is an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself/herself or some other person.

Examples of fraud may involve:

- Knowingly submitting false statements or making misrepresentations of fact to obtain a health care payment for which no entitlement may otherwise exist;

- Knowingly soliciting, paying, and/or accepting remuneration to induce or reward referrals for items or services under the CHIP program;

- Making prohibited referrals for certain designated health services

Abuse - incidents or practices that are inconsistent with accepted sound medical, business or fiscal practices. These practices may, directly or indirectly, result in unnecessary costs to the CHIP Program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider/entity has not knowingly or intentionally misrepresented facts to obtain payment.

Section I of the report generally requires contractors to provide:

- Information regarding internal company policies and procedures;
- Organization chart of office responsible for fraud and abuse activity;
- Fraud training and frequency;
• Instances of successful prosecution of either a contractor, subcontractor, provider, enrollee or employee and subsequent corrective actions;
• Methods of detecting fraud and abuse;
• Process for referral to appropriate law enforcement authorities;
• Provider application content regarding fraud and abuse;
• Toll free number/website for reporting fraud and abuse for both providers and enrollees;
• Contract language for providers/contractors/subcontractors regarding fraud and abuse; and
• Monitoring of contractors/subcontractors;

Section II of the report requires information specific to the number, dollar amounts, and content of fraud and abuse cases referred to law enforcement authorities within the contract year from the standpoint of either: providers, enrollees, employees, or contractor/subcontractors.

Attachments A and B provide the details of the confirmed and dismissed or unfounded fraud and abuse cases by category.

NOTE: Calls from the public to the Department (“whistleblowers”) will be referred to the appropriate contractor for investigation. Contractors are required to report back to the Department on case status within the first ten (10) calendar days following the referral and in thirty (30) day increments thereafter until resolved.

18.2.2 FREQUENCY

This report is due annually on March 1. If the due date occurs on a Saturday, Sunday or holiday, then the report is due by close of business on the first working day following the non-working day.

NOTE: This report can be submitted via regular mail, fax, or email to CHIP Division of Quality Assurance – 1142 Strawberry Square. P.O. Box 2675. Harrisburg, PA 17105-2675.

18.2.3 FORMAT

(See Appendix 18-A). No other format is acceptable.
# APPENDIX 18-A: ANNUAL FRAUD AND ABUSE ANNUAL REPORT

Due Date: March 1, 20XX

<table>
<thead>
<tr>
<th>Program: CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year: January 1, 20XX – December 31, 20XX</td>
</tr>
<tr>
<td>Contractor Name:</td>
</tr>
<tr>
<td>Contractor Representative Submitting Report:</td>
</tr>
<tr>
<td>Title:</td>
</tr>
<tr>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Email Address:</td>
</tr>
</tbody>
</table>
## Fraud and Abuse Report
### Section I
### Policy and Procedure Reporting

<table>
<thead>
<tr>
<th>Rating Factor</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are the contractor’s most current fraud and abuse policies and procedures on file with the Department?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If not, please submit any changes with this report.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide name of office/department responsible for fraud and abuse activities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To whom in senior management (name/title) is the fraud and abuse department accountable, such as Vice President or a Board?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating Factor</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>2. What departments/employees receive training in fraud and abuse in order to assist in the detection of fraud and abuse? (e.g.: customer service, representatives, claims examiners, all employees, others-specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often is the training provided to each group of employees?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What type of training is provided, e.g. computer based, periodic classes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who provides the training?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is training:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Voluntary?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Mandatory?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Which of the following fraud and abuse detection methods are employed by the contractor?

- Routine audits (describe)
- Fraud detection software (specify software and what it achieves)
- Case referrals
- Other (specify)
<table>
<thead>
<tr>
<th>Rating Factor</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Does the contractor have a dedicated toll free hotline for reporting suspected fraud and abuse activity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, provide toll free hotline number and hours of operation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. How does the contractor educate <em>providers</em> about the consequences of fraudulent behavior and or reporting fraud/abuse?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mailings (provide sample)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Toll free number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Contracts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Website (provide website address)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other (please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating Factor</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>6. How does the contractor educate <strong>consumers</strong> about the consequences of fraudulent behavior and or reporting fraud/abuse?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Mailings (please provide sample)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Toll free number (provide toll free number if different from #4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Subscriber agreements/handbooks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Website (provide website address if different from #5 above)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Other (please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Does the contractor use the standard Pennsylvania provider application or some other version?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the contractor is using a different version, or something in addition to the standard version, please explain and attach a copy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating Factor</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>8. Do providers have a means available to them to verify an individual’s eligibility prior to providing a service?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what is available?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. How does the contractor monitor contractors/subcontractors to assure they are providing the same level of fraud and abuse procedural protections as required of the CHIP contractor? Please include monitoring frequency in your description.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Fraud and Abuse Report

### Section II: Referral Reporting

<table>
<thead>
<tr>
<th>General</th>
<th># Confirmed</th>
<th># Excused or Unfounded</th>
<th># Pending</th>
<th>Total Referrals</th>
<th>$ Amount Recouped:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many fraud and abuse referrals were received in this calendar year?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Enrollees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Employees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Contractor/Subcontractors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

2 For confirmed cases of fraud/abuse, please describe each case on *Attachment A* by category, i.e. providers, members, etc.

3 For excused or unfounded cases please describe each case on *Attachment B* by category, i.e., providers, members, etc.
<table>
<thead>
<tr>
<th>General</th>
<th># of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. How many of the referrals received during this calendar year were identified through activities internal to the contractor?</td>
<td></td>
</tr>
<tr>
<td>• Providers</td>
<td></td>
</tr>
<tr>
<td>• Enrollees</td>
<td></td>
</tr>
<tr>
<td>• Employees</td>
<td></td>
</tr>
<tr>
<td>• Contractor/Subcontractors</td>
<td></td>
</tr>
<tr>
<td>TOTAL:</td>
<td></td>
</tr>
</tbody>
</table>
3. How many of the referrals received during this calendar year were identified by external sources?

<table>
<thead>
<tr>
<th>General</th>
<th># of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td></td>
</tr>
<tr>
<td>Enrollees</td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td></td>
</tr>
<tr>
<td>Contractor/Subcontractors</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td># of Cases</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>4. How many cases of Provider Credentialing were investigated? 4</td>
<td></td>
</tr>
<tr>
<td>5. How many cases of Provider Billing were investigated? 5</td>
<td></td>
</tr>
<tr>
<td>6. How many cases of Enrollee Eligibility were investigated? 6</td>
<td></td>
</tr>
</tbody>
</table>

4 Question added per CMS Annual Report on “Program Integrity”.
5 Question added per CMS Annual Report on “Program Integrity”.
6 Question added per CMS Annual Report on Program Integrity.”
<table>
<thead>
<tr>
<th>Law Enforcement Actions</th>
<th># of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. How many cases were referred to law enforcement entities during this calendar year? (e.g. Attorney General, District Attorney, etc.)</td>
<td></td>
</tr>
<tr>
<td>8. How many cases of Provider Credentialing were referred to law enforcement entities during this calendar year?</td>
<td>7</td>
</tr>
<tr>
<td>9. How many cases of Provider Billing were referred to law enforcement entities during this calendar year?</td>
<td>8</td>
</tr>
<tr>
<td>10. How many cases of Enrollee Eligibility were referred to law enforcement entities during this calendar year?</td>
<td>9</td>
</tr>
<tr>
<td>11. How many cases which were referred during this calendar year were accepted by law enforcement entities?</td>
<td></td>
</tr>
</tbody>
</table>

---

7 Question added per CMS Annual Report on “Program Integrity”.
8 Question added per CMS Annual Report on “Program Integrity”.
9 Question added per CMS Annual Report on “Program Integrity”.
Attachment 18-A

Department of Human Services
Office of CHIP
Annual Fraud and Abuse Report

Description of Confirmed Fraud and Abuse Cases by Category

Contractor Name:

Calendar Year under Review:

Provider(s)

Name:

Provider NPI #:

Description of case:

Outcome:

- Law enforcement action (what type, if applicable):
- Suspension:
- Revocation:
- Restitution:
- Other, please specify

Note: Please add as many providers as appropriate and number each case.
Attachment A (cont’d)
Office of CHIP Annual Fraud and Abuse Report
Description of Confirmed Fraud and Abuse Cases by Category

**Enrollee(s)**

Name:

Enrollee UFI

Description of Case:

Outcome:

- Law enforcement action:
- Termination:
- Restitution/refund back to Department:
- Other (please specify)

Note: Please add as many enrollees as appropriate and number each case.
Attachment A (cont’d)
Office of CHIP Annual Fraud and Abuse Report
Description of Confirmed Fraud and Abuse Cases by Category

**Employee(s)**

Name:

Position:

Description of Case:

Outcome:

- Law enforcement action
- Termination
- Restitution:
  - Other (please specify)

Note: Please add as many employees as appropriate and number each case
Attachment A (cont’d)
Office of CHIP Annual Fraud and Abuse Report
Description of Confirmed Fraud and Abuse Cases by Category

Other (please specify, e.g. subcontractor, etc.)

Name:

Identification number, if applicable:

Description of Case:

Outcome:

- Law enforcement action
- Termination
- Restitution
- Other (please specify)

Note: Please add as many “other” as appropriate and number each case
Attachment B

Department of Human Services  
Office of CHIP  
Annual Fraud and Abuse Report

Description of Dismissed or Unfounded Fraud and Abuse Cases by Category

<table>
<thead>
<tr>
<th>Contractor Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year:</td>
<td></td>
</tr>
</tbody>
</table>

**Provider(s)**

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider I.D. #:</td>
<td></td>
</tr>
</tbody>
</table>

Description of case:

**Note:** Add as many providers as appropriate and number each case.
Enrollee(s)

Name:

Enrollee UFI

Description of Case:

Note: Add as many enrollees as appropriate and number each case
Attachment B (cont’d)
Office of CHIP Annual Fraud and Abuse Report
Description of Dismissed or Unfounded Fraud and Abuse Cases by Category

**Employee(s)**

Name:

Position:

Description of Case:

Note: Add as many employees as appropriate and number each case
Attachment B (cont’d)

Office of CHIP Annual Fraud and Abuse Report
Description of Dismissed or Unfounded Fraud and Abuse Cases by Category

**Other (please specify, e.g. subcontractor, etc.)**

Name:

Description of Case:

Note: Add as many “other” as appropriate and number each case
19.1 SUBCONTRACTING

Contractors are required to develop and implement written agreements regarding the interaction and coordination of all physical, behavioral, dental and vision services provided to enrollees in the CHIP Program. Complete agreements, including operational procedures, must be available for review by the Department upon request. The MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Enrollees have access to all services covered by the CHIP Program.

Written agreements must contain, at a minimum:

- Provisions for ongoing communications; exchange of relevant enrollment and individual health related information; service needs among the MCO, PCP and the community Provider, including a process to monitor such activity; and the Quality Management and Utilization Management program responsibilities of each entity.

- Provisions which govern referral, collaboration and coordination of diagnostic assessment and treatment, prescribing practices and other treatment issues necessary for optimal health and disease prevention, including coordination of specialized service plans for Enrollees with special health needs.

- A requirement that the MCO must not exclude or terminate a Provider from participation in the MCO’s Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

- A requirement that the MCO must not exclude a Provider from the MCO’s Provider Network because the Provider advocated on behalf of an Enrollee for Medically Necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable Health Care Provider practicing according to the applicable legal standard of care.

- Notification of the prohibition and sanctions for submission of false Claims and statements.

- The definition of Medically Necessary as defined in Section II of the Agreement, Definitions.
A requirement that the MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from discussing care and advising or advocating appropriate medical care with or on behalf of an Enrollee including; information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

A requirement that the MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from providing information the Enrollee needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.

A requirement that the MCO cannot terminate a contract or employment with a Health Care Provider for filing a Grievance on an Enrollee’s behalf.

A clause which specifies that the agreement will not be construed as requiring the MCO to provide, reimburse for, or provide coverage of, a counseling or referral service if the Provider objects to the provision of such services on moral or religious grounds.


A requirement for cooperation for the submission of Encounter Data for all services provided within the time frames required in Section VIII of the Agreement, Reporting Requirements, no matter whether reimbursement for these services is made by the MCO either directly or indirectly through capitation.

A continuation of benefits provision which states that the Provider agrees that in the event of the MCO’s insolvency or other cessation of operations, the Provider must continue to provide benefits to the MCO’s Enrollees, including Enrollees in an inpatient setting, through the period for which the Capitation has been paid.

A requirement that the PCPs who serve Enrollees under the age of nineteen (19) are responsible for conducting all Bright Futures screens for individuals on their panel under the age of nineteen (19). Should the PCP be unable to conduct the necessary Bright Futures screens, the PCP is responsible for arranging to have the necessary screens conducted by another Network Provider and ensure that all relevant
medical information, including the results of the screens, are incorporated into the Enrollee's PCP medical record. For details on access requirements, (See Section 19.1.2: Provider Network Composition/Service Access of the CHIP Procedures Handbook).

- A requirement that PCPs who serve Enrollees under the age of nineteen (19) report Encounter Data associated with Bright Futures screens, using a format approved by the Department, to the MCO within ninety (90) days from the date of service.

- A requirement that PCPs contact new Enrollees identified in the quarterly Encounter lists who have not had an Encounter during the first six (6) months of Enrollment, or who have not complied with the Bright Futures periodicity and immunization schedules for children. The PCP must also be required to document the reasons for noncompliance, where possible, and to document its efforts to bring the Enrollee's care into compliance with the standards.

- A requirement that ensures each physician providing services to Enrollees eligible for CHIP under the State Plan to have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act.

- A requirement that health care facilities and ambulatory surgical facilities develop and implement, in accordance with P.L.154, No. 13 known as the Medical Care Availability and Reduction of Error (MCARE) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures for the detection, control and prevention of Health Care-Associated Infections.

- A provision that the MCO’s Utilization Management (UM) Departments are mandated by the Department to monitor the progress of an Enrollee’s inpatient hospital stay. This must be accomplished by the MCO’s UM department receiving appropriate clinical information from the hospital that details the Enrollee’s admission information, progress to date, and any pertinent data within two (2) business days from the time of admission. The MCO’s providers must agree to the MCO’s UM Department’s monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the MCO’s Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the MCO must receive all clinical information on the
inpatient stay in a timely manner which allows for decision and appropriate management of care.

- Requirements regarding coordination with Behavioral Health Providers (if applicable):
  - Comply with all applicable laws and regulations pertaining to the confidentiality of Enrollees’ medical records, including obtaining any required written Enrollee consents to disclose confidential medical records.
  - Make referrals for social, vocational, education or human services when a need for such service is identified through assessment.
  - Provide health records if requested by the Behavioral Health Provider.
  - Notify BH Provider of all prescriptions, and when deemed advisable, check with BH Provider before prescribing medication. Make certain BH clinicians have complete, up-to-date record of medications.
  - Be available to the BH Provider on a timely basis for consultations.
  - The MCO must require that participating ER staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for the county.
  - Provisions for requiring interaction by the PCP for prompt treatment, coordination of care or referral of Enrollees for other identified services that are not the responsibility of the Provider.
  - Provisions for jointly identifying the services to be delivered and monitoring by the MCO to determine the quality of the service delivered.
  - Provisions for the MCO and the Provider to work cooperatively to establish programmatic responsibility for each CHIP Enrollees.
  - Provisions for serving on interagency teams, when requested.
  - Provisions for assisting, when appropriate, in the coordination of services with the behavioral health Provider, including Pharmacy Coordination, to the extent permitted by law.
  - Provisions for mutual intensive outreach efforts to Enrollees identified as needing service (processes to conduct outreach and the measurement of the outreach efforts must be documented in the procedures governing the execution of the written agreement).
- Provisions for a timely resolution of any disputes.
- Provisions for training and consultations between both parties to facilitate continuity of care and the cost-effective use of resources.
- Provisions for assisting, when appropriate, in the development of an adequate Provider Network to serve enrollees with chronic and complex medical conditions.
- Provisions for obtaining the appropriate releases necessary to share clinical information and provide health records to each other as requested consistent with state and federal laws.
- Provisions for the development and implementation of corrective action plans in the event the provisions of the agreement are not being met.
- Provisions for the maintenance and confidentiality of medical records and other information considered confidential, including provisions for resolving confidentiality problems.
- Provisions for the collection of information on the service(s) delivered to be shared with the Department, upon request.
- Provisions for collaboration on identifying and reducing the frequency of Fraud, Abuse, overuse, under use, inappropriate or unnecessary medical care.
- Provisions for the reporting of health related information to the appropriate regulatory agency, if necessary.

The MCO may not enter into a Provider Agreement that prohibits the Provider from contracting with another MCO or that prohibits or penalizes the MCO for contracting with other Providers.

The MCO must make all necessary revisions to its Provider Agreements to be in compliance with the requirements set forth in this section. Revisions may be completed as Provider Agreements become due for renewal provided that all Provider Agreements are amended within one (1) year of the effective date of this Agreement with the exception of the Encounter Data requirements which must be amended immediately, if necessary, to ensure that all Providers are submitting Encounter Data to the MCO within
the time frames specified in Section VIII.B.1 of this Agreement, Encounter Data Reporting.

19.1.1 MCO REQUIREMENTS FOR PROVIDER TERMINATIONS

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

1. Termination by the MCO

   A. Notification to Department (See Chapter 20 – Contractor Report on Company or Programmatic Changes).

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

      The MCO must submit a Provider termination work plan and supporting documentation within ten (10) Business Days of the MCO notifying the Department of the termination and must provide weekly updates to this information. The requirements for the workplan and supporting documentation are under Section 3. Workplans and Supporting Documentation.

   B. Continuity of Care

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

      Unless the Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), the MCO must allow an Enrollee to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Enrollee is notified by the MCO of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater. A Enrollee is considered to be receiving an
ongoing course of treatment from a Provider if during the previous twelve (12) months the Enrollee was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been Prior Authorized. Any child (under age 19) with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing course of treatment from the provider. Per Department of Health regulation Title 28, §9.684(d), the transitional period may be extended by the MCO if the extension is determined to be clinically appropriate. The MCO shall consult with the Enrollee and the health care provider in making the determination. The MCO must also allow a Enrollee who is pregnant to continue to receive care from the Provider that is being terminated through the completion of the Enrollee’s postpartum care.

The MCO must review each request to continue an ongoing course of treatment and notify the Enrollees of the decision as expeditiously as the Enrollee’s health condition requires, but no later than 2 business days. If the MCO determines what the Enrollees is requesting is not an ongoing course of treatment, the MCO must issue the Enrollees a denial notice.

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

C. Notification to Enrollees

If the Provider that is being terminated from the Network is a PCP, the MCO, must notify all Enrollees who receive primary care services from the Provider thirty (30) days prior to the effective date of the Provider’s termination. Enrollees who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Enrollees is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is not a PCP or a hospital, the MCO must notify all Enrollees who have received services from the Provider during the previous twelve (12) months, as identified through referral and claims data; all Enrollees who are scheduled to receive services from the Provider; and all Enrollees who have a pending or approved prior
authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider’s termination. Enrollees who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Enrollees is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is a hospital (including a specialty unit within a facility or hospital), the MCO must notify all Enrollees assigned to a PCP with admitting privileges at the hospital, all Enrollees assigned to a PCP that is owned by the hospital, and all Enrollees who have utilized the hospital’s services within the past twelve (12) months thirty (30) days prior to the effective date of the hospital’s termination. The MCO must utilize claims data to identify these Enrollees.

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

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

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

The thirty (30) day advance written notice requirement does not apply to terminations by the MCO for cause in accordance with 40 P.S. Section 991.2117(b). The MCO must notify Enrollees within five (5) Business Days.

The MCO must update web-based Provider directories on a monthly basis to reflect changes in the Provider Network. MCO must provide Provider directories in alternate formats, such as hard copy, when requested.

2. Termination by the Provider

A. Notification to Department

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

The MCO must submit a Provider termination work plan within ten (10) Business Days of the MCO notifying the Department of the termination and must provide weekly status updates to the workplan. The requirements for the workplan are found below, under 3. Workplans and Supporting Documentation.

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

B. Notification to Enrollees

If the Provider that is terminating its participation in the Network is a PCP, the MCO must notify all Enrollees who receive primary care services from the Provider.

If the Provider that is terminating its participation in the Network is not a PCP or a hospital, the MCO must notify all Enrollees, who have received services from the Provider during the previous twelve (12) months; all Enrollees who were scheduled to receive services from the terminating Provider; and all Enrollees who have a pending or approved Prior Authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider’s termination. The MCO must use referral and claims data to identify these Enrollees.

If the Provider that is terminating its participation in the Network is a hospital or specialty unit within a facility, the MCO must notify all Enrollees assigned to a PCP with admitting privileges at the hospital, all Enrollees assigned to a PCP that is owned by the hospital, and all enrollees who have utilized the terminating hospital’s services within the past twelve (12) months thirty (30) days prior to the effective date of the Hospital’s termination. The MCO must use referral and claims data to identify these Enrollees.

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

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

The MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network.

3. Workplans and Supporting Documentation

A. Workplan Submission

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

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

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

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

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

3) Enrollees Identification and Notification Process
   a) Submit information that identifies the total number of Enrollees affected by the termination, i.e., assigned to an...
owned/affiliated PCP or utilizing the hospital or
owned/affiliated provider within the twelve (12) months
preceding the termination date, broken down by Provider.
b) Submit information on the number of enrollees with prior
authorizations in place that will extend beyond the provider
termination date.
c) Submit draft and final Enrollees notices as appropriate, for
Department review and prior approval.

19.1.2 PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition
The MCO must consider, at a minimum, the following in
establishing and maintaining its Provider Network:

- The anticipated CHIP enrollment,
- The expected utilization of services, taking into consideration
  the characteristics and health care needs of specific CHIP
  populations represented in the MCO,
- The number and types, in terms of training, experience, and
  specialization, of Providers required to furnish the contracted
  services,
- The number of Network Providers who have closed panels,
- The geographic location of Providers and Enrollees,
  considering distance, travel time, the means of transportation
  ordinarily used by Enrollees, and whether the location provides
  physical access for Enrollees with disabilities,
- Ability of providers to communicate with enrollees with limited
  English proficiency in their preferred language,
- Ability of providers to ensure physical access, reasonable
  accommodations, culturally competent communication, and
  accessible equipment to enrollees with physical or mental
  disabilities,
- Availability of triage lines or screening systems, telemedicine and
  e-visits, and/or other evolving and innovative technological
  solutions.

The MCO must ensure that its Provider Network is adequate to
provide its Enrollees in its service area with access to quality care
through participating professionals, in a timely manner, and
without the need to travel excessive distances. Upon request
from the Department, the MCO must supply geographic access
maps using Enrollee level data detailing the number, location, and
specialties of their Provider Network to the Department in order to
verify accessibility of Providers within their Network in relation to
the location of its Enrollees. The Department may require additional
numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The MCO must also have a process in place which ensures that the MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

MCOs must submit documentation in a format specified by the state to demonstrate compliance with network adequacy standards. This documentation must be submitted when the MCO enters into a contract with the Commonwealth and subsequently, this documentation must be provided at least annually. Documentation must be updated when there has been a significant change that would affect adequacy and capacity of services.

The MCO must make all reasonable efforts to honor an Enrollee’s choice of Providers who are credentialed in the Network. Enrollees are permitted to use providers of their choice in the contractor’s provider network. Additionally, the MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire CHIP service area in which the MCO operates if providers exist.

A. PCPs

Make available to every Enrollee a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available.

Enrollees may, at their discretion, select PCPs located further from their homes.

1) Pediatricians as PCPs

Ensure an adequate number of pediatricians with open panels to permit all Enrollees who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (30 minutes Urban, 60 minutes Rural).

2) Primary Care Practitioner Responsibilities

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

a) Providing primary and preventive care and acting as the Enrollee’s advocate, providing, recommending, and arranging for care.

b) Documenting all care rendered in a complete and accurate Encounter record that meets or exceeds the DHS data specifications.

c) Maintaining continuity of each Enrollee’s health care, participating in or coordinating with an overall chronic care management team, where appropriate.

d) Communicating effectively with the Enrollees by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with LEP when needed by the Enrollees. Services must be free of charge to the Enrollees.

e) Making referrals for specialty care and other Medically Necessary services, both in and out-of-plan.

f) Maintaining a current medical record for the Enrollees, including documentation of all services provided to the Enrollees by the PCP, as well as any specialty or referral services.

g) Arranging for Behavioral Health Services in accordance with Section 19.8 of this Handbook, Behavioral Health Services.

h) Providing office hours accessible to enrollees for a minimum of twenty (20) hours per week and be available directly or through on-call arrangements with other qualified, plan-participating PCPs twenty-four (24) hours per day, seven (7) days a week for urgent and emergency care.

i) Compliance with all conditions and standards applicable to managed care plans set forth in Act 68 unless otherwise specified. The MCO will retain responsibility for monitoring PCP actions to ensure they comply with the provisions of the Agreement.
3) Specialists as PCPs

An enrollee with a life-threatening, degenerative, or disabling disease or condition shall have access to a specialist as a PCP/Medical Home, consistent with the procedure developed by the awarded supplier pursuant to Section 2111(6) of Act 68 of 1998. An enrollee shall have the right to request and receive an evaluation, and if the plan's standards are met, the enrollee shall receive either a standing referral to a specialist with clinical expertise in treating the disease or the designation of a specialist to provide and coordinate the enrollee’s primary and specialty care.

An awarded supplier is not required to maintain specific enrollee-to-specialist provider ratios. However, each awarded supplier must agree to provide adequate access to physician specialists for PCP/Medical Home referrals and to employ or contract with pediatric specialists in sufficient numbers to ensure specialty services can be made available in a timely and geographically accessible manner, as determined by the Department in consultation with the DOH.

The MCO must adopt and maintain procedures by which an Enrollee with a life-threatening, degenerative or disabling disease or condition requiring an ongoing course of treatment, care and monitoring shall upon request, receive an evaluation by appropriate health care professionals and, if the MCO 's established standards are met, be permitted to receive direct access to an appropriate specialist through:

- A standing referral to a specialist with clinical expertise in treating the disease or condition; or
- The designation of a specialist to provide and coordinate the Enrollee’s primary and specialty care.

The referral to or designation of a specialist must be pursuant to a treatment plan approved by the MCO, in consultation with the PCP, the Enrollees and, as appropriate, the specialist. When possible, the specialist must be a Health Care Provider participating in the MCO’s Network. If the specialist is not a Network Provider, the MCO may require the specialist to meet the requirements of the MCO’s Network Providers, including the MCO’s credentialing criteria and QM/UM Program policies and procedures.
Information for Recipients must include a description of the procedures that an Enrollee with a life-threatening, degenerative or disabling disease or condition shall follow and satisfy to be eligible for:

- A standing referral to a specialist with clinical expertise in treating the disease or condition; or

- The designation of a specialist to provide and coordinate the Enrollee’s primary and specialty care.

The MCO must have adequate Network capacity of qualified specialists to act as PCPs. These physicians may be predetermined and listed in the directory but may also be determined on an as needed basis. All determinations must comply with specifications set out by Act 68 regulations. The MCO must establish and maintain its own credentialing and recredentialing policies and procedures to ensure compliance with these specifications.

The MCO must require that Providers credentialed as specialists and as PCPs agree to meet all of the MCO’s standards for credentialing PCPs and specialists, including compliance with record keeping standards, the Department's access and availability standards and other QM/UM Program standards. The specialist as a PCP must agree to provide or arrange for all primary care, consistent with MCO preventive care guidelines, including routine preventive care, and to provide those specialty medical services consistent with the Enrollee’s needs in accordance with the MCO’s standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist as a PCP also must have admitting privileges at a hospital in the MCO’s Network.

For the following provider types, the MCO must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

- General Surgery
- Obstetrics & Gynecology
- Oncology
- Physical Therapy
- General Dentistry
- Cardiology
- Pharmacy
- Orthopedic Surgery
For the following provider types, the MCO must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the CHIP Zone:

- Oral Surgery
- Urology
- Nursing Facility
- Neurology
- Dermatology
- Otolaryngology

For all other specialists and subspecialists, the MCO must have a choice of two (2) providers who are accepting new patients within the CHIP Zone.

B. Hospitals

Ensure at least one (1) hospital within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice within the CHIP service area.

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

C. Anesthesia for Dental Care

For Enrollees needing anesthesia for dental care, the MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay out of Network.

D. Rehabilitation Facilities

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network. CNMs / CRNPs, Other Health Care Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. The MCO must demonstrate its attempts
to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

E. Behavioral Health Providers

Ensure a choice of at least two (2) behavioral health providers within the provider network who are accepting new patients within the travel times of 30 minutes urban, and 60 minutes rural. The MCO must demonstrate its efforts to contract in good faith with a sufficient number of psychiatrists, psychologists, licensed clinical social workers, and other behavioral health care providers to serve the needs of their Enrollees.

F. Qualified Providers

The MCO must limit its PCP Network to appropriately qualified Providers. MCOs must ensure that enrolled providers have an maintain the necessary licensure and certifications required by the State in order to practice in their field. The MCO's PCP Network must meet the following:

- Seventy-five to one hundred percent (75-100%) of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics; and

- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

Enrollees Freedom of Choice

The MCO must demonstrate its ability to offer its Enrollees freedom of choice in selecting a PCP. At a minimum, the MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) patients. For the purposes of this section, a full-time equivalent PCP must be a physician involved in clinical care. The minimum
weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Enrollees to the panel. The number of Enrollees assigned to a PCP may be decreased by the MCO if necessary to maintain the appointment availability standards.

The MCO must make reasonable efforts to honor an Enrollee's choice of Providers among Network Providers as long as:

- The MCO's agreement with the Network Provider covers the services required by the Enrollees; and
- The MCO has not determined that the Enrollee's choice is clinically inappropriate.

2. Mainstreaming

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

The MCO must investigate Complaints and take affirmative action so that Enrollees are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition, anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

- Denying or not providing an Enrollee any CHIP covered service or availability of a facility within the MCO's Network. The MCO must have explicit policies to provide access to complex interventions such as cardiopulmonary resuscitations, intensive care, transplantation, and rehabilitation when medically indicated and must educate its Providers on these policies. Health care and treatment necessary to preserve life must be provided to all persons who are not terminally ill or permanently unconscious, except where a competent Enrollees objects to such care on his/her own behalf.

- Subjecting a Enrollees to segregated, separate, or different
treatment, including a different place or time from that provided to other Enrollees, public or private patients, in any manner related to the receipt of any CHIP covered service, except where Medically Necessary. MCOs cannot discriminate against CHIP enrollees by offering them access to physician services which differ from the access offered commercial enrollees. For example, a plan may not specifically close a practice to CHIP enrollees if the practice is open to commercial enrollees.

- The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, language, MA status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the participants to be served.

- If the MCO knowingly executes an agreement with a Provider with the intent of allowing or permitting the Provider to implement barriers to care (i.e. the terms of the Provider Agreement are more restrictive than this Agreement), the MCO shall be in breach of this Agreement.

3. Network Changes/Provider Terminations

A. Network Changes

1) Notification to the Department

Other than terminations outlined in Section 19.1.1 (MCO Requirements for Provider Terminations), the MCO must review its network and notify the Department of any changes to its Provider Network (closed panels, relocations, death of a provider, etc.) through the quarterly additions/deletions provider network reporting. The MCO must notify the Department of any changes to its provider network that materially affect the awarded supplier's ability to make available all services in a timely manner. Each awarded supplier also must have procedures to address changes in its network that negatively affect the ability of enrollees to access services.

DOH regulations require that a managed care plan must report any probable loss from the network of any general acute care hospital and any primary care provider, whether an individual practice or a group practice, with 2,000 or more
assigned enrollees. At such time as an awarded supplier submits such a report to DOH, a copy of the report shall be sent to the Department.

2) Procedures and Work Plans

The MCO must have procedures to address changes in its Network that impact Enrollees access to services, in accordance with the requirements of Section 19.1.2, (Provider Network Composition / Service Access), as applicable. Failure of the MCO to address changes in Network composition that negatively affect Enrollees access to services may be grounds for termination of the Agreement.

3) Timeframes for Notification to Enrollees

The MCO must update web-based Provider directories to reflect any changes in the Provider Network.

4) Provider Terminations

The MCO must comply with the Department’s requirements for provider terminations as outlined in Section 19.1.1 (MCO Requirements for Provider Terminations).

4. PCP Composition and Location

MCO must organize its PCP Sites so as to ensure continuity of care to Enrollees and must identify a specific PCP or PCP group for each Enrollee.

5. FQHCs / RHCs

The MCO must include in its Provider Network every FQHC and RHC that is willing to accept PPS rates as payment in full and is located within the operational CHIP service area in which the MCO operates. If the MCO’s primary care Network includes FQHCs and RHCs, these sites may be designated as PCP sites.

6. Medically Necessary Emergency Services

seq. pertaining to coverage and payment of Medically Necessary Emergency Services.

7. ADA Accessibility Guidelines

The MCO must inspect the office of any PCP or dentist who seeks to participate in the MCO’s Provider Network (excluding offices located in hospitals) to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the MCO’s Provider Network provided that the PCP or dentist: 1) requests and is determined by the MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within six (6) months after the MCO identified the barrier.

The MCO must document its efforts to determine architectural accessibility. The MCO must submit this documentation to the Department upon request.

8. Laboratory Testing Sites

The MCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number in accordance with CLIA 1988. Those laboratories with certificates of waiver will provide only the eight (8) types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The PCP must provide all required demographics to the laboratory when submitting a specimen for analysis.

9. Second Opinions

The MCO must provide for a second opinion from a qualified Health Care Provider within the Network, at no cost to the Enrollees. If a qualified Health Care Provider is not available within the Network, the MCO must assist the Enrollees in
obtaining a second opinion from a qualified Health Care Provider outside the Network, at no cost to the Enrollees, unless co-payments apply.

10. Appointment Standards

The MCO must have written policies and procedures for disseminating its appointment standards to all Enrollees through its Enrollees handbook and through other means. In addition, the MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

The MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever an Enrollee misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Enrollee. Such attempts may include, but are not limited to: written attempts, telephone calls, and home visits. At least one (1) such attempt must be a follow-up telephone call.

A. General

PCP scheduling procedures must ensure that:

- Emergency Medical Condition cases must be immediately seen or referred to an emergency facility.
- Urgent Medical Condition cases must be scheduled within twenty-four (24) hours.
- Routine appointments must be scheduled within ten (10) Business Days.
- Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.
- The MCO must provide the Department with its protocol for ensuring that an Enrollee’s average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters
an unanticipated Urgent Medical Condition visit or is treating a Enrollees with a difficult medical need. The Enrollees must be informed of scheduling time frames through educational outreach efforts.

- The MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room visits.

B. Persons with HIV/AIDS

The MCO must have adequate PCP scheduling procedures in place to ensure that an appointment with a PCP or specialist must be scheduled within seven (7) days from the effective date of Enrollment for any person known to the MCO to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the Enrollees is already in active care with a PCP or specialist.

C. Specialty Referrals

For specialty referrals, the MCO must be able to provide for:

a. Emergency Medical Condition appointments immediately upon referral.

b. Urgent Medical Condition care appointments within twenty-four (24) hours of referral.

c. Scheduling of appointments for routine care within fifteen (15) business days for the following specialty provider types:

<table>
<thead>
<tr>
<th>Specialty Provider Type</th>
<th>Specialty Provider Type</th>
</tr>
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<tbody>
<tr>
<td>Otolaryngology</td>
<td>Orthopedic Surgery</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Pediatric</td>
</tr>
<tr>
<td>Allergy &amp; Immunology</td>
<td>Pediatric Endocrinology</td>
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<tr>
<td>Pediatric Gastroenterology</td>
<td>Pediatric General Surgery</td>
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<tr>
<td>Pediatric Hematology</td>
<td>Pediatric Infectious Disease</td>
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<tr>
<td>Pediatric Nephrology</td>
<td>Pediatric Neurology</td>
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<tr>
<td>Pediatric Oncology</td>
<td>Pediatric Pulmonology</td>
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<tr>
<td>Pediatric Rehab Medicine</td>
<td>Pediatric Rheumatology</td>
</tr>
<tr>
<td>Pediatric Urology</td>
<td>Dentist</td>
</tr>
</tbody>
</table>

d. Scheduling of appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.
D. Pregnant Women

Should the Enrollees notify the MCO that a new Enrollee is pregnant or there is a pregnancy indication on the files transmitted to the MCO by the Department, the MCO must contact the Enrollees within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the MCO must arrange initial prenatal care appointments for enrolled pregnant Enrollees as follows:

a. First trimester — within ten (10) Business Days of the Enrollees being identified as being pregnant.

b. Second trimester — within five (5) Business Days of the Enrollees being identified as being pregnant.

c. Third trimester — within four (4) Business Days of the Enrollees being identified as being pregnant.

d. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the MCO or maternity care Provider, or immediately if an emergency exists.

E. MCO’s Corrective Action

The MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a termination action or other sanction by the Department, the MCO will be given the opportunity to institute a corrective action plan. The MCO must submit a corrective action plan to the Department for approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the MCO shall be notified of the deficiencies of the corrective action plan. In such event, the MCO must submit a revised corrective action plan within fifteen (15) days of notification. If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the MCO. Failure to implement the corrective action plan may result in the
imposition of a sanction as provided in the Agreement.

19.2 QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS

The Department will monitor the Quality Management (QM) and Utilization Management (UM) programs of all MCOs. The MCO’s QM and UM programs must be designed to assure and improve the accessibility, availability, and quality of care being provided to its enrollees. The MCO’s QM and UM programs must, at a minimum:

1. Contain a written program description, work plan, evaluation and policies/procedures that meet requirements outlined in the agreement;

2. Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the MCO in collaboration with the Department;

3. Be based on statistically valid clinical and financial analysis of Encounter Data, Enrollees demographic information, HEDIS®, CAHPS, Pennsylvania Performance Measures and other data that allows for the identification of prevalent medical conditions, barriers to care and racial/ethnic disparities to be targeted for quality improvement, case and disease management initiatives;

4. Allow for the continuous evaluation of its activities and adjustments to the program based on these evaluations;

5. Demonstrate sustained improvement for clinical performance over time; and

6. Allow for the timely, complete and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including CAHPS and Healthcare Effectiveness Data and Information Set (HEDIS®).

7. Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the MCO or the Department that:

   A. Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;
   B. Allow for submission of improvement plans, as determined by and within time frames established by the Department. Failure by the MCO to comply with the requirements and improvement actions
requested by the Department may result in the application of penalties and/or sanctions.

8. Obtain accreditation by a nationally recognized organization, such as National Committee of Quality Assurance (NCQA).

**Standard I:** The scope of the QM and UM programs must be comprehensive in nature; allow for improvement and be consistent with the Department’s goals related to access, availability and quality of care. At a minimum, the MCO’s QM and UM programs, must:

1. Adhere to current CHIP CMS guidelines.

2. Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and techniques of peer review.

3. Ensure that all QM and UM activities and initiatives undertaken by the MCO are based upon clinical and financial analysis of Encounter Data, Enrollees demographic information, HEDIS®, CAHPS, Pennsylvania Performance Measures and/or other identified areas.

4. Contain policies and procedures which provide for the ongoing review of the entire scope of care provided by the MCO assuring that all demographic groups, races, ethnicities, care settings, and types of services are addressed.

5. Contain a written program description that addresses all standards, requirements and objectives established by the Department and that describes the goals, objectives, and structure of the MCO’s QM and UM programs. The written program description must, at a minimum:

   A. Include standards and mechanisms for ensuring the accessibility of primary care services, specialty care services, urgent care services, and Enrollees services in accordance with timeframes outlined in CHIP Procedure Handbook Section 19.1.2, Provider Network Composition/Service Access, as applicable.

   B. Include mechanisms for planned assessment and analysis of the quality of care provided and the utilization of services against formalized standards, including but not limited to:

   1) Primary, secondary, and tertiary care;
   2) Preventive care and wellness programs;
   3) Acute and/or chronic conditions;
   4) Dental care;
   5) Care coordination; and
6) Continuity of care.

C. Allow for the timely, accurate, complete collection and clinical and financial analysis of Encounter Data and other data including, but not limited to, HEDIS®, CAHPS, and Pennsylvania Performance Measures.

D. Allow for systematic analysis and re-measurement of barriers to care, the quality of care provided to Enrollees, and utilization of services over time.

6. Provide a comprehensive written evaluation, completed on at least an annual basis, that details all QM and UM program activities including, but not limited to:

   A. Studies and activities undertaken; including the rationale, methodology and results

   B. Subsequent improvement actions; and

       a. Aggregate clinical and financial analysis of Encounter, HEDIS®, CAHPS, Pennsylvania Performance Measures and other data on the quality of care rendered to Enrollees and utilization of services.

7. Include a work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, including, but not limited to:

   A. Data collection and analysis;

   B. Evaluation and reporting of findings;

   C. Implementation of improvement actions where applicable; and

   D. Individual accountability for each activity.

8. Provide for aggregate and individual analysis and feedback of Provider performance and MCC performance in improving access to care, the quality of care provided to Enrollees and utilization of services.

9. Include mechanisms and processes which ensure related and relevant operational components, activities, and initiatives from the QM and UM programs are integrated into activities and initiatives
undertaken by other departments within the MCO including, but not limited to, the following:

A. Special Needs;

B. Provider Relations;

C. Enrollee Enrollees Services; and

D. Management Information Systems

10. Include procedures for informing both physician and non-physician Providers about the written QM and UM programs, and for securing cooperation with the QM and UM programs in all physician and non-physician Provider agreements.

11. Include procedures for feedback and interpretation of findings from analysis of quality and utilization data to Providers, health professionals, MCO staff, and CHIP Consumers/family enrollees.

12. Include mechanisms and processes which allow for the development and implementation of MCO wide and Provider specific improvement actions in response to identified barriers to care, quality of care concerns, and over-utilization, under-utilization and/or mis-utilization of services.

**Standard II: The organizational structures of the MCO must ensure that:**

1. The Governing Body:

A. Has formally designated an accountable entity or entities, within the MCO, to provide oversight of QM and UM program activities or has formally decided to provide such oversight as a committee, e.g. Quality Management Committee.

B. Regularly receives written reports on the QM and UM program activities that describe actions taken, progress in meeting objectives and improvements made. The governing body formally reviews, on at least an annual basis, a written evaluation of the QM and UM program activities that includes studies undertaken, results of studies, and subsequent improvement actions taken. The written evaluation must include aggregate clinical and financial analysis of quality and utilization data, including HEDIS®, CAHPS, and Pennsylvania Performance Measures.
C. Documents actions taken by the governing body in response to findings from QM and UM program activities.

2. The Quality Management Committee (QMC):
   A. Must contain policies and procedures which describe the role, structure and function of the QMC that:
      1) Demonstrate that the QMC has oversight responsibility and input, including review and approval, on all QM and UM program activities;
      2) Ensure active participation by individuals representative of the composition of the MCO 's Providers;
      3) Provide for documentation of the QMC's activities, findings, recommendations, and actions.

   B. Meets at least monthly, and otherwise as needed.

3. The Medical Director:
   A. Serves as liaison and is accountable to the governing body and Quality Management Committee for all QM and UM activities and initiatives;
   B. Is available to the MCO 's medical staff for consultation on referrals, denials, complaints and problems;
   C. Is directly involved in the MCO 's recruiting and credentialing activities;
   D. Is familiar with local standards of medical practice and nationally accepted standards of practice;
   E. Has knowledge of due process procedures for resolving issues between participating Providers and the MCO administration, including those related to medical decision making and utilization review;
   F. Is available to review, advise and take action on questionable hospital admissions, Medically Necessary length of stay and all other medical care and medical cost issues;
   G. Is directly involved in the MCO 's process for prior authorizing or denying services and is available to interact with Providers on denied authorizations;
H. Has knowledge of current peer review standards and techniques;

I. Has knowledge of risk management standards;

J. Is directly accountable for all Quality Management and Utilization Management activities and

K. Oversees and is accountable for:

1) Referrals to the Department and appropriate agencies for cases involving quality of care that have adverse effects or outcomes; and

2) The processes for potential Fraud and Abuse investigation, review, sanctioning, and referral to the appropriate oversight agencies.

4. The MCO must have sufficient material resources, and staff with the appropriate education, experience and training, to effectively implement the written QM and UM programs and related activities.

**Standard III:** The QM and UM programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services provided to Enrollees through quality of care studies and related activities with a focus on identifying and pursuing opportunities for continuous and sustained improvement.

1. The QM and UM programs must include professionally developed practice guidelines/standards of care that are:

   A. Written in measurable and accepted professional formats,

   B. Based on scientific evidence; and

   C. Applicable to Providers for the delivery of certain types or aspects of health care.

2. The QM and UM programs must include clinical/quality Indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.
3. Practice guidelines and clinical indicators must address the full range of health care needs of the populations served by the MCO. The clinical areas addressed must include, but are not limited to:

A. Pediatric and adolescent preventive care with a focus on Bright Futures guidelines;

B. Obstetrical care including a requirement that Enrollees be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;

C. Selected diagnoses and procedures relevant to the enrolled population;

D. Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the MCO’s enrollment population;

E. Preventive dental care; and

F. Behavioral care

4. The QM and UM programs must provide practice guidelines, clinical indicators and medical record keeping standards to all Providers and appropriate subcontractors. This information must also be provided to Enrollees upon request.

5. The MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, Behavioral Health Providers and Providers of ancillary services not less than every two years (i.e. medical record audits). These methodologies must, at a minimum:

A. Demonstrate the degree to which PCPs, specialists, behavioral health providers and dental Providers are complying with clinical and preventive care guidelines adopted by the plan;

B. Allow for the tracking and trending of individual and MCO wide Provider performance over time;

C. Include active mechanisms and processes that allow for the identification, investigation and resolution of quality of care concerns, including events such as Health Care-Associated Infections and medical errors; and
D. Include mechanisms for detecting instances of over-utilization, under-utilization, and mis-utilization;

6. The QM and UM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:

A. Processes that allow for the identification, investigation and resolution of quality of care concerns including Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care patterns;

B. Processes for tracking and trending problematic patterns of care;

C. Use of progressive sanctions as indicated;

D. Person(s) or body responsible for making the final determinations regarding quality problems; and

E. Types of actions to be taken, such as:
   1) Education;
   2) Follow-up monitoring and re-evaluation;
   3) Changes in processes, structures, forms;
   4) Informal counseling;
   5) Procedures for terminating the affiliation with the physician or other health professional or Provider;
   6) Assessment of the effectiveness of the actions taken; and
   7) Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care).

7. The QM and UM programs must include methodologies that allow for the identification, verification, and timely resolution of inpatient and outpatient quality of care concerns, Enrollee quality of care complaints, over-utilization, under-utilization, and/or mis-utilization, access/availability issues, and quality of care referrals from other sources;

8. The QM and UM programs must contain procedures for Enrollee satisfaction surveys that are conducted on at least an annual basis including the collection of annual Enrollee satisfaction data through application of the CAHPS instrument.

9. The QM and UM programs must contain procedures for Provider satisfaction surveys to be conducted on at least an annual basis.
Surveys are to include PCPs, and specialists, dental Providers, hospitals, behavioral health providers and Providers of ancillary services.

10. Each MCO will be required to comply with requirements for Performance Improvement Projects (PIPs).

**Standard IV:** The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to Enrollees through utilization review activities with a focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization.

A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web-based electronic formats) profiles comparing the average medical care utilization rates of the Enrollees of each PCP to the average utilization rates of all MCO Enrollees. The MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to:

1) Utilization information on Enrollees Encounters with PCPs;
2) Specialty Claims;
3) Prescriptions;
4) Inpatient stays;
5) Emergency room use;
6) Clinical indicators for preventive care services (i.e. Mammograms, immunizations, pap smear, etc.); and
7) Clinical indicators for EPSDT requirements.

B. The MCO must have mechanisms and processes for profiling physicians using risk adjusted diagnostic data for profiles.

C. The QM and UM programs must implement statistically valid methodologies for analysis and follow-up of semi-annual practitioner utilization profiles for patterns and instances of over-utilization, under-utilization, and mis-utilization across the continuum of care, as well as, trending of Provider utilization patterns over time. Follow up includes but is not limited to Provider education, Provider improvement plans, and Provider sanctions as necessary.

D. The QM and UM programs must at least annually, provide for verification of Encounter reporting rates and accuracy and completeness of Encounter information submitted by PCPs.

**Standard V:** The MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of
complications and treatment of chronic conditions for Enrollees identified. Case/Disease and health management programs must:

A. Include mechanisms and processes that ensure the active collaboration and coordination of care and services for identified enrollees.

B. Include mechanisms and processes that allow for the identification of conditions to be targeted for case/disease and health management programs and that allow for the assessment and evaluation of the effectiveness of these programs in improving outcomes for and meeting the needs of individuals with targeted conditions.

C. Include care guidelines and/or protocols for appropriate and effective management of individuals with specified conditions. These guidelines must be written in measurable and accepted professional formats and be based on scientific evidence.

D. Include performance indicators that allow for the objective measurement and analysis of individual and MCO wide performance in order to demonstrate progress made in improving access and quality of care.

E. Include mechanisms and processes that lead to healthy lifestyles such as weight loss program memberships, gym members, and asthma camps.

**Standard VI:** The QM and UM programs must have mechanisms to ensure that Enrollees receive seamless, continuous, and appropriate care throughout the continuum of care, by means of coordination of care, benefits, and quality improvement activities between:

A. PCPs and specialty care practitioners and other Providers;

B. Other CHIP MCOs;

C. The MCO and other third party insurers

**Standard VII:** The MCO must demonstrate that it retains accountability for all QM and UM program functions, including those that are delegated to other entities. The MCO must:

A. Have a written description of the delegated activities, the delegate’s accountability for these activities, and the frequency of reporting to the MCO.

B. Have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.
C. Document evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

D. Make available to the Department, and its authorized representatives, any and all records, documents, and data detailing its oversight of delegated QM and UM program functions.

E. Must ensure that delegated entities make available to the Department, and its authorized representatives, any and all records, documents and data detailing the delegated QM and UM program functions undertaken by the entity on behalf of the MCO.

F. Compensation and payments to individuals or entities that conduct Utilization Management activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollees.

**Standard VIII:** The QM/UM program must have standards for credentialing/recredentialing Providers to determine whether physicians and other Health Care Providers, who are licensed by the Commonwealth and are under contract to the PH-MCO, are qualified to perform their services.

A. The MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types. Recredentialing activities must be conducted by the MCO at least every three (3) years. Criteria must include, but not be limited to, the following:

1) Appropriate license or certification as required by Pennsylvania state law;

2) Verification that Providers have not been suspended, terminated or entered into a settlement for voluntary withdrawal from the CHIP program;

3) Verification that Providers and/or subcontractors have a current Provider Agreement and an active PROMISe™ Provider ID issued by the Department;

4) Evidence of malpractice/liability insurance;

5) A valid Drug Enforcement Agency (DEA) certification;

6) Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach;

7) Consideration of quality issues such as Enrollees Complaint and/or Enrollees satisfaction information, sentinel events and quality of care concerns.
B. For purposes of credentialing and recredentialing, the MCO must perform a check on all PCPs and other physicians by contacting the National Practitioner Data Bank (NPDB). If the MCO does not meet the statutory requirements for accessing the NPDB, then the MCO must obtain information from the Federation of State Medical Boards.

C. Appropriate PCP qualifications:

1) A PCP must have the ability to perform or directly supervise the ambulatory primary care services of Enrollees;

2) Enrollees Enrollment of the medical staff with admitting privileges of at least one general hospital or an acceptable arrangement with a PCP with admitting privileges;

3) Demonstrate evidence of continuing professional medical education;

4) Attend at least one MCO sponsored Provider education training session

D. Assurance that any CRNP, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team, is performing under the scope of their respective licensure; and

E. As part of the Provider release form, the potential Provider must agree to release all CHIP records pertaining to sanctions and/or settlement to the MCO and the Department.

F. The Department will recoup from the MCO any and all payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by the MCO in a manner that is not consistent with the Provider's licensure. In addition, the MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.

G. The MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the MCO’s credentialing practices.

H. Any economic profiles used by the MCOs to credential Providers should be adjusted to adequately account for factors that influence utilization independent of the Provider's clinical management, including Enrollees age, Enrollees sex, Provider case-mix and Enrollees severity. The MCO must report any utilization profile that it utilizes in its credentialing process and the methodology that it uses to adjust the profile to account for non-clinical management factors at the time and in the manner requested by the Department.
I. In the event that a MCO renders an adverse credentialing decision, the MCO must provide the affected Provider with a written notice of the decision. The notice should include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors. All credentialing decisions made by the MCO are final and may not be appealed to the Department.

J. The MCO must meet the following standards related to timeliness of processing new provider applications for credentialing.

1) The MCO must begin its credentialing process upon receipt of a provider’s credentialing application if the application contains all required information.

2) The MCO may not delay processing the application if the provider does not have an MAID number that is issued by the DHS. However, the MCO cannot complete its process until the provider has received its MAID number from DHS.

3) Provider applications submitted to the MCO for credentialing must be completed within sixty (60) days of receipt of the application packet if the information is complete.

Standard IX: The MCO’s written UM program must contain policies and procedures that describe the scope of the program, mechanisms, information sources used to make determinations of medical necessity and in conjunction with the requirements in Prior Authorization Guidelines for Participating Managed Care Organizations in the CHIP Program.

A. The UM program must contain policies and procedures for Prospective, Concurrent, and Retrospective review determinations of medical necessity.

B. The UM program must allow for determinations of medical necessity that are consistent with the CHIP Program definition of Medically Necessary:

Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review, or Retrospective Review basis, shall be documented in writing. The MCO shall base its determination on medical information provided by the Enrollees, the Enrollee’s family/care taker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Enrollee. Medical necessity determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under the Agreement. Satisfaction of any one of the following standards will result in authorization of the service:
1) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability;

2) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability;

3) The service or benefit will, assist the Enrollees to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollees and those functional capacities that are appropriate for Enrollees of the same age.

C. If the MCO wishes to require Prior Authorization of any services, they must establish and maintain written policies and procedures for the Prior Authorization review process. Prior Authorization policies and procedures must:

1) Meet the CHIP Program’s definition of Medically Necessary;

2) Contain timeframes for decision making or cross reference policies on timeframes for decision making that meet requirements outlined in the Prior Authorization of Services Section.

3) Contain language or cross reference policies and procedures of notifying Enrollees of adverse decisions and how to file a Complaint/Grievance/CHIP Review;

4) Comply with state/federal regulations;

5) Comply with CHIP agreement and other contractual requirements;

6) Specify populations covered by the policy;

7) Contain an effective date; and

8) Be received under signature of individuals authorized by the plan.

D. The MCO must provide all Licensed Proprietary Products which include, but are not limited to: Interqual and Milliman. All Utilization Review Criteria and/or policies and procedures that contain Utilization Review Criteria used to determine medical necessity must:

1) Not contain any definition of medical necessity that differs from the CHIP definition of Medically Necessary;

2) Allow for determinations of medical necessity that are consistent with the CHIP Program definition of Medically Necessary;
3) Allow for the assessment of the individual’s current condition and response to treatment and/or co-morbidities, psychosocial, environmental, and/or other needs that influences care;

4) Provide direction to clinical reviewers on how to use clinical information gathered in making a determination to approve, deny, continue, reduce or terminate a service;

5) Be developed using a scientific based process;

6) Be reviewed at least annually and updated as necessary; and

7) Provide for evaluation of the consistency with which reviewers implement the criteria on at least an annual basis.

E. The MCO must ensure that Prior Authorization and Concurrent review decisions:

1) Are supervised by a physician or Health Care practitioner with appropriate clinical expertise in treating the Enrollee’s condition or disease;

2) That result in a denial may only be made by a licensed physician;

3) Are made in accordance with established time-frames outlined in the Agreement for routine, urgent, or emergency care; and

4) Are made by clinical reviewers using the CHIP definition of medical necessity.

F. MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, and medical supplies. The MCO must have written policies and procedures that address how Enrollees and Providers can make contact with the MCO to receive instruction or Prior Authorization, as necessary. In addition, the MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated hotline to respond to Enrollees inquiries, issues and problems regarding services. The MCO’s internal Enrollee hotline staff are required to ask the callers whether or not they are satisfied with the response given to their call. The MCO must document all calls and if the caller is not satisfied, the MCO must refer the call to the appropriate individual within the MCO for follow-up and/or resolution. This referral must take place within forty-eight (48) hours of the call. The MCO is not permitted to utilize electronic call answering methods, as a substitute for staff persons, to perform this service. The MCO must ensure that its dedicated hotline meets the following Enrollee services performance standards: provides for a dedicated phone line for its Enrollees; provide for
necessary translation and interpreter assistance for LEP Enrollees; be staffed by individuals trained in: cultural competency, addressing the needs of special populations, the availability of and the functions of the SNU, the services which the MCO is required to make available to all Enrollees, and the availability of social services within the community. Be staffed with an adequate number of service representatives to handle call volumes. Provide for TTY and/or Pennsylvania Telecommunication Relay Service availability for Enrollees who are deaf or hard of hearing.

G. Additional Prior Authorization requirements can be found in Section 19.4 (Prior Authorization Guidelines) for Participating Managed Care Organizations in the CHIP Program.

H. The MCO must ensure that utilization records document efforts made to obtain all pertinent clinical information and efforts to consult with the prescribing Provider before issuing a denial based upon medical necessity.

I. The MCO must ensure that sources of utilization criteria are provided to Enrollees and Providers upon request.

J. The UM program must contain procedures for providing written notification to Enrollees of denials of medical necessity and terminations, reductions and changes in level of care or placement, which clearly document and communicate the reasons for each denial. These procedures must:

1) Meet requirements outlined in Complaints, Grievances, and the CHIP Review process.

2) Provide for written notification to Enrollees of denials, terminations, reductions and changes in medical services at least ten (10) days before the effective date.

3) Include notification to Enrollees of their right to file a Complaint, Grievance or CHIP Review as outlined in Complaints, Grievances, and the CHIP Review Process.

K. The MCO must agree to comply with the Department's utilization review monitoring processes, including, but not limited to:

1) Submission of a log of all denials issued using formats to be specified by the Department.

2) Submission of denial notices for review as requested by the Department.

3) Submission of utilization review records and documentation as requested by the Department.
4) Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.

5) Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department prior to implementation.

**Standard X:** The MCO must have a mechanism in place for Provider Appeals/Provider Disputes related to the following:

A. Administrative denials including denials of Claims/payment issues, and payment of Claims at an alternate level of care than what was provided, i.e. acute versus skilled days. This includes the appeal by Health Care Providers of a MCO’s decision to deny payment for services already rendered by the Provider to an Enrollee.

B. QM/UM sanctions

C. Adverse credentialing/recredentialing decisions

D. Provider Terminations

**Standard XI:** The MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM and UM program activities are documented and reported to appropriate individuals within the MCO for use in other management activities.

A. The QM and UM program must have procedures which describe how findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to individuals within the MCO for use in conjunction with other related activities such as:

1) MCO Provider Network changes;
2) Benefit changes;
3) Medical management systems (e.g., pre-certification); and
4) Practices feedback to Providers.

**Standard XII:** The MCO must have written policies and procedures for conducting prospective and retrospective DUR that meet requirements of Outpatient Drug Services.

**Standard XIII:** The MCO must have written standards for medical record keeping. The MCO must ensure that the medical records contain written documentation of the medical necessity of a rendered, ordered, or prescribed service.
A. The MCO must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for medical records that promote maintenance of medical records in a legible, current, detailed, organized, and comprehensive manner that permits effective patient care and quality review.

B. Medical record standards must meet or exceed medical record keeping requirements contained in medical record keeping standards adopted by DOH.

C. Additional standards for patient visit data must, at a minimum, include the following:

1) History and physical that is appropriate to the patient’s current condition;
2) Treatment plan, progress, and changes in treatment plan;
3) Diagnostic tests and results
4) Therapies and other prescribed regimens;
5) Disposition and follow-up;
6) Referrals and results thereof;
7) Hospitalizations;
8) Reports of operative procedures and excised tissues; and
9) All other aspects of patient care.

D. The MCO must have written policies and procedures to assess the content of medical records for legibility, organization, completion, and conformance to its standards.

E. The MCO must ensure access of the Enrollees to his/her medical record at no charge and upon request. The Enrollee’s medical records are the property of the Provider who generates the record.

F. The Department and/or its authorized agents (i.e., any individual or corporation or entity employed, contracted, or subcontracted with by the Department) shall be afforded prompt access to all Enrollees’ medical records whether electronic or paper. All medical record copies are to be forwarded to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. The Department is not required to obtain written approval from an Enrollee before requesting the Enrollee’s medical record from the PCP or any other agency.

G. Medical records must be preserved and maintained for a minimum of ten years from expiration of the MCO’s contract. Medical records must be made available in paper form upon request.
H. When an Enrollee changes PCPs, the MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PCP within seven business days from receipt of the request. In emergency situations, the MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

I. When Enrollees changes MCOs, the MCO must facilitate the transfer of his/her medical records or copies of medical records to the new MCO within seven business days from the effective date of enrollment in the gaining MCO. In emergency situations, the MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

**Standard XIV:** The QM and UM program must demonstrate a commitment to ensuring that Enrollees are treated in a manner that acknowledges their defined rights and responsibilities.

A. The MCO must have a written policy that recognizes the following rights of Enrollees:

1) To be treated with respect, and recognition of their dignity and need for privacy;

2) To be provided with information about the MCO, its services, the practitioners providing care, and Enrollees rights and responsibilities;

3) To be able to choose Providers, within the limits of the MCO Network, including the right to refuse treatment from specific practitioners;

4) To participate in decision making regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions;

5) To have a Health Care Provider, acting within the lawful scope of practice, discuss Medically Necessary care and advise or advocate appropriate care with or on behalf of the Enrollees including; information regarding the nature of treatment options; risks of treatment; alternative therapies; and consultation or tests that may be self-administered; without any restriction or prohibition from the MCO ;

6) To file a Grievance about the MCO or care provided;

7) To file a CHIP Review with the Department;

8) To formulate advance directives (durable healthcare power of attorney and living wills) for enrollees including:

   a) The description of State law, if applicable.
b) The process for notifying the Participant of any changes in applicable state law as soon as possible, but no later than ninety (90) days after the effective date of the changes.

c) Any limitation the MCO has regarding implementation of advanced directives as a matter of conscience.

d) The process for Participants to file a Complaint concerning noncompliance with the advanced directive requirements with the MCO and the State survey and certification agency.

e) How to request written information on advance directive policies.

9) To have access to his/her medical records in accordance with applicable Federal and State laws and the right to request that they be amended or corrected as specified as in 45 CFR Section 164.526.

B. The MCO must have a written policy that addresses Enrollee’s responsibility for cooperating with those providing health care services. This written policy must address Enrollee’s responsibility for:

1) Providing, to the extent possible, information needed by professional staff in caring for the Enrollees; and

2) Following instructions and guidelines given by those providing health care services.

3) Enrollees shall provide consent to managed care plans, Health Care Providers, and their respective designees for the purpose of providing patient care management, outcomes improvement, and research. For these purposes, Enrollees will remain anonymous to the greatest extent possible.

C. The MCO’s policies on Enrollees rights and responsibilities must be provided to all participating Providers.

D. Upon enrollment, Enrollees must be provided with a written statement that includes information on the following:

1) Rights and responsibilities of Enrollees;

2) Benefits and services included as a condition of enrollment, and how to obtain them, including a description of:
a) Any special benefit provisions (for example, co-payment, higher deductibles, rejection of Claim) that may apply to services obtained outside the system; and
b) The procedures for obtaining Out-of-Area Services;
c) Charges to Enrollees if applicable;
d) Benefits and services excluded.
e) Provisions for after-hours, urgent, and emergency coverage;
f) The MCO’s policy on referrals for specialty care;
g) MCO Procedures for notifying, in writing, those Enrollees affected by denial, termination or change in any benefit or service including denials, terminations or changes in level of care or placement;
h) Procedures for appealing decisions adversely affecting the Enrollee’s coverage, benefits, or relationship to the MCO;
i) Procedures for changing practitioners;
j) Procedures for disenrolling from the MCO;
k) Procedures for filing Complaints and/or Grievances; CHIP Reviews; and
l) Procedures for recommending changes in policies and services.

E. The MCO must have policies and procedures for resolving Enrollees Complaints and Grievances that meet all requirements outlined concerning Complaints, Grievances, and CHIP Review Processes. These procedures must include mechanisms that allow for the review of all Complaints and Grievances to determine if quality of care issues exists and for appropriate referral of identified issues.

F. Opportunity must be provided for Enrollees to offer suggestions for changes in policies and procedures.

G. The MCO must take steps to promote accessibility of services offered to Enrollees. These steps must include identification of the points of access to primary care, specialty care and hospital services. At a minimum, Enrollees are given information about:

1) How to obtain services during regular hours of operation;
2) How to obtain after-hours, urgent and emergency care; and
3) How to obtain the names, qualifications, and titles of the Health Care Provider providing and/or responsible for their care.

H. Enrollee information (for example, Enrollees brochures, announcements, and handbooks) must be written in language that is readable and easily understood. MCO website must post or link to the enrollee handbook, provider directory, and formulary in a manner that is readily accessible. Handbooks must be posted on the MCO website.
1) Common managed care terminology included in the definitions of the CHIP Procedures Handbook and the CHIP Agreement must be incorporated in relevant documents, including enrollee handbooks and notices.

2) A model enrollee handbook and model enrollee notices must be developed and written in language that is readable and easily understood.

I. The MCO must make vital documents disseminated to English speaking enrollees available in alternate languages, upon request of the Enrollees. Documents may be deemed vital if related to the access of LEP persons to programs and services.

**Standard XV:** The MCO must maintain systems, which document implementation of the written QM and UM program descriptions.

A. The MCO must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM and UM programs.

B. The MCO must adhere to all systems requirements provided by the Department.

C. The MCO must adhere to all Encounter Data requirements of the Agreement.

**19.3 SPECIAL NEEDS/CASE MANAGEMENT UNITS**

**19.3.1 ESTABLISHMENT OF SPECIAL NEEDS/CASE MANAGEMENT UNITS**

The MCO will be required to develop, train, and maintain a unit within its organization structure whose primary responsibility will be to deal, in a timely manner, with issues relating to Enrollees with more complex or chronic health conditions. This unit will be headed by a Special Needs/Case Management Coordinator who must have access to and periodically consult with the Medical Director. The Department expects the MCO’s Special Needs/Case Management Unit to be staffed by individuals with either a medical and/or social services background, in sufficient number to initiate a response to an Enrollee’s inquiry within two (2) Business Days or sooner in urgent situations. The Department expects the core staff members of the Special Needs/Case Management Unit to be responsible primarily for the functions and operations associated with the unit. The Department also expects that at times the Unit staff will have access to the resources of other departments within the MCO to supplement the Unit in assisting Enrollees. The MCO must show evidence of their access to and use of individuals with expertise in the treatment of Enrollees with chronic and complex health conditions.
needs to provide consultation to the Special Needs/Case Management Unit staff, as needed.

The primary purpose of the Special Needs/Case Management Unit is to ensure that each Enrollee receives access to appropriate primary care, access to specialists trained and skilled in the needs of the Enrollee, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the Enrollee's condition or circumstance, including pharmaceuticals and DME, and access to needed community services. The Special Needs/Care Management Unit must have a direct link to the Utilization Management functions of the MCO and have input into the case review process. The MCO must have procedures in place that ensure the proactive identification of and outreach to Enrollees with Special Needs who may not self-identify as having a chronic or complex health need.

Services are available to all CHIP enrollees. Enrollees must have an active policy with the MCO to qualify for services. There are no requirements for a case management referral. Enrollees are not required to participate in the case management program, but may opt out. There is no limit to the Enrollee's access to case management.

19.3.2 IDENTIFICATION OF ENROLLEES

Identification of enrollees in need of case management services is based on:

1. Health assessment questionnaires to identify general health status and concerns
2. Family concerns
3. Overall knowledge of their diagnosis and ability to manage their health condition
4. Concurrent review activities
5. Post payment review of high dollar claims
6. Review of claims for emergency room visits and inpatient stays
7. Review of pharmacy data
8. Need for extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve the level of functioning for the individual
9. Need for primary care be managed by a specialist, due to the nature of the condition
10. Enrollees who may incur higher morbidity without intervention and coordination in the care of the individual
11. Requirement for care and/or services that necessitate coordination and communication among Network Providers and/or Out-of-Network Providers
12. Need for language, communication, or mobility accommodations
13. Need for an Enrollee to be accompanied or assisted while seeking or receiving care by an individual who may act on the Enrollee’s behalf
14. Enrollee who requires assistance in discharge planning from an inpatient or long term care setting to ensure the Enrollees will receive services in the least restrictive environment possible
15. Any condition, event, or life circumstance that as a result inhibits a Enrollee’s access to any necessary service or support needed to address their medical condition or maintain their current level of functioning

19.3.3 FUNCTIONS OF THE SPECIAL NEEDS/CASE MANAGEMENT UNIT

The staff of the MCO Special Needs/Case Management Unit will ensure the receipt of care and/or services by acting as the MCO case manager for each Enrollee with an identified need. The case manager will be responsible for coordinating the delivery of all services for which the Enrollee is eligible under the MCO benefit package. In the event that an Enrollee is not satisfied with MCO performance in any area, the case manager will be responsible for facilitating dispute resolution and for informing the Enrollee of the Complaint, Grievance, and DPW Fair Hearing mechanisms that are available and assisting in that process as needed or requested. Enrollees determined to have ongoing needs for assistance will be assigned to a particular case manager and will have ready access to their case manager as long as they are enrolled in the MCO. Enrollees are permitted to change case managers as needed during their enrollment.

Special Needs/Case Management Unit Functions include:
1. Provide education to Enrollees and their families to better understand and take care of their condition
2. Assist in finding community resources, and assistance locating specialist services for Enrollees
3. Assist with questions regarding medications, making appointments
4. Develop a plan of care based on the level of intervention and support needed to address the identified issues
5. Coordinate care between providers, such as physical health and behavioral health providers
6. Assist families with disabled children to find the support resources they need
7. Assist the family with the application to transfer from CHIP to MA and remain involved in the child’s care during the transfer process
8. Services may be provided telephonically, face-to-face in the doctor’s office, or home or hospital visits

19.3.4 MCO RESPONSIBILITIES

The MCO must
1. Conduct necessary training for all MCO staff to acquaint them with the purpose and function of the Special Needs Unit and the need to coordinate within departments to serve Enrollees with Special Needs.
2. Provide sufficient telephone and alternative communication channels to allow ready and timely interactions between the MCO Special Needs/Case Management Unit Coordinator and case managers and the Office CHIP, Enrollees, and Providers (Network and Out-of-Network).
3. Provide services to effectively assist Enrollees with Special Needs who speak languages other than English in accordance with the RFA and Agreement requirements. In addition, efforts must be made to match Enrollees with communication barriers due to disability or linguistic background with Providers with whom they can effectively communicate.
4. Ensure cooperation of the MCO's Provider Network. Special Needs Unit case managers must facilitate communication and coordinate service delivery between primary care, specialty, ancillary, and behavioral health Providers to ensure Enrollee's timely and uninterrupted access to care.
5. Assist in the development of adequate Provider Networks, such as pediatric specialists, to serve Enrollee. Case managers must assist and support Enrollees in making an informed choice between Providers of equivalent services within the network. When adequate network capacity does not exist to allow for choice between network Providers of equivalent services, case managers must facilitate and coordinate services rendered by Out-of-Network Providers.
6. Conduct necessary training for all MCO providers to acquaint them with the purpose and function of the Special Needs/Case Management Unit and identify a contact as a direct contact for any provider to refer Enrollees with special needs for assistance.
7. Conduct face-to-face case management activities with enrollees for whom telephonic case management has proven ineffective, and desired goals have not been attained.

19.4 PRIOR AUTHORIZATION GUIDELINES

19.4.1 GENERAL REQUIREMENT

The CHIP Managed Care Organizations (MCOs) must submit to the Department all written policies and procedures for the Prior Authorization of services. The MCO must notify the Department of services they will continue to prior authorize and the basis for determining if the service is Medically Necessary. The policies and procedures must:

- Be submitted in writing, for all new and revised criteria, prior to implementation;
- Be approved by the Department in writing prior to implementation; to specifications of the CHIP RFA, CHIP Agreement, federal regulations, and applicable policy
- Ensure that physical health care is Medically Necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- Include an expedited review process to address those situations when an item or service must be provided on an urgent basis.

Future changes in state and federal law, state and federal regulations, and court cases may require re-evaluation of any previously approved Prior Authorization proposal. Any deviation from the policies and procedures approved by the Department, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure of the MCO to comply may result in sanctions and/or penalties by the Department.

The Department defines prior authorization as:

a determination made by a MCO to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to an Enrollee prior to the Provider's initiation or continuation of the requested service.

19.4.2 GUIDELINES FOR REVIEW

1. Basic Requirements:

   a. The MCO must identify individual service(s), medical item(s), and/or therapeutic categories of drugs to be Prior Authorized.
b. If the Prior Authorization is limited to specific populations, the MCO must identify all populations who will be affected by the proposal for Prior Authorization.

2. Medically Necessary Requirements:

a. The MCO must describe the process to validate medical necessity for:
   - Covered care and services;
   - Procedures and level of care;
   - Medical or therapeutic items.

b. The MCO must identify the source of the criteria used to review the request for Prior Authorization of services. The criteria must be consistent with the CHIP contract definition for a service or benefit that is Medically Necessary. All criteria must be submitted to the Department for evaluation and approval under Utilization Review Criteria Assessment Process (URCAP) prior to implementation.

c. For MCOs, if the criteria being used are:
   - Purchased and licensed, the MCO must identify the vendor;
   - Developed/recommended/endorsed by a national or state health care provider association or society, the MCO must identify the association or society;
   - Based on national best practice guidelines, the MCO must identify the source of those guidelines;
   - Based on the medical training, qualifications, and experience of the PH-MCO’s Medical Director or other qualified and trained practitioners, the PH-MCO must identify the individuals who will determine if the service or benefit is Medically Necessary.

d. MCO guidelines to determine medical necessity of all drugs that require prior authorization must be posted for public view on the MCO’s website. This includes, but is not limited to, guidelines to determine medical necessity of both specific drugs and entire classes of drugs that require prior authorization for health and safety reasons, non-formulary designations, appropriate utilization, quantity limits, or mandatory generic substitution. The guidelines must specify all of the conditions that the MCO reviewers will consider when determining medical necessity including requirements for step therapy.
e. The MCO must identify the qualification of staff that will determine if the service is Medically Necessary. Health Care Providers, qualified and trained in accordance with the CMS Guidelines, the RFA, the CHIP Agreement, and applicable legal settlements must make the determination of Medically Necessary services.

For requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Enrollee’s condition or disease determines:

- That the prescriber did not make a good faith effort to submit a complete request, or
- That the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

3. Administrative Requirements

a. The MCO’s written policies and procedures must identify the time frames for review and decisions and the MCO must demonstrate that the time frames are consistent with the following required maximum time frames:

- Immediate: Inpatient Place of Service Review for emergency and urgent admissions.
- 24 hours: All drugs; and items or services which must be provided on an urgent basis.
- 48 hours: (following receipt of required documentation): Home Health Services.
- 21 days: All other services.

b. The MCO’s written policies and procedures must demonstrate how the PH-MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

c. The MCO’s written policies and procedures must explain how Prior Authorization data will be incorporated into the MCO’s overall Quality Management plan.

4. NOTICE OF DENIAL PROCEDURES

A written notice of denial must be issued to the Enrollees for the following:
a. The denial or limited authorization of a requested service, including the type or level of service.

b. The reduction, suspension, or termination of a previously authorized service.

c. The denial of a requested service because it is not a covered service for the Enrollees.

d. The denial of a requested service but approval of an alternative service.

5. Notification, Grievance, and DHS Fair Hearing Requirements

The MCO must demonstrate how written policies and procedures for requests for Prior Authorization comply and are integrated with the Enrollees and Provider notification requirements and Enrollees Grievance and DHS Fair Hearing requirements of the RFA and Agreement.

6. Requirements for Care Management/Care Coordination of Non Prior Authorized Service(s)/Items(s)

For purposes of tracking care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the MCO may choose to establish a process or protocol requiring notification prior to service delivery. This process must not involve any approvals/denials or delays in receiving the service. The MCO must notify Providers of this notification requirement. This process may not be administratively cumbersome to Providers and Enrollees.

19.5 PRIMARY AND PREVENTIVE CARE GUIDELINES

CHIP MCOs must provide for primary and preventive care to their enrollees. This includes well-child care in accordance with the schedule established by the American Academy of Pediatrics and the services related to those visits, including, but not limited to: immunizations, health education (to include all types of tobacco use prevention and cessation), tuberculosis testing, and developmental screening in accordance with the routine schedule of well-child visits. Care must also include a comprehensive physical examination, including x-rays, if necessary, for any child exhibiting symptoms of possible child abuse. Allergy diagnosis and treatment is also covered. Outpatient physical health services relating to ambulatory surgery, outpatient hospitalization, specialist office visits and consults, and follow-up appointments or sick visits are covered.

The primary and preventive services are based on recommendations from organizations such as the American Academy of Pediatrics; the American College of Physicians; the U.S. Preventive Services Task Force (USPSTF), all items or
services with a rate of A or B in the current recommendations; the American Cancer Society; and the Health Resources and Services Administration (HRSA).

19.5.1 Screening

The MCO must ensure that Bright Futures periodic screens are conducted for all eligible enrollees to identify health and developmental problems. These screens must be in accordance with the most current periodicity schedule and recommended pediatric immunization schedules based on guidelines issued by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC).

19.5.2 Diagnoses and Treatment

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. If the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, s/he is required to refer the child for the appropriate service. The MCO is responsible for developing a system that tracks treatment needs as they are identified and ensures that appropriate follow-up is pursued and reflected in the medical record (See Section 19.5.3, Tracking, for all requirements).

Any Medically Necessary health care, eligible under the CHIP program, required to treat conditions detected during a visit must be covered by the MCO.

MCO must have policies in place to connect enrollees identified as in need of services with providers appropriate to their needs. Such policies will be clearly communicated to Providers and Recipient through the Provider Manual and the Enrollees Handbook. If a Health Care Provider prescribes services or equipment for an enrollee, which is not normally covered by the CHIP Program, or for which the MCO requires Prior Authorization, the MCO must follow the Prior Authorization requirements outlined in 19.4 (Prior Authorization Guidelines).

19.5.3 Tracking

The MCO must establish a tracking system that provides information on adherence with the Bright Futures periodicity schedule.

- Initial visit for newborns. The initial screen shall be the newborn physical exam in the hospital.

- Bright Futures screening and reporting of all screening results.

- Diagnosis and/or treatment, or other referrals for children.
Other tracking activities include: Number of comprehensive screens (reported by age); hearing and vision examinations; dental screens; age appropriate screens; complete age appropriate immunizations; blood lead screens; prenatal care for teen mothers; provision of eyeglasses to those in need of them; dental sealants; newborn home visits; referral of very low birth weight babies to early intervention; referral of Enrollees with elevated blood lead levels to early intervention; routine evaluation for iron deficiencies; and timely identification and treatment of asthma.

19.5.4 Follow-ups and Outreach

The MCO must have an established process for reminders, follow-ups and outreach to Enrollees that includes:

- Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Enrollees.

- Telephone protocols to remind Enrollees of upcoming visits and follow-up on missed appointments within a set time period.

- Protocols for conducting outreach with non-compliant Enrollees, including home visits, as appropriate.

- The MCO may develop alternate processes for follow up and outreach subject to prior written approval from the Department.

The MCO shall submit to the Department reports that identify its performance in the above four required services (Screening, Diagnosis and Treatment, Tracking and Follow-up and Outreach).

Medically Necessary follow-up care for health care services is an integral part of the Provider's continuing care responsibility after a screen or any other health care contact.

The goal is to ensure that children have access to appropriate, coordinated, comprehensive health care. To achieve this goal, The MCO must ensure the following:

- Children have access to adequate pediatric care.

- Development of adequate specialty Provider Networks.

- Prevention against duplication of services.
• Adherence to state and federal laws, regulations and court requirements relating to individuals with Special Needs.

• Cooperation of MCO Provider Networks.

• Applicable training for PCPs and Providers including the identification of MCO contact persons.

19.6 EMERGENCY SERVICES

The MCO must agree to accept the Department's definition of Emergency Services. Case management protocols will not apply in cases where they would interfere with treatment of emergencies. In the case of a pregnant woman who is having contractions, if the MCO attempts to utilize its case management protocols to direct its Enrollees from an Out-of-Network provider to a Network Provider, it must collect and maintain data to demonstrate that there was adequate time to effect a safe transfer to another hospital before delivery or that the transfer would not pose a threat to the health and safety of the patient or the unborn child. Where a transfer is enacted, the MCO must be able to demonstrate that its case management protocols did not interfere with the transferring hospital's obligation to:

• Restrict transfer until the patient is stabilized;

• Effect an appropriate transfer or provide medical treatment within its capacity to minimize the risk of transfer to the individual's health;

• Require a supervised transfer;

• Offer the Enrollees informed refusal to consent to transfer along with documentation of the associated risks and benefits and;

• Not divert a Enrollees being transported by emergency vehicle from its Emergency Service on the basis of his/her insurance.

Emergency providers may initiate the necessary intervention to stabilize the condition of the patient without seeking or receiving prospective authorization by the MCO.

The MCO must develop a process for paying for emergency services (including their plans, if any, to pay for triage). The MCO shall pay for Emergency Services in or outside of the service area (including outside of Pennsylvania). Payment for Emergency Services shall be made in accordance with applicable law.
The MCO may not deny payment for treatment obtained under either of the following circumstances:

- A Enrollee has an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- A representative of the MCO instructs the Enrollee to seek emergency services.

The MCO may not:

- Limit what constitutes an Emergency Medical Condition with reference to the definition of “Emergency Medical Condition, Emergency Services, and Post Stabilization Services” on the basis of lists of diagnoses or symptoms.

- Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee’s Primary Care Practitioner, MCO, or applicable state entity of the Enrollee’s screening and treatment within ten (10) calendar days of presentation for emergency services.

- Hold an Enrollee who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The MCO must also develop a process to ensure that PCPs promptly see Enrollees who did not require or receive hospital Emergency Services for the symptoms prompting the attempted emergency room visit.

MCO is responsible for all Emergency Services including those categorized as mental health or drug and alcohol.

19.7 FAMILY PLANNING SERVICES PROCEDURES

Procedures which may be included with a family planning clinic comprehensive visit, a family planning clinic problem visit or a family planning clinic routine revisit:

- Insertion, implantable contraceptive capsules

- Implantation of contraceptives, including device (e.g. Norplant) (once every five years) (females only)
• Removal, Implantable contraceptive capsules
• Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only)
• Destruction of vaginal lesion(s); simple, any method (females only)
• Biopsy of vaginal mucosa; simple (separate procedure) (females only)
• Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only)
• Colposcopy (vaginoscopy); separate procedure (females only)A
• Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage A
• Colposcopy (vaginoscopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only)B
• Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only)B
• Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure) (females only)
• Cauterization of cervix; electro or thermal (females only)
• Cauterization of cervix; cryocaury, initial or repeat (females only)
• Cauterization of cervix; laser ablation (females only)
• Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only)
• Alpha-fetoprotein; serum (females only)
• Nuclear molecular diagnostics; nucleic acid probe, each
• Nuclear molecular diagnosis; nucleic acid probe, each
• Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each
• Fluorescent antibody; screen, each antibody
• Immunoassay for infectious agent antibody; quantitative, not elsewhere specified
• Antibody; HIV-1
• Antibody; HIV-2
• Treponema Pallidum, confirmatory test (e.g., FTA-abs)
• Culture, chlamydia
• Cytopathology, any other source; preparation, screening and interpretation
• Progestasert I.U.D. (females only)
• Depo-Provera injection (once per 60 days) (females only)
• ParaGuard I.U.D. (females only)
• Hemoglobin electrophoresis (e.g., A2, S, C)
• Microbial Identification, Nucleic Acid Probes, each probe used
• Microbial Identification, Nucleic Acid probes, each probe used; with amplification (PCR)

A Medical record must show a Class II or higher pathology.

B Medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure.

Procedures which may be included with a planning clinic problem visit:
• Gonadotropin, chorionic, (hCG); quantitative
• Gonadotropin, chorionic, (hCG); qualitative
• Syphilis test; qualitative (e.g., VDRL, RPR, ART)
• Culture, bacterial, definitive; any other source
• Culture, bacterial, any source; anaerobic (isolation)
• Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography

• Culture, bacterial, urine; quantitative, colony count

• Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection

• Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types

• Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)

• Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites

• Smear, primary source, with interpretation; wet and dry mount, for ova and parasites

• Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision

• Level IV - Surgical pathology, gross and microscopic examination

• Antibiotics for Sexually Transmitted Diseases (course of treatment for 10 days) (two units may be dispensed per visit)

• Medication for Vaginal Infection (course of treatment for 10 days) two units may be dispensed per visit

• Breast cancer screen (females only)

• Mammography, bilateral (females only)

Genetic Risk Assessment

19.8 BEHAVIORAL HEALTH SERVICES

The MCO must ensure compliance with the mental health parity regulations. 45 CFR § 147.126 prohibits lifetime or annual limits on the dollar amount of essential health benefits (EHBs). Section 1302(b) of the ACA includes ambulatory (outpatient) care and hospitalization, as well as mental health and substance use disorder (SUD) services, as EHBs. And the mental health parity act requires that limitations on benefits for mental health and substance use disorder be no more restrictive than those for physical health. As for services for physical health issues,
there are no day limits on inpatient care or visit limits for outpatient care for mental health and SUD services. There are no copays.

The MCO will provide timely access to diagnostic, assessment, referral, and treatment services for enrollee’s enrollees for the following benefits:

- Inpatient psychiatric hospital services, except when provided in a state mental hospital;
- Inpatient drug and alcohol detoxification;
- Psychiatric partial hospitalization services;
- Inpatient drug and alcohol rehabilitation;
- Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol dependence/addiction;
- Emergency room evaluations for voluntary and involuntary commitments pursuant to the Mental Health Procedures Act of 1976, 50 P.S. 7101 et seq.;
- Psychiatric outpatient clinic services, licensed psychologist, and psychiatrist services;
- Behavioral health rehabilitation services (BHRS) for individuals under the age of 19 with psychiatric, substance abuse or mental retardation disorders;
- Residential treatment services for individuals under the age of 19 whether treatment is provided in facilities that are Joint Commission for the Accreditation for Healthcare Organizations [JCAHO] accredited and/or without JCAHO accreditation;
- Outpatient drug and alcohol services, including Methadone Maintenance Clinic;
- Methadone when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services provider;
- Laboratory studies ordered by behavioral health physicians and clozapine support services;
- Crisis intervention with in-home capability;
- Family-based mental health services for individuals under the age of 19;
- Targeted mental health case management (intensive case management and resource coordination)
- Partial hospitalization for drug and alcohol dependence/addiction;
- Targeted drug and alcohol case management and Intensive Outpatient Services

19.9 OUTPATIENT DRUG SERVICES

19.9.1 General Requirements

The MCO must cover all Covered Outpatient Drugs when determined to be Medically Necessary, unless otherwise excluded from coverage. (See 2. Coverage Exclusions below for exclusions.) This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers.

The MCO must provide drug benefit coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C.A. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature.

Unless financial responsibility is otherwise assigned, all Covered Outpatient Drugs are the payment responsibility of the Enrollee’s MCO.

All Covered Outpatient Drugs must be dispensed through MCO Network Providers.

Under no circumstances will the MCO permit the therapeutic substitution of an outpatient drug by a pharmacist without explicit authorization from the licensed prescriber.

All proposed pharmacy programs and drug utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. must be submitted to the Department for review and approval prior to implementation.

The MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Outpatient Drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, reporting, notices of decision, etc. will apply, regardless of whether the Covered Outpatient Drug is provided as an outpatient drug benefit or as a
“medical benefit” incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).

Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-reviewed medical literature.

The MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2117 regarding continuity of care requirements and 28 PA Code Ch. 9. The MCO must also comply with the procedures outlined in Section “Continuity of Care” of the Agreement. The MCO policy and procedures for continuity of care for outpatient drugs, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to outpatient drugs that the Enrollees was prescribed before enrolling in the MCO.

19.9.2 Coverage Exclusions

a. The MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

b. The MCO must exclude coverage of noncompensable drugs in accordance with 55 PA Code §1121.54.

19.9.3 Formularies and Preferred Drug Lists (PDLs)

a. The MCO may use a Formulary or a Preferred Drug List (PDL). All drugs must be Covered Outpatient Drugs.

b. The Formulary or PDL must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee.

c. The Formulary or PDL must meet the clinical needs of the CHIP population. The Formulary or PDL must include a range of drugs in each therapeutic drug class represented. The Department reserves the right to determine if the Formulary or PDL meets the clinical needs of the CHIP population.

d. The Formulary or PDL must be clinically based. Only those drugs that do not have a significant, clinically meaningful therapeutic advantage, in terms of safety, effectiveness, or clinical outcomes, over other
drugs included in the Formulary or PDL, may be designated as non-formulary or non-preferred.

e. The MCO must make a satisfactory written explanation of the reason(s) for designating a drug as non-formulary or non-preferred available to the Department upon request.

f. The MCO must allow access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy), in accordance with Prior Authorization of Services Section V. B.1. and the CHIP Procedures Manual Prior Authorization Guidelines for Participating Managed Care Organizations in the CHIP Program.

g. The MCO must receive written approval from the Department of the Formulary or PDL, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred, prior to implementation of the Formulary or PDL and the requirements.

h. The MCO must submit all Formulary or PDL changes (other than additions) and deletions to the Department for review and written approval prior to implementation.

i. The MCO must submit written notification of any Formulary or PDL additions to the Department within fifteen (15) days of implementation.

j. The Formulary or PDL must be re-submitted for Department review and approval annually.

k. The MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Outpatient Drug either by addition to the Formulary or PDL, or through prior authorization, within 10 days from their availability in the marketplace.

**19.9.4 Prior Authorization of Outpatient Drugs**

The MCO may require Prior Authorization (includes step therapy) as a condition of coverage or payment for a Covered Outpatient Drug provided that:
i. The MCO provides a response to the request for prior authorization by telephone or other telecommunication device indicating approval or denial of the prescription within twenty-four (24) hours of the request, and

ii. If an Enrollee’s prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the MCO instructs the pharmacist to dispense either a:

   a) Fifteen (15) day supply if the prescription qualifies as an Ongoing Medication, unless the MCO or its designated subcontractor issued a proper written notice of benefit reduction or termination at least ten (10) days prior to the end of the period for which the medication was previously authorized and a Grievance or DHS Fair Hearing request has not been filed, or

   b) A seventy-two (72) hour supply of a new medication.

iii. For drugs not able to be divided and dispensed into individual doses, the MCO must instruct the pharmacist to dispense the smallest amount that will provide at least a seventy-two (72) hour or fifteen (15) day supply, whichever is applicable.

iv. The requirement that the Enrollees be given at least a seventy-two (72) hour supply for a new medication or a fifteen (15) day supply for an Ongoing Medication does not apply when a pharmacist determines that the taking of the prescribed medication, either alone or along with other medication that the Enrollees may be taking, would jeopardize the health or safety of the Enrollees.

v. In such an event, the MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber.

vi. If the MCO denies the request for prior authorization, the MCO must issue a written denial notice within twenty-four (24) hours of receiving the request for prior authorization.

vii. If the Enrollee files a Grievance or DHS Fair Hearing request from a denial of an Ongoing Medication, the MCO must authorize the medication until the Grievance or DHS Fair Hearing request is resolved.
viii. When medication is authorized due to the MCO’s obligation to continue services while an Enrollee’s Grievance or Fair Hearing is pending, and the final binding decision is in favor of the MCO, a request for subsequent refill of the prescribed medication does not constitute an Ongoing Medication.

ix. The MCO must establish and maintain written prior authorization policies, procedures, and guidelines to determine Medical Necessity of Covered Outpatient Drugs that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred.

x. The MCO must comply with the requirements for Prior Authorization of Services, Section V. B. 1, and Prior Authorization Guidelines for Participating Managed Care Organizations in the CHIP Program, and receive written approval from the Department prior to implementation.

xi. The MCO must submit additions, changes, and deletions to Prior Authorization (including Step Therapy) policies, procedures and any associated medical necessity guidelines for Department review and written approval prior to implementation.

19.9.5 Provider and Enrollees Notification

The MCO must have policies and procedures for notification to Providers and Enrollees of changes to the Formulary or PDL and Prior Authorization requirements.

l. Written and electronic notification for changes to the Formulary or PDL and Prior Authorization requirements must be provided to all affected Providers and Enrollees at least thirty (30) days prior to the effective date of the change.

m. The MCO must provide all other Providers and Enrollees written notification and electronic notification of changes to the Formulary or PDL and Prior Authorization requirements upon request.

c. The MCO also must generally notify Providers and Enrollees of Formulary or PDL and Prior Authorization changes through Enrollees and Provider newsletters, its web site in a readable format, or other regularly published media of general distribution.

19.9.6 MCO Pharmacy & Therapeutics (P&T) Committee
The P&T Committee membership must include physicians, including a minimum of two (2) behavioral health physicians, pharmacists, CHIP program consumers, and other appropriate clinicians. CHIP program consumer representative membership must include the following:

i. One (1) physical health consumer representative. The physical health consumer representative must be a consumer enrolled in the MCO, or a physician, a pharmacist, or a physical health consumer advocate designated by consumers enrolled in the MCO to represent them.

ii. One (1) behavioral health consumer representative. The behavioral health consumer representative must be a consumer enrolled in the MCO, or a physician, a pharmacist, a behavioral health consumer advocate, or a family member designated by consumers enrolled in the MCO to represent them.

iii. The MCO must submit a P&T Committee membership list for Department review and approval upon request.

iv. When the P&T Committee addresses specific drugs or entire drug classes requiring medical expertise beyond the P&T Committee membership, specialists with knowledge appropriate to the drug(s) or class of drugs being addressed must be added as non-voting, ad hoc members.

v. The minutes from each MCO P&T Committee meeting must be posted for public view on the MCO’s website within 30 days of the date of the meeting at which the minutes are approved. Minutes will include vote totals.

19.9.7 Pharmacy Provider Network - Any Willing Pharmacy

The MCO must contract on an equal basis with any pharmacy qualified to participate in the CHIP Program that is willing to comply with the MCO’s payment rates and terms.

The provisions for any willing pharmacy apply if the MCO Subcontracts with specialty pharmacies, or designates specific network pharmacies as the preferred provider(s) of specialty drugs(s). MCOs are required to contract on an equal basis with any pharmacy qualified to participate in the CHIP program that is willing to accept the same payment rate(s) as the preferred provider(s) of specialty drugs and comply with the same terms and conditions for quality standards and reporting as the preferred provider(s) of specialty drugs.
19.9.8 Drug Utilization Review (DUR) Program

The MCO must provide a DUR Program to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes, and to enhance the quality of patient care by educating prescribers, pharmacists, and Enrollees.

a. Prospective Drug Utilization Review (Pro-DUR)
   i. The MCO must provide for a review of drug therapy before each prescription is filled or delivered to an Enrollee at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage, or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.
   ii. The MCO must provide for counseling of Enrollees receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

b. Retrospective Drug Utilization Review (Retro-DUR)
   i. The MCO must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and Enrollees.
   ii. The MCO shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.
   iii. The MCO shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.
In no case shall an awarded supplier's DUR program provide any financial or other incentive to a pharmacist, the pharmacist's employer, or a PBM for encouraging the physician to change his/her prescription order. Changes are accepted only when warranted by clinical reasons of enrollee safety and approved efficacy.

The MCO must submit an annual report on the operation of its Pennsylvania Medicaid Drug Utilization Review (DUR) program in a format designated by the Department. The format of the report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

c. Drug Utilization Review Board (DUR Board)

The Department maintains a DUR Board that reflects the structure of the health care delivery model that includes both a managed care and a fee-for-service delivery system. Each MCO and BH-MCO is required to include a representative to serve as Enrollees of the DUR Board. The DUR Board is a standing advisory committee that recommends the application of predetermined standards related to Pro-DUR, Retro-DUR, and related administrative and educational interventions designed to protect the health and safety of the MA program recipients. The Board reviews and evaluates pharmacy claims data and prescribing practices for efficacy, safety, and quality against predetermined standards using nationally recognized drug compendia and peer reviewed medical literature as a source. The Board recommends appropriate utilization controls and protocols including prior authorization, automated prior authorization, system edits, and guidelines to determine medical necessity, generic substitution, and quantity limits for individual medications or for therapeutic categories.

19.9.9 Pharmacy Benefit Manager (PBM)

The MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions in Section XII: Subcontractural Relationships, and has received advance written approval by the Department. The standards for Network composition and adequacy for outpatient drug services includes the requirements for any willing pharmacy as described above. The MCO must indicate the intent to use a PBM, identify the proposed PBM Subcontract and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly or in part by a MCO, retail pharmacy Provider, chain drug store, or pharmaceutical manufacturer, the MCO must submit a written description of the assurances and procedures that will be put in place
under the proposed PBM Subcontract, such as an independent audit, to assure confidentiality of proprietary information. These assurances and procedures must be submitted and receive advance written approval by the Department prior to initiating the PBM Subcontract. The Department will allow the continued operation of existing PBM Subcontracts while the Department is reviewing new contracts.
20.1 CONTRACTOR REPORT ON COMPANY OR PROGRAMMATIC CHANGES

20.1.1 CONTENT

This report should be submitted when operational or structured changes occur within the contractor’s company; if there are changes in the contractor’s key personnel, benefits/services, or service area; or contractors have marketing/outreach materials that are to be submitted for approval.

20.1.2 FREQUENCY

This report should be submitted when changes occur. Changes imposed by the Department or state/federal mandates need not be reported on this form.

20.1.3 FORMAT

The report must be formatted as noted in Appendix 20-A. No alternative format will be accepted.

When lengthy documents such as handbooks, subscriber agreements, etc. are being submitted for review/approval, the specific text that is being revised must be highlighted in the document and noted on the Programmatic Change Form. This will speed the review/approval process. If the entire document is being revised, please note this on the Programmatic Change form.

The Department will respond to contractor’s notices via the CHIP Approval/Review Form (See Appendix 20-B).

NOTE: The report can be submitted via mail, fax, or email as the contractor deems appropriate. All requests for reviews and approvals (along with the Programmatic Change form) are to be directed to: Division Chief of Marketing & Outreach, Office of CHIP, 1142 Strawberry Square, Harrisburg,
PA 17120; Fax (717) 346-1368. (See form at Appendix 20-A). Requests will be directed to the appropriate Division(s) within the office for review and approval. The Division that will be reviewing/approving a particular request is noted on the Programmatic Change form.
# ATTACHMENT 1 – CHANGE IN KEY ADMINISTRATIVE POSITIONS

## CHANGE IN KEY ADMINISTRATIVE POSITIONS

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### ATTACHMENT 2 – LIST OF SUBCONTRACTORS

#### LIST OF SUBCONTRACTORS

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APPENDIX 20-A

DEPARTMENT OF HUMAN SERVICES
CHILDREN’S HEALTH INSURANCE PROGRAM

CONTRACTOR REPORT ON COMPANY OR PROGRAMMATIC CHANGES

CONTRACTOR:

DATE:

CONTACT PERSON:

TELEPHONE:

1. Key Administrative Positions – The following position changes need to be reported:
   (Marketing & Outreach and Quality Assurance):
   - CEO/CFO
   - Medical Director
   - HEDIS®/CAHPS Coordinator
   - CHIP Director/Administrator
   - CHIP Manager/Supervisor
   - Outreach Coordinator
   - Eligibility/Enrollment Coordinator
   - Information Systems Coordinator
   - Billing Contact Person
   - Press/Communications Director

Required information and format (See Attachment 1):

2. Organizational - Please attach new organizational chart, if applicable, in addition to explanation of change(s).

Example: Company merger, corporate restructuring, office relocation
(Marketing & Outreach and Quality Assurance)
3. **Providers/contractors/subcontractors** (See Attachment 2) (Quality Assurance):
   - Material change(s) in provider’s contract/subcontract language, if applicable: Attach copy of changes and DOH approval.
   - Probable loss from the network of any general acute care hospital and any primary care provider with 2,000 or more assigned enrollees. Attach copy of changes and DOH approval.

4. **Benefits/Services** (Quality Assurance)

<table>
<thead>
<tr>
<th>Type of Benefit/Service</th>
<th>Effective Date</th>
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<tbody>
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</tbody>
</table>

**NOTE:** It is not necessary to submit changes in benefits or services if benefits/services have been imposed by the Department of Human Services or federal or state mandate. If the company is providing benefits on its own accord, please explain rationale for adding new benefits/services, and any special requirements for accessing services.

5. **Drug Formulary**
   Please attach copy of new formulary with change(s) **highlighted** (Quality Assurance):
   - Restrictive
   - Open

   Effective date of change(s):

6. **Enrollee Handbook**
   Provide copy of revised text with change(s) **highlighted** (Marketing & Outreach and Quality Assurance)

7. **Provider Directories/Subscriber Agreements**
   Provide copy of revised text with change(s) **highlighted** (Quality Assurance)
8. **Service area expansion changes** *(Attach DOH approval)* (Quality Assurance)

<table>
<thead>
<tr>
<th>County</th>
<th>Effective Date</th>
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</table>

9. **I.D. Cards** *(Provide prototype of new card, as well as details of anticipated change(s) and effective date. Paper copy to be faxed or e-mailed, actual card to be mailed)* (Quality Assurance):

10. **Marketing & Outreach materials** *(Marketing & Outreach)*:

11. **Other** *(specify)*:

**This form should be directed to the attention of:**

Chief, Marketing and Outreach  
Bureau of Children’s Health Insurance Program (CHIP)  
1142 Strawberry Square  
P.O. Box 2675  
Harrisburg, PA 17105-2675

**A copy should also be directed to:**

CHIP Administration  
Bureau of Children’s Health Insurance Program (CHIP)  
1142 Strawberry Square  
P.O. Box 2675  
Harrisburg, PA 17105-2675

**NOTE:** Notations in parenthesis regarding “Marketing & Outreach and/or “Quality Assurance” refer to the Division(s) with primary oversite.
# APPENDIX 20-B: COMPANY OR PROGRAMMATIC CHANGES APPROVAL/REVIEW FORM

## CHIP COMPANY/PROGRAMMATIC CHANGES APPROVAL/REVIEW FORM

- Contractor: ______________________________
- Contact Person: __________________________
- Date of Submission: ________________________
- Date of Approval: __________________________

### Section 1: Item(s) submitted for approval or review:

Not all documents in the Procedures Manual which are required to be sent to the Department necessitate official Department approval prior to implementation. If a document or notification is required to be approved, it will be marked “Approved” in the Approved/Reviewed column once approved. If the document or notice does not require approval, it will be marked “Reviewed” once reviewed. If the Department has comments or corrections, the item will be marked “See Comments”. In this instance the contractor should refer to the “Comments” section of this document (Section 2).

<table>
<thead>
<tr>
<th>ITEM</th>
<th>APPROVED/REVIEWED</th>
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<tbody>
<tr>
<td>1. Handbook/Subscriber Agreement</td>
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<tr>
<td>2. Educational Materials</td>
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<tr>
<td>3. Provider Directories</td>
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<td>4. Marketing Materials</td>
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<td>o Flyers/Brochures</td>
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<td>o Print Media (Newspaper/Magazine)</td>
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<td>o Media</td>
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<td>o Other</td>
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<td>5. Changes in personnel</td>
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<td>6. Changes in subcontractors or contracts</td>
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<td>7. Changes in provider contracts/network</td>
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<td>8. Applications</td>
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<td>9. I.D. Cards</td>
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<td>10. Form Letters</td>
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<td>o Eligibility</td>
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<td>o Renewal</td>
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<td>o Termination</td>
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<td>o Denial – income too low</td>
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<tr>
<td>o Denial – income too high</td>
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<td>o Incomplete</td>
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<td>o Other (specify):</td>
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<td>11. Benefits (specify):</td>
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<td>12. Service area expansion (specify):</td>
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<td>13. Other (specify):</td>
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Section 2: Comments:

_________________________________________________________________
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Section 3: Department Sign-Off:

Name: ________________________________________________________

Title: _________________________________________________________
CHAPTER 21: MARKETING AND OUTREACH

21.1 GRAPHIC IDENTITY

The CHIP logo reflects the program’s fundamental purpose – ensuring Pennsylvania's uninsured children grow up healthy. The CHIP logo must be used on all CHIP-related materials.

Using the CHIP logo across all communications, whether initiated by the Commonwealth or a contractor, ensures a clear and consistent CHIP brand in the market. Contractors are required to use the updated CHIP logo on all marketing and outreach materials. This section provides guidance regarding the use of CHIP’s graphic identity and the process for obtaining approval of marketing and outreach materials.

21.1.1 USAGE

The CHIP logo must be included on all materials used to communicate to external audiences about the program. These pieces include, but are not limited to: applications (new and renewal), all applicant and enrollee correspondence, flyers, billboards, transit, brochures, enrollee handbooks, newsletters, television ads, newspaper advertisements, websites, and posters.

CHIP logo usage must follow the standards outlined in the CHIP Graphic Standards Manual. All contractors may obtain the CHIP Graphic Standards Manual and CHIP logos on the CHIP website’s online e-toolkit by going to www.chipcoverspakids.com, clicking on the CHIP Resources tab, choosing CHIP Materials, then choosing Download CHIP materials. Hyperlinks to the manual and logos can be found under the miscellaneous section of the e-toolkit page.

Questions and/or requests for information, additional camera-ready reproduction art, and electronic files should be sent to:

CHILDREN’S HEALTH INSURANCE PROGRAM
Communications/Press Office
Phone: 717-787-3289
Fax: 717-772-1969
21.1.2 Format

All pieces of communication that include the CHIP logo must be reviewed and approved by a representative from the Pennsylvania Children’s Health Insurance Department’s Communications/Press Office and Children’s Health Insurance Program.

Materials must be submitted for approval as outlined in Section 21.2.2. Please allow a minimum of two weeks for review and approval.

21.2 MARKETING AND OUTREACH PROHIBITIONS AND PRIOR APPROVAL OF MARKETING AND OUTREACH MATERIALS AND ACTIVITIES

Contractors are required to conduct outreach activities to identify and inform potentially eligible families of the availability of the program. This section provides guidance about limitations and prohibitions on marketing and outreach and the process for obtaining prior approval of marketing and outreach materials and activities.

- All outreach materials utilizing CHIP and the contractor’s name should use the phrase, “CHIP, brought to you by ______________”.
- Contractors are prohibited from distributing, directly or through any agent or independent contractors, outreach materials that contain false or misleading information.
- Contractors are prohibited from selling or sharing a CHIP consumer list with other organizations.
- Contractors are prohibited from engaging in cold-call marketing activities (does not include contacting families for renewal or related outreach purposes).
- CHIP does not prohibit the use of licensed producers, appointed by and under contract with any compensation arrangement with CHIP insurance contractors, in marketing, outreach and enrollment for CHIP, as long as the CHIP insurance contractors and the licensed producers follow CMS regulations for the Medicare Advantage and Medicare Part D programs, abide by all applicable laws, and do not increase the administrative costs for which these insurance contractors seek compensation from the CHIP program.
- Contractors are prohibited from distributing charts which compare other CHIP contractors to itself and/or which are disparaging to other contractors.
- Contractors may use, but are not limited to, commonly accepted media advertising. These include television, radio, billboard, print, transportation,
social media and the internet. All advertisements, including but not limited to the media identified above, must be submitted to the Department for review and approval prior to production.

- CHIP is separate from other insurance programs (e.g. Medical Assistance); therefore, approval must be obtained from the Department as well as from other applicable departments on any materials that include CHIP.
- Contractors are also required to obtain prior approval from the Department before issuing or reissuing the following materials:
  - Premium incentives (which may ordinarily have no greater than a $15.00 retail value)
  - Provider directories
  - Printed media
  - Any materials that include mention of CHIP or that use the CHIP logo

- Approved written materials provided to applicants and enrollees of the CHIP program may be transmitted to applicants and enrollees electronically instead of in hard copy format. The Department has no objection to electronic transmission of required information, so long as all applicable laws and regulations, including but not limited to the Electronic Transactions Act, 73 P.S. §§2260.101; 31 Pa. Code Ch. 146a; and 31 Pa. Code Ch. 146b, are satisfied. Any communications will also need to satisfy HIPAA security standards. If a contractor wishes to begin implementing electronic transmissions in place of written materials, please forward requests to the Department via the standard programmatic request process.

- Notice of television and radio advertising media schedules must be given to the Department prior to the start date for the purposes of coordination.
- The Department reserves the right to suspend any and all marketing and outreach activities when deemed necessary.

**21.2.1 FREQUENCY**

Marketing and Outreach materials and activities requiring prior approval should be submitted as the contractor has materials and activities requiring prior approval. Please allow a minimum of two weeks for review/approval by the Department.
21.2.2 FORMAT

Materials requiring prior approval must be submitted via the Department’s “Contractor Report on Company or Programmatic Changes” form (See Appendix 21-A). All advertisements, including but not limited to the media identified above, must be submitted to the Department for review and approval prior to production and again in final form. Television and radio advertisements should be submitted via media file compatible with Windows Media Player.

Advance notices regarding television and radio advertising media, including a brief description of the medium you are using, are to be reported via the Department’s “Contractor Report on Company or Programmatic Changes” form (See Appendix 21-A).

The Department will respond to contractors’ marketing and outreach approval requests via the CHIP Approval/Review Form (See Appendix 21-B).

NOTE: Requests for prior approval and notices of marketing and outreach materials and activities can be submitted via email, fax or mail, as the contractor deems appropriate. Requests should be submitted to:

CHIP Outreach Coordinator
1142 Strawberry Square
P.O. Box 2675
Harrisburg, PA 17120
Fax: (717) 705-1643

21.3 INTENDED MARKETING AND OUTREACH SUMMARY

In an effort to strengthen coordination between the Department’s marketing and outreach activities with those of the contractors, contractors are required to report intended marketing and outreach activities to the Department on a quarterly basis. This report should include any future marketing and outreach activities already planned for the quarter and an informal description of other marketing and outreach plans as of the submission date.

21.3.1 CONTENT
The Intended Marketing and Outreach Summary describes marketing and outreach activities planned for the upcoming quarter.

**Intended Marketing and Outreach Summary** (See Appendix 21-A)
- A quarterly notification of planned activity as well as non-activity is required using this report. Contractors are required to submit this report, designate planned/unplanned marketing and outreach activity, and provide an informal summary of planned activities.

Where television, cable, or radio advertising is planned, contractors must list the relevant station, channel, program, flight dates and time period information, if available.

**21.3.2 FREQUENCY**

The Intended Marketing and Outreach Summary is to be submitted to the Department at the beginning of each quarter in accordance with the following schedule:

<table>
<thead>
<tr>
<th>Quarter reporting on</th>
<th>Dates quarter includes</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>First quarter</td>
<td>January 1-March 31</td>
<td>January 1</td>
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<tr>
<td>Second quarter</td>
<td>April 1-June 30</td>
<td>April 1</td>
</tr>
<tr>
<td>Third quarter</td>
<td>July 1-September 30</td>
<td>July 1</td>
</tr>
<tr>
<td>Fourth quarter</td>
<td>October 1-December 31</td>
<td>October 1</td>
</tr>
</tbody>
</table>

If the due date occurs on a Saturday, Sunday or holiday, then the report is due by close of business on the first working day following the non-working day.

**NOTE:** Contractors are required to submit the report even when no reportable activity is planned.

**21.3.3 Format**

See Appendix 21-A. No alternative format will be accepted.
These reports are to be submitted to:

CHIP Outreach Coordinator
1142 Strawberry Square
P.O. Box 2675
Harrisburg, PA 17120
Fax: (717) 705-1643

21.4 COMPLETED MARKETING AND OUTREACH ACTIVITY AND EXPENDITURE REPORT

21.4.1 Content

In an effort to strengthen coordination between the Department’s marketing and outreach activities with those of the contractors, contractors are required to report on a quarterly basis to the Department marketing and outreach activities that have occurred. This report should itemize all of the quarter’s completed marketing and outreach activities and corresponding expenditures for the following:

Completed Marketing and Outreach Summary (See Appendix 21-B)

- A quarterly notification of completed activity as well as non-activity is required using this report. Contractors are required to submit this report, designate completed/non-active marketing and outreach activity, and provide an informal summary, describing the highlights of the marketing and outreach activities for the completed quarter.

Completed Marketing and Advertising Activity Report (See Appendix 21-C)

- Column 1: Contractors must list the type of media used for each advertising activity. Examples of types of media include, but are not limited to: television station, cable channel, radio station, magazine, newspaper, billboard, transportation, and electronic, online, and social media.
- Column 2: Contractors must list the name of the media organization running each advertising activity, including its location (e.g. Comcast, Channel 21-WHTP, WITF-FM, Comcast SportsNet, Central Penn Parent, Post-Gazette, Lamar Advertising, SEPTA, google.com, Facebook).
- Column 3: Contractors must list the county or counties reached by each advertising activity.
- Column 4: Contractors must list the type of audience targeted by each advertising activity (e.g. general, certain ethnic group, trade, religious, locale, age group, social group, and other demographics).
- Column 5: Contractors must list the date on which approval was given by the Department for each advertising activity, in accordance with the process outlined in Appendix 21-B.
- Column 6: Contractors must list the number of people/households estimated to be reached by each advertisement, based on the media organization’s estimate, if available.
- Column 7: Contractors must list any non-English language used in the advertisement (e.g. Spanish). If a given advertisement is in English, this field may be left blank. If the advertisement is bilingual, list both languages used.
- Column 8: Contractors must list the date(s) the advertising was run (e.g. Tuesdays at 9:00 A.M., daily, weekly, monthly, quarterly, and annually. Note that an annual entry should appear in only one quarterly report) and, where relevant, the duration of the advertising.
- Contractors must also provide costs for the reported advertising and marketing activity, including, if applicable, production, and placement costs (See Appendix 21-E).

**NOTE:** Contractors may submit a media buy in lieu of placing this information in the report.

**Completed Outreach and Promotional Activity Report** (See Appendix 21-D)

- Column 1: Contractors must list the type of each outreach and promotional activity. Examples of promotional activity include, but are not limited to:
  - Deliver/mail/email materials (to a 3rd party to distribute for you)
  - Sponsor/Table/Booth at an event
  - Presentation to an internal or external group
  - Visit an organization
  - Face-to-face meeting/Individual application or renewal assistance

Note that there should be only one entry for each event, using the primary type of activity to describe it. Contractors should not include activities associated with Customer Service.
- Column 2: Contractors must list the name and location of the organization mailed/emailed/delivered to, holding the event, presented to, visited or met with, etc. for each promotional activity.
- Column 3: Contractors must list the county or counties reached by each promotional activity, which will usually be the location of the activity.
- Column 4: Contractors must list the type of audience targeted by each promotional activity (e.g. general, certain ethnic group, trade, religious, locale, age group, social group, other demographic, etc.).
- Column 5: Contractors must list the type of materials distributed or mailed for each promotional activity, where applicable. Promotional materials include, but are not limited to, brochure, application, brochure holder, flyer, calendar, business card, business card holder, promotional item, giveaway, incentive, premium incentive (which may ordinarily have no greater than a $15.00 retail value), etc.

Note that all materials listed should be CHIP materials which contain the CHIP logo. Contractors should not include materials related to contractual obligations, such as Enrollee Handbooks and Provider Directories.

Note also that all materials must have been approved following the process described in Section 21.2.

- Column 6: Contractors must list the number of materials mailed, delivered, audience members, people talked to, people called, etc. for each promotional activity.
- Column 7: Contractors must list the number of non-English (e.g. Spanish) materials (such as those listed for column 6) distributed or mailed for each promotional activity. If a material is in English, this field may be left blank. If the material is bilingual, list both languages used.
- Column 8: Contractors must list the date(s) for each promotional activity.
- Contractors may list beneath the chart other comments/highlights of the outreach and promotional activities reported. For example, a contractor may wish to note certain examples of sponsorship, a breakdown of what an internal/external meeting or event encompassed, or what the standard contents of a packet containing many kinds of materials might include.
- Contractors also must provide all outreach and promotional costs, including, but not limited to, sponsorship fees, travel expenses, the cost of promotional materials distributed during the relevant quarter, and mailing of the same (See Appendix 21-E).
**Completed Marketing and Outreach Expenditure Report** (See Appendix 21-E)

- This report outlines total expenditures by category, corresponding to the activities reported in Appendices 21-C and 21-D.

Contractors only need to report aggregate costs for each category.

Note that the aggregate cost for materials is determined by multiplying each individual cost per item by the number of those items which were distributed or mailed during the quarter. Contractors should not report the aggregate cost for number of items merely taken to events. Contractors should not report the aggregate costs paid for materials during the quarter. Contractors should not include the costs of producing or mailing any materials related to contractual obligations.

### 21.4.2 Frequency

Post Marketing/Outreach and Expenditure Reports are submitted to the Department two months after the quarter in accordance with the following schedule:

<table>
<thead>
<tr>
<th>Quarter reporting on</th>
<th>Dates quarter includes</th>
<th>Due Date</th>
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</thead>
<tbody>
<tr>
<td>First quarter</td>
<td>January 1-March 31</td>
<td>May 31</td>
</tr>
<tr>
<td>Second quarter</td>
<td>April 1-June 30</td>
<td>August 31</td>
</tr>
<tr>
<td>Third quarter</td>
<td>July 1-September 30</td>
<td>November 30</td>
</tr>
<tr>
<td>Fourth quarter</td>
<td>October 1-December 31</td>
<td>February 28</td>
</tr>
</tbody>
</table>

If the due date occurs on a Saturday, Sunday, or holiday, then the report is due by close of business on the first working day following the non-working day.

**NOTE**: A quarterly notification of completed activity as well as non-activity is required using this report. Contractors are not required to submit a report for each marketing area, but they are required to submit this report and designate for which marketing areas there was activity and, if any, for which marketing areas there was no activity (See Appendix 21-B).

### 21.4.3 Format
See Appendices 21-A, 21-B, 21-C, 21-D and 21-E. No alternative format will be accepted.

Expenditures for marketing and outreach materials and activities should be listed in Appendix 21-E.

**NOTE:** These reports are to be submitted to:

CHIP Outreach & Marketing Division  
1142 Strawberry Square  
P.O. Box 2675  
Harrisburg, PA 17120  
Fax: (717) 705-1643
APPENDIX 21-A:
INTENDED MARKETING AND OUTREACH SUMMARY

Contractor: __________________

Quarter 1 □  Quarter 2 □  Quarter 3 □  Quarter 4 □

Please indicate for each area whether or not you currently have any planned activities. Then provide an informal description of your planned activities.

☐ Yes  ☐ No  Marketing and Advertising,

Examples: television station, cable channel, radio station, magazine, newspaper, billboard, transportation, electronic, online, and social media

Note: For any television, cable, or radio advertising planned, list the relevant station, channel, program, flight dates, and time period information, if available.

☐ Yes  ☐ No  Outreach and Promotion

Examples: deliver/mail/email materials (to a 3rd party to distribute for you), sponsor/table/booth at an event, presentation to an internal/external group, visit to an organization, face-to-face meeting/individual application, or renewal assistance

Summary of planned activities for next quarter:
APPENDIX 21-B:
COMPLETED MARKETING AND OUTREACH ACTIVITY SUMMARY

Contractor: __________________

Quarter 1 □  Quarter 2 □  Quarter 3 □  Quarter 4 □

Please indicate for each area whether or not you are submitting a report for that area.

☐ Yes  ☐ No  Marketing and Advertising Report (Appendix 21-C)

Examples: television station, cable channel, radio station, magazine, newspaper, billboard, transportation, electronic, online, and social media

☐ Yes  ☐ No  Outreach and Promotion Activity Report (Appendix 21-D)

Examples: deliver/mail/email materials (to a 3rd party to distribute for you), sponsor/table/booth at an event, presentation to an internal/external group, visit to an organization, face-to-face meeting/individual application, or renewal assistance

☐ Yes  ☐ No  Marketing and Outreach Expenditure Report (Appendix 21-E)

Summary/Highlights of Marketing and Outreach activities for completed quarter:
APPENDIX 21-C:
COMPLETED MARKETING AND ADVERTISING REPORT

Contractor: ________________

Quarter 1 □  Quarter 2 □  Quarter 3 □  Quarter 4 □

<table>
<thead>
<tr>
<th>1-Type of Media used</th>
<th>2- Name and Location of Media Organization</th>
<th>3- County (ies) Reached</th>
<th>4- Type of Audience Targeted</th>
<th>5- Date of Approval</th>
<th>6- # of People/ Households Reached</th>
<th>7- Non-English Language Used</th>
<th>8- Date(s) Advertising Was Run</th>
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APPENDIX 21-D: COMPLETED OUTREACH AND PROMOTIONAL ACTIVITY REPORT

Contractor: __________________

Quarter 1 ☐  Quarter 2 ☐  Quarter 3 ☐  Quarter 4 ☐

<table>
<thead>
<tr>
<th>1-Type of Activity</th>
<th>2-Name and Location of Organization</th>
<th>3-County (ies) Reached</th>
<th>4-Type of Audience/Recipient</th>
<th>5-Type of Materials Distributed</th>
<th>6-# of Materials Distributed</th>
<th>7-Non-English Material Used</th>
<th>8-Date(s) of Activity</th>
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</table>

Further description/clarification of outreach and promotional activities (optional):
APPENDIX 21-E:
COMPLETED MARKETING AND OUTREACH EXPENDITURES REPORT

Contractor: __________________

Quarter 1 ☐  Quarter 2 ☐  Quarter 3 ☐  Quarter 4 ☐

**Marketing and Advertising Activities** ( Appendix 21-C)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>TV/Radio</td>
<td>$</td>
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<tr>
<td>Print Media</td>
<td>$</td>
</tr>
<tr>
<td>Billboard Advertising</td>
<td>$</td>
</tr>
<tr>
<td>Transportation Advertising</td>
<td>$</td>
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<tr>
<td>Electronic Media</td>
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</tr>
<tr>
<td>Other Advertising Costs</td>
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</tr>
</tbody>
</table>

Total Marketing and Advertising Costs $  

**Outreach and Promotional Activities** ( Appendix 21-D)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentations and Promotional Events including:</td>
<td></td>
</tr>
<tr>
<td>Sponsorship Fees</td>
<td>$</td>
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<tr>
<td>Travel Expenses</td>
<td>$</td>
</tr>
<tr>
<td>Marketing Supplies &amp; Materials, including Applications, Flyers and Brochures, etc.</td>
<td>$</td>
</tr>
<tr>
<td>Premium Incentives (which may ordinarily have no greater than a $15.00 retail value), Incentives/Giveaways</td>
<td>$</td>
</tr>
<tr>
<td>Postage/Shipping</td>
<td>$</td>
</tr>
<tr>
<td>Other Promotional Costs</td>
<td>$</td>
</tr>
</tbody>
</table>

Total Outreach and Promotional Costs $
TOTAL Marketing and Outreach Expenditures: $