pennsylvania
INSURANCE DEPARTMENT

Solicitation for State Proposals to Operate Qualified High-Risk Pools

State: Pennsylvania

State Contact for Solicitation:

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Solicitation for State proposals to Operate Qualified High-Risk Pools

Pennsylvania

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PROPOSAL CERTIFICATION

I, Joel Ario, Insurance Commissioner, attest to the following:

I have read the contents of the completed proposal and the information contained herein is true, correct, and complete. If I become aware of any information in this proposal that is not true, correct, or complete, I agree to notify the Department of Health and Human Services (HHS) immediately and in writing.

I authorize HHS to verify the information contained herein. I agree to notify HHS in writing of any changes that may jeopardize my State's ability to meet the qualifications stated in this proposal prior to such change or within 30 days of the effective date of such change.

I agree that if HHS approves this proposal and awards a contract to my State or State's designated high risk pool, that my State or State's designated high risk pool will abide by the requirements contained in the contract and provide the services as outlined in this proposal.

I agree that HHS may inspect any and all information necessary, including inspecting the premises of the high risk pool program's organization or contractors to ensure compliance with Stated Federal requirements. I further agree to immediately notify HHS if, despite these attestations, I become aware of circumstances which preclude full compliance with the requirements stated in this proposal.

I certify that I am authorized to certify this submission on behalf of my State or my State's designated entity.

Joel Ario	Insurance Commissioner
Authorized Representative Name (printed)	Title
______________________________	06/01/2010
Authorized Representative Signature	Date

C.4.1 TECHNICAL APPROACH CONTENT

Pennsylvania's proposal for establishing and providing for the ongoing administrative functions of operating a temporary health insurance program for individuals with pre-existing conditions and who have not had creditable coverage for six months.

The Commonwealth of Pennsylvania proposes a contract between the Pennsylvania Insurance Department (hereafter known as "Department") and the Department of Health and Human Services (hereafter known as "HHS"). The Department will contract with one or more third-party administrator services (hereafter known as "Contractor") to operate a temporary health insurance program (hereafter known as "Program") for eligible individuals within the limitation of funding made available for this purpose and to perform, or subcontract, all administrative tasks necessary to operate the Program in compliance with federal law and the forthcoming final federal regulations. The Contractor may subcontract with enrollment assistance organizations (hereafter known as "Subcontractor") for the purposes of eligibility decisions, premium collection and other duties to be determined. The Department derives its authority to establish the Program under its authority pursuant to 40. P.S. §41.

The Department will simplify the application and eligibility process as much as possible, in order to limit expenses associated with the application process. If, after final regulations are promulgated, it is determined that certain administrative functions must be performed or must be performed only by the state, the Department will provide the necessary services and submit its claim for reimbursement of expenses to the federal government.

The Commonwealth of Pennsylvania does not currently operate a high-risk pool program (hereafter known as "Program"), and this proposal is solely for the intent of creating this Program, for eligible individuals with pre-existing conditions who have not had creditable coverage for the continuous six months period prior to enrolling in the Program. No segregation of funding and expenditures from any existing Program is applicable under Pennsylvania's proposal.

Overview of the Proposal:

The Department will contract with HHS to fund the Program to provide health insurance coverage to eligible individuals until December 31, 2013. Neither the Commonwealth of Pennsylvania nor the Department will be responsible for the cost of covered health insurance claims filed by enrollees or for administrative expenses of operating the Program to the extent those claims and administrative expenses are in excess of the premiums collected by the Contractor.

The Department will subcontract with one or more Contractors for delivery of benefits (to administer the program) through a Third Party Administrator (TPA)/Administrative Services Only (ASO) agreement.

Timeline:

Date	Milestone
June 1, 2010	Submit proposal for HHS evaluation and contract award by July 1, 2010
June 18, 2010	Submit revised proposal
June 25, 2010	HHS awards contract
June 25, 2010	PA Insurance Department & Department of General Services issue procurement opportunity (Letter of Interest)
June 28, 2010	Commence discussions and negotiations with Contractors
June 28, 2010	Announce approval and start date of the program by HHS
July 2, 2010	Deadline for submission of proposals (Letter of Interest)
Week of July 5, 2010	Award made to Contractor
July 10, 2010	Submit Project Implementation Plan to HHS
July 12, 2010	Begin taking applications & open call center
July 26, 2010	Contractor makes initial offers to all or selected applicants and requests payment of initial monthly premium
August 1, 2010	Contractor initiates enrollment of eligible applicants who have paid their premiums.
September 15, 2010	Submit monthly report to HHS
October 1, 2010	Submit quarterly progress report to HHS

October 15, 2010	Submit monthly report to HHS
February 1, 2011	Evaluate the initial six months of the program at 70% enrollment and determine if additional applicants may be offered coverage

Operation of Program:

The Department will subcontract with one or more Contractors for a TPA/ASO arrangement for delivery of benefits, enrollment of applicants as provided in this proposal (e.g., the total number to be offered coverage) and to administer all other aspects of the program except any that the Department cannot subcontract such as ensuring that the program is audited.

Contractors selected to administer the program under this proposal shall use policies that satisfy all rating, pricing and coverage requirements specified in section 1101 of the federal Patient Protection and Affordable Care Act (hereafter known as “federal Act”).

The Department shall:

1. Subcontract with legal, actuarial, auditing and other persons or entities as it deems appropriate to provide technical assistance in operating the Program and performing any of the functions of the Program.
2. Operate, supervise, administer and audit the Program.
3. Submit to HHS invoices for its administrative expenses and for administrative and claims costs incurred by any Subcontractors.

Other than payments for subcontracted work under this proposal, Contractors selected to administer any aspect of this program shall not receive a fee or profit for the performance of this work.

Duties of Administering Contractors:

An administering Contractor must demonstrate the following capabilities:

1. The ability to provide a full range of third-party administrator services in the operation of a temporary health insurance program consistent with section 1101 of the federal Act, providing services that include:
    a. Claims processing, including health care claims and point of sale prescription drug claims;
    b. Provision of contracted health care provider and pharmacy networks;
    c. Utilization review;
    d. Appeals processes;
    e. Eligibility determinations and enrollment/disenrollment functions
    f. Full range of member and provider relations services, including call center and website management;
    g. Plan marketing; and
    h. Collection of premiums.
    i. Perform all necessary functions to assure timely payment of benefits to covered persons under the Program, including, but not limited to, the following:

        I. Determining eligibility, communicating with applicants about eligibility, enrolling and disenrolling applicants offered coverage under this program and tracking the reasons for eligibility terminations.
        II. Making available information relating to the proper manner of submitting a claim for benefits under the Program and distributing forms upon which submissions will be made.
        III. Evaluating the eligibility of each claim for payment under the Program.
        IV. Notifying each claimant within 30 days after receiving a clean claim whether the claim is accepted, rejected or compromised.
2. The ability to have in place a provider network capable of providing a full range of high-quality and accessible health care to Program members throughout the state.
3. The capacity to begin all TPA functions promptly after the award of contract.

4. The capacity to provide membership, claims and utilization data as may be required by the Department and HHS, including the capacity to establish the accounting and fund controls needed to permit timely tracking of claims payments under each state's Program.
5. The capacity to monitor and report to the Department and HHS information related to misconduct that takes place in the marketplace, including allegations relating to health insurance issuers and employment-based health plans discouraging individuals from remaining enrolled in prior coverage based on an individual's health status, as well as allegations related to fraud and abuse within the Program.

C.4.2 PROGRAM DESIGN

How Pennsylvania will design a temporary health insurance program to meet the basic requirements to operate the Program.

C.4.2.1 ELIGIBILITY CRITERIA

The following criteria will be used to determine if individuals are eligible to enroll in the Program.

1. An individual who is a resident of the Commonwealth of Pennsylvania and satisfies all of the following:
    a. Is a citizen or national of the United States or is lawfully present in the United States, as required by the federal Act.
    b. Has not been covered under creditable coverage during the six-month period prior to the date the individual is applying for coverage under the Program.
    c. Has evidence one of the following:
        I. A pre-existing condition, as identified on a list promulgated by the Department (see Appendix A)
        II. Denial of health insurance coverage due to a pre-existing condition.
        III. Was offered coverage only with the exclusion of a pre-existing condition.

IV. Health insurance coverage was quoted as at least 150% of the standard premium for a product due to a pre-existing condition.

2. An individual is ineligible for coverage from the Program if the person is eligible for Medicare, Medical Assistance, the Children's Health Insurance Program or private health insurance with benefits that are actuarially the equivalent of at least 90 percent of the Program's benefits and cost no more than 150 percent of the Program's premium.

Termination of Coverage:

Coverage under this Program will terminate:

1. On the date a person is no longer a resident of this commonwealth;
2. On the date a person requests coverage to end;
3. On the death of the covered person;
4. At the option of the Program, 30 days after the Program sends to the person to the person's most recent address on file an inquiry concerning the person's eligibility, including an inquiry concerning the person's residence, to which the person does not reply;
5. On the 31st day after the day on which a premium payment for Program coverage becomes due, if the payment is not made before that date;
6. At such time as the person ceases to meet the eligibility requirements of this section; or
7. The date the individual is enrolled in an exchange or this Act terminates, whichever is later.

An applicant who has had coverage under the Program, is terminated and re-applies, shall be deemed a new applicant for purposes of any waiting list.

C.4.2.2 COVERAGE AND BENEFITS

Plan benefits:

The Program shall offer policy coverage that shall be renewable until December 31, 2013.

Benefit	In-Network	Out-of-Network
Calendar Year Deductible	$1,000	$10,000
Coinsurance after Deductible	80%	50%
Out-of-Pocket Maximum	$5,000	$20,000
Lifetime Maximum	Unlimited	Unlimited
Primary Care Office Visit	$25 copay	50 % after deductible
Specialist Office Visit	$30 copay	50% after deductible
Preventive Care	100%	50% after deductible
Routine Gynecological Exam/Pap test	100%	50% after deductible
Mammogram	100%	50% after deductible
Nutritional Counseling for Weight Management	100%	50% after deductible
Therapy Services: Physical & Occupational (15 visits per CY) Speech (15 visits per CY) Cardiac Rehab (36 visits/CY) Pulmonary Rehab (36 visits per CY)	$30 copay	50% after deductible
Emergency Room	80% after deductible	50% after deductible
Outpatient Laboratory/Pathology	80% after deductible	50% after deductible
Maternity and Newborn Care (31 days)	80% after deductible	50% after deductible
Inpatient Hospital Services (120 days/CY in-network; 90 days/CY out-of-network)	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible
Skilled Nursing Facility (60 days per CY)	80% after deductible	50% after deductible
Home Health Care (30 visits per CY)	80% after deductible	50% after deductible
Hospice	80% after deductible	50% after deductible
Outpatient X-ray/Radiology	80% after	50% after deductible

	deductible	
Prescription Drugs	$20 copay generic, $50 brand copay. Brand used only if generic is not available, or if medically necessary	50% after deductible
Serious Mental Illness	The same as medical conditions	

The Program will provide the following benefit package:

1. Preventive care
2. Physician services
3. Diagnosis and treatment of illness or injury, including all medically necessary covered services related to the diagnosis and treatment of sickness or injury and other conditions provided on an ambulatory basis, such as laboratory tests, x-rays, wound dressing and casting to immobilize fractures
4. Therapy Services
5. Skilled Nursing
6. Maternity and newborn care (up to 31 days)
7. Inpatient hospitalization
8. Outpatient hospital services
9. Emergency accident and emergency medical care
10. Prescription medications
11. Durable Medical Equipment
12. Serious Mental Illness
13. Hospice

The benefit package will include the following core of specific services is within the scope of the statutory requirements:

Primary Care Services: Includes sick office visits during office hours, and during non-office hours and routine physical examinations once per year for the detection and minimization of the effects and causes of disease or disability.

Preventive Care Services: Includes office visits during office hours and routine physical examinations once per year for the detection and minimization of the effects and causes of disease or disability.

Injections and Medications: Includes all injections and medications provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital or free-standing ambulatory service center, including immunizations and the immunizing agents, which, as determined by the PA Department of Health (PA DOH), conform with standards of the Advisory Committee on Immunization Practices of the Center for disease Control, HHS and anesthesia services when performed in connection with covered services.

Routine Gynecological Services: Includes one routine annual gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per year for all female enrollees. Each enrollee may utilize her primary care physician or she may choose any participating professional provider.

Obstetrical Services: Includes prenatal and postnatal care, and complications of pregnancy and childbirth. A referral is not required when the maternity care is provided by a network obstetrician, network nurse-midwife or a network Primary Care Provider (PCP).

Newborn Care: Includes the provision of benefits for a newborn child of an enrollee for a period of thirty-one days (31) following birth. Includes routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Abortions: Includes only abortions and contraceptives that satisfy the requirements of 18 Pa.C.S. § 3204-3206 and 35 P.S. §§10101, 10103-10105.

1. Elective abortions are not covered. Services rendered to treat illness or injuries resulting from an elective abortion are covered.
2. The Program and its Subcontractors will respect the conscience rights of individual providers and provider organizations and comply with the Pennsylvania law prohibiting discrimination on the basis of the refusal or willingness to participate in certain abortion and sterilization-related activities as outlined in 43 P.S. §955.2 and 18 Pa. C.S.A. §3213(d).

Routine Mammograms: Includes an initial baseline mammographic screening for all enrollees; an annual routine mammographic screening for all enrollees; and a mammographic screening for all enrollees regardless when such service is prescribed by the PCP or by a network obstetrician/gynecologist.

Adult Preventive Care: Includes the following:

- Fecal Occult Blood Test. One (1) test every calendar year, beginning at fifty (50) years of age
- Flexible Sigmoidoscopy. One (1) test every three (3) calendar years, beginning at fifty (50) years of age
- Routine Colonoscopy. One (1) test every ten (10) calendar years, beginning at fifty (50) years of age

Prostate Specific Antigen (PSA):

- One (1) test every calendar year, beginning at fifty (50) years of age

Diagnostic, Laboratory and X-ray Services: Includes all laboratory and X-ray services, EKGs and other diagnostic services related to the diagnosis and treatment of sickness and injury provided on an ambulatory or inpatient hospital basis.

Diabetic Treatment, Equipment and Supplies: Includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, orthotics and outpatient self-management training and education, including information on proper diets.

Specialist Physician Services: Includes medical care in any generally accepted medical specialty or subspecialty. The Program may require prior authorization for specialty services.

Inpatient Hospitalization (up to 120 days per calendar year for in-network care and up to 60 days per calendar year for out-of-network care) **and Skilled Nursing Facility** (in lieu of inpatient hospitalization): Includes semi-private room and board accommodations; private accommodations when medically necessary; general nursing care, use of intensive or special care facilities when medically necessary; diagnostic and therapeutic radiological procedures; use of operating room and related facilities; drugs, medications, and biologicals; laboratory testing and services; pre- and post-operative care, special tests when medically necessary; therapy services, oxygen, anesthesia and anesthesia services and any other services normally provided by the Contractor relating to inpatient hospitalization and skilled nursing inpatient care.

Reconstructive Surgery: Includes surgical procedure for mastectomy, including prosthetic devices and reconstructive surgery incident to any mastectomy.

Emergency Medical and Accident Services (including emergency transportation): Includes at a minimum emergency services as defined herein. Emergency providers may initiate the necessary intervention to stabilize the condition of the patient without seeking or receiving prior authorization by the contractor.

Disease Management: Includes education, self-management tools, monitoring, support between office visits to a physician through any media--telephone, print, Internet or in person, or a combination of these in coordination of a physician's treatment plan. Specific to this RFP, the targeted diseases for management include high-risk pregnancy, diabetes, cardiac care, asthma and obesity.

Prescription Drugs: Includes any substance taken by mouth, injected into a muscle, the skin, a blood vessel, or a cavity of the body, or applied topically to treat or prevent a disease or condition, dispensed by order of a health care provider with applicable prescriptive authority. Contractors may use a closed or restrictive formulary provided it meets the minimum clinical needs of enrollees. A mail order or designated pharmacy process can be used for maintenance prescriptions.

Rehabilitative Therapies: Physical therapy, speech therapy and occupational therapy delivered in an acute care hospital, skilled nursing facility, rehabilitation hospital or outpatient setting when the primary or only reason for the admission or appointment is for the purpose of receiving physical, speech or occupational therapy. Physical, speech and occupational therapy are combined for the purpose of calculating any benefit limits. Therapy must be provided in order to correct impairment from which substantial improvement can be anticipated and the condition being treated is due to accidental injury or episodic sickness or a congenital condition for which corrective surgery has been performed.

Durable Medical Equipment (DME): Medically necessary equipment that is primarily and customarily used to serve a medical purpose, durable and able to withstand repeated use, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home. For the purpose of this contract, the only DME that is authorized is for equipment that is medically necessary, will result in an earlier release from a facility thus resulting in cost savings, and result in improvement in the health condition of the patient to a point of no longer requiring the DME. Authorized DME may be purchased or rented at the Plan’s option.

- **Items that do not qualify as DME include but are not limited to:** Medical equipment/supplies of an expendable nature (incontinence pads, catheters, irrigation kits, disposable electrodes, ace bandages, elastic stockings and dressings); medical equipment/supplies that are primarily used for non-medical purposes (air conditioners, humidifiers, electric air cleaners); and equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for an enrollee (exercise or other physical fitness equipment, elevators, hover lifts, shower/bath bench, etc).

Palliative and Hospice Care: Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families.

- **Care includes** palliative and hospice care services and supplies authorized by a physician for an enrollee whose life expectancy is six (6) months or less, as certified by a physician. (Hospice room and board, if applicable; other hospice services routinely furnished by a licensed hospice or a hospice team; counseling services provided by members of a hospice team; and home health aide services.) A hospice team includes a physician and a registered nurse and may include one or more of the following: a licensed social worker, a clergyman/counselor, volunteers, a clinical psychologist, a physical therapist or an occupational therapist.

Mental Health Services for Serious Mental Illness: Serious mental illness means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

The Program will not cover:

1. services not medically necessary;
2. services or supplies that are experimental or investigative except routine costs associated with clinical trials;

3. hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices;
4. assisted fertilization techniques such as in vitro fertilization, GIFT and ZIFT;
5. alternative therapies/complementary medicine;
6. dental care, including dental implants and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
7. routine foot care, unless medically necessary or associated with the treatment of diabetes;
8. foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
9. contraceptive devices;
10. immunizations for travel or employment;
11. service or supplies payable under workers' compensation, motor vehicle insurance, Medicare or other legislation of similar purpose;
12. cosmetic services/supplies;
13. vision care;
14. services for mental health conditions other than serious mental illness.

C.4.2.3 PRE-EXISTING CONDITIONS COMPLIANCE

The Program will provide coverage to all enrolled individuals and that coverage will not impose any pre-existing condition exclusions with respect to such coverage. Individuals eligible for enrollment will not denied based on a pre-existing condition.

C.4.2.4 PREMIUMS AND STANDARD RISK RATE

Individuals enrolled in the Program will pay a premium rate of $283.20 per month.

The **Program rate** was derived using the following steps:

1. A guaranteed issue (GI) PPO plan, developed specifically for the Program by an insurer in response to the Departments' request, was used as the starting point. The plan developed does <u>not</u> exclude pre-existing conditions.

2. An adjustment of 300 percent was made for adverse selection since the Program population has not had any coverage for the last six months.
3. Adjustments were made for the benefit design using the group benefit factors. Please note that benefit factors are based on the type of population mix (healthy versus one with health issues). Since the Department does not have experience on the Program population, the group benefit factors were used as a proxy.
4. The PMPM (per member per month) developed in the three preceding steps is the medical cost per enrollee per month without any administrative expenses. This amount is $990.84.
5. The maximum that the Department can charge any enrollee is the Standard premium rate of $283.20.
6. The annual cost of claims that would be paid by subsidy dollars is calculated by subtracting the enrollee share from $990.84 and multiplying by 12.
7. The Department and Contractor will bill only actual administrative expenses not to exceed 10 percent of the total subsidy available.

The actuarial value of the proposed plan is 71.8%.

Department studies on the claims costs of the programs under CHIP and adultBasic show that claim costs are significantly higher for programs in which the enrollee pays a higher premium. The reason may be attributed to the fact that people only pay for insurance if they have a need for it. The higher the rate, the greater is the probability of sicker people enrolling into that product. The evidence is as follows:

CHIP – the rate charged to the enrollee varies with the family income. For the free component of the program, enrollees do not pay any premium. In the low-cost component, enrollees pay 25 percent, 35 percent and 40 percent of the rate. Enrollees in the at-cost component of the program pay 100 percent of the rate. The Department study shows that the claims costs of the low-cost component were **7.6** percent higher than the free component. The claims costs of the at-cost component were **26.5** percent higher than the free component.

adultBasic Program – Enrollees in this subsidized program pay about $36 per month (the state subsidizes the rest of the rate). The enrollees that obtain coverage while on the waiting list pay 100 percent of the rate. The experience of the enrollees paying 100 percent of the rate was found to be about **three** times higher than the experience of the subsidized program enrollees.

Standard Risk Premium Rate:

Individuals enrolled in the Program will pay a premium rate of $283.20 per month.

The **Standard Risk rate** is calculated as follows:

1. A medically underwritten (MU) plan with $250 deductible was used as the starting point. This plan was selected as it had the highest enrollment as compared to other deductible plans.
2. The MU plan is rated by age, gender and underwriting tier.
    a. Age band of 45 to 49 was used
    b. Actual male-female ratio of 53%:47% was used – taken from the selected MU plan
    c. An assumption to use Underwriting Tier 2 rates was made since this is the middle tier.
3. The standard risk rate was developed using the above assumptions.

The rationale for using the MU plan for the development of the standard risk rate is –

- Medically underwritten business is becoming more popular in Pennsylvania since 2007. Of the applications submitted, 70% are accepted by the MU business. The 30% applicants rejected by the underwriting process are offered the guaranteed issue (GI) plans. The market share of the GI business is going down. Therefore, the MU plan was used as it represents the standard population for the standard risk.
- The use of GI plan in the standard rate development produces a rate that is unaffordable for the 64.4% of eligible population that fall below the 200% FPL.

C.4.2.5 COST SHARING STRUCTURE

Benefit Design:

Benefit	In-Network	Out-of-Network
Calendar Year Deductible	$1,000	$10,000
Coinsurance after Deductible	80%	50%
Out-of-Pocket Maximum	$5,000	$20,000
Lifetime Maximum	Unlimited	Unlimited
Primary Care Office Visit	$25 copay	50% after deductible
Specialist Office Visit	$30 copay	50% after deductible
Preventive Care	100%	50% after deductible
Routine Gynecological Exam/Pap test	100%	50% after deductible
Mammogram	100%	50% after deductible
Nutritional Counseling for Weight Management	100%	50% after deductible
Therapy Services: Physical & Occupational (15 visits per CY) Speech (15 visits per CY) Cardiac Rehab (36 visits/CY) Pulmonary Rehab (36 visits per CY)	$30 copay	50% after deductible
Emergency Room	80% after deductible	50% after deductible
Outpatient Laboratory/Pathology	80% after deductible	50% after deductible
Maternity and Newborn Care (31 days)	80% after deductible	50% after deductible
Inpatient Hospital Services (120 days/CY in-network; 90 days/CY out-of-network)	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible
Skilled Nursing Facility	80% after deductible	50% after deductible
Home Health Care (30 visits per CY)	80% after deductible	50% after deductible
Hospice	80% after	50% after

	deductible	deductible
Outpatient X-ray/Radiology	80% after deductible	50% after deductible
Prescription Drugs	$20 copay generic, $50 brand copay. Brand used only if generic is not available, or if medically necessary	50% after deductible
Serious Mental Illness	The same as medical conditions	

C.4.2.6 PROVIDER NETWORK

The Department will subcontract with a Contractor through a TPA/ASO arrangement to procure a sufficient number and range of providers through a managed care plan delivery system for which the contractors will agree to abide by all requirements under Pennsylvania's Act 68 (e.g., provider network adequacy and enrollees' appeal rights).

Contractor will have a contracted and credentialed provider network to meet the needs of its enrolled population in the geographic areas in which it is licensed and approved by PA DOH to provide services. Contractor must ensure that its provider network is adequate to provide its enrollees with access to quality enrollee care through participating professionals, in a timely manner, and within a reasonable travel time and distance. The Department may require additional numbers of specialists and ancillary providers should it be determined, in consultation with the PA DOH, that geographic access is not adequate. Contractor must also have a process in place which ensures they are aware of the capacity of its network PCP panels at all times and have the ability to report on this capacity.

Contractor must notify the Department of any changes to the composition of its provider network that materially affects the Contractor's ability to make available services in a timely manner. Contractor also must have procedures to address changes in its network that negatively affect the ability of enrollees to access services. Material changes in network composition that negatively affect enrollee access to services may be grounds for contract termination, suspension of new enrollment or other sanctions.

PA DOH regulations require that a managed care plan must report any probable loss from the network of any general acute care hospital and any PCP, whether an individual practice or a group practice, with 2000 or more assigned enrollees. At such time as a Contractor submits such report to PA DOH, a copy of the report shall be sent to the Department.

Contractor may enter into subcontracts to fulfill its obligations under this agreement. All vendors subcontracted to perform part or all of the Contractor's responsibilities shall provide the same level of services and procedural protections set forth in any contract with the Department and as required by the HHS.

Contractor shall not enter into any subcontracts, or utilize the services of any subcontractor, unless the subcontractor complies with federal and state laws and regulations, Commonwealth Management Directives and this agreement.

Contractor shall make subcontracts available to the Department within ten (10) business days when requested by the Department. Subcontracts entered into by a Contractor shall not abrogate the Contractor's obligations under its contract with the Department.

Contractors that subcontract with behavioral health organizations must provide a copy of their subcontracts to the Department. Contractor will be required to list the names of its behavioral health and substance abuse providers in their provider directories in addition to any specific access number the Contractor might utilize.

C.4.2.7 APPEALS & RECONSIDERATION

The Department will provide a final appeal for non-clinical matters, including eligibility and termination determinations. A Member or the Member's representative may request that Contractor review an adverse benefit determination. The request must be made within 180 days of receipt of the determination. If the adverse benefit determination is a denial of reimbursement for a health care service based on a lack of medical necessity and appropriateness, the review will be processed as a grievance as described below.

Contractor will provide an appropriate appeal processes for clinical matters, including medical necessity determinations in relation to claim denials which includes:

1. First Level Complaint Review:
    a. Decision within 30 days and notification of the decision within five business days of the decision.
    b. Decision may be appealed to the Second Level Complaint Review Committee within 60 days of receipt of the decision.
2. Second Level Complaint Review:
    a. Must be requested in writing or orally to Contractor.
    b. Decision will be completed within 45 days.
    c. Notification of the decision will be completed within five business days of the Decision.
    d. Decision may be appealed within 15 days of receipt of the decision to the Pennsylvania Insurance Department (PID) or PA DOH
3. External Complaint Review:
    a. May be requested in writing or orally to the PID or PA DOH.
    b. Upon request by the PID or PA DOH, Contractor will forward all records of the Complaint Review decision within 30 days of request.
    c. The Member or the Member's representative (or provider acting on the Member's behalf with the Member's consent in the case of a grievance) may submit written comments, documents, records and other information relating to the complaint or grievance at any stage of the review process.
    d. The Member or the Member's representative may request an expedited review at any stage of the review process if

I. The Member's life, health or ability to regain maximum function will be placed in jeopardy by following the timeframes in the review process described below, or

II. In the opinion of a physician with knowledge of the Member's condition, the Member would be subject to severe pain that cannot adequately be managed without the care or treatment for which coverage is being sought.

C.4.2 8 PREMIUM GRACE PERIOD & TERMINTAION APPEAL PROCESS

There will be a 30 day grace period for premium payments. On the 31st day after the day on which a premium payment for Program coverage becomes due, if the payment is not made before that date then coverage for an individual will be terminated. The Contractor(s) will agree to abide by all requirements under Pennsylvania's Act 68 regarding enrollees' appeal rights referenced in section C.4.2.7

C.4.2.8 9) INITIAL 2010 PREMIUM RATE

The initial premium rate is $283.20. See Table A.

C.4.2.8 10) PREMIUM RATE ADJUSTMENT SCHEDULE

The State will adjust premiums for changes in the market rates on an annual basis.

C.4.2.8 11) PREMIUM PAYMENTS FROM THIRD PARTY PAYERS

The Department is not proposing to accept premium payments from a third party payer.

C.4.2.8 10) PLAN YEAR FOR ACCUMULATION OF DEDUCTIBLES & OUT OF POCKET LIMITS

The plan year will be on a calendar year basis for accumulation of member deductibles and out of pocket limits.

C.4.3 ENROLLMENT STANDARDS

C.4.3.1 ELIGIBILITY DETERMINATION PROCESS

The Program will establish eligibility criteria for determining if an individual is eligible to enroll in the Program. An individual must be a resident of the Commonwealth of Pennsylvania and satisfy all of the following:

1. Is a citizen or national of the United States or is lawfully present in the United States, as required by the federal Act.
2. Has not been covered under creditable coverage during the six-month period prior to the date the individual is applying for coverage under the Program.
3. Has evidence that the individual has one of the following:
    a. A pre-existing condition, as identified on a list promulgated by the Department.
    b. Denial of health insurance coverage due to a pre-existing condition.
    c. Coverage is available only with the exclusion of a pre-existing condition.
    d. Health insurance coverage was quoted as at least 150% of the standard premium rate.

The Program will require applicants to provide information on or with the application so that the Department and Contractor have sufficient information to confirm the validity of the information. The application will include an attestation as to the validity of the information, and a waiver to allow the Department and or Contractor(s) to release information and receive information for the purposes of validating the information provided and a statement that the application provides false or fraudulent information coverage may be rescinded and the individual will be responsible for the cost of the claims incurred, including reimbursing the Program for any claims paid on the individual's behalf.

The Department will prepare an application requiring the following information:

1. name

2. address
3. date of birth
4. Social Security Number
5. contact information (Email address & Primary Phone number), and
6. the applicants
    a. Pennsylvania residency status
    b. Pennsylvania driver's license or identification number
    c. name on birth certificate
    d. name on Social Security card
    e. name on Pennsylvania driver's license
    f. previous health insurance policies or coverage(s) in last 18 months
    g. name of physician last treated applicant with pre-existing condition
7. if the applicant
    a. currently has health insurance;
    b. has had health insurance in the last six months;
    c. is eligible to enroll in Medicaid;
    d. is eligible to enroll in Medicare,
    e. has a pre-existing medical condition
    f. is a citizen of the United States, U.S. national or a lawful alien
    g. has been offered health insurance with a rating and/or premium higher than standard rates because of a health condition or pre-existing condition;
    h. has been offered health insurance coverage with a pre-existing condition or rider exclusion
    i. was encouraged by any insurance company or employer to terminate current health insurance and apply for the Program coverage
    j. is currently employed (including name and address of employer)
    k. can obtain health insurance through an employer; if so, why applicant is not covered
8. applicant will be asked to certify, authorize and/or understand
    a. compliance with federal requirements in relation to providing claims and utilization data to Department of Health & Human Services

b. third parties obtaining relevant medical history and information about re-existing conditions listed on the application with waiver of confidentiality for relevant medical records
c. compliance with documentation requests for verification purposes to include citizenship, pre-existing conditions, and health insurance coverage information
d. any significant misrepresentation or omission may terminate or void coverage

The specific use of the collected information is described in detail below.

C.4.3.2 METHODS OF OBTAINING ELIGIBILITY DOCUMENTATION

The Program will require the applicants for the Program to provide evidence that the applicant is a resident of the commonwealth, a citizen or national of the United States or is lawfully present in the United States, as required by the Federal Act, that the individual not been covered under creditable coverage during the six-month period prior to the date the individual is applying for coverage under the Program and that the individual has a pre-existing condition.

Applicants may provide written or telephone verification to document lack prior coverage or existence of a pre-existing condition, and an individual may apply for coverage by attesting to the same and cooperating with the state in obtaining documentation.

1. Lack of creditable coverage at time of enrollment and for a continuous six-month period prior to enrollment.
2. Evidence of a pre-existing condition, including
    a. denial letter from health insurance company, or
    b. health insurance quote as at least 150% of the standard premium rate, or
    c. other evidence deemed by the Department as adequate to prove existence of a pre-existing condition
3. Income level determination

    a. Copy of PA or U.S. income tax return
    b. Copy of W2 forms
4. Citizenship verification (see C.4.3.3)
5. Other documents as determined by the Department

C.4.3.3 CITIZENSHIP VERIFICATION

The Program will require the applicants for the Program to provide evidence that the applicant is a citizen or national of the United States or is lawfully present in the United States, as required by the federal Act. Applicants will provide a Social Security Number and basic demographic information in their applications, as well as whether they claim to be a U.S. citizen, U.S. national or alien lawfully present in the U.S. In addition, they must indicate whether they claim to be residents of Pennsylvania.

The Social Security Number will be used to verify citizenship. The Department will verify through the Social Security Administration, through its pre-existing connections with the PA Department of Public Welfare, which is the single state agency currently allowed to access SSA databases.

For those not able to provide a valid Social Security Number, the following documents and forms will be accepted as proof of citizenship and identification:

Proof of Citizenship:

1. U.S. Passport (current valid or one that has been expired no more than five years)
2. Valid U.S. Passport Card
3. Certificate of Naturalization
4. Certificate of Citizenship
5. U.S. Department of State consular report of birth abroad.
6. Original, certified birth certificate. The birth certificate must have been issued by a city, county or state and must have all of the following:
    a) a registrar’s raised, embossed, impressed, or multicolored seal.
    b) a control number that can be validated with the issuing authority.

c) a registrar's signature.

d) the date the certificate was filed with the registrar's office. The date must be within one year of birth.

7. Current immigration documents showing evidence of current lawful non-citizen status if not a U.S. citizen.
8. Social Security card in conjunction with federal tax return & photo ID

Proof of Identification:

1. U.S. Passport
2. Naturalization Certificate
3. Valid PA driver's license
4. Current Government ID (city, state or federal)
5. Current Military ID (military and dependents)

The following secondary identification will not be accepted:

1. Adjudication form or ticket citation
2. Bank account statement
3. Bank card or credit card
4. Baptismal certificate
5. Bus pass
6. Cell phone bill
7. College ID or Associated Student Body
8. Credit Card
9. Employee ID (non-Government)
10. Food handler card
11. Hunting or fishing license
12. Internet printout
13. Membership card (such as library, athletic club or store cards)
14. Personal check
15. Rental or lease agreement
16. Renters insurance policy

17. Vehicle insurance card
18. Utility bill
19. Vehicle registration

Process by which an applicant demonstrates s/he has not been continuously covered under creditable coverage during the six-month period prior to the date the individual is applying for coverage under the Program.

Applicants may provide written or telephone verification to document lack of prior coverage or existence of a pre-existing condition, and an individual may apply for coverage by attesting to the same and cooperating with the state in obtaining documentation when requested.

1. Self-certification for period of uninsurance.
2. Verification of a pre-existing condition including
    a. Evidence of denial of coverage.
    b. Evidence that coverage is available only with an exclusionary rider.
    c. The presence of certain medical conditions specified by the Department (Attachment A)

C.4.3.4 ENROLLMENT PROCESS

During the enrollment process, the Contractor shall:

1. Obtain standardized information from each applicant on an application prescribed by the Department, using an online application form to the maximum extent possible.
2. Ask each applicant in the application whether the applicant is a citizen or national of the United States or lawfully present in the United States.
3. Ask each applicant in the application whether the applicant has meet the pre-requisite that the applicant not covered under creditable coverage for a continuous six-month period of time prior to the date on which such individual applies for coverage under this Program, as well as whether the applicant is currently without coverage. Review the responses in each applicant's application for this Program to determine by self certification whether the applicant meets the pre-existing

condition prerequisite for this Program. If HHS requires the use of an external verification of each applicant's insurance coverage, the Contractors will undertake this after the fact. However, this step will be undertaken only for those applicants who will be offered coverage if they are determined to be eligible if there are more applicants than funding permits coverage.

4. Ask each applicant in the application whether the applicant meets the pre-existing condition requirement established for a Program. Methods used to define pre-existing condition are:
   a. Evidence of denial of coverage.
   b. Evidence that coverage is available only with an exclusionary rider.
   c. The presence of certain medical conditions specified by the Department (Attached)
5. Review the responses in each applicant's application for this program to determine by self certification whether the applicant meets the pre-existing condition prerequisite for this Program. Self certification should be sufficient because applicants in Pennsylvania without pre-existing conditions should be able to obtain individual health insurance policies with comparable benefits for approximately the same cost on average as the coverage under this Program.
6. Contractor will notify each applicant of eligibility or ineligibility. The notices will indicate that those applicants determined ineligible will have the right to appeal first to the Contractor making the ineligibility decision, and then to the Department, as is done now in the Pennsylvania CHIP program.
7. Contractor will bill for and collect the premium from each applicant offered coverage.
8. Contractor will maintain a list of applicants in the priority to be offered coverage under this program and offer coverage so that the total number of applicants covered does not exceed the total determined by the Department as the total number to which coverage should be provided.
9. Contractor will send notices of disenrollment to applicants granted coverage who are identified as not meeting eligibility criteria, such as failure to pay premiums. This will include the mandatory one-month grace period. The Contractor will

track and report both enrollment and disenrollment information, including the reason for disenrollment.

The Department may enter into subcontracts and/or agreements with parties for

1. A determination if the interested party is currently insured or has met the six-month go bare requirement for eligibility purposes;
2. A match with the Social Security Administration for citizenship verification purposes; and
3. Cross matches with other agencies as necessary for administration simplification purposes.

After an eligibility determination is made, and any required premium collected, the Department will communicate to Contractors the individuals eligible for enrollment in the Program to receive health insurance benefits.

C.4.3.5 DISENROLLMENT PROCESS

Program coverage will terminate and an individual will be disenrolled:

1. On the date a person is no longer a resident of this commonwealth;
2. On the date a person requests coverage to end;
3. On the death of the covered person;
4. At the option of the Program, 30 days after the Program sends to the person’s most recent address on file, an inquiry concerning the person's eligibility, including an inquiry concerning the person's residence, to which the person does not reply;
5. On the 31st day after the day on which a premium payment for Program coverage becomes due, if the payment is not made before that date;
6. At such time as the person ceases to meet the eligibility requirements of this section; or
7. The date the individual is enrolled in an exchange or this federal Act terminates, whichever is later.

An applicant who has had coverage under the Program, is terminated, and re-applies, shall be deemed a new applicant for purposes of any waiting list.

Contractor may subcontract with enrollment assistance organization for the purposes of eligibility decisions, premium collection, and other duties to be determined.

Proposal for initial enrollment

Initial enrollment, Waiting List Creation and Enrollment from the Waiting List

1. Announce the availability of the Program using the Department's website, communications through advocacy groups and press releases.
2. Begin accepting applications.
3. Contractor/Subcontractor will attempt to gather any missing data so that received incomplete applications can be handled as a complete application.
4. All completed and accepted applications submitted which are not offered enrollment because of overcapacity will be placed on the waiting list according to their assigned random number.
5. Initial enrollees will be notified that their applications have been accepted and will be instructed to submit premium payment prior to enrollment.
6. Applications received after the initial enrollment period will be ranked on the waiting list based on application completion dates.
7. The Contractor/Subcontractor will maintain a current waiting list and will answer inquiries from applications about placement on the waiting list.
8. Any waiting list is only valid until the close of Program on December 31, 2013 and shall not have any effect on transfers into existing exchanges.

Enrollment of Waiting List Applicants into the Program

Six months after the Program coverage begins, the Department, in conjunction with HHS, will re-evaluate claim and administrative costs of the Program to determine if additional individuals on the waiting list may be enrolled in the program. Thereafter on a monthly basis, enrollment offers will be made to individuals on the waiting list to maintain an adequate enrollment level if such level has decreased and funds are available for additional enrollees.

Upon notice of an offer of enrollment, an individual on the waiting list will have 30 days to submit premium payment and any additional information needed for enrollment in the Program.

Premiums

Individuals enrolling in the Program will pay a premium of $283.20.

C.4.4 CUSTOMER SERVICE STANDARDS

A successful Contractor shall:

1. Accept Program applications via Internet, paper form and over the phone including the name, address, date of birth, SSN and other information necessary to assist with the determination of eligibility, at a minimum
2. Reconcile applications for missing or inaccurate data.
3. Conduct outreach activities to identify and inform potentially eligible persons of the availability of the program for purposes of enrollment into the program in accordance with an outreach plan submitted to the Department. The Department will review and utilize the outreach plan to establish goals and standards, including but not limited to enrollment goals. Periodic reports regarding outreach efforts including results of the efforts will be required. A portion of the individuals served by the program will be minority and other underserved populations. Outreach activities must be sensitive to the culturally and ethnically diverse persons served. (Instead, the Department may rely on use of press releases and assistance from community organizations, as demand is expected to be high and funding limited.)
4. Operate a call center for plan enrollees that is appropriately staffed to provide prompt and accurate information and services.
5. Maintain a toll-free help line available to all applicants and enrollees for the purpose of providing information and for problem resolution related to eligibility

and enrollment issues as well as the selection of an insurer under this contract. The helpline must be available during customary business hours (Monday through Friday) and provisions for leaving messages must be available during non-operational hours. Bilingual, multilingual, TDD/TTY services must be provided. Calls must be logged to track and report telephone service performance areas (such as call volume, response time, live answer rate, length of time in queue, length of time on hold and abandonment rate.)

6. Maintain a website containing specific information about the Program, which is also accessible via a link from the Department's website, as well as the website designated by HHS. The website must contain the toll-free contact number for both English- and Spanish-speaking consumers with questions. At a minimum, the following items must be included on the website:
   a. Eligibility criteria for the program;
   b. Instruction on how an individual may enroll in the program;
   c. Benefit information;
   d. Premium costs;
   e. Frequently asked questions and
   f. Costs related to enrollment in the Program and utilization of services.
7. Issue written materials to applicants and enrollees. These materials include, but are not limited to, application forms, brochures, notices of eligibility determinations for enrollment and disenrollment from the Program and premium collection communications. The Department will provide direction for the content of certain types of notices and letters. All printed material should be understandable at the sixth (6th) grade level. Communications should include a tagline for Spanish-speaking members needing assistance.
8. Obtain review and approval of all marketing, outreach and written or website communications from the Department.
9. Provide information and referrals to applicants who are eligible for other available programs such as Medical Assistance, CHIP or Medicare.

10. Determine initial eligibility for insurance coverage and renew enrollees on an annual basis in accordance with requirements in Section 1101 of the federal Act and any regulations that may be promulgated by the HHS.
11. Provide sufficient personnel, staff time and technology in order to meet the demands of eligibility and enrollment procedures in a manner that ensures timely access to benefits.
12. The enrollment process will provide an eligible individual, who submits a complete enrollment request by the 15th day of the month, coverage in effect by the 1st of the following month, except in exceptional circumstances that are subject to HHS approval.
13. Provide appeals process for eligibility determination.
14. Determine initial enrollment and establish waitlist if there are more qualified applicants than available funds permit enrolling;
15. Administer waiting lists developed by the Department, if required, or freeze the application process and enrollment to assure that the federal government's costs to implement and administer the Program do not exceed the monies made available for the Program.
16. Collection of premiums. Collect a monthly premium from the eligible applicant for either the subsidized or unsubsidized component of the Program, in an amount determined by the Department in accordance with Section 1101 of the federal Act.
17. Notify each enrollee of any chance in the monthly payment amount at least thirty (30) days in advance of any change.
18. Provide Notice of Terminations as required.

C.4.5 TECHNICAL SUPPORT

Customer Service

The Department is committed to meeting the needs of customers by providing the information and assistance that they need in applying for coverage and receiving health care services. In addition to providing the health care services described in the benefit package to all enrollees, customer service is comprised of the following components and requirements:

Enrollee Helpline

Each Contractor is required to maintain a toll-free helpline available to all applicants and enrollees for the purpose of providing information and for problem resolution related to eligibility and enrollment issues. At its option, each Contractor may use the toll-free helpline as a means of offering applicants and enrollees the opportunity to apply for or renew coverage over the telephone. The helpline must be available during customary business hours (Monday through Friday) and provisions for leaving messages must be available during non-operational hours. Bilingual, multilingual, TDD/TTY services must be provided for applicants. Calls must be logged to track and report telephone service performance areas (such as call volume, response time, live answer rate, length of time in queue, length of time on hold and abandonment rate).

At a minimum, Contractors are required to staff internal help lines with individuals trained in:

1. Cultural competency;
2. Addressing the needs of special populations;
3. The services which the Contractor is required to make available to Pennsylvania's enrollees.

Contractor Website

Each Contractor is required to have a website containing specific information in English and Spanish. The website must contain a toll-free contact number for both English- and Spanish-speaking consumers with questions. At a minimum, the following items must be included on the website:

1. How to Apply;
2. Benefit Information;
3. Participating Providers;
4. Frequently Asked Questions and
5. Costs related to enrollment in the program and utilization of services.

Written Materials

Each Contractor is responsible for the issuance of written materials to applicants and enrollees. Written materials include: application forms, brochures, enrollee handbooks, notices regarding eligibility determinations, health education materials and the like. Each Contractor must use the templates provided by the Department for notices generated for applicants and enrollees. Each Contractor must use the PA Fair Care logo and program identification on all materials and correspondence sent to applicants and enrollees, in accordance with Department standards. All printed material should be understandable at the sixth (6^{th}) grade level and available in English and Spanish. At a minimum, communications should include a tagline for Spanish-speaking members needing assistance. All printed materials must also be placed through the Department's formal approval process prior to public dissemination.

To provide consistent messaging to all enrollees on a statewide basis, the Department may centralize certain correspondence at a future date. When centralization efforts occur, the Contractor(s) will be required to fully cooperate and support the effort.

1. Application and Renewal Forms - Each Contractor must use the standard application format provided by the Department in producing application and renewal materials.
2. Each Contractor may produce promotional and informational material for the Program. Such materials must be approved by the Department prior to public dissemination.
3. Enrollee Handbooks - Each Contractor must provide to each new enrollee an Enrollee Handbook that provides all the information necessary to explain benefit coverage and services, including any exclusion(s) as determined by the Department. The Department reserves the right to review and comment on the Enrollee Handbook prior to printing and distribution through its formal approval process. Any subsequent updates to the Enrollee Handbook must be submitted to the Department for review and comment prior to printing and distribution. Each

Contractor must update Enrollee Handbooks at least annually, if applicable revisions have occurred.

4. Notices of Eligibility Determinations - Contractors must provide notice regarding eligibility determinations.

Eligibility, Enrollment and Renewal Procedures

Each Contractor is required to determine initial and renewal eligibility, enroll and renew enrollees on an annual basis in accordance with statutory requirements and directives issued by the Department. Each Contractor will be required to process applications and renewals and to update enrollee information.

Each Contractor must provide sufficient personnel, staff time and technology in order to meet the demands of eligibility and enrollment procedures in a timely manner as prescribed by the Department.

Each Contractor is required to obtain standardized information, as prescribed by the Department, on the Contractors' application forms. Each Contractor may add data elements that are not related to the determination of eligibility, if the addition of the data element is related to a contractor practice for enrollment (e.g., selection of primary care practitioner).

Each Contractor must have protocols in place that identify persons who may be eligible for Medicaid categories of coverage for which federal funds are available (e.g., pregnant women, persons with temporary or permanent disabilities, patients that may require transplants). Protocols must include actions at the time of application and renewal, as well as periodic reviews of utilization data throughout the enrollment cycle.

In no instance may an eligible adult be denied enrollment or coverage on the basis of a pre-existing condition.

Identification Cards

Each Contractor will provide each enrollee with an identification card. The card must not specifically identify the holder as being in the PA Fair Care program. The Department reserves the right to review and approve identification cards prior to production and distribution.

I.D. cards should at a minimum include the following:

a) Contractor Company Name
b) Name of Enrollee
c) Name of Provider or Practice
d) Group or I.D. #
e) Phone number for provider or practice
f) Phone number for customer service
g) Copays

No personal identifying information other than the name of the individual is permitted, e.g. SSN, birth dates. This requirement is valid for both temporary and permanent ID cards.

Eligibility Review Process

Each Contractor must provide applicants and enrollees with a written notice of the opportunity for review of an adverse decision regarding ineligibility for coverage. Information about this must be included in the letters of notification regarding eligibility decisions, enrollee handbooks and application documents.

Waiting List

The Contractor will maintain a waiting list of eligible applicants who have applied for the program but who are not enrolled due to insufficient appropriations.

For applications received while the waiting list is in effect, the Contractors are required to enter all data and complete a determination of eligibility. When applicants are placed on the waiting list, the contractor must send the appropriate notice to the applicants informing them of their status and providing the options for other coverages.

C.4.6 BILLING, COLLECTING, ACCOUNTING FOR PREMIUMS

Collection of Premiums

Each Contractor is solely responsible for the collection of a monthly payment from eligible and enrolled adults. The initial monthly payment will be $283.20. The Department may adjust the monthly payment amount.

Each Contractor shall notify the applicant that he or she is eligible and invoice the applicant for his or her monthly premium. The notification shall state the date the premium must be paid, the amount to be paid and the address to which payment should be sent. Contractors will provide a 30-day grace period for the receipt of premium payments. If the payment is not received in the 30-day period, coverage will be retro terminated to the first of the month following the last month of paid coverage.

C.4.6(2) CLAIMS PAYMENT

95 percent (95%) of all eligible clean claims shall be paid within 30 days of receipt.

95 percent (95%) of individual clean claim payments for a month shall be accurate.

C.4.7 CARE MANAGEMENT

1. Quality Management and Improvement (QMI)

Quality care means all care and services meet or exceed the expectations of the client or consumer, and when patients receive all recommended evidenced-based care for their health status. Although expected outcomes for each person may be different, each feels the amount of their relief was directly related to the amount of quality care rendered by the healthcare provider. In addition, the healthcare provider strives to reduce the occurrence of undesired outcomes given the current state of their professional knowledge.

The Department is committed to requiring that individuals enrolled in the program receive quality health care services that are delivered in a cost-effective manner and to continuously improving the quality of care through:

a. Proactive interventions designed to identify and address problems relating to access and quality of care. Regular and routine analysis and reporting of collected data.

b. Development of interventions which are designed to continuously meet and improve upon established standards of care.

c. Ongoing evaluation and assessment of the overall clinical care provided.

2. Utilization Management (UM)

Utilization management is the planning, organizing, directing and coordinating of health care resources to provide medically necessary, timely and quality health care in the most cost-effective manner. The Department is committed to requiring that individuals eligible for and enrolled in the program receive medically necessary and appropriate care through a planned program of UM and review. This standard:

a) Provides for medical case management systems that are accountable to enrollees and providers that manage care across the service continuum.
b) Assesses the medical necessity and appropriate level of care of services.
c) Identifies instances and patterns of both over-utilization and under-utilization and analyzes how UM activities affect the quality of care provided.
d) Provides for the regular and routine analysis and reporting of collected data.

3. Complaint and Grievance Procedures

Each Contractor must have written policies and procedures for processing complaints and grievances pursuant to PA Act 68 and the Department's and PA DOH regulations. The standard of review for complaints, grievances and appeals shall be de novo.

Each Contractor must link its complaint and grievance system to its Quality Management and Utilization Management Program (QM/UMP) for review, corrective action, resolution, follow-up and provider re-credentialing decisions. Each Contractor must have a data system in place capable of processing, tracking, and trending all complaints and grievances.

4. General Requirements

Each Contractor utilizing provider networks must have written policies and procedures for the quality and accessibility of care being provided in its network and to monitor utilization by its providers and enrollees.

Each Contractor shall comply with the requirements set forth in Section 2191 of Pa.Act 68 (relating to compliance with national accrediting standards) and PA DOH regulations. Contractors should attach a copy of their latest NCQA certificate reflecting their accreditation status, if applicable. If no certification of accreditation status is available, provide an explanation of the circumstances that has prevented the Contractor from obtaining certification. Each Contractor will be required to submit copies of future external reviews as they occur utilizing the External Quality Review Organizations (EQRO) approved by PA DOH. Each Contractor is subject to any other standards imposed by the Department which may exceed the EQRO's requirements.

Each Contractor must have systems in place which provide for continuity of care and for case management of services in accordance with 28 Pa. Code §9.684 and Pa. Act 68.

Each Contractor must maintain and make available to the Department, upon request, studies, reports, protocols, standards, worksheets, minutes or other such documentation as may be appropriate, concerning its QMI/UMP activities and corrective actions.
Each Contractor must have written policies and procedure for maintaining the confidentiality of data and for complying with applicable state and federal laws and regulations.

5. Department Oversight

Each Contractor must agree to cooperate fully with all medical audit reviews conducted by the Department or its designee which assess the contractor's quality of care and agree to assist in the identification and collection of any data or clinical records to be reviewed by the Department. Each contractor must make data, clinical records and workspace available to the Department either electronically or manually upon request and at a site selected by the Department.

Each Contractor must submit a corrective action plan, as determined by the Department, and within timeframes established by the Department, to resolve any performance quality of care deficiencies identified as a result of the Department's evaluation. Failure to timely submit a corrective action plan may result in termination of the contract or other sanctions.

Each Contractor must obtain advance written approval from the Department before releasing or sharing with any of the other contractors, data, correspondence and/or corrective actions from the Department regarding the contractor's internal QMI/UMP.

6. **External Independent Assessment**

Each contractor must agree to cooperate fully with any authorized external evaluations and assessments of its performance under the terms of the contract. Independent assessments will include, but are not limited to, HEDIS/CAHPS reviews by IPRO or other EQROs approved by PA DOH pursuant to Pa.Act 68, and any independent evaluation required by the Department or state or federal statute or regulation.

Each Contractor must agree to assist in the identification and collection of any data or clinical records and to cooperate fully with all external medical audit reviews which assess the contractor's quality of care. Each Contractor must make data, clinical records and workspace available to the independent review team and to the Department or its designee upon request and at a site selected by the Department.

Each Contractor 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 by the independent assessor as a result of the independent evaluation and/or by the Department. Failure to timely submit a corrective action plan may result in termination of the contract or other sanctions.

C.4.8 PROCESSING AND PAYING FOR HEALTH AND PRESCRIPTION DRUG CLAIMS

The Department will contract with one or more third-party administrator services to operate the Program. The Contractor will submit to the Department its proposal for processing and paying health and prescription drug claims, including the basis for payment rates and the timeliness of payments to providers. The description will also include point-of-sale claim systems that will be utilized for prescription drug claims.

C.4.9 OUTREACH & MARKETING

The Department will develop methods to publicize the existence of the Program coverage, the eligibility requirements, and the procedures for enrollment that will include the following:

Identify name of program

   a. Develop logo
   b. Include in all communications

2. Audiences

   a. adultBasic (aB) waiting list
   b. Advocates (community-based organizations as well as individuals which focus on health care issues and the uninsured)
   c. Press (health and consumer reporters)
   d. Health insurers, brokers and legislators
   e. Insurance Department – Consumer Service Representatives
   f. Reaching Out list (Interagency and advocate group which focus on health care issues)
   g. Insurance contractors for other programs

h. Associations for chronic diseases
i. Small Business Association
j. Hospital and Medical Associations
k. Advisory Committees
l. Federally Qualified Health Centers
m. County Assistance Offices
n. Other commonwealth agencies

3. Website Communications

a. Pennsylvania Insurance Department site (under “health insurance” tab) and under federal health care reform icon (on the PA Insurance Department’s website) www.insurance.pa.gov
b. PA CHIP site www.ChipCoversPaKids.com
c. PA Governor’s site www.pa.gov
d. PA “Here to Help” site (umbrella for many services for Pennsylvania residents) www.heretohelp.pa.gov
e. Facebook – post on commonwealth’s Call Center (Policy Studies Inc.) “Help in PA” Facebook page www.facebook.com/HelpinPa

4. Print Materials/Toolkit

a. Fact Sheet for clients (TPA/networks in their area)
b. Fact sheet for advocates/ associations for chronic diseases
c. Newsletter articles (for internal and external use)
d. Create online banner ad to link to our site from other agency sites, as well as other members of the Audience list above.

5. Electronic/Online

a. aB waiting list – send an email to all individuals on the aB waiting list
b. Webinars – kick off program
c. E-blasts to existing e-mail lists
d. Banner ads if possible

Outreach

Each Contractor is required to conduct outreach activities to inform potentially eligible enrollees of the availability of the program for purposes of enrollment into the program. Each Contractor shall develop and submit to the Department for approval an Outreach Plan within one month of the effective date of the contract. The Outreach Plan must describe the strategies of the contractor to inform potential enrollees about the program and to encourage enrollment.

As directed by the Department, each successful Contractor will be required to provide periodic reports regarding outreach efforts, including results of the efforts.

C.4.10 IDENTIFYING & REPORTING INSTANCES OF 'DUMPING'

The Department will develop an application which will contain a series of questions designed specifically to identify insurance issuers or employment based health plans that might be engaged in the practice of 'dumping', i.e., discouraging 'high risk' individuals from enrolling in available coverage or remain being enrolled in current coverage. (refer to Section C.4.3.1).

The Contractor(s) shall establish a review process and procedures to track trends,. The Contractor will identify and immediately report to the Department and HHS instances where health insurance issuers or employment based health plans are suspected of violating anti-dumping provisions.

C.4.11 WASTE, FRAUD ABUSE PREVENTION, DETECTION & REPORTING

Each Contractor will establish written policies and procedures for the detection and prevention of fraud that may be committed by providers within their networks, by enrollees or by the contractor's employees.

Each Contractor will provide copies of its fraud detection and prevention policies and procedures when requested to do so by the Department.

Each Contractor will designate appropriate staff to be responsible for the proactive detection, prevention and elimination of instances or patterns of fraud or abuse involving services to enrollees.

Each Contractor will submit to the Department annual statistical and narrative reports which relate to its fraud detection and sanctioning activities where fraud has been confirmed.

Fraud detection activities must be compatible with the requirements of appropriate law enforcement agencies responsible for fraud detection and prosecution.

Each Contractor will have an affirmative responsibility to refer information or suspected fraudulent activities of Subcontractors, Providers and enrollees to relevant law enforcement agencies and shall cooperate fully with the investigation and prosecution by appropriate law enforcement agencies.

Each Contractor will require as a written provision in all contracts and/or subcontracts that the Subcontractors recognize that payments made to the Subcontractors are derived from government funds. Accordingly, Contractor shall advise all Subcontractors of the prohibitions against fraudulent activities relating to their involvement with the program. Each Contractor shall also, as a written provision in all contracts with providers, advise all Providers of the prohibitions against the submission of false or fraudulent statements and claims related to the program.

In the event of confirmation of successful prosecution of a Subcontractor or Provider related to involvement with the program, each Contractor will take action to suspend or terminate the Subcontractor or Provider. Each Contractor shall notify the Department immediately of any action being taken against a Subcontractor or Provider because of successful prosecution for fraudulent activities. Failure to report such information to the Department shall constitute a default of the contract.

In the event of successful prosecution of a Contractor for fraudulent activities relating to the program, the Department shall consider the Contractor in default of the contract.

Each Contractor will comply with the Exclusion Program of the United States Department of Health and Human Services Office of Inspector General, §1128 et seq of the Social Security Act (42 U.S.C.S. §13202-7 et seq).

The fraud and abuse requirements identified in this subsection are performance standards.

C.4.12 ROUTINE MONITORING & IDENTIFICATION OF COMPLIANCE RISK

The Contractor will monitor the performance of operations staff, processes, and systems against established standards. These programs will help to accurately and reliably provide services to enrollees and administer claims. These will be available for the Program and must include the following unless the Contractor establishes alternative measures of comparable outcomes agreed upon by the Contractor, Department and HHS:

- Pre-payment reviews will be conducted by high-dollar claim specialists on 100% of all hospital inpatient charges totaling more than $30,000 and 100% of all other charges more than $15,000.

- For all high-dollar claims exceeding $50,000 in payment to providers and for all member-payee checks of more than $2,500, an independent high-dollar pre-payment audit is conducted by the Contractor. The audit will encompass all functions supporting the claim determinations.

- Specific to the current Program, the following audits will be conducted by the Contractor:

    - Audits will be conducted of claim entry and pend analyst’s statistical accuracy and enrollee impact (enrollee impact is defined as the effect an incorrectly processed claim will have on a member’s payment).

- Audits of eligibility will be conducted to provide regular feedback to Department staff to develop specific individual quality objectives, and implement process improvements.

- Audits will be performed on all new and existing updated benefit system plan load setups to ensure accurate processing of the HRP's benefit plan provisions.

The Contractor will conduct audits of control processes and procedures. Additionally, each month, the Contractor will randomly select a statistically valid sample of processed claims to be examined for both payment and statistical processing accuracy. The sample selection will utilize a 90% confidence level and a precision level of 5%. Monthly claims samples will be selected from the population of all self-funded claims processed during the calendar month. The Contractor will also track claims turnaround time to help manage performance.

All Contractor staff will required to successfully complete a HIPAA privacy training course. In addition, all staff must sign a confidentiality agreement and participate in annual ethics and code of conduct training.

C.4.13 IMPLEMENTATION, CLAIMS HANDLING & COORDINATION OF BENEFITS

The Department will contract with one or more third-party administrator services to operate the Program. The Contractor will submit to the Department its proposal for coordination of benefits.

Claims Handling

The Contractor will comply with all claims handling procedures set forth in Act 68 of 1998 (40 P.S. §§991.2101 – 991.2193) and its accompanying regulations, 28 Pa. Code Ch. 9 and 31 Pa. Code Ch. 154 as described in the attached documents.

Expiration

The federal Act shall expire at the later of when all eligible individuals enrolled in coverage under the Program are transitioned into coverage offered through an exchange, or three months after an exchange is implemented in the commonwealth.

Transition Program

The Department will develop an effective transition into the Exchange program January 1, 2014. At this time because Pennsylvania does not operate an Exchange program, it will not be possible for us to develop a transition plan. However, as the Exchange program is developed, the Department will develop and implement an effective transition plan to move individuals from the Program into the Exchange on January 1, 2014 with no breaks in coverage.

C.5 COST PROPOSAL

The proposed budget for the Program is reflected in Table 2 on page 53. We estimate the initial enrollment will be approximately 3,470 individuals. In the final year of the program, we expect to have approximately 5,600 enrollees at a cost of approximately \$222 million and administrative expenses of approximately \$16 million. Administrative costs will include those expenses listed in Table 1 on page 52.

The Department will contract with one or more third-party administrator services (hereafter known as "Contractor") to operate a temporary health insurance program (hereafter known as "Program") for eligible individuals within the limitation of funding made available for this purpose and to perform, or subcontract, all administrative tasks necessary to operate the Program in compliance with federal law and the forthcoming final federal regulations. The Contractor may subcontract with enrollment assistance organizations (hereafter known as "Subcontractor") for the purposes of eligibility decisions, premium collection and other duties to be determined. The contractor or contractors will ensure that the administrative expenses are incurred are within the terms of the contract and that the expenses do not exceed \$16 million.

See attached attestation from the Department's actuary.

Table 1

Breakdown of Administrative Expenses by Expense Category

Expense Categories	% Expenses	2010	2011	2012	2013
Marketing & Outreach	8.1%	$ 158,049	$ 379,317	$ 379,317	$ 379,317
Member Material		Included in Marketing and Outreach			
Customer Service	10.0%	$ 195,122	$ 468,293	$ 468,293	$ 468,293
Provider Relations		Included in Customer Service			
Information Technology	18.5%	$ 360,976	$ 866,341	$ 866,341	$ 866,341
Eligibility & Enrollment	7.0%	$ 136,585	$ 327,805	$ 327,805	$ 327,805
Premium Administration		Included in Eligibility & Enrollment			
Claims Adjustment	3.3%	$ 64,390	$ 154,537	$ 154,537	$ 154,537
Appeals/Reconsideration	3.0%	$ 58,537	$ 140,488	$ 140,488	$ 140,488
Legal Services	1.2%	$ 23,415	$ 56,195	$ 56,195	$ 56,195
Accounting Services	0.9%	$ 17,561	$ 42,146	$ 42,146	$ 42,146
Actuarial Services	5.0%	$ 97,561	$ 234,146	$ 234,146	$ 234,146
Procurement	3.0%	$ 58,537	$ 140,488	$ 140,488	$ 140,488
Personnel Expenses	13.4%	$ 261,463	$ 627,512	$ 627,512	$ 627,512
Others	26.6%	$ 519,025	$1,245,659	$1,245,659	$1,245,659
Total	**100.0%**	**$ 1,951,220**	**$4,682,927**	**$4,682,927**	**$4,682,927**

Table 2

Administrative and Claims Costs

Year	Average Enrollment*	70% Enrollment in 2010	Premium Revenue Monthly	Premium Yearly	Total Claims @ $990.84 pmpm	Total subsidy	Carry Over	Administrative Costs	Total Claims against Federal Fund Allotment
					$ 990.84	$160,000,000			$ 16,000,000
					(Trended at 5%)	$144,000,000			$ 390,244
						$ 3,512,195			
2010	4,963	3,474	$ 983,865	$ 4,919,326	$ 17,211,386	$ 17,560,976	$5,268,915	$ 1,951,220	$ 14,243,280
2011	4,983		$1,672,255	$ 20,067,059	$ 62,210,682	$ 42,146,341	$ 2,719	$ 4,682,927	$ 46,826,550
2012	4,994		$1,944,098	$ 23,329,175	$ 65,465,413	$ 42,146,341	$ 10,103	$ 4,682,927	$ 46,819,165
2013	5,635		$2,511,707	$ 30,140,485	$ 77,561,571	$ 42,146,341		$ 4,682,927	$ 52,104,013
				$ 78,456,045	$ 222,449,052	$144,000,000		$ 16,000,000	$159,993,008

* - This is maximum enrollment that can be supported given the subsidy available, premiums and expected claims. .

Monthly Premium Projections:

	2010	2011	2012	2013
Premium Revenue	$ 283.20	$ 335.59	$ 389.29	$ 445.73
Rate Change		18.5%	16.0%	14.5%

Appendix A

Qualifying pre-existing conditions for purposes of enrollment in the Program.

Acromegaly
AIDS
AIDS-related complex (ARC)
Alzheimer’s
ALS, Lou Gehrig’s
Amputation
Anaplastic Carcinoma
Anemia, Aplastic
Anemia, Cooley’s/ Mediterranean/Major Thalessemia
Anemia, Cooley’s/ Mediterranean/Minor Thalessemia with symptoms
Anemia, Hemolytic, Auto-Immune
Aneurysm – Aortic, Abdominal, Thoracic
Aneurysm, Cerebral Artery (Brain) with Stint/Shunt
Angina
Angioplasty
Aortic Obstruction
Aortic Valve Stenosis
Apnea (see Sleep Apnea)
Arnold-Chiari Syndrome
Arteriosclerosis
Arteriovenous Malformation, unoperated
Arteriovenous Malformation, operated but shunt in place or with residuals
Arteritis, Necrotizing
Arthritis, Osteoarthritis severe
Arthritis, Psoriatic
Arthritis, Rheumatoid:chronic, severe or under treatment
Ascites
Atrial Fibrillation on blood thinners
Atrial Tachycardia
Asbestosis
Back sprain/strain, chronic
Banti’s Disease
Barrett’s Esophageal Ulceration
Basal Cell Skin Cancer, multiple removals in one site
Behcet’s Syndrome
Bicuspid Aortic Valve
Bipolar Disease
Bladder Stones, present
Bradycardia with pacemaker
Breast Microcalcifications– severe after biopsy or present without biopsy
Bypass Surgery – all cases
Cancer, all non-localized
Cancer, Liver
Cancer, Ovarian
Cancer, Pancreas
Cardiomyopathy
Carotid Artery Disease
Carotid Endarterectomy
Carotid Bruit
Cellulitis, Chronic
Cerebral Palsy: moderate to severe
Chemical Dependency
Chorea, Huntington’s
Chronic Obstructive Pulmonary Disease (COPD): moderate to severe or smoking
Chronic Pancreatitis
Chronic Renal Failure
Christmas Disease
Cirrhosis
Cleft Lip/Palate: unoperated \ under age 19
Coagulation Defects
Colitis, Ulcerative: unoperated or with partial colectomy
Colitis, Ulcerative with or ileostomy or colostomy
Congestive Heart Failure
Connective Tissue Disease
Cor Pulmonale
Corneal Degeneration
Corneal Ulcer: chronic and unoperated
Coronary Artery/Heart Disease
Coronary Insufficiency
Coronary Occlusion
Cretinism
Crohn’s Disease (Regional Eneritis)
Cystic Fibrosis
Cytomegalovirus
Dandy Walker Syndrome (see Hydrocephalus)
Delirium Tremens
Demyelinating Disease
Dermatomyositis
Diabetes
Diabetic Neuropathy
Diabetic Retinopathy
Dialysis
Dysplastic Nevus Syndrome
Endometriosis: symptomatic before or after surgical or natural menopause
Esophageal Ulcerations or Varicosities
Factor VIII, IX or XI Disorders/Deficiencies
Fallot’s Tetrology
Fanconi’s Syndrome
Fasciitis: chronic or recurrent
Fatty Liver
Fibromyalgia
Flexion Contracture
Friedrich’s Ataxia
Gallstones, unoperated
Gangrene, Diabetic/ Arteriosclerotic
Glomerulonephritis: Nephritis, chronic
Glomerulosclerosis
Goodpasture’s Syndrome
Gout: Tophaceous or with renal involvement
Guillain-Barre Syndrome: present or with residuals
Hamman-Rich Disease
Hansen’s Disease (Leprosy)
Heart Attack, Myocardial
Infarction within 10 years
Heart Enlargement
Heart Pacemaker
Heart Valve Replacement
Heart Valve Stenosis
Hemangioendothelioma
Hemochromatosis
Hemoglobinuria
Hemophilia
Hepatitis: all those other than A, B or E
Hepatitis: any type – present, chronic or persistent
Herpes Zoster: eye or ear involvement
Hirschsprung’s, unoperated
History of Major Organ
Transplant
Hodgkin’s Lymphoma
Huntington’s Chorea
Hyaline Membrane Disease within 2 years
Hydrocephalus

Hyperprolactinemia with tumor
Hypertension
Hypertension over weight guidelines or uncontrolled or hospitalized within 1 year
Hyperthyroidism
Hypogammaglobulinemia
Hypothyroidism
Immunodeficiency Disorder, except HIV infection
Insuliln Dependent Diabetes
Infertility treatment within past 2 years
Interstitial Cystitis
Ischemic Attack, transient
Ischemic Heart Disease
Kaposi's Sarcoma
Kidney Dialysis
Kidney Stones, present
Kimmelstiel-Wilson Syndrome
Kleinfelter's Syndrome
Leprosy (Hansen's Disease)
Leriche Syndrome
Leukemia
Lou Gehrig's Disease
Lupus Erythematous: discoid – chronic
Lupus Erythematous: systemic
Lyme's Disease: chronic or symptomatic
Lymphedema
Macular Degeneration: exudative
Major Depression
Malignant Lymphoma
Malignant Tumors
Manic Depression
Marfan's Syndrome
Metastatic Cancer
Mitral Valve Prolapse: more than trace regurgitation or not on prophylactic antibiotics
Mitral Valve Stenosis
Motor/Sensory Aphasia
Multiple Myeloma
Multiple Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Myocardial Infarction
Myotonia
Nephrectomy: persistent renal or cardiovascular abnormalities
Neuroblastoma
Neurofibromatosis
Nevus: Dysplastic Syndrome or Giant Melanocytic
Non-Hodgkin's Lymphoma
Obesity with Prior Surgery
Open Heart Surgery
Osler-Weber-Rendu Disease
Otosclerosis, unoperated
Pacemaker
Pancreatitis: recurrent or chronic or secondary to alcoholism
Paralysis: Quadraplegia, Paraplegia
Parkinson's Disease
Pelvic Inflammatory Disease (PID): present
Pemphigus
Pericarditis: constrictive
Peripheral Vascular Disease
Phlebitis, Deep Vein: present or on anti-coagulants
Pleurisy, unresolved
Pneumocystis Carinii
Polio with bladder or bowel residuals
Polyarteritis Nodosa
Polycystic Kidney
Polycystic Ovaries (Stein Levinthal Syndrome) without removal of ovaries
Polycythemia Vera
Polyp, anal or rectal: more than 4 and/or unoperated
Polyp, bladder: present or recurrent
Polyp, gastrointestinal: unoperated
Pott's Disease
Pregnancy
Primary Cardiomyopathy
Progeria
Progressive Systemic Sclerosis (Scleroderma)
Prostate Stones with Prostatitis
Psoriasis, Severe
Psoriatic Arthritis
Psychopathic Personalities
Psychotic Disorders
Pulmonary Embolism: present
Pulmonary Fibrosis
Pulmonary Hypertension
Pulmonary Osteoarthropathy
Pulmonic Stenosis
Quadriplegic Paralysis
Reiter's Syndrome: within 6 months of diagnosis
Renal Failure: chronic or end stage
Retinoblastoma
Rett's Syndrome
Rheumatic Heart Disease
Sarcoidosis
Schizophrenia
Scleroderma: recurrent, extensive or diagnosed within 1 year
Sezary's Syndrome
Shingles: eye or ear involvement
Shunts or Stints
Sick Sinus Syndrome
Sickle Cell Anemia
Sjogrens Syndrome
Sleep Apnea: obstructive or poorly controlled or requiring CPAP (continuous positive airway pressure)
Spina Bifida, Cystica:unoperated or operated with residuals
Spina Bifida, Occulta:unoperated under age 20
Spinal Curvature: Kyphosis, Scoliosis or Kyphoscoliosis, unoperated
Stein-Leventhal Syndrome (polycystic ovaries)
Stroke
Subdural Hematoma: unoperated
Superior Vena Cava Syndrome
Surrogacy Planned within 2 years with surrogate mother or applicant as surrogate
Syphilis: tertiary
Syringomyelia
Systemic Lupus Erythematous
Tabes Dorsalis
Tay-Sachs Disease
Temporal Arteritis
Temporomandibular Joint Syndrome (TMJ): operated with residuals
Tetrology of Fallot
Thalessemia Major
Thrombocytosis
Tonsillitis: chronic, recurrent (3 or more attacks per year)
Toxoplasmosis
Tracheotomy present
Transient Ischemic Attack (TIA)
Transplants: all except corneal
Transposition of the great vessels: unoperated
Treatment with AZT, HIVID or Pentamidine
Trigeminal Pulse

Tuberculosis, Epididymus Turner’s Syndrome Ulcer, Peptic: active within 2 years or H. Pylori Positive Upper Airway Resistance Syndrome Urethral Stricture: chronic, recurrent Uterine Fibroid Tumor: unoperated, moderate-tolarge size Valve Disease, Valve Replacement Varicose Veins: moderate to severe Ventricular Fibrillation Ventricular Tachycardia Von Recklinghausen’s Disease Von Willebrand’s Disease Wegener’s Granulomatosis Wilson’s Disease Wolff-Parkinson-White Syndrome: without cardiac ablation		

Appendix B

DISPUTES

a) This contract is subject to the Contract Disputes Act of 1978, as amended (41 U.S.C. 601-613).

(b) Except as provided in the Act, all disputes arising under or relating to this contract shall be resolved under this clause.

(c) "Claim," as used in this clause, means a written demand or written assertion by one of the contracting parties seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to this contract. However, a written demand or written assertion by the Contractor seeking the payment of money exceeding $100,000 is not a claim under the Act until certified. A voucher, invoice, or other routine request for payment that is not in dispute when submitted is not a claim under the Act. The submission may be converted to a claim under the Act, by complying with the submission and certification requirements of this clause, if it is disputed either as to liability or amount or is not acted upon in a reasonable time.

(d)(1) A claim by the Contractor shall be made in writing and, unless otherwise stated in this contract, submitted within 6 years after accrual of the claim to the Contracting Officer for a written decision. A claim by the Government against the Contractor shall be subject to a written decision by the Contracting Officer.

(2)(i) The Contractor shall provide the certification specified in paragraph (d)(2)(iii) of this clause when submitting any claim exceeding $100,000.

(ii) The certification requirement does not apply to issues in controversy that have not been submitted as all or part of a claim.

(iii) The certification shall state as follows: "I certify that the claim is made in good faith; that the supporting data are accurate and complete to the best of my knowledge and belief; that the amount requested accurately reflects the contract adjustment for which the Contractor believes the Government is liable; and that I am duly authorized to certify the claim on behalf of the Contractor."

(3) The certification may be executed by any person duly authorized to bind the Contractor with respect to the claim.

(e) For Contractor claims of $100,000 or less, the Contracting Officer must, if requested in writing by the Contractor, render a decision within 60 days of the request. For Contractor-certified claims over $100,000, the Contracting Officer must, within 60 days, decide the claim or notify the Contractor of the date by which the decision will be made.

(f) The Contracting Officer's decision shall be final unless the Contractor appeals or files a suit as provided in the Act.

(g) If the claim by the Contractor is submitted to the Contracting Officer or a claim by the Government is presented to the Contractor, the parties, by mutual consent, may agree to use alternative dispute resolution (ADR). If the Contractor refuses an offer for ADR, the Contractor shall inform the Contracting Officer, in writing, of the Contractor's specific reasons for rejecting the offer.

(h) The Government shall pay interest on the amount found due and unpaid from (1) the date that the Contracting Officer receives the claim (certified, if required); or (2) the date that payment otherwise would be due, if that date is later, until the date of payment. With regard to claims having defective certifications, as defined in FAR 33.201, interest shall be paid from the date that the Contracting Officer initially receives the claim. Simple interest on claims shall be paid at the rate, fixed by the Secretary of the Treasury as provided in the Act, which is applicable to the period during which the Contracting Officer receives the claim and then at the rate applicable for each 6-month period as fixed by the Treasury Secretary during the pendency of the claim.

(i) The Contractor shall proceed diligently with performance of this contract, pending final resolution of any request for relief, claim, appeal, or action arising under the contract, and comply with any decision of the Contracting Officer.