2023 Program Agreement Reference	Current Language from Program Agreement	New Proposed Language *from Program Agreement*
E. Communications_(1.Open Enrollment Materials, 2.Informational/Marketing Materials)	No current language...Expanding language to this section	Separate attachment exhibit (XX) will be added to the health plans account manager's manual.
H. Administrative Services & Support_(1.Account Management and Staffing)	No current language...Add language that allows periodic non-substantive reviews to the Agreement.	Suggested language "The DEPARTMENT reserves the right to make non-substantive updates to the AGREEMENT annually without triggering an amendment approval."
K. Reporting Requirements_(2.Reporting on Compliance with Federal Mandates)	No current language…Renamed section "K. Reporting Requirements_(2. Federal Mandates)"...adding CMS CAA (Prescription Drug RxDC reporting requirement	c. In cases where the DEPARTMENT must provide federal reporting that requires data to be submitted by the CONTRACTOR, the CONTRACTOR must provide that data in the format and by the timeline requested by the DEPARTMENT.
D. Data & Information Security_(4.Data Integration and Use_e. (i) - Data Integration and Use	Pharmacy Claims Data – The CONTRACTOR must be able to accept and accommodate a daily file from the DEPARTMENT'S PBM for the CONTRACTOR'S PARTICIPANTS and integrate the data as required later in this section. The file must be in a file format compliant with the most recent Pharmacy Data Specifications provided by the DEPARTMENT in consultation with the PBM. If directed by the DEPARTMENT, the CONTRACTOR must establish a data transfer process to retrieve pharmacy claims data from the DEPARTMENT'S data warehouse for the CONTRACTOR'S PARTICIPANTS and integrate the data as required later in this section. The pharmacy claims data is based on data provided by the PBM to the DEPARTMENT'S data warehouse.	Pharmacy Claims Data – The CONTRACTOR must be able to accept and accommodate a daily file from the DEPARTMENT'S PBM for the CONTRACTOR'S PARTICIPANTS and integrate the data as required later in this section. The file must be in a file format compliant with the most recent Pharmacy Data Specifications provided by the DEPARTMENT in consultation with the PBM.
IV.G.1. Business Recovery Plan and Simulation Report	Add "Business" to clarify that a penalty is incurred after each business day not calendar day.	*One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met*
IV.G.3. Customer Service Inquiry System Certification	Add "Business" to clarify that a penalty is incurred after each business day not calendar day.	*One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met*
IV.G.4. Financial and Utilization Data Submission	Add "Business" to clarify that a penalty is incurred after each business day not calendar day.	*One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met*
IV.G.5. Financial Stability Documentation	Add "Business" to clarify that a penalty is incurred after each business day not calendar day.	*One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met*
IV.G.6. Grievance Summary Report	Add "Business" to clarify that a penalty is incurred after each business day not calendar day.	*One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met*
IV.G.8. Model Audit Rule (MAR) Certification	Add "Business" to clarify that a penalty is incurred after each business day not calendar day.	*One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met*

IV.H.1. Fraud and Abuse Review Results	Add "Business" to clarify that a penalty is incurred after each business day not calendar day.	*One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met*
IV.H.2. Contractor Quarterly Performance Report	Add "Business" to clarify that a penalty is incurred after each business day not calendar day.	*One thousand ($1,000) dollars per BUSINESS DAY for which the standard is not met*
G. Care Management_(1.a. Department Initiatives)	The CONTRACTOR is required to implement and report on the DEPARTMENT Initiatives upon request by the DEPARTMENT. DEPARTMENT Initiatives are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM PARTICIPANTS. The CONTRACTOR may coordinate with HOSPITALS, PROVIDER groups, or vendors to ensure the requirements of the DEPARTMENT Initiatives are met.	The CONTRACTOR is required to implement and report on DEPARTMENT Initiatives upon request by the DEPARTMENT. DEPARTMENT Initiatives are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM PARTICIPANTS. The DEPARTMENT may request input and collaboration from the CONTRACTOR in identifying opportunities for population health management initiatives across GHIP CONTRACTORS. The CONTRACTOR may coordinate with HOSPITALS, PROVIDER groups, or vendors to ensure the requirements of the DEPARTMENT Initiatives are met.
G. Care Management_(1. Department Initiatives_ii. High Tech Radiology)	High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.	Remove High Tech Radiology section G.1.b.ii.
G. Care Management_(1. Department Initiatives_iii. Low Back Surgery)	Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses or scenarios that require immediate or expedited orthopedic, neurosurgical, or other specialty referrals.	Remove Low Back Surgery section G.1.b.iii.
G. Care Management_(1. Department Initiatives_iv. Shared Decision Making (SDM))	The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion	Remove Shared Decision Making section G.1.b.iv.
G. Care Management_(1.Department Initiatives_v. Advance Care Planning (ACP) / Palliative Care	The CONTRACTOR must provide a credible ACP program that includes hospice care and palliative care. The CONTRACTOR must ensure ACP conversation(s) and/or palliative care consultation(s) are offered to all PARTICIPANTS with a serious disease and/or a likely survival of less than twelve (12) months.	Remove Advance Care Planning / Palliative Care section G.1.b.v.

G. Care Management_(1. Department Initiatives_vi. Monitoring of Potentially Low-Value Services)	Monitoring of Potentially Low-Value Services – The CONTRACTOR must provide reporting on select services identified by the DEPARTMENT as potentially low value to PARTICIPANTS. The DEPARTMENT will develop the list of services to be studied on an annual basis. The CONTRACTOR will provide analysis of the utilization of services and potential impact of alternate care pathways.	Remove Monitoring of Potentially Low-Value Services section G.1.b.vi.
K. Reporting Requirements_(2.Reporting on Compliance with Federal Mandates)	No current language...Renamed section "K. Reporting Requirements_(2. Federal Mandates)"...Amend health plan contract language to require vendor payment of any tax penalties, interest and fees associated with errors originating with them beginning in 2024.	d. If any action or inaction by the CONTRACTOR results in federal or state tax penalties, interest, or fees associated with errors, the CONTRACTOR is responsible to pay or reimburse the DEPARTMENT, or PARTICIPANTS, for paying them.

2023 Certificate of Coverage Reference	Current Language in the Certificate of Coverage	New Proposed Language for Certificate of Coverage
1. Glossary of Terms	No current definition for Coordination of Benefits. Review all associated sections	Suggested Definition: "**Coordination of Benefits:** means the process health plans use to determine which plan will pay first for covered medical services or prescription drugs and what the second plan will pay after the first plan has paid."
7. Member Rights & Responsibilities	Link to Patient Rights and Responsibilities	will add active links for easy access
4.F. Covered Services_(23. Hospice Care)	Further, define palliative care….Current Contract Language: Certificate of Coverage Language: **23. Hospice Care** **Hospice Care, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. Hospice Care is covered if your Primary Care Provider certifies that your life expectancy is 6 months or less and the care is palliative in nature. Hospice Care must be authorized by your Health Plan. Hospice Care includes, but is not limited to, Medical Supplies and services, counseling, bereavement counseling for one year after the patient's death, Durable Medical Equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a 6-month period if authorized by the Health Plan.** Your policy covers Advance Care Planning after you receive a terminal diagnosis, regardless of life expectancy. Advance Care Planning can include developing healthcare directives, living wills, health care proxies, and health care power of attorney. Your policy also covers a one-time, in-home palliative care consultation after a terminal diagnosis, regardless of life expectancy.	**23. Hospice Care** Hospice Care, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. Hospice Care is covered if your Primary Care Provider certifies that your life expectancy is 6 months or less and the care is palliative in nature. Hospice Care must be authorized by your Health Plan. Hospice Care includes, but is not limited to, Medical Supplies and services, counseling, bereavement counseling for one year after the patient's death, Durable Medical Equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a 6-month period if authorized by the Health Plan. **Palliative Care (New section)** • Palliative care is specialized medical care ordered by a palliative care provider for people living with an advanced life-limiting illness, focused on providing relief from the symptoms and stress of the illness. • Palliative care team may include providers such as doctors, nurses, or social workers. • These services are coordinated by a palliative care provider and must be Medically Necessary. • Prior Authorization is required for in-home palliative care services. **Palliative Care (New glossary term)** Specialized medical care for people living with an advanced life-limiting illness focused on providing relief from the symptoms and stress of the illness. **Advanced Care Planning (New section)** Your policy covers Advanced Care Planning which can include developing healthcare directives, living wills, healthcare proxies, and healthcare power of attorney.
IV.F.16. Durable Diabetic Equipment and Related Supplies	Remove "you must use the pump for thirty (30) calendar days before purchase" language.	*Durable diabetic equipment includes automated injection devices, continuous glucose monitoring devices, and insulin infusion pumps. Infusion pumps are limited to one pump in a calendar year. ~~and you must use the pump for thirty (30) calendar days before purchase.~~*
IV.F.24. Hospital Services & Inpatient Confinements	Inpatient stays to be covered until discharge by the Health Plan the member had when admitted.	*If you change Health Plans while you are Confined as an Inpatient, ~~your prior Health Plan and new Health Plan will work together to transition your care and coverage to the new Health Plan. Your Health Plans will also work to transfer you to an In-Network facility if appropriate. If transfer to an In-Network facility is not appropriate~~ , your coverage at the current facility will continue under your prior Health Plan.*
IV.F.30. Physical, Speech and Occupational Therapy	Remove language - Prior Authorization is not required for the first 50 visits. An example of this would be continued speech therapy for children. Typically, this treatment is greater than two months and improvements may not be made until several months in.	~~*These therapies benefits are only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.*~~
IV.F.17.a. Durable Medical Equipment and Medical Supplies	Prior Authorization Review in Certificate of Coverage - Remove eyes from list of prosthetics requiring authorization	*All Durable Medical Equipment purchases, or monthly rentals must have Prior Authorization as determined by your Health Plan. In addition, the following Durable Medical Equipment and Medical Supplies may require Prior Authorization by your Health Plan:* *a. Initial acquisition of artificial limbs ~~and eyes~~ , including replacements due to significant physiological changes, such as physical maturation, when medically necessary and when refitting of any existing prosthesis is not possible.*

4.F. Covered Services_(9. Cardiac Rehabilitation)	Prior Authorization Review in Certificate of Coverage - Remove "must have" and replace with "may require"...Phase I and Phase II cardiac Rehabilitation Services are covered by your Benefit Plan. Phase II services must have Prior Authorization from your Health Plan and provided in an outpatient department of a Hospital, in a medical center, or through a clinic program.	9. Cardiac Rehabilitation Phase I and Phase II cardiac Rehabilitation Services are covered by your Benefit Plan. Phase II services ~~must have~~ may require Prior Authorization from your Health Plan and provided in an outpatient department of a Hospital, in a medical center, or through a clinic program.
4.F. Covered Services_(34. Pulmonary Rehabilitation Therapy)	Prior Authorization Review in Certificate of Coverage - Remove "must have" and replace with "may require"...Phase I and Phase II pulmonary Rehabilitation Services are covered as medically necessary by your Benefit Plan when provided by physicians, therapists, and other qualified providers. Phase II services must have Prior Authorization from the Health Plan and be provided in an outpatient department of a Hospital, in a medical center, or through a clinic program.	34. Pulmonary Rehabilitation Therapy Phase I and Phase II pulmonary Rehabilitation Services are covered as medically necessary by your Benefit Plan when provided by physicians, therapists, and other qualified providers. Phase II services ~~must have~~ may require Prior Authorization from the Health Plan and be provided in an outpatient department of a Hospital, in a medical center, or through a clinic program.
1. Glossary of Terms	Prior Authorization Review in Certificate of Coverage - Prior Authorization: means obtaining approval from the Health Plan before obtaining the services. Unless otherwise indicated by the Health Plan, Prior Authorization is required for care from any Out-of-Network Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan. Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion	Prior Authorization: means obtaining approval from the Health Plan before obtaining the services. This is a request for coverage of a service or procedure. While the authorization is to a specific provider/clinic; it is for the services that provider or clinic will perform. Unless otherwise indicated by the Health Plan, Prior Authorization is required for care from any Out-of-Network Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan. Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.
Required Prior Authorizations (59 references in the Certificate of Coverage)	Prior Authorization Review in Certificate of Coverage - The following services are called out in the Certificate of Coverage as either having a "required" or "must have" prior authorization; while other services state "may require". Our recommendation is to consistently use "may require" to allow carriers to freely utilize their medical policies and procedures and programs with providers. --Back Surgeries --Bariatric Surgery --Cardiac Rehabilitation --Diagnostic Services --Pulmonary Rehabilitation Therapy --Surgical Services --Transplants	Change prior authorization language from "required" and/or "must have" to "may require".
5.Exclusion & Limitations_(A. Excluded Services_24. Vision Correction)	Vision Correction a. Eyeglasses or corrective contact lenses. b. Fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery or keratoconus. c. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens. d. Keratoefractive eye surgery is not covered by this policy, including but not limited to tangential or radial keratotomy, or laser surgeries for the correction of vision.	Vision Correction a. Eyeglasses or corrective contact lenses and fitting of those contact lenses, except lenses that are medically necessary to heal from surgery or are needed due to a malformation of or injury to the eye. b. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens. c. Keratoefractive eye surgery is not covered by this policy, including but not limited to tangential or radial keratotomy, or laser surgeries for the correction of vision.
F. Covered Services_(17. Durable Medical Equipment and Medical Supplies)	Durable Medical Equipment and Medical Supplies f. An initial external lens per eye directly related to cataract surgery (contact lens or framed lens) or keratoconus (hard contact lens).	Durable Medical Equipment and Medical Supplies f. An initial external lens per eye when determined medically necessary to heal from surgery or needed due to a malformation of or injury to the eye.