COOPERATIVE AGREEMENT
BETWEEN
PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE
AND
MEDICARE ADVANTAGE HEALTH PLAN

This agreement is effective January 1, 2014, (the "Effective Date") and is between the Commonwealth of Pennsylvania, Department of Public Welfare, Office of Medical Assistance Programs, Health and Welfare Building, Room 515, P.O. Box 2675, Harrisburg, PA 17105-2675 (the "Department") and <UPMC for You, Inc., U.S. Steel Building - 55th Floor, 600 Grant Street, Pittsburgh, PA 15219 ("Medicare Advantage Health Plan")

WHEREAS, Medicare Advantage Health Plan has entered into a Contract with the Centers for Medicare and Medicaid Services ("CMS") to provide a Medicare Advantage Health Plan for Pennsylvania residents who are dually eligible for Medicare and Medicaid ("Medicaid Advantage Health Plan Agreement"); and

WHEREAS, the Congress of the United States enacted the Medicare Improvements for Patients and Providers Act ("MIPPA") H.R. 6331 on July 15, 2008; and

WHEREAS, MIPPA requires Medicare Advantage Health Plan, dual eligible Special Needs Plan (SNP) to have a contract with the Department to provide, or arrange for the provision of, Medical Assistance benefits to members of Medicare Advantage Health Plan; and

WHEREAS, the Department and Medicare Advantage Health Plan wish to enter into such a contract.

NOW, THEREFORE, the parties to this Agreement hereby agree as follows:

I. Definitions.

Care Transitions. The movement of patients from one health care practitioner or setting to another as their condition and care needs change. This includes, but is not limited to, within settings, between settings, and across health states.

Coinsurance. A percentage of costs normally paid by a Medicare Advantage Health Plan member for medical services provided by a Medicare Advantage Health Plan. Coinsurance amounts must comply with the terms of the Medicare Advantage Health Plan Agreement.

Collaboration. A partnership or team approach to delivering measures including, but not limited to, enrollment, quality, coordination of care, long-term care placement, and monitoring, hospital admission and monitoring and appeals.

Coordination of Care. The Medicare Advantage Health Plan's collaborative efforts and mechanisms that promote increased coordination between the services provided by the Medicare Advantage Health Plan and the services provided under the Commonwealth's Medicaid State Plan.

Copayments. Fixed dollar amounts that a member of a Medicare Advantage Health Plan member normally must pay for a medical service provided by a Medicare Advantage Product. Copayment amounts must comply with the terms of the Medicare Advantage Health Plan Agreement.

Cost Sharing Obligations. Those financial payment obligations incurred by the State in satisfaction of the Deductibles, Coinsurance, Premiums, and Copayments for the Medicare Part A and Part B programs with respect to Dual Eligible Members.

Deductible. Fixed dollar amounts that a Medicare Advantage Health Plan member normally must pay out-of-pocket before the costs of services are covered by a Medicare Advantage Health Plan. Deductibles must comply with the terms of the Medicare Advantage Health Plan Agreement.

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

Dual Eligible Member. A Dual Eligible who is eligible to participate in, and is voluntarily enrolled in, the Medicare Advantage Health Plan's Dual Eligible Special Needs Medicare Advantage Plan ("Dual-SNP MA Product"). The categories of Dual Eligible Members for this Medicare Advantage Health Plan's Dual-SNP MA Product include (check boxes below):

_ Qualified Disabled and Working Individual
x Qualified Medicare Beneficiary (QMB) Only
x Qualified Medicare Beneficiary (QMB) Plus
_ Qualifying Individual
_ Specified Low-Income Medicare Beneficiary (SLMB) Only
x Specified Low-Income Medicare Beneficiary (SLMB) Plus
x Other Full Benefit Dual Eligible (FBDE)

Eligibility Verification System ("EVS"). An automated system available to Medical Assistance Providers and other specified organizations for automated verification of Medical Assistance Recipients' current and past (up to three hundred sixty-five [365] days) Medical Assistance eligibility.

Follow-Up Care. Facilitating the safe transition of patients from one level of care or provider to another through effective follow-up care activities. This includes providing patients and families timely access to key healthcare providers after an episode of care as required by a patient's condition and need(s) and communicating with patients and/or families and other healthcare providers post-transition from an episode of care.

Healthcare Provider Engagement. Demonstrating ownership, responsibility, and accountability for the care of the patient and family/caregiver at all times through: the clear identification of a patient's personal physician (primary care provider) and/or case manager; use of nationally recognized practice guidelines (evidence-based guidelines); hub of case management activities; patient and family education and counseling activities; and open and timely communication among healthcare providers, patients and families.

Information Transfer. Sharing of important care information among patient, family, caregiver and healthcare providers in a timely and effective manner through: implementation of clearly defined communication model(s); use of formal communication tool(s); and clearly identified practitioner to facilitate timely transfer of important information.

Medicaid Benefits. The healthcare covered services, items, and supplies that are included under the Pennsylvania State Plan.

Medicaid Recipient. An individual eligible for Medicaid benefits under the Pennsylvania State Plan.

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

Medicare Advantage Health Plan Affiliate. Any person or entity which directly or indirectly controls, is controlled by, or is under common control with the Medicare Advantage Health Plan.

Medication(s) Management. Ensuring the safe use of medications by patients and their families based on the patients' plan(s) of care through: assessment of the patient's medication(s) intake; patient and family education and counseling about medications; and development and implementation of a plan for medication(s) management as part of the patient's overall plan of care.

Network Provider. A hospital, physician, or other health care practitioner or other organization which has a contractual relationship with the Medicare Advantage Health Plan, or its Subcontractor, for the delivery of health services to the Medicare Advantage Health Plan's members.

Patient and Family Engagement/Education. Education and counseling of patients and families to enhance their active participation in their own care including informed decision made through: patients and families/caregiver knowledge about condition and plan of care; patient and family-centered transition communication; and development of self-care management skills.

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

Pennsylvania Open Systems Network (PosNet). The network that is used to access the Department's computer system and to send and receive files from the Department's contractors.

Providers and SNP Accountability. Enhancing the transition of care process through accountability for care of the patient by both the healthcare provider and/or SNP transitioning and receiving the patient through: clear and timely communication of the patient's plan of care; ensuring that a healthcare provider is responsible for the care of the patient at all times; and assuming responsibility for the outcomes of the care transition process by both the provider and/or SNP sending and receiving the patient.

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

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

QMB Only – QMBs who do not qualify for any additional QMB Medicaid Benefits.
QMB Plus – QMBs who also meet the financial criteria for full Medicaid coverage. QMB Plus individuals are entitled to QMB Medicaid benefits, plus all benefits available under the Pennsylvania State Plan for fully eligible Medicaid recipients.

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

Service Area. The counties in the Commonwealth of Pennsylvania where Medicare Advantage Health Plans are approved by CMS to offer service. The counties are listed in Exhibit A, "Service Area" attached hereto and incorporated herein by reference.

Specified Low-income Medicare Beneficiary (SLMB Only). A SLMB is an individual who is entitled to Medicare Part A, has income that exceeds 100% FPL but is less than 120% FPL, and whose resources do not exceed twice the SSI limit. The only Medicaid benefit a SLMB is eligible for is payment of Medicare Part B premiums. SLMBs who do not qualify for any additional Medicaid benefits are called SLMB only.

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

State. The Commonwealth of Pennsylvania.

Subcontract. Any contract between the Medicare Advantage Health Plan and an individual business or entity to perform part of or all of the Medicare Advantage Health Plan's responsibilities under this Agreement.

Subcontractor. An individual business or entity with which the Medicare Advantage Health Plan has a Subcontract.

Transition Planning. A formal process that facilitates the safe transition of patients from one level of care to another including to the patients home or from one practitioner to another through: a clearly identified practitioner/team to facilitate and coordinate the patient's transition plan(s); the management of the patient's and family's transition needs; the use of formal transition planning tools; the completion of a transition summary; and the transition of patients from Medicare to Medicaid services.

II. Term

This Agreement is effective for the contract year beginning January 1, 2014 through December 31, 2014, and shall be extended for subsequent contract years in the absence

of a notice by the Department or the Medicare Advantage Health Plan to terminate the agreement.

III. Termination

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

3.2 **Without Cause.** Either party may terminate this agreement for any reason effective at the close of the initial term or at any renewal term upon providing the other party with prior written notice of termination at least ninety (90) days in advance of the close of the then current term.

3.3 **Termination for Cause.** Either party may terminate this Agreement in the event the other party breaches any material provision of this Agreement and fails to cure or take substantial steps to cure such breach to the non-breaching party's satisfaction within twenty (20) business days of receipt of written notice of such breach. Termination shall be effective twenty (20) business days following the completion of the twenty (20) business day cure period, or such later date as determined by the party providing notice of termination.

3.4 **Obligation Upon Termination.** If the Department terminates this Agreement, it shall not be liable for any costs of the Medicare Advantage Health Plan associated with this termination, including, but not limited to, any expenditures made by the Medicare Advantage Health Plan prior to termination or related to implementation of termination.

3.5 **Termination Conditions.** The effective dates of termination under Sections 3.1-3.3 are subject to CMS regulations regarding the notification to Dual Eligible Members.

IV. Medicare Advantage Plan Obligations

4.1 **Enrollment.** Except for Dual Eligibles who are otherwise excluded under federal rules applicable to Medicare Advantage Health Plans, the Medicare Advantage Health Plan shall accept Dual Eligibles who select the Medicare Advantage Health Plan and who are qualified to receive such services under the eligibility requirements of the Medicare Advantage Health Plan's plan, without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, national origin, race, color, or religion, and shall not use any policy or practice that Medicare Advantage Health Plan knows, or should know, has the effect of such discrimination.

4.2 **Benefits.** The Medicare Advantage Health Plan shall provide the Medicare Advantage Health Plan's benefits to all Dual Eligible Members who are qualified to receive such benefits under the eligibility requirements of the Medicare Advantage Health Plan.

4.2.1 The Medicare Advantage Health Plan shall identify for Dual Eligible Members those benefits the dual eligible member may be eligible for under the state Medicaid program that are not covered services under the

Member's Medicare Advantage Health Plan. To facilitate this process, the Department will provide the Medicare Advantage Health Plan with benefit information on an annual basis, or by May of the preceding year, if CMS requires the Medicare Advantage Health Plan to provide such information in its Summary of Benefits.

4.2.2 The Medicare Advantage Health Plan shall assist in the coordination and access to needed Medicaid services, and arrange for the provision of such Medicaid services, to Dual Eligible Members. Coordination of care shall include the following for Dual Eligible Members:

(1) identification of participating Medicaid providers of Medicaid covered services, including long-term living services, in the CMS-approved service areas;
(2) help with access to needed Medicaid covered services, including long-term living services to the extent they are available to the member; and
(3) assist with the coordination of care for Medicaid covered services, including long-term living services and Medicare benefits and services.
(4) coverage and financial responsibility for all acute care services as well as pharmaceuticals excluded from Medicare Part D.

The Department shall provide to Medicare Advantage Health Plan contact and resource information for the Department's Intensive Case Management Unit, Waiver program information, and county case manager information.

4.2.3 The Medicare Advantage Health Plan shall make information available to its Network Providers regarding Medicaid so that such Network Providers may assist Dual Eligible Members to receive needed services not covered by Medicare. The Medicare Advantage Health Plan shall also inform Network Providers of the Medicaid and Medicare eligibility rules. The Medicare Advantage Health Plan shall inform Network Providers of the Medicaid benefits and Medicaid long-term living services available to Dual Eligible Members and shall provide training to Network Providers regarding Medicaid long-term care services so that members may receive needed long-term care services that are not covered by Medicare.

4.2.4 The Medicare Advantage Health Plan shall assist in the coordination of, and access to Care Transitions; including medication(s) management, transition planning, patient and family engagement/education, information transfer, follow-up care, healthcare provider engagement, and provider and SNP accountability. This shall include transitions such as: a nursing facility (NF) to the community, home and community based services (HCBS) to HCBS, HCBS to NF, hospital to NF, NF to home, HCBS to home, hospital to home, hospital to community, and any other appropriate setting as necessary.

4.3 **Enrollee Liability for Payment.** Neither the Medicare Advantage Health Plan, its Network Providers nor any of its Subcontractors may collect Medicare Cost Sharing Obligations from a Dual Eligible Member.

The Medicare Advantage Health Plan must notify its Network Providers and Subcontractors (via a provider manual, provider bulletin, or other contractual document) that they may not seek additional payments for Medicare Cost Sharing Obligations from the Department or Dual Eligible Members for health care services rendered to Dual Eligible Members. The Medicare Advantage Health Plan must provide the Department with a copy of such written notice at the address identified in Section 6.4.

4.4 **Medicaid Benefits.** The Medicare Advantage Health Plan is not obligated to provide or pay for Medicaid Benefits or Cost Sharing Obligations where the Department holds that obligation. The Department shall have no obligation to provide reimbursement or payment for any supplemental Medicaid Benefits provided by the Medicare Advantage Health Plan.

4.4.1 A list of Medicaid Benefits and HCBS Waiver Services to be identified by the Medicare Advantage Health Plan for the purposes of coordination of information for its Dual Eligible Members is attached hereto as Exhibit C.

4.5 **Medicaid Eligibility Verification.** Medicare Advantage Health Plan shall verify the Medicaid eligibility status of its Members. Information obtained by the Medicare Advantage Health Plan from the Department's Eligibility Verification System (EVS) shall not be used by the Medicare Advantage Health Plan for marketing purposes.

4.5.1 For initial verification of an individual's Medical Assistance eligibility, Medicare Advantage Health Plan shall enroll as an Out of Network Provider with the Department's EVS system or utilize the eligibility verification system (PosNet) in order to complete eligibility verifications.

4.5.2 For ongoing eligibility verification, the Medicare Advantage Health Plan shall enter into a Data Exchange Agreement with the Department or otherwise engage in an alternative verification process as approved by the Department.

4.6 **Third Party Liability Coverage Verification.** Medicare Advantage Health Plan shall provide for the Department to have access to verify a recipient's eligibility and effective dates with the Medicare Advantage Health Plan. In addition, the Medicare Advantage Health Plan shall provide the Department access to its claims payment information.

4.7 **Other Integration Initiatives.** Medicare Advantage Health Plan, in conjunction with the Department and other services, such as but not limited to local Area Agencies on Aging and Centers for Independent Living, shall collaborate further in the areas of enrollment, quality, coordination of care, long-term care placement and monitoring, hospital admission and monitoring, appeals and other areas of interest, as appropriate for its Dual Eligible members. Medicare Advantage Health Plan shall submit quarterly reports to the Office of Long-Term Living, via RA-MIPPA@pa.gov, Subject: MIPPA Reporting, identifying areas of collaboration, number of individuals assisted in each area of collaboration, and if applicable, dollars expended on such areas of collaboration (See Exhibit D).

The Medicare Advantage Health Plan will provide the Department with the following information within sixty (60) calendar days of the following developments:

a) Whether or not the Medicare Advantage Health Plan intends to expand its service areas, and if yes, what additional service areas the Plan intends to cover.
b) Any benefits provided by the Medicare Advantage Health Plan which go beyond the Medicare fee-for-service benefit package.
c) The Medicare Advantage Health Plan's Medicare cost-sharing requirements (i.e., co-payments and deductibles).
d) The Medicare Advantage Health Plan's model of care including, comprehensive risk assessment for its members and care management policies.

4.8 **Provider Information.** To the extent possible, Medicare Advantage Health Plan shall use the Medical Assistance provider listing to identify in its provider directory those Medicare Network Providers and Subcontractors who accept both Medicare and Medicaid insurances in order to meet Federal requirements and provide information to the recipient of which providers accept insurance from both Medicare and Medicaid.

The Medicare Advantage Health Plan is prohibited from using the Medical Assistance provider listing as a resource for marketing purposes. Any attempt to use the Medical Assistance provider information without obtaining explicit written approval from the Department may result in termination of this Agreement.

4.9 **Change in Service Area.** The Medicare Advantage Health Plan shall provide the Department's contact identified in Section 6.4 with written notice of the addition or deletion of a Pennsylvania service area no later than thirty (30) business days after receiving notice of such change from CMS. The notice must include the effective date of the change. In addition, the Medicare Advantage Health Plan must provide the Department's contact identified in Section 6.4 with written notice of any other change to the information set forth in the reporting template found in Exhibit A no later than thirty (30) business days after the effective date of the change.

4.10 **Health Insurance Portability and Accountability Act (HIPAA).** Medicare Advantage Health Plan agrees to comply with the terms contained in Exhibit B to this Agreement.

4.11 **Confidential Proprietary Information or Trade Secrets.** If the Medicare Advantage Health Plan submits data in accordance with Section 4.7 which it believes contains confidential proprietary information or trade secrets, a signed written statement to this effect must be provided with the data submission in accordance with 65 P.S. Section 67.707(b) in order for the data to be considered exempt under 65 P.S. Section 67.708(b) (11). Data submitted will be treated as confidential and will not be disclosed to third parties except where required by law.

4.12 **Dual Eligible Member Information.** The Medicare Advantage Health Plan shall provide the Department with member enrollment information and Medicare service utilization data. The information shall be provided to the Office of Long-Term Living in addition to the information required for section 4.6 Third Party Liability Coverage Verification. The frequency, data file format, and method of transferring data shall be agreed to by the parties to this Agreement.

V. Department Obligations

5.1 Medicaid Actively Enrolled Providers. The Department shall provide Medicare Advantage Health Plan with an electronic file of actively enrolled Medical Assistance providers on at least an annual basis. The process is to provide the Medicare Advantage Health Plan with a duplicate copy of the monthly provider file the Department shares with the Medicaid Mandatory Managed Care Plans.

5.2 Medicaid Eligibility Verification. To verify Medical Assistance eligibility prior to the point of enrollment, and on an on-going basis, in the Medicare Advantage Health Plan, the Department agrees to provide Medicare Advantage Health Plan with access to the Pennsylvania EVS.

5.3 Eligibility Verification Exchange. The Department shall provide the Medicare Advantage Health Plan with a matched eligibility verification file currently arranged for and accessed through a data exchange agreement with the Office of Income Maintenance or through some other verification methodology as new systems are developed and agreed upon by both parties.

5.4 Health Insurance Portability and Accountability Act (HIPAA). The Department agrees to comply with the terms contained in Exhibit B to this Agreement. The Department further represents that it is a "Covered Entity" as that term is defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations. The Department agrees that it will comply with all regulations under HIPAA, its accompanying regulations and protect any Protected Health Information (PHI) as the term is defined by HIPAA that the Medicare Advantage Plan sends pursuant to this Agreement.

VI. General Provisions

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

6.2 No Third Party Beneficiaries. Nothing in this Agreement is intended to, or shall be deemed or construed to create any rights or remedies in any third party.

6.3 Headings. The section headings used herein are for reference and convenience only, and shall not enter into the interpretation of this Agreement.

6.4 Notices. All notices required under this Agreement shall be in writing and sent by certified mail, return receipt requested, hand delivery or overnight delivery by a nationally recognized service to the address as follows:

If to the Medicare Advantage Health Plan:

UPMC for You, Inc.
U.S. Steel Building - 55th Floor
600 Grant Street
Pittsburgh, PA 15219

If to the Department:

Deputy Secretary Vincent Gordon
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Health and Welfare Building, Room 515
P.O. Box 2675
Harrisburg, PA 17105-2675

6.5 **Amendments.** This Agreement may be amended only in writing when signed by duly authorized representatives of each party.

6.6 **Assignment**. This Agreement and the rights and obligations of the parties under this Agreement shall be assignable, in whole or in part, by the Medicare Advantage Health Plan with (i) prior notice if to a Medicare Advantage Health Plan Affiliate and (ii) with the prior written consent of the Department.

6.7 **Modification, Amendment, or Waiver.** No provision of this Agreement may be modified, amended, or waived except by a written agreement signed by both parties to this Agreement. No course of dealing between the parties shall modify, amend, or waive any provision of this Agreement or any rights or obligations of any party under or by reason of this Agreement.

6.8 **Audit.** The Department reserves the right to inspect records.

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

6.10 **Governing Law.** This Agreement shall be construed in accordance with and governed by the laws of the Commonwealth of Pennsylvania, except to the extent pre-empted by federal law, in which case such federal law shall apply.

6.11 **Entire Agreement.** This Agreement and its Exhibits, embody the entire understanding of the parties in relation to the subject matter hereof, supersedes any prior agreements among the parties in relation to the subject matter hereof, and no other agreements, understandings, or representations, verbal or otherwise, relative to the subject matter hereof exists among the parties at the time of execution of this Agreement.

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

6.13 **Compliance with Federal and State Law.** The parties agree to comply with all relevant federal and state laws, including MIPPA.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officials.

MEDICARE ADVANTAGE HEALTH PLAN

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

MEDICARE ADVANTAGE HEALTH PLAN
UPMC for You, Inc.
U.S. Steel Building – 55th Floor
600 Grant Street
Pittsburgh, PA 15219

By: John Lovelace

Typed Name: John Lovelace

Title: President

Date: June 23, 2013

STATE AGENCY
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
P.O. Box 2675
Harrisburg, PA 17105

By: _____

Typed Name: Vincent D. Gordon

Title: Deputy Secretary, OMAP

Date: 6/26/2013

By: _____

Typed Name: _____

Title: _____

Date: _____

APPROVED AS TO FORM AND LEGALITY

Kathleen Grogan 6-27-13

Office of Chief Counsel Date
Pennsylvania Department of Public Welfare

EXHIBIT A

Service Area

(To be completed by the Medicare Advantage Health Plan.)

Please note: As stated in Section 4.9, the Medicare Advantage Health Plan shall provide the Department's contact identified in Section 6.4 with written notice of the addition or deletion of a Pennsylvania service area no later than thirty (30) business days after receiving notice of such change from the CMS. The notice must include the effective date of the change. In addition, the Medicare Advantage Health Plan must provide the Department's contact identified in Section 6.4 with written notice of any other change to the information set forth in reporting template found in Exhibit A no later than thirty (30) business days after the effective date of the change.

Reporting Template				
CMS Contract Code	**Contract Name**	**Plan ID**	**Plan Name**	**Service Area (Counties Served)**
H4279	UPMC for You, Inc.	001	UPMC *for You* Advantage	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Washington, Warren, and Westmoreland

EXHIBIT B

COMMONWEALTH OF PENNSYLVANIA
BUSINESS ASSOCIATE AGREEMENT

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

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

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

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

1. **Definitions.**
   a. "Business Associate" shall have the meaning given to such term under HIPAA, the HITECH Act, applicable regulations and agency guidance.
   b. "Covered Entity" shall have the meaning given to such term under HIPAA, the HITECH Act and applicable regulations and agency guidance.
   c. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
   d. "HITECH Act" shall mean the Health Information Technology for Economic and
   e. Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009).
   f. "Privacy Rule" shall mean the standards for privacy of individually identifiable health information in 45 C.F.R. Parts 160 and 164, as amended, and related agency guidance.
   g. "Protected Health Information" or "PHI" means any information, transmitted or recorded in any form or medium; (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and (ii) that identifies the individual or with respect to which there is a

reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA, the HITECH Act and related regulations and agency guidance. PHI also includes any and all information that can be used to identify a current or former applicant or recipient of benefits or services of Covered Entity (or Covered Entity's contractors/business associates).

h. "Security Rule" shall mean the security standards in 45 C.F.R. Parts 160, 162 and 164, as amended, and related agency guidance.

i. "Unsecured PHI" shall mean PHI that is not secured through the use of a technology or methodology as specified in HITECH regulations and agency guidance or as otherwise defined in the HITECH Act.

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

"To perform any and all of the obligations set forth in or required by this Agreement, to the greatest extent permitted by law."

NO OTHER DISCLOSURES OF PHI OR OTHER INFORMATION ARE PERMITTED.

3. **BUSINESS ASSOCIATE OBLIGATIONS:**

a) **Limits on Use and Further Disclosure Established by Agreement and Law.** Business Associate hereby agrees that the PHI provided by, or created or obtained on behalf of Covered Entity shall not be further used or disclosed other than as permitted or required by this Agreement or as required by law and agency guidance.

b) **Appropriate Safeguards.** Business Associate shall establish and maintain appropriate safeguards to prevent any use or disclosure of PHI other than as provided for by this Agreement. Appropriate safeguards shall include implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that is created, received, maintained, or transmitted on behalf of the Covered Entity and limiting use and disclosure to applicable minimum necessary requirements as set forth in applicable federal and state statutory and regulatory requirements and agency guidance.

c) **Reports of Improper Use or Disclosure.** Business Associate hereby agrees that it shall report to the Office of Long-Term Living, via RA-MIPPA@pa.gov, Subject: MIPPA Reporting, within two (2) days of discovery any use or disclosure of PHI not provided for or allowed by this Agreement.

d) **Security Incidents.** In addition to following the breach notification requirements in section 13402 of the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act") and related regulations, agency guidance and other applicable federal and state laws, Business Associate shall report to the Office of Long-Term Living via RA-MIPPA@pa.gov, Subject: MIPPA Reporting, within two (2) days of discovery any security incident of which it becomes aware. At the sole expense of Business Associate, Business Associate shall comply with all applicable federal and state breach notification requirements. Business Associate shall indemnify

the Covered Entity for costs associated with any incident involving the acquisition, access, use or disclosure of Unsecured PHI in a manner not permitted under federal or state law and agency guidance.

(e) **Subcontractors and Agents.** Business Associate hereby agrees that any time PHI is provided or made available to any subcontractors or agents, Business Associate shall provide only the minimum necessary PHI for the purpose of the covered transaction and shall first enter into a subcontract or contract with the subcontractor or agent that contains the same terms, conditions and restrictions on the use and disclosure of PHI as contained in this Agreement.

(f) **Right of Access to PHI.** Business Associate hereby agrees to allow an individual who is the subject of PHI maintained in a designated record set, to have access to and copy that individual's PHI within five (5) business days of receiving a written request from the Covered Entity. Business Associate shall provide PHI to the extent and in the manner required by 45 C.F.R. § 164.524 and other applicable federal and state law and agency guidance. If Business Associate maintains an electronic health record, Business Associate must provide the PHI in electronic format if requested. If any individual requests from Business Associate or its agents or subcontractors access to PHI, Business Associate shall notify Covered Entity of same within five (5) business days. Business associate shall further conform with and meet all of the requirements of 45 C.F.R. §164.524 and other applicable laws, including the HITECH Act and related regulations, and agency guidance.

(g) **Amendment and Incorporation of Amendments.** Within five (5) business days of receiving a request from Covered Entity for an amendment of PHI maintained in a designated record set, Business Associate shall make the PHI available and incorporate the amendment to enable Covered Entity to comply with 45 C.F.R. §164.526, applicable federal and state law, including the HITECH Act and related regulations, and agency guidance. If any individual requests an amendment from Business Associate or its agents or subcontractors, Business Associate shall notify Covered Entity within five (5) business days.

(h) **Provide Accounting of Disclosures.** Business Associate agrees to maintain a record of all disclosures of PHI in accordance with 45 C.F.R. §164.528 and other applicable laws and agency guidance, including the HITECH Act and related regulations. Such records shall include, for each disclosure, the date of the disclosure, the name and address of the recipient of the PHI, a description of the PHI disclosed, the name of the individual who is the subject of the PHI disclosed, and the purpose of the disclosure. Business Associate shall make such record available to the individual or the Covered Entity within five (5) business days of a request for an accounting of disclosures.

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

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

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

(l) **Maintenance of PHI.** Notwithstanding Section 3(k) of this Agreement, Business Associate and its subcontractors or agents shall retain all PHI throughout the term of the Agreement and shall continue to maintain the information required under the various documentation requirements of this Agreement (such as those in §3(h)) for a period of six (6) years after termination of the Agreement, unless Covered Entity and Business Associate agree otherwise.

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

(n) **Sanction Procedures.** Business Associate agrees that it shall develop and implement a system of sanctions for any employee, subcontractor or agent who violates this Agreement, applicable laws or agency guidance.

(o) **Grounds for Breach.** Non-compliance by Business Associate with this Agreement or the Privacy or Security Rules, as amended, is a breach of the Agreement, if Business Associate knew or reasonably should have known of such non-compliance and failed to immediately take reasonable steps to cure the non-compliance.

(p) **Termination by Commonwealth.** Business Associate authorizes termination of this Agreement by the Commonwealth if the Commonwealth determines, in its sole discretion that the Business Associate has violated a material term of this Agreement.

(q) **Failure to Perform Obligations.** In the event Business Associate fails to perform its obligations under this Agreement, Covered Entity may immediately discontinue providing PHI to Business Associate. Covered Entity may also, at its option, require Business Associate to submit to a plan of compliance, including monitoring by Covered Entity and reporting by Business Associate, as Covered Entity in its sole discretion determines to be necessary to maintain compliance with this Agreement and applicable laws and agency guidance.

(r) **Privacy Practices.** The Department will provide and Business Associate shall immediately begin using any applicable form, including but not limited to, any form used for Notice of Privacy Practices, Accounting for Disclosures, or Authorization, upon the effective date designated by the Program or Department. The Department retains the right to change the applicable privacy practices, documents, and forms. The Business Associate shall implement changes as soon as practicable, but not later than forty-five (45) days from the date of notice of the change.

4. OBLIGATIONS OF COVERED ENTITY:

a) **Provision of Notice of Privacy Practices.** Covered Entity shall provide Business Associate with the notice of privacy practices that the Covered Entity produces in accordance with applicable law and agency guidance, as well as changes to such notice.

b) **Permissions.** Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by individual to use or disclose PHI of which Covered Entity is aware, if such changes affect Business Associate's permitted or required uses and disclosures.

c) **Restrictions.** Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 C.F.R. §164.522 and other applicable laws and applicable agency guidance, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

EXHIBIT C

List of Medicaid State Plan Benefits and HCBS Waiver Services to be Identified by the Medicare Advantage Health Plan for Coordination Purposes

Service Category	Covered	Benefit Limits
Inpatient Acute Hospital	YES	N/A
Inpatient Rehab Hospital	YES	N/A
Inpatient Psych	YES	30 Days per Fiscal Year
Inpatient Drug & Alcohol	YES	30 Days per Fiscal Year
Emergency Room	YES	N/A
Outpatient Hospital Short Procedure Unit and Ambulatory Surgical Center	YES	N/A
Outpatient Hospital Clinic	YES	18 visits per Fiscal Year*
Outpatient Psych Clinic	YES	5 hrs psychotherapy per 30 days
Psych Partial	YES	540 hrs per Fiscal Year
Outpatient Drug & Alcohol Clinic	YES	8 hrs psychotherapy per 30 days 7 methadone visits per week 42 opiate detox visits per 365 days
Independent Medical Clinic	YES	18 visits per Fiscal Year *
Federally Qualified Health Center/Rural Health Center	YES	18 visits per Fiscal Year *
Family Planning Clinic	YES	18 visits per Fiscal Year *
Maternity – Physician, Certified Nurse Midwife, Birth Center	YES	N/A
Physician Services	YES	18 visits per Fiscal Year *
Certified Registered Nurse Practitioner Services	YES	18 visits per Fiscal Year *
Optometrist Services	YES	18 visits per Fiscal Year *
Podiatrist Services	YES	18 visits per Fiscal Year *
Renal Dialysis	YES	N/A
Hospice	YES	N/A
Skilled Nursing Facility/Long Term Care	YES	N/A
Intermediate Care Facility/Mental Retardation and Intermediate Care Facility/Other Related Conditions	YES	N/A
Laboratory	YES	N/A
Radiology (x-ray)	YES	N/A
Home Health Agency	YES	N/A
Medical Supplies	YES	Categorically Needy – unlimited Medically Needy - only in conjunction w/Home Health Agency services
Durable Medical Equipment	YES	Categorically Needy – unlimited Medically Needy - only in conjunction w/Home Health Agency services
Ambulance (emergency)	YES	N/A
Non Emergency Medical Treatment	YES	N/A

Pharmacy	YES	Categorically Needy Medically Needy- Birth Control only. Long Term Care – all legend RX
Audiologist Services	YES	under age 21 only
Case Management (Targeted Case Management)	YES	Limited to target groups
Chiropractor Services	YES	18 visits per Fiscal Year *
Dentist Services (office)	YES	Categorically Needy- N/A[2] Medically Needy- Not covered
Eyeglasses	YES	under age 21 only
Hearing Aids	YES	under age 21 only
Personal Care	YES	under age 21 only
Private Duty Nursing	YES	under age 21 only
Psychologist Services (office)	YES	under age 21 only
Residential Treatment Facility	YES	under age 21 only
Social Worker Services	YES	under age 21 only
Therapy (Speech, Language, Hearing)	YES	under age 21 only
Home and Community-Based Services	YES	Personal Assistance Services Home Health Accessibility Adaptations, Equipment, Technology, and Medical Supplies Respite Therapeutic and Counseling Services Financial Management Services Community Transition Services Personal Emergency Response System (PERS) Adult Daily Living TeleCare Non-Medical Transportation Community Integration Supported Employment Education Services Service Coordination Home Delivered Meals Prevocational Services Participant-Directed Community Supports Participant-Directed Goods and Services Residential Habilitation Structured Day Habilitation

* Combined total of specific evaluation, management and consultation procedures by physicians, podiatrists, optometrists, CRNPs, chiropractors, outpatient and independent clinics, RHCs and FQHCs. Limit applies to adults, excluding adults who are pregnant or live in a nursing facility, ICF/MR or ICF/ORC settings. A Benefit Limit Exceptions process is available.

[1] A 6 RX limit per month will apply to adults eff. 1/1/12. A Benefit Limit Exceptions process will be available.

[2] New dental limits will apply to adults eff. 9/30/11: Dental exams and prophylaxis are limited to 1 per 180 days, per recipient; crowns, endodontic and periodontal services will not be covered; and dentures will be limited to one upper arch or partial and one lower arch or partial, or one full set of dentures per lifetime. A Benefit Limit Exceptions process will be available. These dental changes do not apply to adults who live in a nursing facility, ICF/MR or ICF/ORC settings.

EXHIBIT D

Integration Initiative
Quarterly Report Template

(To be completed by the Medicare Advantage Health Plan.)
Quarterly reports are due within 45 days of the end of the reporting quarter and should be submitted to RA-MIPPA@pa.gov

<Insert Medicare Advantage Health Plan Address>
<insert current date>
<insert quarter> Quarter of <insert state fiscal year>

Pennsylvania Department of Public Welfare

Collaboration Measure	Collaboration Area		
	Individuals or Entities involved in Collaboration Measure (list)	(# individual assisted)	$ expended
Enrollment -			
Quality -			
Coordination of Care -			
Long-Term Care Placement -			
Long-Term Care Monitoring -			
Hospital Admission -			
Hospital Monitoring -			
Appeals -			

Exhibit E

Integration Initiative
Quarterly Report Definitions

Enrollment – Unique individuals who became eligible and started receiving benefits from the Medicare Advantage Health Plan during the applicable reporting period. Please list by collaboration organization/entity.

Quality - Measures that promote improved health outcomes. Measures may include, but are not limited to the following:

- **Members' needs for social support services and assistance (to delay or prevent the need for institutional placement) are met.***
- **Members' transition plans address all services necessary to safely transition the individual to the community, including at a minimum needs related to housing, transportation, availability of caregivers, and other transition needs and supports, barriers to a safe transition, and strategies to overcome those barriers.***
- **Member's who have questions related to Medicaid and/or Medicaid services are directed to the appropriate information source and have their questions answered/resolved.**
- **Members who are at high risk or who have unique, chronic or complex needs have enhanced service coordination.**

Coordination of Care – Collaborate efforts that promote increased coordination between the services provided by the Medicare Advantage Health Plan and the services provided by Medicaid.

- **Members whose service coordination team coordinates the individual's physical health, behavioral health, and long-term care needs.**
- **Providers receive training to support members to achieve independence, including knowledge of community based services and providers and knowledge of how to report Abuse, Neglect, and Exploitation. Type of training and how often provided.**
- **Members have a risk assessment and services and supports in the service plan to mitigate the risk where appropriate after discharge.**
- **Members use community resources and natural supports prior to paid services.**

Long-Term Care Placement – Collaboration during the applicable reporting period resulting in enrolled members being placed in a Medicaid Waiver program or Nursing Facility.

Long-Term Care Monitoring – Routine assessment during the applicable reporting period for enrolled members who are receiving services through a Medicaid Waiver program or Nursing Facility.

- **Providers receive training to support members to achieve independence including for individuals to achieve personal goals for transition back to the community.**
- **Members who report they do not feel safe where they currently reside.**
- **Members who wish to move from institutional care to community living transition in the setting of their choice.**

Hospital Admission – Collaboration during the applicable reporting period resulting in enrolled members being placed in a Hospital.

- **All cause readmissions such as fall risks, choice, lack of care, improper care, preventable illness, etc.**

Hospital Monitoring – Routine assessment for enrolled members who are receiving services in a hospital or hospital setting.

- **Number and percent of members who transfer from institution to a community setting who are readmitted to an institution.**

Appeals – Assistance to enrolled members for appeal rights (both Medicare and Medicaid).