Copy

Agreement Number:
10188576000012021

Amendment # 2

PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

HealthChoices Behavioral Health Agreement

Purpose – HealthChoices Behavioral Health Agreement Between DPW and the Tuscarora Managed Care Alliance

NAME AND ADDRESS:

Melissa L. Reisinger, Executive Director
The Tuscarora Managed Care Alliance
425 Franklin Farm Lane
Chambersburg, PA 17201

Email: mlreisinger@franklincoutypa.gov
Telephone: 717-709-4332

Federal ID Number: 86-1175928
Vendor Number: 744311

AMENDMENT # 2
HEALTHCHOICES BEHAVIORAL HEALTH AGREEMENT
No. 10188576000012021

THIS AMENDMENT to the HealthChoices Behavioral Health Grant Agreement, No. 10188576000012021, by and between the Commonwealth of Pennsylvania, acting through its Department of Human Services (the Department), and The Tuscarora Managed Care Alliance (Primary Contractor) is effective January 1, 2022.

W I T N E S S E T H:

WHEREAS, the Pennsylvania Medical Assistance (MA) Program is organized under Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) and under the Pennsylvania Human Services Code, 62 P.S. § 201 et seq., to provide payment for medical services to persons eligible for MA;

WHEREAS, Section 443.5 of the Human Services Code (62 P.S. § 443.5) authorizes the Department to provide prepaid capitation payments for services to eligible MA beneficiaries;

WHEREAS, the Department submitted a waiver request to the Centers for Medicare & Medicaid Services under Section 1915(b) of the Social Security Act, 42 U.S.C. § 1396n to implement a mandatory managed care program, under the name HealthChoices Behavioral Health (HealthChoices BH Program), for MA beneficiaries in Bedford, Blair, Cambria, Carbon, Clinton, Crawford, Erie, Franklin, Fulton, Lycoming, Mercer, Monroe, Pike, Somerset and Venango Counties, (the "Counties") (the "HealthChoices Waiver");

WHEREAS, Pennsylvania's Mental Health and Intellectual Disability Act of 1966, 50 P.S. §§ 4101 et seq. (1966 MH/ID Act), Mental Health Procedures Act of 1976, 50 P.S. §§ 7101 et seq., and Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. §§ 1690.101 et seq., as amended, authorize county governments to administer a broad array of publicly funded mental health and drug and alcohol services for both MA and non-MA populations;

WHEREAS, the Commonwealth of Pennsylvania offered the Counties the right of first opportunity to administer the HealthChoices BH Program in order to coordinate behavioral health services provided under MA with other publicly funded behavioral health and human services;

WHEREAS, Franklin and Fulton Counties agreed to jointly administer the HealthChoices BH Program for residents of Franklin and Fulton Counties through the Primary Contractor;

WHEREAS, the Primary Contractor submitted a Letter of Intent with respect to its participation in the HealthChoices BH Program for the Agreement period beginning January 1, 2021;

WHEREAS, the Department entered into an agreement with the Primary Contractor to provide all HealthChoices BH Program services subject to the terms of the Agreement, its Appendices, including their appendices (collectively, the "Agreement");

WHEREAS, the Department and the Primary Contractor have agreed to various amendments to the Agreement and its Appendices; and

WHEREAS, the Department and the Primary Contractor wish to amend the Agreement effective January 1, 2022.

NOW, THEREFORE, the parties intending to be legally bound agree as follows:

1. **Amendments to Agreement.** Effective January 1, 2022, the following Agreement Appendices are amended as follows:

A. Agreement Appendix 2 HealthChoices Behavioral Health Program Standards and Requirements ("PSR") is deleted and replaced with the attached Agreement Appendix 2 PSR dated January 1, 2022. The listed Appendices to Appendix 2 PSR are amended as follows:

(1) Appendix C Addendum to Standard Contract Terms and Conditions is deleted and replaced by the attached Appendix C Addendum to Standard Contract Terms and Conditions dated January 1, 2022

(2) Appendix E Pay for Performance – Integrated Care Plan Program is deleted and replaced by the attached Appendix E Pay for Performance – Integrated Care Plan Program dated January 1, 2022

(3) Appendix F Duty to Report Fraud, Waste and Abuse to the Department is deleted and replaced by the attached Appendix F Duty to Report Fraud, Waste and Abuse to the Department dated January 1, 2022

(4) Appendix G Opioid Use Disorder Centers of Excellence is deleted and replaced by the attached Appendix G Opioid Use Disorder Centers of Excellence dated January 1, 2022

(5) Appendix H Complaint, Grievance and Fair Hearing Process is deleted and replaced by the attached Appendix H Complaint, Grievance and Fair Hearing Process dated January 1, 2022

(6) Appendix S Medical Necessity Guidelines for Intensive Behavioral Health Services (IBHS) Delivered Through Individual Services, ABA Services and Group Services is deleted and replaced by the attached Appendix S Medical Necessity Guidelines for Intensive Behavioral Health Services (IBHS) Delivered Through Individual Services, ABA Services and Group Services dated January 1, 2022

(7) Appendix T HealthChoices Behavioral Health Medical Necessity Criteria is deleted and replaced by the attached Appendix T HealthChoices Behavioral Health Medical Necessity Criteria dated January 1, 2022

(8) Appendix U Value Based Purchasing is deleted and replaced by the attached Appendix U Value Based Purchasing dated January 1, 2022

(9) Appendix V HealthChoices Behavioral Health Recipient Coverage Document is deleted and replaced by the attached Appendix V HealthChoices Behavioral Health Recipient Coverage Document dated January 1, 2022
(10) Appendix Z HealthChoices Procedures for Medical Assistance Enrollment is deleted and replaced by the attached Appendix Z HealthChoices Procedures for Medical Assistance Enrollment dated January 1, 2022
(11) Appendix AA Health Managed Care Organizations in the HealthChoices Program is deleted and replaced by the attached Appendix AA Health Managed Care Organizations in the HealthChoices Program dated January 1, 2022
(12) Appendix BB(1) Regulations and Policies Not Applicable to the HealthChoices Program is deleted and replaced by the attached Appendix BB(1) Regulations and Policies Not Applicable to the HealthChoices Program dated January 1, 2022
(13) Appendix BB(2) Regulations and Policies That Must Not Be Enforced Within HealthChoices is deleted and replaced by the attached Appendix BB(2) Regulations and Policies That Must Not Be Enforced Within HealthChoices dated January 1, 2022
(14) Appendix EE Community Based Care Management is deleted and replaced by the attached Appendix EE Community Based Care Management dated January 1, 2022
(15) Appendix FF Regional Accountable Health Councils Requirements is deleted and replaced by the attached Appendix FF Regional Accountable Health Councils Requirements dated January 1, 2022
(16) Appendix GG Pay for Performance Program is deleted and replaced by the attached Appendix GG Pay for Performance Program dated January 1, 2022

B. Appendix 1 Reinvestment Sharing Arrangement is deleted and replaced by the attached Appendix 1 Reinvestment Sharing Arrangement dated January 1, 2022.

C. Appendix 4 Rate Setting Methodology Overview is deleted and replaced by the attached Appendix 4 Rate Setting Methodology Overview dated January 1, 2022.

2. All referenced Appendices and Attachments are incorporated and made a part of the Agreement.

3. Except as explicitly modified by this Amendment, the Agreement, as amended, shall remain in full force and effect.

SECTION 1: INCORPORATION OF DOCUMENTS

1.1. Operative Documents.

A. The Primary Contractor shall perform the services as described and in conformance with this Agreement, including all appendices. These services shall be provided in conformity with:

Appendix 1 – Reinvestment Sharing Arrangement

Appendix 2 – HealthChoices Behavioral Health Program Standards & Requirements (PSR) – January 1, 2022
Appendix 3 – Rates
Appendix 4 – Rate Setting Methodology
Appendix 5 – Reserved
Appendix 6 – Medical Loss Ratio Requirements
Appendix 7 – Reserved
Appendix 8 – MCO Assessment
Appendix 9 – Commonwealth of Pennsylvania Business Associate Addendum

B. These appendices are attached and made part of this Agreement.

C. If any conflicts or discrepancies should arise in the terms and conditions of this Agreement, the order of precedence shall be first, the terms of this Agreement and secondly, the terms of the PSR.

SECTION 2: RELATIONSHIP OF PARTIES

2.1. Basic Relationship.

A. The Department and the Primary Contractor are independent contracting parties. The Primary Contractor, its employees, Subcontractors, Providers, servants, agents, and representatives are not and may not hold themselves out as employees, Subcontractors, servants, agents or representatives of the Department or the Commonwealth.

B. The Primary Contractor, its employees, servants, agents and representatives do not have the authority to bind the Department or the Commonwealth, and they shall not make any claim or demand for any right or privilege applicable to an officer or employee of the Department or the Commonwealth.

C. The Primary Contractor acknowledges that no workers' compensation or unemployment insurance coverage will be provided by the Department for the Primary Contractor or its Subcontractor's(s') employees, servants, agents and representatives.

D. The Primary Contractor will be responsible for maintaining for its employees, and for requiring of its Providers and Subcontractors, agents and representatives, workers' compensation and unemployment compensation insurance in such amounts as may be required by law or as otherwise authorized by the Department. The Primary Contractor shall provide the Department, upon the Department's request, certificates evidencing such insurance coverage.

E. Evidence of an existing governmental plan of self-insurance may be acceptable to meet this requirement.

F. The Primary Contractor has full responsibility for the withholding of federal, state, and local income taxes and other legally required taxes, contributions, and amounts from the compensation of all of its employees.

G. Nothing in this Agreement is intended to limit, modify, alter or impair, directly or indirectly, the sovereign immunities of the Commonwealth, the Department, the Counties or Primary Contractor respectively, including but not limited to sovereign immunities as applicable to their dealings with third parties.

2.2. Nature of Contract.

A. The Primary Contractor must arrange for the provision of behavioral health services to MA beneficiaries through behavioral health Providers and practitioners who are qualified, in accordance with the terms and conditions of Appendix 2 PSR and this Agreement.

B. In administering the HealthChoices BH Program, the Primary Contractor must comply fully with Appendix 2 PSR, including but not limited to the HealthChoices BH Program and financial requirements as set forth in Part II-7.

SECTION 3: APPLICABLE LAWS AND REGULATIONS AND DEPARTMENT OBLIGATIONS

3.1. Certification and Licensing.

A. The Primary Contractor must include in its contracts with its Behavioral Health Managed Care Organization (BH-MCO) and must require the BH-MCO to include in each of its contracts with Providers, provisions requiring compliance with all applicable federal and state certification and licensing laws and regulations.

B. The Primary Contractor must also include in its BH-MCO contract, and must require the BH-MCO to include in its subcontracts, provisions requiring that its BH-MCO and Providers perform services in accordance with the standard of care to which each entity or individual is held at law, and adhere to all applicable mental health and drug and alcohol program regulations, those policy directives which are sent by the Department to the Primary Contractor, and the terms of this Agreement, unless a waiver is granted by the Commonwealth.

3.2. Specific to MA Program.

A. The Primary Contractor shall participate in the MA Program and arrange for the provision of behavioral health services included in Appendix 2 PSR, and comply with all federal and Pennsylvania laws generally and specifically governing participation in the MA Program, subject to applicable waivers granted by the Commonwealth or CMS,

or any such regulations, directives or written policies, procedures or similar provisions are inapplicable in whole or in part to the Primary Contractor's obligations or rights under this Agreement.

B. The Primary Contractor shall comply with all applicable bulletins that are provided in writing to Primary Contractor, rules, and regulations established under law including, but not limited to applicable provisions of: 42 U.S.C. § 1396 et. seq.; 62 P.S. § 101 et. seq.; and applicable U.S. Department of Health & Human Services regulations, including but not limited to 42 CFR Parts 431 through 481 and 45 CFR Parts 80 and 84. The Primary Contractor shall require each BH-MCO and each Subcontractor to comply fully with this Section, and shall require that its Subcontractors require their Subcontractors and Providers to comply with same.

C. The Primary Contractor may request waivers of specific MA requirements from the Department. The Department will review such requests promptly and will not unreasonably withhold approval for appropriate waiver requests. The Primary Contractor may submit joint waiver requests to the Department. The Department will notify Primary Contractor when it grants any waivers related to the HealthChoices BH Program, or determines that any regulations, directives, or other policies, procedures, or similar provisions are inapplicable in whole or in part to the Primary Contractor's obligations or rights under this Agreement.

3.3. General Laws and Regulations.

A. The Primary Contractor must comply with Titles VI and VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et. seq. and 2000e et. seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 701 et. seq.); the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et. seq.); Title II of the Americans with Disabilities Act of 1990, as amended (42 U.S.C. § 12101 et. seq.); and the Pennsylvania Human Relations Act of 1955 (71 P.S. § 941 et. seq.), as amended; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH), the HIPAA Privacy and Security Rules, 45 CFR Parts 160, 162 and 164, Title IX of the Education of 1972 (20 U.S.C. § 1681 et. seq., Section 1557 of the Patient Protection and Affordable Care Act and Drug and Alcohol Use and Dependency Coverage Act 106 of 1989, 40 P.S.§§ 908-1 et. seq.

B. The Primary Contractor must comply with the Commonwealth's Contract Compliance Regulations set forth at 16 Pa. Code 49.101. The Primary Contractor also shall comply with all policies (which are provided in writing to the Primary Contractor), applicable laws, and regulations of the Department, the Pennsylvania Department of Health, and the Pennsylvania Insurance Department.

C. The Primary Contractor shall comply with any assessment imposed on the Primary Contractor pursuant to law. The Primary Contractor shall require its BH-MCO and each of its Subcontractors and Providers to comply fully with this Section, and to require that its Subcontractors require their Subcontractors to comply with same.

3.4. Limitation on the Department's Obligations.

A. The obligations of the Department to make payments to the Primary Contractor are limited and subject to the availability of funds appropriated by the General Assembly of the Commonwealth and certified by the Comptroller. The Primary Contractor agrees that this limitation will not discharge any of the Primary Contractor's obligations under this Agreement, except as otherwise provided.

B. If the Primary Contractor provides services under this Agreement for which the Department is unable to make timely payment due to the unavailability of funds, the Department will make all such payments that have been missed when funds become available.

3.5. Reserved.

3.6. Disclosure of Change in Circumstances by the Department.

A. The Department will notify the Primary Contractor within at least ten days of the Department's actual knowledge of a change in circumstances as follows:

(1) The Department's lack of ability or notification of a lack of ability to pay funds that the Department is required to provide in a timely manner;

(2) Withdrawal or notification to the Department of a withdrawal of some or all of the federal or Commonwealth funding available for the HealthChoices BH Program;

(3) A change or notification to the Department or CMS or other federal or state agency of a change in the requirements of the HealthChoices BH Program; and

(4) The Department's failure or notification of the failure to obtain or maintain waivers and approvals consistent with the requirements of the PSR and Letters of Intent necessary for the implementation or continuation of the HealthChoices BH Program.

3.7. Program Changes and Other Material Events Affecting Rates.

A. Amendments, revisions, or additions to the State Plan or to state or federal regulations, waiver approval terms and conditions, law, guidelines, or policies will, insofar as they materially affect the scope or nature of benefits available to eligible persons, amend the Primary Contractor's obligations as specified in this Agreement, unless the Department notifies the Primary Contractor otherwise. The Department will give written notice to the Primary Contractor 120 days prior to implementing any such amendments, revisions, or additions to the State Plan or changes in the Department's regulations,

waiver approval terms and conditions, guidelines or policies, unless such change is required to be sooner by state statute or federal law.

B. If the Department seeks to change State Plan Services covered by this Agreement or implement a Departmental initiative, the Department and Primary Contractor will adjust, as necessary, the capitation rates, consistent with Section 4.4 to reflect the increase or decrease in cost or utilization, if any, associated with the change, addition or deletion of services. Such adjustments, if warranted, shall be retroactive to the effective date of the change. In addition, should an event or events arise that are extraordinary in nature and beyond the control of the Primary Contractor, BH-MCO or the Department, upon written notice of either party to the other, the Department will adjust, as necessary, the capitation rates reflecting the increase or decrease in costs or utilization, if any associated with such event, consistent with Section 4.4.

3.8. **Capitation Payments.** The Department will pay to the Primary Contractor capitated payments at the rates set forth in Appendix 3 as updated in accordance with Sections 3.7, 4.4, and 7.1.

SECTION 4: REPRESENTATIONS AND WARRANTIES OF THE CONTRACTOR

4.1. Disclosure of Interests.

A. The Primary Contractor shall require its BH-MCO and each of its Subcontractors to provide written disclosure to the Department of information on ownership and control, prohibited affiliations under 42 CFR § 438.610, business transactions, and persons convicted of crimes in accordance with 42 CFR § 438.608 and 42 CFR Part 455, Subpart B.

B. The Primary Contractor shall disclose the above-referenced information at the following times:

(1) when the Primary Contractor submits a proposal, if any;

(2) when the Primary Contractor executes this Agreement;

(3) when the Agreement is renewed or extended; and

(4) within 35 days after any change in ownership of the BH-MCO or its Subcontractors.

C. The Primary Contractor shall require its BH-MCO and each of its Subcontractors to report to the Department a description of transactions between the BH-MCO or its subcontractor and a party in interest (as defined in 42 USC § 300e-17(b)), including the transactions, described below.

(1) Any sale or exchange or leasing of any property between the BH-MCO or its Subcontractor and such a party.

(2) Any furnishing for consideration of goods, services (including management services), or facilities between the BH-MCO or its Subcontractor and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(3) Any lending of money or other extension of credit between the BH-MCO or its subcontractor and such a party.

D. The Primary Contractor warrants that the members of its governing body, if applicable, and the governing body of its BH-MCO and its officers and directors, if applicable, and its BH-MCO's officers and directors have no interest and will not acquire any interest, direct or indirect, which conflicts with the performance of its services required by this Agreement. The Primary Contractor and its BH-MCO will not knowingly employ any person having such interest.

E. The Department may terminate this Agreement based on the Primary Contractor's or BH-MCO's failure to properly disclose required information and may recover as overpayments any payments improperly made by the Primary Contractor or its BH-MCO.

4.2. <u>Disclosure of Change in Circumstances by Primary Contractor.</u>

A. The Primary Contractor shall report to the Department, as well as the Departments of Health and Insurance, within ten business days of the Primary Contractor's notice, circumstances that may have a material adverse effect upon Primary Contractor's or its BH-MCO's, or BH-MCO's Affiliate's financial or operational conditions, including, but not limited to, the following:

(1) Suspension, or debarment, or exclusion from participating in procurement activities or exclusion from participation in federally funded healthcare programs of the Primary Contractor, BH-MCO, or BH-MCO's parent(s) or any Affiliate(s) or Related Party by any state or the federal government;

(2) Having a person who is debarred or suspended, or excluded act as a director, officer, or partner of the Primary Contractor or the BH-MCO or having a person with beneficial ownership of more than five percent of the BH-MCO's equity who has been debarred from participating in procurement activities under Federal regulations or in federally funded healthcare programs;

(3) Notice of suspension, debarment, or exclusion from participation in healthcare programs or notice of an intent to suspend, debar, or exclude issued by any state or the federal government to Primary Contractor, or BH-MCO, or BH-MCO's parent(s), or any Affiliate or Related Party;

(4) Any lawsuits or investigations by any federal or state agency involving Primary Contractor or BH-MCO, or BH-MCO's parent(s), or any Affiliate or Related Party;

(5) Any other change in circumstances during the term of this Agreement that is reasonably likely, in magnitude and scope, to have a material and adverse effect on the financial condition or operations of the Primary Contractor as a whole, or the BH-MCO, or an Affiliate or Related Party, or the ability of Primary Contractor or its BH-MCO to perform its material obligations under this Agreement.

4.3. Reserved.

4.4. Rate Setting Methodology Overview. The Department will (A) develop and implement actuarially sound rates; and (B) adjust the actuarially sound rates as provided in Section 3.7 and 3.8 in accordance with the rate setting methodology overview contained in Appendix 4. Appendix 8 MCO Assessment establishes the requirements for the MCO Assessment.

4.5. Medical Loss Ratio Reporting Requirements. The Primary Contractor shall comply with Appendix 6 which establishes requirements for the Primary Contractor's responsibility to calculate and report its medical loss ratio.

SECTION 5: ON-SITE REVIEW

5.1. On-Site Review. The Department will conduct On-Site Reviews of the Primary Contractor and its BH-MCO to assess the Primary Contractor's compliance with program requirements as defined in this Agreement that are critical to the Primary Contractor's ongoing participation in the HealthChoices BH Program.

5.2. Compliance with On-Site Review.

A. Mandatory Compliance. The Primary Contractor shall comply with the On-Site Review in accordance with Section 5.1 as a condition of participation in the HealthChoices BH Program.

B. Primary Contractor's Corrective Action.

(1) If the Department requires the Primary Contractor to submit and implement a corrective action plan, the Primary Contractor shall take all necessary steps to resolve its failure to comply as identified by the Department. The Primary Contractor shall submit for the Department's approval a corrective action plan within 15 days of written receipt of the Department's notification to the Primary Contractor of its failure to comply, unless the Department approves a time.

(2) The Department's approval of the Primary Contractor's corrective action plan will not be unreasonably withheld. If the Department does not receive an acceptable corrective action plan, or the Primary Contractor fails to implement the corrective action plan as approved by the Department on a timely basis, the Department may take any of the actions specified in Section 14.1.

SECTION 6: OBLIGATIONS OF THE PRIMARY CONTRACTOR

6.1. Program Requirements.

A. The Primary Contractor shall fully comply with the terms and conditions set forth in Appendix 2 PSR. The Primary Contractor shall submit to and shall include in its contract with its BH-MCO, a provision requiring the BH-MCO, absent a resolution by informal means, to submit to, a binding independent arbitration process in the event of a dispute between the Primary Contractor and its BH-MCO or a HealthChoices PH-MCO concerning their respective obligations pursuant to this Agreement and a HealthChoices PH-MCO agreement. The Primary Contractor, in its Member services enrollment procedures, will make no references to HealthChoices PH-MCOs, and references to HealthChoices BH-MCOs that serve as physical health contractors will designate only their behavioral health capacity.

(1) Licensure/Certification. The Primary Contractor shall comply with the requirements regarding licensure which are set forth in Appendix 2 PSR. The Primary Contractor shall only contract with a BH-MCO that possesses and maintains a current HMO or risk-bearing Preferred Provider Organization license throughout the term of this Agreement. Any entity performing utilization review for the Primary Contractor shall be certified in accordance with Department of Health regulations, 28 Pa. Code Chapter 9.

(2) Transition Plan. The Primary Contractor must have written policies and procedures to authorize care and to transition Members to Network Providers for Members who are in care on the effective date of the HealthChoices BH agreement or at the time of a change in the BH-MCO. The Primary Contractor must include protocols for authorization, denial of authorization, and transfer to alternative facilities or Providers in its policies and procedures. The Primary Contractor must provide for approval of services and inclusion of Providers in the network in those instances where disruption of services would have a significant negative impact on the Member. The Primary Contractor shall require its BH-MCO and each of its Subcontractors to comply fully with the terms and conditions of this Section.

(3) Financial. The Primary Contractor shall maintain all HealthChoices BH Program revenues and expenditures in an Enterprise or Special Revenue Fund. The Primary Contractor and the BH-MCO must have a contract specific bank account or account(s) for HealthChoices BH Program capitation transactions

and reinvestment transactions, and procedures for accurately recording, tracking and monitoring HealthChoices BH Program revenues and expenses separate from non-Behavioral HealthChoices revenues and expenses. The Primary Contractor may also be required to maintain a Restricted Reserve Account for HealthChoices BH Program equity requirements.

(4) Risk Moderation. The Primary Contractor must comply with the risk protection for high cost cases, equity requirements, and insolvency arrangement requirements set forth in Part II-7 of the PSR. The Primary Contractor must submit to the Department, for approval, the draft risk protection arrangements at least 60 days prior to January 1 of each Agreement year beginning on and after January 1, 2022.

(5) Restitution. The Primary Contractor must report to the Department within 60 days when it has identified an Overpayment of Capitation payments or other Overpayments. The Primary Contractor shall make full and prompt restitution to the Department, as directed by the Department, for Overpayments whether such Overpayment is discovered by the Primary Contractor, the Department, or other third party.

(6) Cooperation. The Primary Contractor and its BH-MCO shall cooperate fully in reporting all suspected Fraud, Waste and Abuse directly to the Department's Bureau of Program Integrity and the Commonwealth's Office of Attorney General's Medicaid Fraud Control Section as well as to the appropriate Office of Mental Health and Substance Abuse Services Field Office. In addition, the BH-MCO must cooperate fully with state detection and prosecution activities. Such cooperation shall include providing immediate access to all necessary case information including but not limited to clinical and billing information requested in the investigative process.

SECTION 7: DURATION OF AGREEMENT AND RENEWAL

7.1. Initial Term.

A. This Agreement will have an initial term of five (5) years commencing on January 1, 2022, unless sooner terminated in accordance with Section 8; and provided that no court order, administrative decision, or action by any other instrumentality of the United States Government or the Commonwealth prevents implementation of this Agreement.

B. For Agreement year Two, Agreement year Four and Agreement year Five of the Initial Term, the Department will adjust Capitation rates, if necessary, to maintain actuarial soundness based upon a material and demonstrated impact caused by any or all of the following:

(1) Changes in medical costs;

(2) Changes in utilization patterns; and

(3) Program changes as more fully described in Section 3.7 that affect the Primary Contractor's delivery or coverage of benefits.

C. The Department will notify Primary Contractor as to the proposed Capitation rates on or about three months prior to the commencement of each Agreement Year. The Department will disclose to the Primary Contractor the basis and assumptions of its determination with respect to adjustments to Capitation rates. The Department will provide Primary Contractor with a reasonable opportunity to review and comment on the proposed Capitation rates. If agreement is not reached prior to the start of an Agreement year, the rates applicable to the previous rating period will continue to apply until new rates are agreed upon and effective. If no adjustments are made, rates applicable to the previous period will apply.

D. At the Department's discretion, Capitation rates may be negotiated Agreement Year Three.

7.2. <u>Renewal.</u>

A. The Department will have the option to extend this Agreement for one additional three year period after the Initial Term. The Department will give written notice to the Primary Contractor 180 days prior to the expiration of the Initial Term as to whether it wishes to extend this Agreement as currently written or with additional terms and conditions. Any such renewal will be based upon mutual agreement of the parties. Primary Contractor shall notify the Department of its intent to renew within 45 days of the Department's notice. If the Department exercises its option to renew this Agreement, the parties will commence rate negotiations promptly after notice of the same.

B. If the Agreement is extended, prior to the Agreement Year Six, Capitation rates will be negotiated within actuarially sound rate ranges. The parties will negotiate in good faith. If no agreement is reached on Capitation rates, and the parties have not otherwise terminated this Agreement, rates applicable to the previous Agreement period will continue to apply until new rates are agreed upon and effective.

C. If the Agreement is extended, for the Agreement Years Seven and Eight, the Department will adjust Capitation rates, if necessary, to maintain actuarial soundness based upon a material and demonstrated impact caused by any one or all of the following:

(1) Changes in medical costs;

(2) Changes in utilization patterns; and

(3) Program changes as more fully described in Section 3.7 that affect the Primary Contractor's delivery or coverage of benefits.

D. If no adjustments are made, rates applicable to the previous period will apply. The Department will disclose to the Primary Contractor the basis and assumptions of its determination with respect to adjustments Capitation rates. The Department will provide Primary Contractor with a reasonable opportunity to review and comment on the proposed Capitation rates.

E. Upon expiration of the Initial Term and the extension, the Agreement then in effect will continue to be effective for a period of 120 days, if the Primary Contractor and the Department agree to a subsequent term but cannot reach resolution of subsequent terms and conditions, or if the parties have not proceeded to terminate the Agreement in accordance with Section 8.

SECTION 8: TERMINATION AND DEFAULT

8.1. **Termination by the Department.** In accordance with PSR Appendix B Standard Grant Terms and Condition, the Department may terminate this Agreement upon the happening of any of the following events and upon compliance with the notice provisions set forth below.

A. Without Cause Upon Notice. The Department may terminate this Agreement at any time upon giving 180 days prior written notice to the Primary Contractor.

B. Termination for Cause. The Department may terminate this Agreement for cause upon 45 days written notice, which notice will set forth the grounds for termination and, with the exception of termination under Section 8.1.B.(2) below will provide the Primary Contractor with 45 days in which to initiate corrective action and cure the deficiency. If corrective action is not completed to the reasonable satisfaction of the Department within the 45 day cure period, the termination will be effective at the expiration of the 45 day cure period. If the Department determines that the deficiency by its nature cannot be cured within 45 days, the Department may not terminate this Agreement provided corrective action is implemented within 45 days and the Primary Contractor diligently proceeds to completion of the corrective action. The Department may allow the Primary Contractor more than a 45-day cure period if the Department determines that Primary Contractor has demonstrated substantial progress and a substantial need for additional time. In addition to the events listed in PSR Appendix B Standard Grant Terms and Condition Default, the Department may terminate this Agreement for cause when:

(1) Primary Contractor defaults in the performance of any material duties or obligations or is in material breach of any provision of this Agreement, whether

or not such default or material breach results from an action or omission of its BH-MCO or a Subcontractor;

(2) The Primary Contractor, BH-MCO or any of its Subcontractors commits an act of theft or fraud against the Department, any other state agency, or the federal government; or

(3) An adverse material change in circumstances occurs as described in Section 4.2. If an action constituting cause for termination is the result of actions or inactions of the Primary Contractor's BH-MCO or a Subcontractor, the Primary Contractor may request approval from the Department to replace the BH-MCO, which approval will not be unreasonably withheld. If approved, the Department recognizes that the transition to a new entity may require the collateral assignment of Provider agreements to the new entity and will make a good faith effort to assist in that transition. The parties shall establish mutually agreeable protections governing the transition to the new entity. If the transition to a mutually acceptable new entity cannot be made in a mutually acceptable timeframe and manner, the Agreement will terminate pursuant to this Section 8.1.B.

C. Termination Due to Unavailability of Funds or Approvals. The Department will notify Primary Contractor in writing within 10 days of receipt of notice that any of the following events has occurred. The Department may terminate this Agreement consistent with the terms of the notice it receives concerning any of these events.

(1) Notification by the United States Department of Health and Human Services of the withdrawal of federal financial participation in all or a material part of the costs for covered services, agreements or contracts;

(2) Notification of a material unavailability of funds for the HealthChoices BH Program;

(3) Notification that the federal approvals necessary to operate the HealthChoices BH Program will not be retained; or

(4) Notification by the Pennsylvania Insurance Department or Department of Health that the authority under which the Primary Contractor's BH-MCO operates is subject to suspension or revocation proceedings or sanctions, has been suspended, limited, or curtailed to any extent, has been revoked, or has expired and will not be renewed. If an action constituting cause for termination is the result of actions or inactions of the Primary Contractor's BH-MCO or a Subcontractor, Primary Contractor may request approval from the Department to replace the BH-MCO, which approval will not be unreasonably withheld.

D. Termination Due to Force Majeure Event. The Department may terminate this Agreement if, as a result of the occurrence and continuation of a Force Majeure event as identified in PSR Appendix B Standard Grant Terms and Conditions Force Majeure, the ability of the Primary Contractor and its BH-MCO to provide services is substantially interrupted. In such event, the Department will give the Primary Contractor 30 days written notice of a termination pursuant to this Subsection, and such notice shall set forth the proposed termination date.

8.2. Termination by the Primary Contractor. The Primary Contractor may terminate this Agreement at any time upon giving at least 180 days prior written notice to the Department. The effective date of the termination will be the last day of the month in which the 180th day falls.

8.3. Responsibilities of the Parties Upon Termination.

A. Continuing Obligations. Termination of this Agreement will not discharge the obligations of the Primary Contractor with respect to services or items furnished prior to termination, including retention of records and verification of overpayments or underpayments. Termination will not discharge the Department's payment obligations incurred prior to the effective date of termination to the Primary Contractor or the Primary Contractor's payment obligations incurred prior to the effective date of termination to Subcontractors and Providers.

B. Notice to Members. If this Agreement is terminated pursuant to Sections 8.1 or 8.2 above, the Primary Contractor will notify all Members of such termination in a form and manner approved by the Department at least 45 days in advance of the effective date of termination, if practicable. The Primary Contractor shall be responsible for coordinating the continuation of care for all Members who are in active treatment in accordance with the Department's Recipient Coverage Document, Appendix V HealthChoices Behavioral Health Medical Necessity Criteria of the PSR, and as otherwise required by applicable law.

SECTION 9: RECORDS

9.1. Financial Records Retention.

A. The Primary Contractor shall maintain, and will cause its BH-MCO and its respective Subcontractors and Providers to maintain, all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity pursuant to this Agreement in accordance with Part II-5,C.6 Records Retention and Appendix W Behavioral Health Audit Clause of Appendix 2 PSR .

B. In accordance with 42 C.F.R. § 420.205, the Primary Contractor shall submit to the Department or to the Secretary of Health and Human Services or their designees, within 35 days of request, information related to the Primary Contractor's business

transactions as it relates to this Agreement which, if requested, will include complete information regarding:

(1) The Primary Contractor's or its BH-MCO ownership of any Subcontractor with whom the Primary Contractor or BH-MCO has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the Primary Contractor or its BH-MCO and any wholly owned supplier, or between the Primary Contractor or its BH-MCO and any other Provider, vendor, or Subcontractor during the five-year period ending on the date of the request.

C. The Primary Contractor shall include in its BH-MCO contracts and in its Subcontracts the requirements set forth at Section 9.1.A. and B. and require its BH-MCO to include the same in all its contracts and agreements with Subcontractors and Providers under the HealthChoices BH Program, and to require that all persons and entities with whom it contracts to comply with said provisions.

9.2. **Operational Data Reports.** The Primary Contractor must maintain, and must require its BH-MCO, its respective Subcontractors and Providers to maintain and to include in their Subcontracts and Agreements the requirement to maintain, all source records for data reports in accordance with the procedures specified in Part II-5.C.6) .c. Operational Data Reports of the PSR.

9.3. **Clinical Records Retention.** The Primary Contractor must maintain and must require its BH-MCO, its respective Subcontractors and Providers to provide all clinical records in accordance with the procedures outlined in Part II-5.C.6) .d. Clinical Records of the PSR.

9.4. **Review of Records.**

A. The Primary Contractor shall make, and shall require its BH-MCO and Subcontractors and Providers to make, all records and documents relating to the HealthChoices BH Program, including but not limited to the records referenced in this Section 9, available upon reasonable notice for audit, review, or evaluation by the Department, the Pennsylvania Office of Attorney General, the Department of Health and Human Services, CMS, the federal Office of Inspector General, the Comptroller General, or any of their duly authorized representatives. Such records will be made available on site at the Primary Contractor's chosen location subject to the Department's approval, during normal business hours, or through the mail. Further, the Primary Contractor shall make and shall require its BH-MCO and Subcontractors to provide the Department, the Pennsylvania Office of Attorney General, the Department of Health and Human Services, CMS, the federal Office of Inspector General, the Comptroller General with access to inspect the facilities and equipment where MA related activities or work is being performed. These rights to inspect and audit extend for ten years after

the expiration of the Agreement or from the date of the completion of any audit, whichever is later.

B. If the Department, the Department of Health and Human Services, CMS, the Pennsylvania Office of Attorney General, the Comptroller General, or any of their duly authorized representatives request access to records after the expiration or termination of this Agreement, or at such time that the records no longer are required to be maintained at the Primary Contractor's location, but in any case before the expiration of the period for which Primary Contractor is required to retain records, the Primary Contractor, at its own expense, will send copies of the requested records to the requesting entity within 30 days of such request.

SECTION 10: SUBCONTRACTUAL AND PROVIDER RELATIONSHIPS

10.1. Ability to Subcontract.

A. The Primary Contractor may enter into contracts with a BH-MCO and other Subcontractors to provide for and administer the behavioral health services required under this Agreement. The Department must approve any such Contract or Subcontract prior to its implementation. Such approval will not be unreasonably withheld. The Primary Contractor agrees that the execution of contracts and subcontracts shall not diminish or alter the Primary Contractor's responsibilities under this Agreement. The Primary Contractor agrees that its general and specific obligations under this Agreement will be specifically enforceable.

B. The Primary Contractor shall require its BH-MCO and each of its Subcontractors to comply fully with the terms and conditions of this Agreement and shall further cause its Subcontractors to require their Subcontractors and Providers to comply with same.

C. The Primary Contractor shall be liable to the Department if its BH-MCO or any of its Subcontractors fail to so comply with the terms of this Agreement.

10.2. Department Approval of Subcontracts and Provider Agreements.

A. Prior to program implementation, the Department will review and approve all draft Subcontracts and form Provider Agreements of the Primary Contractor and its BH-MCO for compliance with Appendix 2 PSR, including programmatic and financial provisions. Once the Department has approved such Subcontracts and form Provider Agreements, the Primary Contractor and BH-MCO must utilize the approved forms. The Department will review and approve, approve with required modifications, or disapprove all such Subcontracts and Provider Agreements in a timely manner. The Department must approve the Primary Contractor's BH-MCO contract prior to program implementation.

B. The Primary Contractor shall submit to the Department for prior approval any material modifications to its Subcontracts and form Provider Agreements at least 60 days prior to the effective date of such modifications.

C. If the Primary Contractor intends to materially change the responsibilities of its BH-MCO, the new agreement may only be effective at the beginning of an agreement period (Calendar Year or State Fiscal Year). Neither Primary Contractor nor its BH-MCO may enter into a Subcontract with any entity, licensed or unlicensed, through which risk is transferred without the prior approval of the Department.

SECTION 11: CONFIDENTIALITY

11.1. **Compliance with Federal and State Law.** The Primary Contractor and the Department shall comply with all applicable federal and state laws regarding the confidentiality of data, including clinical records and Member information. The Primary Contractor shall cause its BH-MCO and each of its Subcontractors and Providers to comply with all applicable federal and state laws regarding the confidentiality of data, including clinical records and Member information. The Primary Contractor shall and shall require its Subcontractors to comply with Appendix 9 Commonwealth of Pennsylvania Business Associate Addendum. Notwithstanding any provision in this Agreement to the contrary, for the purposes of access to confidential patient records only, the Primary Contractor and its BH-MCO will be authorized to access same on behalf of the Department.

11.2. **Primary Contractor Liability.** The Primary Contractor shall be liable for any state or federal fines, financial penalties, or damages levied upon the Department resulting from a breach of confidentiality by the Primary Contractor, including breaches by its BH-MCO, in accordance with Section 12.1.

11.3. **Primary Contractor Obligations.** The Primary Contractor shall return all data and material obtained in connection with this Agreement and its implementation, including confidential data and material, at the Department's request consistent with applicable state and federal laws regarding confidentiality. Except as needed for notice, auditing, and continuation of care purposes, no material may be used by the Primary Contractor's BH-MCO for any purpose after the expiration or termination of this Agreement. The Primary Contractor shall transfer all information to a subsequent contractor at the direction of the Department. If the Primary Contractor contracts with a BH-MCO, the Primary Contractor shall require that the BH-MCO meet the conditions of this Section.

11.4. **Nondisclosure of Proprietary Information.** The Primary Contractor considers its financial reports and information, marketing plans, Provider rates, trade secrets, information or materials relating to the Primary Contractor’s software, databases or technology, and information or materials licensed from, or otherwise subject to contractual nondisclosure rights of third parties, which would be harmful to the Primary Contractor’s competitive position to be confidential information. This information will not be disclosed by the Department to other parties except as required by law, or as may be determined by

the Department to be related to the administration and operation of the HealthChoices Program.

SECTION 12: INDEMNIFICATION AND INSURANCE

12.1. Indemnification.

A. In addition to the indemnification provisions of PSR Appendix B, Standard Terms and Conditions, the Primary Contractor shall indemnify and hold the Department and the Commonwealth, their respective employees, agents, and other contractors and representatives free and harmless against any and all liabilities, losses, settlement, claims, demands, and expenses of any kind (including but not limited to attorney's fees), which may result or arise out of any dispute with Members, subcontractors, agents, and other clients and the Primary Contractor or its agents, employees, subcontractors or representatives in the performance or omission of any act or responsibility assumed by the Primary Contractor pursuant to this Agreement.

B. In addition to the indemnification provisions of PSR Appendix B, Standard Terms and Conditions, the Primary Contractor shall indemnify and hold harmless the Department and the Commonwealth from any audit disallowance imposed by the federal government resulting from the Primary Contractor's, or its agent's, employee's, contractors, Subcontractor's, Provider's, or representative's failure to follow state or federal rules, regulations, or procedures unless prior written authorization was given by the Department. The Department will provide timely notice of any disallowance to the Primary Contractor and allow the Primary Contractor an opportunity to participate in the disallowance appeal process and any subsequent judicial review to the extent permitted by law.

C. Any payment required under this provision will be due from the Primary Contractor upon notice from the Department. This indemnification provision will not extend to disallowances which result from a determination by the federal government that the terms of this Agreement are not in accordance with federal law. The obligations under this paragraph will survive any termination or cancellation of this Agreement. The parties agree that the Primary Contractor's responsibility to indemnify the Commonwealth under this paragraph will be limited to three years from the end of each Agreement year and:

(1) This limitation will not apply to disallowances involving fraud or failure by the Primary Contractor to abide by the terms of the HealthChoices waiver issued by CMS.

(2) The Primary Contractor shall demonstrate, to the Department's satisfaction (which will not be unreasonably withheld), that the Primary Contractor has arranged for financial protection sufficient to cover the Commonwealth for any liabilities that may arise under this Subsection.

(3) The Primary Contractor shall cooperate with the Department in enforcing its indemnification provisions with its Subcontractor if an audit disallowance is asserted in the fourth or fifth year from the end of the Agreement.

D. In accordance with the indemnification provision of PSR Appendix B Standard Grant Terms and Conditions, indemnification of the Department pursuant to this provision is conditioned on the following:

(1) Pursuant to the Commonwealth Attorneys Act, Act of October 15, 1980, P.L. 950, No. 164, as amended, 71 P.S. § 732-101—732-506, the Commonwealth Office of Attorney General (OAG) has the sole authority to represent the Commonwealth in actions brought against the Commonwealth. The OAG may, however, in its sole discretion and under such terms as it deems appropriate, delegate its right of defense.

(2) The Department will give to the Primary Contractor prompt written notice of any actual claim, loss, liability, damage or expense;

(3) If OAG delegates the defense to Primary Contractor, the Department will at all times cooperate with the Primary Contractor, both in document production and personnel time;

(4) The Primary Contractor will hire and direct counsel in the defense of the Department if the OAG delegates the defense to Primary Contractor;

(5) The Primary Contractor shall, after consultation with the Department, make all decisions regarding any claim, litigation, or settlement in connection with any claim, loss, liability, damage, or expenses that may be asserted against the Department if the OAG delegates the defense to the Contractor; and

(6) Neither party shall enter into any settlement without the other party's written consent, which shall not be unreasonably withheld.

E. Notwithstanding anything to the contrary, the Primary Contractor will not be held responsible for negligent actions taken by the Department, its employees, or its agents, or actions in violation of any federal, state, or local law or breach of this Agreement by the Department.

12.2. Reserved.

SECTION 13: REPORTS AND CERTIFICATION

13.1. General Obligations.

A. The Primary Contractor shall furnish the Department with such reports as may be reasonably requested by the Department in the manner and form and time periods required by the Department. Where appropriate and for good cause shown, the Department may at its sole discretion provide the Primary Contractor a reasonable extension of time in which to comply with reporting requirements.

B. The Department may conduct periodic focused reviews, including a comprehensive annual review, to determine compliance with the terms of this Agreement.

13.2. **Audits.** The Primary Contractor shall furnish the Department with an annual audit of the HealthChoices BH Program, performed in accordance with the Department's HealthChoices Behavioral Health Audit Guide.

13.3. **Financial Reporting Requirements.** The Primary Contractor shall furnish all financial reports in the time and manner prescribed by the Department. The Primary Contractor shall submit financial reports on the Financial Reporting Requirement Forms (Appendix P HealthChoices Behavioral Health Financial Reporting Requirements of PSR) or any subsequent reporting forms issued by the Department.

13.4. **Encounter Data Reports.** The Primary Contractor must submit encounter data reports in accordance with the requirements of the PSR and in the time and manner prescribed by the Department. The Primary Contractor must maintain appropriate systems and mechanisms to obtain all necessary data from its Subcontractors and Providers to comply with the encounter data reporting requirements. The failure of a contractor, Subcontractor or Provider to provide the Primary Contractor with necessary encounter data will not excuse the Primary Contractor's compliance with this requirement.

13.5. **Data Certification.** The Primary Contractor must certify all data, as defined in 42 CFR § 438.604, submitted to the Department, whether in written or electronic form. Such certification must be submitted concurrently with the certified data and must be based on the knowledge, information and belief of the Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to the CEO or CFO according to 42 CFR Part § 438.606. The Primary Contractor shall provide the certification, via hard copy or electronic format, on the form provided by the Department.

SECTION 14: SANCTIONS

14.1. **Sanctions.** The Department may impose sanctions or liquidated damages for non-compliance with any requirement under this Agreement. The sanctions or liquidated damages that will be imposed will depend on the nature and severity of the breach, which the Department, in its reasonable discretion, will determine. Sanctions will be imposed in a progressive fashion and, with the exception of gross violations, will begin with Section 14.1.A. below:

A. Requiring the submission and implementation of a corrective action plan.

B. Imposing monetary fines of up to $1,000 per day per violation.

C. Suspension of all or a portion of payments.

D. Termination of this Agreement in accordance with Section 8.1, upon notice to the Primary Contractor.

SECTION 15: DISPUTES

15.1. **Disputes.** If a dispute arises between the parties under this Agreement, the Contracting Officer of the Department will make a determination in writing of his or her interpretation and will send to the Primary Contractor. That determination will be final, conclusive, and binding on the Primary Contractor, and unreviewable in all respects unless the Primary Contractor within 30 days of its receipt of the determination delivers a written appeal to the Secretary of Human Services. The decision of the Secretary will be final, conclusive, and binding, and the Primary Contractor will thereafter with good faith and diligence render such performance in compliance with the Secretary's determination; subject to the provisions of Section 15.2 below.

15.2. **Appeals.** Any appealable agency action regarding this Agreement shall be filed by the Primary Contractor in the Department's Bureau of Hearings and Appeals in accordance with 55 Pa. Code Chapter 41.

15.3. **Resolution.** Resolution of disputes under this Section must occur prior to any final payment of a disputed amount to the Primary Contractor.

SECTION 16: RESERVED

SECTION 17: GENERAL

17.1. **Suspension from Other Programs.** If the Primary Contractor has actual knowledge that a healthcare practitioner or Provider with whom it has an agreement is suspended or terminated from participation in the MA program of another state or from the Medicare Program, the Primary Contractor shall promptly notify the Department, in writing, of such suspension or termination. If the Primary Contractor contracts with a BH-MCO, the Primary Contractor shall require that the BH-MCO meet the conditions of this Section.

17.2. **Rights of the Parties.**

A. The rights and remedies of the Department provided in this Agreement are not exclusive and are in addition to any rights and remedies as may be provided by law or at equity.

B. Except as otherwise stated in Section 15, the rights and remedies of the Primary Contractor are not exclusive and are in addition to any rights and remedies as may be provided by law or at equity.

17.3. **Waiver.** No waiver by the Department or the Primary Contractor of a breach or default of this Agreement will be considered as a waiver of any other or subsequent breach or default.

17.4. **Invalid Provisions.** Any provision of this Agreement which is in violation of any state or federal law or regulation will be deemed amended to conform with such law or regulation pursuant to the terms of this Agreement. If such change would materially and substantially alter the obligations of the parties under this Agreement, any such provision will be renegotiated by the parties. The invalidity or non-enforceability of any terms or provisions of this Agreement will in no way affect the validity or enforceability of any other terms or provisions hereof.

17.5. **Governing Law.** This Agreement will be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania.

17.6. **Notice.** Any notice, request, demand, or other communication required or permitted hereunder will be given in writing and will be personally delivered by hand, with receipt obtained, by a national overnight express carrier (such as Federal Express), by facsimile with receipt confirmed by sender telephoning recipient, or sent by registered or certified mail, charges prepaid, to the party to be notified. All communications will be deemed given and received upon delivery or attempted delivery to the address specified herein, as from time to time amended.

The addresses for the parties for the purposes of such communication are:

To the Department:

The Department of Human Services
Office of Mental Health and Substance Abuse Services
Commonwealth Towers
P. O. Box 2675
Harrisburg, Pennsylvania 17105
Attention:
Bureau of Financial Management & Administration

With a Copy to:

The Department of Human Services

Office of General Counsel
3rd Floor, West, Health and Welfare Building
Forster and N. 7th Street
Harrisburg, Pennsylvania 17120
Attention: Chief Counsel

To the Primary Contractor:

Melissa L Reisinger, Executive Director
The Tuscarora Managed Care Alliance
425 Franklin Farm Lane
Chambersburg, PA 17202

_____

With a Copy to:

_____
_____
_____
_____
_____

17.7. **Counterparts.** This Agreement may be executed in counterparts, each of which will be deemed an original for all purposes, and all of which when taken together will constitute but one and the same instrument.

17.8. **Headings.** The section headings are for reference and convenience only and will not enter into the interpretation of this Agreement.

17.9. **Assignment.** Neither this Agreement nor any of the parties' rights hereunder will be assignable by either party without the prior written consent of the other party, which consent will not be unreasonably withheld.

17.10. **No Third-Party Beneficiaries.** This Agreement does not, nor is intended to, create any rights, benefits, or interest to any third party, person, or organization.

17.11. **Entire Agreement: Modification.** This Agreement constitutes the entire understanding of the parties and supersedes any and all written or oral agreements, representations, or understandings. No modifications, discharges, amendments, or alterations, with the exception of Program Changes as defined in Section 3.7 of this Agreement, will be effective unless evidenced by an instrument in writing signed by both parties. Furthermore, neither this Agreement nor any modifications, discharges, amendments, or alterations will be considered executed by or binding upon the Department or the Commonwealth unless

and until signed by a duly authorized officer of the Department or Commonwealth and all approvals required by Commonwealth procurement rules have been obtained.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.

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

PROVIDER		
11/15/2021	11/15/2021	11/15/2021
SIGNATURE DATE	SIGNATURE DATE	SIGNATURE DATE
PRINT OR TYPE NAME & TITLE	PRINT OR TYPE NAME & TITLE	PRINT OR TYPE NAME & TITLE
John Flannery, TMCA Board Chairman	David Keller, TMCA Board Treasurer	Melissa Reisinger, TMCA Executive Director

ATTEST: Signature at County Legal Counsel (When Required)	Department of General Services, Secretary (When Required)
SIGNATURE DATE	SIGNATURE DATE

PROGRAM DEPUTY SECRETARY-DEPARTMENT OF HUMAN SERVICES

11/15/21

SIGNATURE DATE

COMPTROLLER-DEPARTMENT OF HUMAN SERVICES
I hereby certify that funds in the amount shown are available under appropriation symbols shown.

AMOUNT	SOURCE	APPROPRIATION SYMBOL	PROGRAM

Ann Lefevre Digitally signed by Ann Lefevre Date: 2022.01.20 11:13:02 -05'00'

SIGNATURE DATE

Approved as to Legality and Form		
Digitally signed by Lara Antonuk Date: 2021.12.17 14:44:58 -05'00'	Digitally signed by David E. Stover Date: 2022.01.14 15:02:03 -05'00'	2022.01.03 14:47:16 -05'00'
SIGNATURE DATE	SIGNATURE DATE	SIGNATURE DATE
Chief Counsel Department of Human Services	Deputy Attorney General Office of the Attorney General	Office of General Counsel (when required)

SECRETARY-DEPARTMENT OF HUMAN SERVICES

Ally Wullbrandt Digitally signed by Ally Wullbrandt Date: 2021.11.24 13:05:47 -05'00'

SIGNATURE DATE

Other Signatures as Required with Title	COMPTROLLER FOR BUDGET SECRETARY
SIGNATURE DATE	SIGNATURE DATE

APPENDIX 1

REINVESTMENT SHARING ARRANGEMENT

I. The Department will recoup any Reinvestment savings from the Primary Contractor in excess of 3% of total HealthChoices BH Capitation revenue, net of any assessment imposed on the Primary Contractor pursuant to law and any Integrated Care Plan (ICP) Program incentive funds received, in accordance with Section IIIC. below. The Reinvestment Sharing arrangement was established by the Department to measure net income and is different from a Medical Loss Ratio calculation, which measures the percentage of capitation revenue that a Primary Contractor spends on service claims, quality improvements and related activities.

II. The Agreement Period is January 1 – December 31.

III. Reinvestment sharing calculations will include all rate cells, with a Reinvestment sharing calculation being done for each rate cell separately. The total will be based on the sum of the results for each rate cell. The manner in which Reinvestment Funds are calculated is intended to be substantially in accordance with and continue in the manner in which Reinvestment funds have been previously calculated.

a. The Department will provide the Primary Contractor with an initial Reinvestment sharing calculation for costs incurred and revenue paid for eligible rate cells during each Agreement period after receipt of the Annual Behavioral Health Contract Audit. The initial calculation will be based on audited financial reports and the Department's own revenue records as follows:

1. Total Capitation Revenue paid for dates of service within the applicable Agreement period for each eligible rate cell will be taken from the Department's revenue records.

2. Net Capitation Revenue will be calculated by taking Total Capitation Revenue above, reduced by the amount of any assessment imposed on the Primary Contractor pursuant to law and any ICP Program incentive funds received included in the revenue for each Agreement period. Net Capitation Revenue is the difference between 100% of the total Capitation payments, less the administrative add-on percentage applicable to any assessment imposed on the Primary Contractor pursuant to law and any ICP Program incentive funds received. Total Expenses incurred during each Agreement period for all expenses provided under the Agreement by rate cell will be taken from the Annual Behavioral Health Contract Audited Report #2 and Report #9.

3. Net Capitation Revenue will be multiplied by 0.03 (3%). The result is the Maximum Retained Revenue, or the amount of Reinvestment savings that will be retained by the Primary Contractor.

4. Total Expenses will be deducted from the sum of Net Capitation Revenue and Investment Revenue from Report #2, resulting in Reinvestment savings.

Reinvestment savings will be reduced by any amount from the Reinvestment savings approved by the Department for transfer to Risk and Contingency or Restricted Reserve, up to the maximum permitted, for the Agreement Period, as applicable. The results, by eligible rate cell, will be added in total. The results will be compared to Maximum Retained Revenue as calculated in A.3 above.

5. The Department will provide written notification, including due date and remittance instructions, of any amount in excess of the Maximum Retained Revenue to be returned to the Department.

B. The Department will provide the Primary Contractor with a final Reinvestment sharing calculation and reconciliation within 60 days following receipt of all relevant Person Level Encounter (PLE) data, including PLE data submissions covering the payments made following the end of the applicable Agreement period (number of months of payment runout determined by DHS) as follows:

1. Total Capitation Revenue paid for dates of service within the applicable Agreement period for each eligible rate cell will be taken from the Department's revenue records.

2. Net Capitation Revenue will be calculated by taking Total Capitation Revenue above, reduced by the amount of any assessment imposed on the Primary Contractor pursuant to law and any ICP Program incentive funds received included in the revenue for each Agreement period. Net Capitation Revenue is the difference between 100% of the total Capitation payments, less the administrative add-on percentage applicable for any assessment imposed on the Primary Contractor pursuant to law and any ICP Program incentive funds received.

3. Total Primary Contractor Administrative expenses, including any allowable administrative costs and/or Department approved incentive distribution to subcontractors, as applicable, will be taken from the HealthChoices Annual Contract Audit.

4. Total Medical Expenses, including all adjustments, incurred during each Agreement period for all eligible rate cells will be determined. The Department will use completion factors to adjust the PLE data to reflect encounters for service dates within the Agreement period that have not been reported. Total Medical Expenses will include State Plan Services, Department approved cost effective alternatives that are included in the rate base (if any) and all other medical services provided under the Agreement. The Department will calculate Total Expenses based on the adjusted PLE data, any alternative payment arrangements, and financial reports.

5. Net Capitation Revenue will be multiplied by 0.03 (3%). The result is the Maximum Retained Revenue, or the amount of Reinvestment savings that will be retained by the Primary Contractor.

6. Total Expenses will be deducted from the sum of Net Capitation Revenue and Investment Revenue from Report #2, resulting in Reinvestment savings. Reinvestment savings will be reduced by any amount from the Reinvestment savings approved by the Department for transfer to Risk and Contingency or Restricted Reserve, up to the maximum permitted, for the Agreement Period, as applicable. In order for the Risk & Contingency transfers to be included in the calculation, they must be approved prior to 12 months after the end of the Agreement year. The results will be compared to Maximum Retained Revenue as calculated in B.5. above.

7. After the final Reinvestment sharing calculation is completed, the Department will reconcile any amounts owed to, or due from, the Primary Contractor, as applicable. The Primary Contractor will have 30 days to review the Department's calculation and provide comments.

8. The Department will provide the Primary Contractor with written notification of the final Reinvestment sharing calculation and process for remittance or refund, as applicable.

9. The Department may reexamine the Reinvestment sharing calculation at a later date based on material changes, if any, subsequently made to the medical expenses reported on the audited, Financial Report #9 or in the PLE data. Refunds of previously returned Reinvestment Sharing funds cannot be made more than two (2) years after the end of the Agreement period.

1.

2.

Appendix 2

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HUMAN SERVICES

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

PROGRAM STANDARDS AND REQUIREMENTS

PRIMARY CONTRACTOR

Appendices

HealthChoices Behavioral Health Definitions

Abuse – Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to the Medical Assistance program, BH-MCO, Primary Contractor, a Subcontractor, or Provider, or a practice that results in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or agreement obligations (including the Agreement, contracts, guidance issued in bulletins, and the requirements of State and Federal statutes and regulations) for health care.

Actuarially Sound Capitation Rate – Actuarially sound Capitation rates are projected to provide reasonable, appropriate and attainable costs that are required under the terms of the contract and for the operation of the Primary Contractor for the time period and the population covered under the terms of the contracts, and such Capitation rates are developed in accordance with the requirement in paragraph (b) of Section §438.4.

Actuary – An individual who meets the qualification standards, established by the American Academy of Actuaries for an actuary and follows the practices established by the Actuarial Standard Board.

Adjudicate - A determination to pay or reject a claim.

Administrative Services Organization (ASO) An uninsured health plan is where an administrator performs administrative services for a third party that is at risk but has not issued an insurance policy. The health plan bears all of insurance risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Under an ASO plan, claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the administrator, but only after receiving funds from the plan sponsor that are adequate to fully cover the claim payments.

Advanced Directives - means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Affiliate - Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlled by or under common control with a Private Sector BH-MCO, including a Private Sector BH-MCO subcontracting with a county, Joinder, or a Private Sector BH-MCO's parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five (5%) percent or more of the outstanding ownership interest of the Private Sector BH-MCO's or Private Sector BH-MCO's parent(s), directors and subsidiaries of the Private Sector BH-MCO, shall be presumed to be Affiliates for purposes of this Agreement. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a Person, whether through the ownership of voting securities, other ownership interest, or by contract or otherwise, including but

not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

Agreement – The HealthChoices Behavioral Health Agreement.

Alternative Payment Arrangement (APA) – refers to any of the various contractual agreements for reimbursement that are not based on a traditional fee for service model. Types of arrangements include but are not limited to the following: retainer payments; case rates; and subcapitation.

Behavioral Health Managed Care Organization (BH-MCO) - An entity, which manages the purchase and provision of Behavioral Health Services under this Agreement.

Behavioral Health Residential Treatment Facility – A mental health or drug and alcohol residential treatment facility.

Behavioral Health Services – Services that are provided to Members to treat mental health and/or substance abuse diagnoses/disorders.

Behavioral Health (BH) Services Provider - A Provider, practitioner, or vendor/supplier which contracts with a BH-MCO to provide Behavioral Health Services or ordering or referring those services and is legally authorized to do so by the Department under the HealthChoices Behavioral Health Program.

Business Day – Normal business operations Monday through Friday except for those days recognized as federal holidays and/or Pennsylvania state holidays and business closures at the Governor's discretion.

Cancellation - Discontinuation of the Agreement for any reason prior to the expiration date.

Capitation - A payment the Department makes periodically to a Primary Contractor on behalf of each Member enrolled under a contract and based on the actuarially sound Capitation rate for the provision of services under the State Plan. The Department makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Care Management/Manager - see Service Management/Manager.

Children and Adolescents in Substitute Care (CISC) - Children and adolescents living outside their homes in the legal custody of a public agency, in any of the following settings: shelters, foster family homes, group homes, supervised independent living, residential treatment facilities, residential placement (other than youth development centers) for children and adolescents who have been adjudicated dependent or delinquent.

Clean Claim – A claim that can be processed without obtaining additional information from the

Provider of the service or from a third party. It includes a claim with errors originating in the Primary Contractor's claims processing computer system, and those originating from human errors. It does not include a claim under review for Medical Necessity, or a claim that is from a Provider who is under investigation by a governmental agency or the Primary Contractor or BH-MCO for fraud or abuse. However, if under investigation by the Primary Contractor or BH-MCO, the Department must have prior notification of the investigation.

Client Information System (CIS) - The Department's automated file of Medical Assistance eligible Recipients.

Community-Based Organizations (CBOs) - Community-Based Organizations (CBOs) are nonprofit organizations that work at a local level to improve life for residents and normally focus on building equality across society in many areas, including but not limited to access to social services. These organizations must also be registered as a 501(c)(3) nonprofit corporation in Pennsylvania. A health care provider is not considered a CBO.

Community HealthChoices (CHC) – Pennsylvania's managed care program that will use managed care organizations to coordinate physical health care and long-term services and supports (LTSS) for older persons, persons with physical disabilities, and persons who are dually eligible for Medicare and Medicaid (dual eligibles).

Community HealthChoices Managed Care Organization (CH-MCO) – A Commonwealth-licensed risk-bearing entity which has entered into an Agreement with the Department to manage the purchase and provisions of physical health and long-term services and supports (LTSS) under Community HealthChoices.

Complaint – A dispute or objection regarding a Network Provider or the coverage, operations, or management of a BH-MCO, which has not been resolved by the BH-MCO and has been filed with BH-MCO or with the Pennsylvania Insurance Department's (PID) Bureau of Managed Care (BMC), including, but not limited to: 1) a denial because the requested service is not a covered service; 2) the failure of the BH-MCO to meet the required timeframes for providing a service; 3) the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames; 4) a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; 5) a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) is not a covered services(s) for the member; (6) a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities; or (7) a member's dissatisfaction with the BH-MCO or a provider. Complaints do not include requests to reconsider a decision concerning the medical necessity and appropriateness of a covered health care service.

Concurrent Review - A review conducted by the BH-MCO during a course of treatment to determine whether services should continue as prescribed or should be terminated, changed or altered.

Co-Occurring Disorder Professional – An individual who is certified by a state or national certification body to provide integrated co-occurring psychiatric and substance use treatment, or trained in a recognized discipline, including but not limited to psychiatry, psychology, social work, or addictions, and has one year of clinical experience in the treatment of co-occurring disorders.

County Assistance Office - The county offices of the Department which administer the Medical Assistance program at the local level. Department staff in these offices perform necessary Medical Assistance functions such as determining Recipient eligibility.

County Operated BH-MCO - An entity organized and directly operated by county government to manage the purchase and provision of Behavioral Health Services under the HealthChoices Program as a Primary Contractor.

Cultural Competency - The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of Behavioral Health Services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Day – A calendar day unless otherwise specified in the Agreement.

Deliverables - Those documents, records, and reports furnished to the Department for review and/or approval in accordance with the terms of the Agreement.

Denial of Services - A determination made by a BH-MCO in response to a Provider's or Member's request for approval to provide a service of a specific amount, duration and scope which:

a. disapproves the request completely, or
b. approves provision of the requested service(s), but for a lesser amount, scope or duration than requested, or
c. .....approves provision of the requested service(s), but by a Network Provider, or
d. disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
e. reduces, suspends, or terminates a previously authorized service.

Department/DHS - The Pennsylvania Department of Human Services

DHS Fair Hearing - A hearing conducted by the Department of Human Services, Bureau of Hearings and Appeals in response to an appeal by a BH-MCO Member.

Discretionary Funds (Profit) - Capitation payments and investment income that are not expended for purchase of services for plan Members (State Plan, in lieu of and in addition to services), administrative costs, risk and contingency, equity requirements or reinvestment.

Drug and Alcohol Addictions Professional - A nationally accredited addictions practitioner or a person possessing a minimum of a bachelor's degree in social science and two years' experience in treatment/case management services for persons with substance abuse/addiction disorders.

Eligibility Verification System (EVS) - An automated system available to MA Providers and other specified organizations for on-line verification of MA eligibility, MCO enrollment, third party resources, and scope of benefits.

Emergency Inpatient Admission – The unscheduled admission of a Member with a severe psychiatric condition who requires immediate treatment to an inpatient psychiatric facility.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
b. serious impairment to bodily functions, or
c. serious dysfunction of any bodily organ or part.

Emergency Services - Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish such services under the Medical Assistance Program and which are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollment Assistance Program (EAP) - The program responsible to assist MA Recipients in enrolling in the HC Program, including the selection of a PH-MCO and Primary Care Practitioner, and obtaining information regarding the HC physical and behavioral health programs.

Enrollment Specialist - The EAP individual who will be responsible to assist Recipients with selecting a PH-MCO and Primary Care Practitioner and providing information about the HealthChoices PH and BH programs.

EPSDT - The Early and Periodic Screening, Diagnosis, and Treatment Program for individuals under age 21.

Federally Qualified Health Clinic (FQHC/ Rural Health Clinic (RHC)) – An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C.A. 1396d(1) or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the

requirements to receive a grant under 42 U.S.C.A. 1396d(1).

Federally Qualified Health Maintenance Organization (HMO) – An HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

Fee-for-Service (FFS) - Payment by the Department to Providers on a per-service basis for health care services provided to Medical Assistance Recipients.

Fraud – Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State Law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting.

Grievance -A request to have a BH-MCO or utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service. A Grievance may be filed regarding a BH-MCO's decision to 1) deny, in whole or in part, payment for a service; 2) deny or issue a limited authorization of a requested service, including a determination based on the type or level of a service; 3) reduce, suspend, or terminate a previously authorized service; and 4) deny the requested service but approve an alternative service.

Health Care Quality Unit (HCQU) – Serves as the entity responsible to county intellectual disabilities programs for the overall health status of individual screening services in county intellectual disabilities programs.

HealthChoices Behavioral Health (HC-BH) Program – The mandatory managed care program which provides Medical Assistance Recipients with Behavioral Health Services in the Commonwealth.

HealthChoices Physical Health (HC-PH) Program – The mandatory managed care program which provides Medical Assistance Recipients with physical health services in the Commonwealth.

HealthChoices (HC) *Program* - The name of Pennsylvania's 1915(b) Waiver program to provide mandatory managed health care to Medical Assistance Recipients.

HealthChoices Zone (HC Zone) – County groupings designated by the Department for participation in the HC-BH Program.

Health Maintenance Organization (HMO) - A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled Members for a fixed pre-paid fee.

Immediate Need – A situation in which, in the professional judgment of the dispensing registered pharmacist and/or prescriber, the dispensing of the drug at the time when the prescription is presented is necessary to reduce or prevent the occurrence or persistence of a serious adverse health

condition.

Incentive Arrangement – Any payment mechanism under which a Primary Contractor may receive additional funds over and above the Capitation rates it was paid for meeting targets specified in the Agreement.

Indian Health Care Provider (IHCP) - a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Institution for Mental Diseases (IMD) - a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Intensive Behavioral Health Services (IBHS) – An array of therapeutic interventions and supports provided to a child, youth or young adult in the home, school or other community setting

Interagency Team - A multi-system planning team comprised of the child, when appropriate, the adolescent, at least one accountable family member, a representative of the county mental health and/or drug and alcohol program, the case manager, the prescribing physician or licensed psychologist, in person when possible, or by consultative conference call, and as applicable, representation from the county children and youth, juvenile probation, intellectual disabilities, and drug and alcohol agencies, a representative of the responsible school district, BH-MCO, PHSS and/or PCP, other agencies that are providing services to the child or adolescent, and other community resource persons as identified by the family. The purpose of the Interagency Team is to collaboratively assess the needs and strengths of the child and family, formulate the measurable goals for treatment, recommend the services, treatment approaches and methods, intensity and frequency of interventions and develop the discharge goals and plan.

Joinder - Local authorities of any county who have joined with the local authorities of any other county to establish a county mental health and intellectual disabilities program, subject to the provisions of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201 et. seq.), or a drug and alcohol program pursuant to the Pa. Drug and Alcohol Abuse Control Act (71 P.S. § 1690.101 et. seq.).

Juvenile Detention Center - A publicly or privately administered, secure residential placement for:

a. Children and adolescents alleged to have committed delinquent acts who are awaiting a court hearing;
b. Children and adolescents who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and
c. Children and adolescents who have been returned from some other form of

disposition and are awaiting a new disposition (e.g., court order regarding custody of child, placement of child, or services to be provided to the child upon discharge from the Juvenile Detention Center).

Limited English Proficient – Enrollees or potential enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English, may be eligible to receive language assistance for a particular type of service, benefit or encounter.

Long-Term Services and Supports – Services and supports provided to a CHC Member who has functional limitations or chronic illnesses that have a primary purpose of supporting the ability of the CHC Member to live or work in the setting of his or her choice, which may include the individual's home or worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed Care Organization (MCO) - An entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is:

a. A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of 42 CFR; or
b. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
    i. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
    ii. ..... Meets the solvency standards of § 438.116 of 42 CFR

Medically Frail – Includes individuals with disabling mental disorders (including adults with serious mental illness) individuals with chronic substance use disorders, individuals with serious complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their functioning, or individuals with a disability determination based on Social Security criteria.

Medical Necessity - Clinical determinations to establish a service or benefit which will, or is reasonably expected to:

a. prevent the onset of an illness, condition, or disability;
b. reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury, or disability;
c. assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age.

Member (Enrollee) - A Medicaid or Medical Assistance Recipient who is currently enrolled in the HC-BH Program.

Member Month - One Member covered by the HC Behavioral Health Program for one month.

Mental Health Professional - A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology, and nursing who has a graduate degree and mental health clinical experience, or a Registered Nurse with at least two years of mental health clinical experience.

Minority Business Enterprise (MBE) - A business concern which is: a sole proprietorship, owned and controlled by a minority; a partnership or joint venture controlled by minorities in which 51% of the beneficial ownership interest is held by minorities; or a corporation or other entity controlled by minorities in which 51% of the voting interest and 51% of the beneficial ownership interest are held by minorities.

Modified Adjusted Gross Income (MAGI) - MAGI is the adjusted gross income found on an individual's Federal Income Tax form, adjusted for certain items such as student loan deductions, IRA-contribution and deductions for higher education costs.

Multi-County Entity – Two or more counties which form a legally binding incorporated entity, such as a 501(c)(3), which has established Articles of Incorporation and intergovernmental agreements and has a single Agreement with the Department. This entity is established for the purpose of offering Behavioral Health Services for Medicaid eligible Recipients under the HealthChoices Program as a Primary Contractor.

Network Provider – An MA enrolled Provider that has a written Network Provider Agreement and participates in the BH-MCO's Network to serve Members.

On-Site Reviews- A formal review process, periodically undertaken by Department staff and other designated representatives to determine the readiness of the Primary Contractor and a BH-MCO contractor to accept Members and to manage and administer the purchase and provision of Behavioral Health Services under this Agreement.

Out-of-Area Services - State Plan Services provided to a Member while the Member is outside the HealthChoices Zone.

Out-of-Network Provider - A Provider that does not have a signed Network Provider Agreement with the BH-MCO and does not participate in the BH-MCO's network but provides services to a BH-MCO Member.

Overpayment - Any payment made to a Network Provider by the Primary Contractor or its BH-MCO to which the Network Provider is not entitled to under Title XIX of the Act or any payment to the Primary Contractor or its BH-MCO by a State to which the Primary Contractor or is BH-MCO is not entitled to under Title XIX of the Act.

Parent - The biological or adoptive mother or father, or the legal guardian of the child, or a responsible relative or caretaker (including resource Parents) with whom the child regularly resides.

Pass-Through Payment - Any amount required by the Department to be added to the contracted payment rates, and considered in calculating the actuarially sound Capitation rate, between the Primary Contractor and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the Agreement; a provider payment methodology permitted under 42 CFR § 438.6(c)(1)(i) through (iii) for services and enrollees covered under the Agreement; a subcapitated payment arrangement for a specific set of services and enrollees covered under the Agreement; GME payments; or FQHC or RHC wrap around payments.

Peer-to-Peer Review – Discussion between a BH-MCO physician or clinical reviewer and the prescriber requesting authorization of a service.

Physical Health Managed Care Organization (PH-MCO) - An entity which has contracted with the Department to manage the purchase and provision of physical health services under the HC Program.

Physical Health Service System (PHSS) - Any system by which a Medical Assistance Recipient receives physical health services (e.g. Fee for Service, HealthChoices Physical Health, Community Health Choices.).

Preferred Provider Organization (PPO) - A Commonwealth licensed person, partnership, association or corporation which establishes, operates, maintains or underwrites in whole or in part a preferred provider arrangement, as defined in 31 Pa. Code § 152.2.

Prepaid Inpatient Health Plan (PIHP) - An entity that:

a. Provides services to enrollees under contract with the Department, and on the basis of Capitation payment, or other payment arrangements that do not use State Plan payment rates.
b. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees.
c. Does not have a comprehensive risk contract.

Primary Care Practitioner (PCP) - A specific physician, physician group, or a certified registered nurse practitioner operating under the scope of his/her licensure who has received an exception from the Department of Health, responsible for supervising, prescribing and providing primary care services and locating, coordinating, and monitoring other medical care and rehabilitation services, and maintaining continuity of care on behalf of a Member.

Primary Contractor - A county, Multi-County Entity or a BH-MCO which has an Agreement with the Department to manage the purchase and provision of Behavioral Health Services.

Primary Diagnosis - The condition established after study to be chiefly responsible for occasioning the visit for outpatient settings or admission for inpatient settings.

Prior Authorization - A determination made by a Primary Contractor or its BH-MCO to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiation or continuation of the requested service.

Priority Population(s) – A specific description of the group(s) is provided in Appendix Q. Generally, however, such populations include: Members with serious mental illness and/or addictive disease, and children and adolescent Members with or at risk of serious emotional disturbance and/or who abuse substances and who, in the absence of effective behavioral health treatment and rehabilitation services, care coordination and management are at risk of separation from their families through placement in long term treatment facilities, homelessness, or incarceration, and/or present a risk of serious harm to self or others. Drug and alcohol Priority Populations include pregnant injection drug users, pregnant substance users, injection drug users, overdose survivors and veterans.

Private Sector BH-MCO - A Commonwealth licensed BH-MCO which has contracted with the Department or county government to manage the purchase and provision of Behavioral Health Services under this Agreement.

PROMISe- (Provider Reimbursement and Operations Management Information System) is the HIPAA-compliant claims processing and management information system implemented by the Department in March 2004.

Provider – An individual, firm, corporation, or other entity which provides behavioral health or medical services or supplies to Medical Assistance Recipients.

Provider Agreement - Any written agreement between the BH-MCO and a Provider or DHS and a Provider to render clinical or professional services to Recipients to fulfill the requirement of the Agreement.

Quality Management - A formal methodology and set of activities designed to assess the quality of services provided and which includes a formal review of care, problem identification, and corrective action to remedy any deficiencies and evaluation of actions taken.

Rate Cell – A set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the Capitation rate and making a Capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the Agreement.

Rating Period - A period of 12 months selected by the Department for which the actuarially sound Capitation rates are developed and documented in the rate certification, submitted to CMS as required by 42 CFR §438.7(a).

Recipient - A person eligible to receive medical and behavioral health services under the MA program of the Commonwealth of Pennsylvania.

Reinvestment Funds - Capitation revenues from DHS and investment income which are not expended during an Agreement period by the Primary Contractor for purchase of services for Members, administrative costs, Risk and Contingency Funds, and equity requirements but may be used in a subsequent Agreement period to purchase start-up costs for State Plan Services, development or purchase of in lieu of and in addition to services or non-medical services, contingent upon DHS prior approval of the Primary Contractor's reinvestment plan.

Related Parties - Any Affiliate that is related to the Primary Contractor or its BH-MCO by common ownership or control (see definition of "Affiliate") and:

a. Performs some of the Primary Contractor or its BH-MCO's management functions under contract or delegation; or
b. Furnishes services to Members under a written agreement; or
c. Leases real property or sells materials to the Primary Contractor or its BH-MCO at a cost of more than $2,500 during any year of a HealthChoices Behavioral Health Agreement with the Department.

Retrospective Review - A review conducted by the BH-MCO to determine whether or not services were delivered as prescribed and consistent with the BH-MCO's payment policies and procedures.

Risk and Contingency Funds – Capitation payments received by the Primary Contractor pursuant to the Agreement, which are not expended on services (State Plan, in lieu of and in addition to services) or administrative functions and which are in excess of the Equity Reserve required to be maintained under the Agreement. Risk and Contingency Funds do not include Reinvestment Funds, or funds designated in a reinvestment plan submitted to DHS.

Risk Assuming PPO - A Commonwealth licensed PPO which meets the definition of a Risk Assuming PPO pursuant to regulations at 31 Pa. Code § 152.2.

Rural - Consists of territory, persons, and housing units in places which are designated as having less than 2,500 persons, as defined by the US Census Bureau.

Service Management/Manager - The BH-MCO function/staff with responsibility to authorize and coordinate the provision of State Plan Services. Care Management/Manager is synonymous.

Social Determinants of Health (SDOH) - Conditions in the environments in which people are born,

live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes which can lead to inequities and risks.

Special Needs Populations - Members whose complex medical, psychiatric, behavioral or substance abuse conditions, living circumstances and/or cultural factors necessitate specialized outreach, assistance in accessing services and/or service delivery and coordination on the part of the MCO and its Provider network.

Start Date - The first date on which Members are eligible for Behavioral Health Services under the Agreement, and on which the Primary Contractor is at risk for providing Behavioral Health Services to Members.

State Plan Services – State Plan Services approved by CMS in the State Medicaid Plan, which are included in the HC-BH Capitation rate and are the payment responsibility of the Primary Contractor.

Subcontract - Any contract (except Provider Agreements, utilities, and salaried employees) between the Primary Contractor or a contracting BH-MCO and an individual, firm, university, governmental entity, or nonprofit organization to perform part or all of the BH-MCO's responsibilities.

Subcontractor – An individual or entity that has a contract with a Primary Contractor or its BH-MCO that relates directly or indirectly to the performance of the Primary Contractor or its BH-MCO's obligation under its contract with the Department.

Third Party Liability (TPL) – Any individual, entity, (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of a Member's health care expenses.

Title XVIII (Medicare) - The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Urban - Consists of territory, persons, and housing units in places which are designated as having 2,500 persons or more, as defined by the US Census Bureau. These places must be in close geographic proximity to one another.

Urgent - Any illness or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a 24-hour period and if left untreated, could rapidly become a crisis or emergency situation. Additionally, it includes situations such as when a Member's discharge from a hospital will be delayed until services are approved or a Member's ability to avoid hospitalization depends upon prompt approval of services.

Utilization Management - The process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria.

Waiver - A process by which a state may obtain an approval from CMS for an exception to a federal Medicaid requirement(s).

Waste –The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.

Withhold Arrangement - Any payment mechanism under which a portion of a Capitation payment is withheld from the Primary Contractor and a portion of or all of the withheld amount will be paid to the Primary Contractor for meeting targets specified in the Agreement. The targets for a withhold arrangement are distinct from general operational requirements under the Agreement. Arrangements that withhold a portion of a Capitation payment for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

Women's Business Enterprise- A small business concern which is: a sole proprietorship, owned and controlled by a woman; a partnership or joint venture controlled by women in which at least 51% of the beneficial ownership interest is held by women; or a corporation or other entity controlled by women in which at least 51% of the voting interest and 51% of the beneficial ownership interest is held by women.

ACRONYMS

ACA	The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010, as amended
ADA	Americans with Disabilities Act
AFDC	Aid to Families with Dependent Children
AIDS	Acquired Immune Deficiency Syndrome
APA	Alternative Payment Arrangement
APD	Advanced Planning Document
ARD	Accelerated Rehabilitation Decision
ASAM	American Society of Addiction Medicine
ASCII	American Standard Code for Information Interchange
ASD	Autism Spectrum Disorder
BEC	Basic Education Circular
BHEF	Behavioral Health Encounter File
BH-MCO	Behavioral Health Managed Care Organization
BMWBO	Bureau of Minority and Women Business Opportunities
BNDD	Bureau of Narcotic Drugs and Devices
BSU	Base Service Unit
CAO	County Assistance Office
CASSP	Child and Adolescent Service System Program
CAU	County Administrative Unit
CBCM	Community Based Care Management
CBO	Community Based Organization

CCRS	Consolidated Community Reporting System
CCYA	County Children and Youth Agency
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
C/FST	Consumer/Family Satisfaction Team
CHADD	Children with Attention Deficit Disorders
CHC	Community HealthChoices
CHC-MCO	Community HealthChoices Managed Care Organization
CIS	Client Information System
CISC	Children and Adolescents in Substitute Care
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CQI	Continuous Quality Improvement
CRCS	Capitation Rate Calculation Sheet
CRD/LIC	Credentials/License
CRF	Consumer Registry File
CRNP	Certified Registered Nurse Practitioner
CRR	Community Residential Rehabilitation
CSI	Consumer Satisfaction Instruments
CSP	Community Support Program
CST	Consumer Satisfaction Team

C&Y	Children and Youth
D&A	Drug and Alcohol
DAP	Disability Advocacy Program
DDAP	Department of Drug and Alcohol Programs
DEA	Drug Enforcement Agency
DHHS	U.S. Department of Health and Human Services
DHS	Department of Human Services
DME	Durable Medical Equipment
DMIRS	Data Management and Information Retrieval System
DOH	Department of Health
DSH	Disproportionate Share
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUR	Drug Utilization Review
EAP	Enrollment Assistance Program
ECC	Electronic Claims Capture
ECM	Electronic Claims Management
EIN	Employee Identification Number
EMC	Electronic Media Claims
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
ED	Emergency Department
ERISA	Employee Retirement Income Security Act, 1974

EVS	Eligibility Verification System
FA	Fiscal Agent
FBMHS	Family Based Mental Health Services
FDA	Food and Drug Administration
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FRR	Financial Reporting Requirements
FST	Family Satisfaction Team
FTE	Full Time Equivalent
FTP	File Transfer Process
FWA	Fraud, Waste and Abuse
GA	General Assistance
GAAP	Generally Accepted Accounting Principles
GME	Graduate Medical Education
HC	HealthChoices
HC BH	HealthChoices Behavioral Health
HC-L/C	HealthChoices Lehigh/Capital
HC N/C	HealthChoices North/Central
HC-NE	HealthChoices Northeast
HCPCS	CMS Common Procedure Coding System
HCQU	Health Care Quality Unit

HC-SE	HealthChoices - Southeast
HC-SW	HealthChoices - Southwest
HEDIS	Healthcare Effectiveness Data and Information Set
HIO	Health Insuring Organizations
HIPAA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HMO	Health Maintenance Organization
IBHS	Intensive Behavioral Health Services
IBNR	Incurred But Not Reported Claims
ICD	International Classification of Diseases
ICF	Intermediate Care Facility
ICF/ID	Intermediate Care Facilities for Persons with Intellectual Disabilities
ICP	Integrated Care Plan
ICWC	Integrated Community Wellness Centers
ID	Insurance Department
IFB	Invitation for Bid
IHCP	Indian Health Care Provider
IMD	Institutions For Mental Diseases
ISP	Individualized Service Plan
JDC	Juvenile Detention Center
JPO	Juvenile Probation Office
L/C	Lehigh/Capital

LEP	Limited English Proficient
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex
LTC	Long Term Care
LTSS	Long Term Services and Support
MA	Medical Assistance
MAGI	Modified Adjusted Gross Income
MAID	Medical Assistance Identification Number
MATP	Medical Assistance Transportation Program
MAWA	Mutually Agreed upon Written Arrangement
MBE	Minority Business Enterprise
MBE/WBE	Minority Business Enterprise/Women Business Enterprise
MCO	Managed Care Organization
MIS	Management Information System
MOE	Method of Evaluation
MPL	Minimum Participating Levels
NCE	Non-Continuous Eligibility
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NMP	Non-money payment
OBRA	Omnibus Budget Reconciliation Act
OCYF	Office of Children, Youth & Families
ODP	Office of Developmental Programs

OIP	Other Insurance Paid
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Services
ORC	Other Related Conditions
OTC	Over the Counter
PCIS	Patient Census Information System
PCO	Private Coverage Organization
PCP	Primary Care Practitioner
PDA	Pennsylvania Department of Aging
PH-MCO	Physical Health Managed Care Organization
PHSS	Physical Health Service System
PIHP	Prepaid Inpatient Health Plan
PIN	Parents Involved Network
PMPM	Per Member Per Month
POM	Performance Outcome Measures
POMS	Performance Outcome Management System
POSNet	Pennsylvania Open Systems Network
PPO	Preferred Provider Organization
PROMISe	Provider Reimbursement and Operations Management Information System in electronic format
PRTF	Psychiatric Residential Treatment Facility
QARI	Quality Assurance Reform Initiative

QM	Quality Management
QMB	Qualified Medicare Beneficiaries
QSF	Quarterly Status File
RBUC	Received But Unpaid Claims
RFP	Request for Proposal
RHC	Rural Health Clinic
RTF	Residential Treatment Facility
SAP	Statutory Accounting Principles
SBP	State Blind Pension
SCA	Single County Authority
SDOH	Social Determinants of Health
SE	Southeast
SMH	State Mental Hospital
SMI	Serious Mental Illness
SMM	State Medicaid Manual
SNF	Skilled Nursing Facility
SNU	Special Needs UnitSPR System Performance Review
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
SUD	Substance Use Disorder
SUR	Surveillance and Utilization Review
SURS	Surveillance and Utilization Review System

SW	Southwest
TANF	Temporary Assistance to Needy Families
TPL	Third Party Liability
TTY	Text Telephone Typewriter
UM	Utilization Management
UM/QM	Utilization Management/Quality Management
UPIN	Unique Physician Identification Number
USC	United States Code
WBE	Women's Business Enterprise

PART I. GENERAL INFORMATION

I-1. PURPOSE

The Department is the single state agency with responsibility for the implementation and administration of the Medical Assistance Program (Medicaid or MA). Medicaid is a federal and state program which provides payment of medical expenses for eligible persons who meet income or other criteria.

The purpose of this document is to set forth the standards and requirements for the HC-BH Program operating under CMS Waiver Section 1915(b) of the Social Security Act, through counties that are Primary Contractors.

County governments which demonstrate capacity to meet the standards and requirements for the HC-BH Program are provided the first opportunity to enter into a capitated contract with the Commonwealth (the "Agreement"). Subject to the Department's approval, a county may implement the Agreement directly or enter into a contract with a Private Sector BH-MCO. In areas in which the county is unable to meet the HC-BH Program standards and requirements or chooses not to participate in this initiative, the Department will select a Primary Contractor through a competitive process resulting in a direct contract with a qualified Private Sector BH-MCO.

I-2. ISSUING OFFICE

This document is issued for the Commonwealth by the Office of Mental Health and Substance Abuse Services, Department of Human Services.

I-3. SCOPE

This document describes Behavioral Health Services standards and requirements with which the Primary Contractor and its BH-MCO must comply. It also includes information on the policies and procedures the Department will follow in carrying out its program management and oversight responsibilities.

A county is the smallest geographic unit for which the Department enters into a HealthChoices behavioral health contract, and the Primary Contractor must be capable of delivering specified services to all Members in the county. A Multi-County Entity must identify an entity as the Primary Contractor. The Department will contract with this entity and conduct all business through this entity.

Should any part of the scope of work under this Agreement relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Primary Contractor and its BH-MCO must do no work on that part after the effective date

of the loss of program authority. The Department will adjust the Capitation rate to remove costs that are specific to any program or activity that is no longer authorized by law. If the Primary Contractor and its BH-MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Primary Contractor will not be paid for that work. If the Department paid the Primary Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement the work was to be performed after the date the legal authority ended, the payment for that work must be returned to the Department. However, if the Primary Contractor and its BH-MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to the Primary Contractor, the Primary Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

I-4. TYPE of AGREEMENT

The Department enters into a full-risk prepaid capitated contract using a flat fee per Member in the counties. The Primary Contractor is responsible for all medically necessary State Plan Services. Should the Primary Contractor incur costs which exceed the Capitation payments, the Department is not responsible for providing additional funds to cover the deficits. The method of payment is monthly; however, the method of payment will be delayed by one month. Example: A program starts on July 1, 2019; the Capitation payment for the month of July 2019 will be made on or before August 15, 2019. The one (1) month payment delay will be reconciled upon termination of the Agreement. Negotiations may be undertaken with qualified vendors demonstrating qualifications, responsibility, and capability for performing the contract work as to price and other factors.

Primary Contractors assume risk for providing services to Members upon the effective date of the Agreement. Subject to the availability of state and federal funds, the Department reserves the right to renew the Agreement for additional periods. The Department will notify the Primary Contractor of its intention to renew prior to the expiration of the Agreement.

The Department has the option of entering into a single contract covering all of the counties covered by a Multi-County Entity. In the event of a Multi-County Entity submitting a single proposal, an entity must be identified as the Primary Contractor. The Department will conduct all business through this entity. Under a multi-county arrangement, each county in the Multi-County Entity will be required to sign one contract with the Department. In addition, one multi-county Capitation rate for each rate cell will be developed covering all of the counties in the Multi-County Entity. Risk for one county may not be assumed by another county or counties in the Multi-County Entity. In its contract with the Department, the Multi-County Entity would be held to the same HC-BH

Program requirements as counties entering into individual county contracts with the Department. The participating counties will not be required to be contiguous and the Department will permit Multi-County Entities consisting of counties in different HealthChoices Zones. A re-procurement will occur for any county that withdraws from the Multi-County Entity. DHS will select a private sector BH-MCO as a Primary Contractor for that county. The remaining county(ies) in a Multi-County Entity must continue to meet the Department's requirements.

In addition to the multi-county contracting option and in order to ensure efficiency in administrative costs, the Department requires HealthChoices Behavioral Health contractors to cover a minimum of 10,000 HealthChoices Members as follows:

- An individual county with less than 10,000 HealthChoices Members that contracts directly with the Department must contract with a BH-MCO that covers or will cover at least 10,000 HealthChoices Members. The Members covered by the BH-MCO may be from other HealthChoices counties or other HealthChoices Zones.

- A Multi-County Entity that chooses to jointly contract with the Department must cover at least 10,000 HealthChoices Members or must contract with a BH-MCO that covers or will cover at least 10,000 HealthChoices Members.

Requirements of this document are part of the Agreement and are not subject to negotiation by the Primary Contractor. The Department will develop a transition plan should it choose to cancel or not extend a contract with one or more Primary Contractors operating the behavioral health program.

The Department reserves the right to terminate or cancel the Agreement for failure to perform as required by Agreement terms, non-availability of funds, failure to secure/retain necessary federal contract and/or Waiver approvals, or change in applicable federal or Commonwealth law, regulations, public policy, or at the convenience of the Department. A Primary Contractor and its BH-MCO must be able to provide services to all Members residing within the county or counties that it proposes to serve.

I-5. ON-SITE REVIEWS

The Department periodically conducts On-Site Reviews of selected Primary Contractors and its BH-MCO. The purpose of an On-Site Review is to determine a Primary Contractor and its BH-MCO's initial and ongoing compliance with respect to meeting work statement tasks and program, standards and requirements. The Department reserves the right to suspend implementation of the Agreement and/or Member enrollment for any Primary Contractor or its BH-MCO that does not demonstrate to the Department's satisfaction, compliance with any critical program standard.

I-6. INCURRING COSTS

The Department is not liable for any costs incurred by potential Primary Contractors prior to the implementation date.

I-7. HEALTHCHOICES RATE INFORMATION

The Department releases historical cost data by rate cell and category of service for the various HealthChoices Zones. Additional data and/or information may also be provided to assist the Primary Contractor in constructing or responding to a Capitation rate proposal.

I-8. RESPONSIBILITY TO EMPLOY CASH ASSISTANCE BENEFICIARIES

The Primary Contractor and its BH-MCO shall make a good faith effort to outreach, train, and employ cash assistance beneficiaries in accordance with the provisions of Appendix C.

I-9 SMALL DIVERSE BUSINESS INFORMATION

The Department encourages participation by small diverse businesses as prime contractors and encourages all prime contractors to make a significant commitment to use small diverse businesses as subcontractors and suppliers.

A Small Diverse Business is a Department of General Services -certified minority-owned business, service-disabled veteran-owned business or veteran-owned business, or United States Small Business Administration-certified 8(a) small disadvantaged business concern that qualifies as a small business.

A small business is a business in the United States which is independently owned, not dominant in its field of operation, employ no more than 100 full-time or full-time equivalent employees and earn less than $20 million in gross annual revenues ($25 million in gross annual revenues for those businesses in the information technology sales or service business).

Questions regarding this Program can be directed to:

Department of General Services
Bureau of Small Business Opportunities
Room 611, North Office Building
Harrisburg, PA 17125
Phone: (717) 783-3119
Fax: (717) 787-7052
Email: gs-bmwbo@pa,gov
Website: www.dgs@pa.gov

The DGS directory of Bureau of Diversity, Inclusion, and Small Business Opportunities ("BDISBO")-verified minority, women, veteran and service disabled veteran-owned businesses can be accessed at:
http://www.dgs.internet.state.pa.us/SBPI/AlphaResults.aspx

I-10. CONTRACTOR RESPONSIBILITY and OFFSET PROVISIONS

The Primary Contractor certifies that it is not currently under suspension or debarment by the Commonwealth, any other state, or the federal government.

If the Primary Contractor enters into contracts or employs under this Agreement any Sub-contractors/individuals currently suspended or debarred by the Commonwealth or the federal government or who become suspended or debarred by the Commonwealth or federal government during the term of this Agreement or any extensions or renewals thereof, the Commonwealth shall have the right to require the Primary Contractor to terminate such contracts or employment.

The Primary Contractor agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of the Inspector General for investigations of the Primary Contractor's compliance with terms of this or any other agreement between the Primary Contractor and the Department which result in the suspension or debarment of the Primary Contractor. Such costs shall include, but not be limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Primary Contractor shall not be responsible for investigative costs for investigations which do not result in the Primary Contractor's suspension or debarment. The Primary Contractor may obtain the current list of suspended and debarred contractors by contacting:

Department of General Services
Office of Chief Counsel
603 North Office Building
Harrisburg, PA 17125
Telephone: (717) 783-6472
FAX: (717) 787-9138

The Primary Contractor agrees that the Commonwealth may offset the amount of any state tax liability or other debt of the Primary Contractor or its subsidiaries owed to the Commonwealth and not contested on appeal against any payment due the Primary Contractor under this or any other contract with the Commonwealth.

I-11. LOBBYING CERTIFICATION and DISCLOSURE

Commonwealth agencies will not contract with outside firms or individuals to perform

lobbying services, regardless of the source of funds. With respect to an award of a federal contract, grant or cooperative agreement exceeding $100,000, or an award of a federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000, all recipients must certify that they will not use federal funds for lobbying and must disclose the use of non-federal funds for lobbying by filing required documentation. See Lobbying Certification Form and Disclosure of Lobbying Activities Form attached as Appendix D. The Primary Contractor must complete and return the Lobbying Certification Form along with the signed Agreement.

I-12. CONTRACTOR'S CONFLICT OF INTEREST

The Primary Contractor and its BH-MCO must comply with the conflict of interest safeguards described in §438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.

The Primary Contractor and its BH-MCO hereby assures that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Primary Contractor and its BH-MCO further assures that in the performance of this Agreement, it will not knowingly employ any person having such interest. The Primary Contractor and its BH-MCO hereby certifies that no member of its Board of Directors or equivalent authorized governing body, or any of its officers or directors has such an adverse interest.

I-13. PROHIBITED AFFILIATIONS

The Primary Contractor and its BH-MCO may not knowingly have a relationship with the following:

A. An individual or entity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

B. An individual or entity who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (A) above.

C. An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

For the purpose of this section, "relationship" means the following:

- A director, officer or partner of the Primary Contractor or its BH-MCO.

- A person with beneficial ownership of five percent (5%) or more of the BH-MCO's equity.
- A person with employment, consulting or other arrangement with the Primary Contractor's or its BH-MCO's obligations under this Agreement.

I-14. INTEREST OF THE COMMONWEALTH AND OTHERS

No officer, member or employee of the Commonwealth and no member of the General Assembly, who exercises any functions or responsibilities under this Agreement, shall participate in any decision relating to this Agreement which affects his/her personal interest or the interest of any corporation, partnership or association in which he is, directly or indirectly, interested; nor shall any such officer, member or employee of the Commonwealth or member of its General Assembly have interest, direct or indirect, in this Agreement or the proceeds thereof.

I-15. PRIMARY CONTRACTOR RESPONSIBILITIES

The Primary Contractor is required to assume responsibility for all services offered in this document and Agreement whether it directly provides or contracts for the provision of the services. Further, the Department will consider the Primary Contractor to be the sole point-of-contact with regard to contract matters.

Where the Primary Contractor or its BH-MCO changes ownership or undergoes a major restructuring, including any major change to the submitted organizational chart or acquisition of another MCO, such change must be reported to the Department 30 days prior to the change or within 48 hours of confirmation of the change. Major organizational changes may result in the Department conducting a complete On-Site Review to assess continued adherence to the terms of the Agreement by the new structure. Continuation of the Agreement is contingent on a finding of the On-Site Review that the terms of the Agreement will be adhered to under the change/restructuring.

Office space, equipment, and logistical support are the responsibility of the Primary Contractor. The BH-MCO's administrative offices, from which the program is operated, must be located in close geographic proximity to the county or counties in which State Plan Services are provided.

I-16. FREEDOM OF INFORMATION AND PRIVACY ACTS

The Primary Contractor should be aware that all materials associated with this Agreement may be subjected to the terms of the Freedom of Information Act (5 U.S.C. Section 552 et seq.), the Privacy Act of 1974 (5 U.S.C. Section 552a), the Right-to-Know Law (65 P.S. Section 66.1 et seq.) and all rules, regulations, and interpretations of these Acts, including those from the offices of the Attorney General of the United States, Health and Human Services (HHS), and CMS.

I-17. NEWS RELEASES

News releases pertaining to this initiative will not be made without prior Commonwealth approval, and then only in coordination with the Department.

I-18 COMMONWEALTH PARTICIPATION

The Department's Office of Mental Health and Substance Abuse Services (OMHSAS) provides the Project Office for formal oversight of the HC BH Program. The OMHSAS in collaboration with the Department's Office of Medical Assistance Programs (OMAP) and the Department of Drug and Alcohol Programs (DDAP), provides responses to requests for clarification and questions. The Department will not provide offices space, reproduction facilities, or other logistical support to any Primary Contractor.

The Department provides enrollment and disenrollment activities for the HealthChoices Program by contract as described in Appendix G.

I-19. PROJECT MONITORING

Project monitoring is the responsibility of the OMHSAS, in collaboration with OMAP and DDAP, and/or other offices, as well as consumers, persons in recovery and family members, as determined by the Department. Designated staff coordinates the project, provide or arrange technical assistance, monitor the Agreement for compliance with requirements, the approved Waiver, and program policies and procedures.

In addition to Department oversight, CMS may also monitor the HC-BH Program through its regional office in Philadelphia, Pennsylvania, and its Office of Managed Care in Baltimore, Maryland.

I-20. CHANGES TO CERTAIN APPENDICES

The following Appendices may be updated, from time to time, by the Department through issuance of an operations memo, and/or policy clarification, or through the Department's internet, and do not require an amendment to this Agreement to be effective and enforceable:

- Appendix L: Guidelines for Consumer/Family Satisfaction Teams and Member Satisfaction Surveys
- Appendix M: Behavioral HealthChoices Data Reporting Requirements Non-Financial
- Appendix O: HealthChoices Data Support for BH-MCOs
- Appendix P: The HealthChoices Behavioral Health Financial Reporting Requirements

- Appendix X: HealthChoices Category/Program Status Coverage Chart
- Appendix V: The HealthChoices Behavioral Health Recipient Coverage Document

1-21. ACCREDITATION BY A PRIVATE INDEPENDENT ACCREDITING ENTITY

The Primary Contractor and its BH-MCO must inform the Department if it has been accredited by a private independent accrediting entity.

The Primary Contractor and/or its BH-MCO that has received accreditation by a private independent accrediting entity must authorize the private independent accrediting entity to provide the Department with a copy of its most recent accreditation review, including:

- Accreditation status, survey type, and level (as applicable)
- Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
- Expiration date of the accreditation.

PART II. WORK STATEMENT – STANDARDS AND REQUIREMENTS

II-1. OVERVIEW

The goal of the HC-BH program is to improve the accessibility, continuity, and quality of services for Pennsylvania's MA populations, while controlling the program's rate of cost increases. The Department intends to achieve these goals by enrolling eligible MA Recipients in BH-MCOs which provide a specified scope of benefits to each enrolled Member in return for a capitated payment made on a PMPM basis.

II-2. OBJECTIVES

A. General

The Department is interested in working with counties and/or Private Sector BH-MCOs to administer the mandatory HC-BH Program within each county in the Commonwealth of Pennsylvania.

B. Specific Objectives

The HC-BH Program provides for the delivery of medically necessary mental health, drug and alcohol, and behavioral services. Specific objectives are:

1. Structure Objectives

   a. To contract with each of the counties in the HealthChoices Zone, individually or in Multi-County Entities, to manage the purchase and provision of Behavioral Health Services in either one or more of the specified counties.

   b. To provide county government the option to directly manage the program through a County Operated BH-MCO or to contract with a Private Sector BH-MCO. Such contracts do not relieve the county of ultimate responsibility for compliance with program and fiscal requirements, including program solvency. Counties may, however, include additional requirements and incentives in their contracts as needed to provide appropriate management oversight and flexibility in addressing local needs.

   c. For counties not able to or not interested in contracting for the managed care program, the Department will contract with a Private Sector BH-MCO to directly manage the purchase and provision of Behavioral Health Services to Members.

2. Program Objectives

a. To promote resiliency-oriented and recovery-oriented best-practices that are cost effective.

b. To create systems of care management that are developed based on input from and responsive to the needs of consumers, persons in recovery, and their families representative of the various cultures and ethnic groups in the county, who depend on public services.

c. To provide incentives to implement Utilization Management techniques resulting in expanded use of less restrictive services while assuring appropriateness of care and increasing prevention and early diagnosis and treatment.

d. To promote partnerships between the public and private sectors that take advantage of the public sector's experience in serving persons with the most serious illnesses and disabilities who often have few resources and supports, and the private sector's expertise in managing financial risk for Behavioral Health Services.

e. To remove incentives to shift costs between behavioral health and other publicly funded human service and correctional programs.

f. To create geographic service areas of optimal size for managing risk under Capitation financing which allow for regional variations in program design and result in administrative cost savings.

g. To develop consumer and family satisfaction mechanisms in partnership with consumers, persons in recovery, and their families representative of the diverse ethnic, cultural and disability groups in the county who are affected by mental illness and addictive diseases.

h. To improve coordination of substance abuse and mental health services, including the development of specialized programs for persons with both psychiatric and substance use disorders.

i. To create new integrated partnerships across child serving systems to reduce duplication and increase responsiveness of services to families and their children and adolescents, including coordination with early intervention and early childhood care and education programs.

j. To shift the focus of state monitoring from process management

to outcome management with an emphasis on reduction of out-of-home placements for children and adolescents, increased community tenure, improved health status, and improved vocational and educational functioning.

k. To accelerate the administration's state mental hospital rightsizing initiative.

l. To improve coordination of care between physical and Behavioral Health Services including disease management, programs to improve health outcomes, educate consumers and Providers, and increase access to Providers.

II-3. NATURE AND SCOPE OF THE PROJECT

The HealthChoices Program ensures that Members have access to quality physical and Behavioral Health Services while allowing the Commonwealth to stabilize the rate of growth in health care costs. Primary Contractors and their BH-MCOs for the behavioral health component of the HealthChoices Program are responsible for locating, coordinating, and monitoring the provision of designated Behavioral Health Services on behalf of Members.

A. Enrollment Process

1. HealthChoices Behavioral Health Care

Members are enrolled in the BH-MCO operating in their county of residence on or after being determined eligible for MA. Eligible individuals must be enrolled regardless of their race, color, ethnicity, national origin, sex, actual or perceived sexual orientation, gender identity, gender expression or disability. As Members are enrolled, information will be forwarded to the BH-MCO. The BH-MCO must establish mechanisms to inform the CAO of any change or update to the Member's residency or eligibility status within 10 days of the date of learning of the change.

The BH-MCO must have in effect written administrative policies and procedures for newly enrolled Members. The BH-MCO must also have a transition plan and procedure for providing Behavioral Health Services for newly enrolled Members. The Department will provide the BH-MCO with enrollment information for its Members including the beginning and ending effective dates of enrollment. It is the responsibility of the BH-MCO to take necessary administrative steps consistent with the dates determined and provided by the Department to determine

periods of coverage and responsibility for services.

As directed by the Department, the BH-MCO must make an effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees. Subsequent attempts to make an initial screening of enrollee's needs should be made if the initial attempt to contact the enrollee is unsuccessful.

B. HealthChoices Program Eligible Groups

The HC-BH population consists of seven different eligible groups, or aid categories which may change from time to time. Qualification for the HC-BH Program is based on a combination of factors, including family composition, income level, insurance status, and/or pregnancy status, depending on the aid category in question. The scope of benefits and program requirements vary by the MA category. Should the Department choose to implement cost sharing options at a future date, these options may also be determined by MA category.

1. The eligible groups (see Appendix X for details) are:

   a. Temporary Assistance to Needy Families (TANF) and TANF-Related MA: A federal block grant program, matched with state funds, which provides cash payments and MA, or MA only (Medically Needy Only and Non-Money Payment), to families which contain dependent children who are deprived of the care or support of one or both Parents due to absence, incapacity, or unemployment of a parent.

   b. Healthy Horizons: An MA program which provides non-money payment (NMP) MA and/or payment of the Medicare premium, deductibles, or coinsurance to disabled persons and persons age 65 and over. Exception: An individual who is determined eligible for Healthy Horizons for cost sharing coverage only (categories PG and PL) will not be enrolled in the HC Program.

   c. SSI with Medicare: Monthly cash payments made to persons who are aged, blind, or determined disabled for over two years under the authority of Title XVI of the Social Security Act, as amended, Section 1616(A) of the Social Security Act, or Section 212(A) of Pub. L. 93-66. This category automatically receives MA.

   d. SSI without Medicare: Monthly cash payments made to persons

who are aged, blind, or have been disabled for less than two years and will become eligible for Medicare when the disability has lasted for two years, under the authority of Title XVI of the Social Security Act, as amended, Section 1616(A) of the Social Security Act, or Section 212(A) of Pub. L. 93-66. This category automatically receives MA.

e. SSI-Related: An MA category which has the same requirements as the corresponding category of SSI. Persons who receive MA in SSI-Related categories are aged, blind or disabled. This includes Medically Needy Only and Non-Money Payment.

f. State-Only GA: A state funded program which provides cash grants and MA (Categorically Needy) or MA only (Medically Needy Only and Non-Money Payment) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.

g. Eligible Groups Under MAGI Rule: MG 00 – Children ages 1-5 inclusive and income at or below 157% FPL. Youth ages 6-18 inclusive and income at or below 119%. Infants and pregnant women at or below 215% FPL. MG19 – Youth ages 6-18 inclusive with income at or below 119% FPL. MG27 – Income at or below 33% FPL. MG 71 – Transitional Medical Assistance.

h. Newly Eligible Groups Under ACA

Childless adults with income less than or equal to 133% of the applicable FPL.

Parents and designated care takers and individuals ages 19 or 20 with income between 4% and 133% of the applicable FPL.

2. MAGI Recipient

The Department will make Capitation payments to the Primary Contractor for eligible Members having a category of assistance "MG" at the TANF rate that is appropriate for the age of the Member.

3. Eligibility Determination

   The Department has sole authority for determining whether individuals or families meet any of the eligibility criteria specified in items a. through i. above. The Department performs eligibility determination using trained eligibility staff. These individuals are stationed at CAOs located throughout the Commonwealth.

4. Guaranteed Eligibility

   Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through the last day of the month in which the 60 days postpartum or post-loss of pregnancy period ends and their newborns are guaranteed coverage for one year, as long as mother and child continue to live together during that year.

5. Involuntary Mental Health Commitment

   Whenever a Member residing in one HealthChoices county is made subject to involuntary examination and/or treatment in another HealthChoices county, the BH-MCO in the county in which the Member resides shall be responsible for the cost of examination and/or involuntary treatment provided in the other county. The BH-MCO providing services in the county in which the HealthChoices Member resides shall abide by the examination and/or involuntary treatment decisions made in the county in which services are rendered. The BH-MCO in the county where the Member receives examination and/or treatment shall notify the Member's BH-MCO within 24 hours of commitment.

6. Placement of Adults and Children NOT in Substitute Care in Behavioral Health Residential Treatment Facilities (see Appendix V – H.).

7. Children and Adolescents in Substitute Care Issues (see Appendix V – H.)

8. For children and adolescents placed in a juvenile detention facility, the BH-MCO is responsible for medically necessary State Plan Services delivered in treatment settings outside (off site) the juvenile detention facility during the first 35 consecutive days of detention. However, the BH-MCO is not responsible at any time for services delivered within the juvenile detention facility.

9. Children whose adoptions have been finalized and for whom the CCYA is continuing to provide support through an adoption assistance agreement with the adoptive Parents residing in the HC Zone are to be enrolled in the

BH-MCO of the county where the adoptive family resides.

10. The BH-MCO will be required to pay for medically necessary Behavioral Health Services for Members provided within a private Intermediate Care Facility for persons with intellectual disabilities (ICF/ID) facility within the HC Zone.

11. In order to serve an individual less than 21 years of age in a psychiatric hospital setting and be reimbursed through Medical Assistance for the services, the facility must be accredited by a national accrediting organization approved by CMS or undergo a State survey conducted by the Department of Health to determine whether the hospital meets the requirements to participate in Medicare (or Medicaid) as a psychiatric hospital under 42 CFR §482.60.

C. Rating Period

A period selected by the Department for which the actuarially sound Capitation rates are developed and documented in the rate certification submitted to CMS as required by §438.7(a)

For the second, fourth and fifth rating periods, the Department will adjust Capitation rates, if necessary, to maintain actuarial soundness based upon a material and demonstrated impact caused by any or all of the following:
Changes in medical costs;

1. Changes in utilization patterns; or

2. Programmatic changes that affect the Primary Contractor and/or its BH-MCO's delivery or coverage of benefits.

In the event that no adjustments are made, pursuant to C.1), 2) or 3) above, the rates applicable to the previous rating period will apply. The Department will disclose to the Primary Contractor the basis and assumptions of its determination with respect to adjustments to the second, fourth and fifth rating period rates.

At the Department's discretion, Capitation rates may be negotiated for the third rating period. In the event the Department does not negotiate Capitation rates for the third rating period, the Department will adjust Capitation rates, if necessary, as provided for the second, fourth and fifth rating period.

If agreement is not reached prior to the start of an Agreement period, the rates applicable to the previous rating period will continue to apply until new rates are agreed upon and effective.

If the Department exercises its option to renew the Agreement for an additional three-year period, pursuant to Part I-4, rate negotiations will commence promptly after notice of same for the sixth rating period. Capitation rates will be adjusted for the seventh and eighth rating period.

The Department reserves the right to expand or contract the scope of the HealthChoices Program during the term of the Agreement to include additional services or reduce services, or covered populations.

D. Termination/Cancellation

The Department reserves the right to terminate or cancel the Agreement for failure to perform as required by Agreement terms, non-availability of funds, failure to secure/retain necessary federal contract and/or Waiver approvals, or change in applicable federal or Commonwealth law, regulation, public policy, or at the option of the Department.

For Agreements with an individual county, DHS requires the Primary Contractor to provide a minimum of 270 days' notice of intent to terminate the Agreement. For an Agreement with a Multi-County Entity, DHS requires a minimum of 270 days' notice in the event the Primary Contractor intends to terminate the Agreement and also if one or more counties intend to withdraw from the Multi-County Entity during the Agreement period. The Agreement will remain in effect for the remaining counties who continue to meet Department requirements and the rates will be recalculated accordingly.

In the event a county or county group intends to release a Request for Proposal (RFP) in order to reprocure a BH-MCO, OMHSAS requires the Primary Contractor to provide written notice. The Primary Contractor is required to notify OMHSAS of the selected BH-MCO 270 days before the effective date of the Initial Term of the Agreement between the Primary Contractor and selected BH-MCO unless an exception for good cause has been obtained from OMHSAS.

Upon termination/Cancellation or expiration of the Agreement, the Primary Contractor must:

1. Provide the Department with all information deemed necessary by the Department within 30 days of the request;

2. Be financially responsible for Provider claims with dates of service through the day of termination, except as provided in D.3) below, including those submitted within established time limits after the day of termination;

3. Be financially responsible for Members placed in inpatient and residential treatment facilities through the dates specified in Section E of the HC-BH Recipient Coverage Document (Appendix V).

4. Be financially responsible for services rendered through 11:59 p.m. on the day of termination, except as provided in D.3) above, for which payment is denied by the BH-MCO and subsequently approved upon appeal by the Provider; and

5. Arrange for the orderly transition of Members and records to those Providers who will be assuming ongoing care for the Members.

During the final quarter of the Agreement, the Primary Contractor and its BH-MCO will work cooperatively with, and supply program information to, any subsequent Primary Contractor. Both the program information and the working relationship between the Primary Contractors will be defined by the Department.

E. Compliance with Federal and State Laws, Regulations, Department Bulletins and Policy Clarifications

The Primary Contractor and its BH-MCO must assure that Network Providers delivering State Plan Services participate in the MA program and, in the course of such participation, provide those services essential to the care for individuals being served, and comply with all federal and state laws generally and specifically governing participation in the Medical Assistance Program. The Primary Contractor's BH-MCO and Behavioral Health Services Providers must also agree to comply with all applicable Department regulations and policy bulletins and clarifications. The Primary Contractor and its BH-MCO and its Subcontractors must agree to comply with all applicable federal and state laws and regulations including: Title VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Section 2000 d. et. seq. and 2000 e. et. seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et. seq.); The Age Discrimination Act of 1975 (42 U.S.C. Section 6101 et. seq.); the Americans with Disabilities Act of 1990 as amended (42 U.S.C. Section 12101 et. seq.) (ADA) the Pennsylvania Human Relations Act of 1955 (71 P.S. Section 941 et. seq.); The Pennsylvania Managed Care Consumer Protection Act (Act 68) of 1998 (Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2101 et. seq.); as amended and Title IX of the Education Amendment of 1972 (regarding education programs and activities), 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information) and 45 CFR Part 74, Appendix A and section 1557 of the Patient Protection and Affordable Care Act.

The Primary Contractor and its BH-MCO agrees to comply with future changes in

federal and state laws, federal and state regulations, Medicaid State Plan, Federal Waivers and Department requirements and procedures related to changes in the Medicaid program.

The Primary Contractor and its BH-MCO must comply with the requirements mandating Provider identification of Provider-preventable conditions as a condition of payment, as well as the prohibition against payment for Provider-preventable conditions as set forth in 42 CFR §§ 438.3(g) and 447.26. The Primary Contractor and its BH-MCO must report all identified provider-preventable conditions in a form and frequency as specified by the Department.

The Primary Contractor and its BH-MCO must comply with the parity requirements set forth in 42 CFR Part 438 Subpart K. The Primary Contractor and its BH-MCO must notify the Department when there is a change in its benefit design or operations that could affect the Primary Contractor's and its BH-MCO's compliance with the parity requirements, and provide the Department with any information the Department needs to conduct an analysis of the Primary Contractor's and its BH-MCO's continued compliance with the parity requirements

The Primary Contractor and its BH-MCO must comply with 42 CFR § 438.62(b)(1). OMHSAS will notify the Primary Contractor and its BH-MCO of the date by which compliance with section 42 CFR § 438.62(b)(1)(vi) is required.

F. False Claims

The Primary Contractor recognizes that payments by the Department to the Primary Contractor will be made from federal and state funds and that any false claim or statement in documents or any concealment of material fact may be a cause for prosecution under applicable federal and state laws. Payments are contingent upon availability of state and federal funds.

The primary contractor and its BH-MCO will require Network Providers to certify the truthfulness, accuracy, and completeness of their claim submissions, acknowledging the Federal and State source of funds and potential for Federal and State prosecution of falsification or concealment of material fact as set forth in 42 CFR § 455.18 and § 455.19.

The Primary Contractor and its BH-MCO will implement and maintain written policies for all employees, Network Providers, and Subcontractors to provide detailed information about the Federal False Claims Act (FCA), 31 U.S.C.A. §§ 3729 et seq., including information about the right of employees to be protected as whistleblowers.

G. Major Disasters or Epidemics

In the event of a major disaster or epidemic as declared by the Governor of the Commonwealth, the Primary Contractor and its BH-MCO shall require Providers to render all services provided for in this document and the Agreement as is practical within the limits of Providers' facilities and staff which are then available. The Primary Contractor and its BH-MCO shall have no obligation or liability for any Provider's failure to provide services or for any delay in the provision of services when such a failure or delay is the direct or proximate result of the depletion of staff or facilities by the major disaster or epidemic.

H. Performance Standards and Damages

1. Performance Standards for the HC BH Program

   Performance standards for the HC BH Program are included throughout this document. Additional standards may be developed for inclusion in subsequent related contracts. The Primary Contractor may develop performance standards consistent with this document. The Department reserves the right to institute incentive payments related to performance standards in the future.

2. Corrective Actions

   The Department may take corrective actions for non-compliance with, or failure to meet performance and program standards indicated in the Agreement and/or subsequent related agreements, including but not limited to:

   a. Requiring the Primary Contractor to submit a corrective action plan.
   b. Imposing sanctions including recovery of overpayments,
   c. Imposing liquidated damages as set forth in the Agreement,
   d. Imposing suspension or denial of payments,
   e. Terminating the Agreement and participation in the Medical Assistance Program.

3. CMS Review and Approval

   The Department must submit to CMS for review and approval, the Primary Contractor's rate certifications concurrent with the review and approval process for HC BH Agreements as specified in §438.3(a).

   The Department may take corrective actions as set forth in section H.2 above if signed HC BH Agreements or amendments are not returned to the

Department by a date specified. As specified in §438.3(a), proposed final Agreements must be submitted to CMS for review no later than 90 days prior to the effective date of the Agreement.

4. Profit, Discretionary Funds and Reinvestment Arrangement

   a. Counties and Multi-County Entities as Primary Contractors and management or oversight entities formed by or organized on behalf of the counties or Multi-County Entities are not permitted to retain any Discretionary Funds. After the closure of each Agreement period, any county or Multi-County Entity's Discretionary Funds which have not been included in a DHS approved reinvestment plan must be returned to DHS (Appendix N, Reinvestment Parameters)

   b. BH-MCOs as Primary Contractors to DHS or Private Sector BH-MCOs as contractors to a county are permitted to retain profit in accordance with the terms of their contract with the Primary Contractor. Profit will be monitored by DHS and will be a factor in future DHS rate adjustments and negotiations with the Primary Contractor.

II-4. TASKS

A. State Plan Services

The program includes medically necessary mental health, substance abuse and behavioral services.

1. The BH-MCO shall provide timely access to behavioral health diagnostic, assessment, referral, and treatment services for Members. At a minimum, State Plan Behavioral Health Services must be provided in the amount, duration and scope set forth in the MA FFS Program and be based on the Recipient's benefit package, unless otherwise specified by the Department. The BH-MCO must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. Additionally, all medically necessary 1905(a) services that correct and ameliorate mental illness and conditions or substance use disorders are covered for EPSDT-eligible beneficiaries ages birth to twenty-one, in accordance with 1905(a) of the Social Security Act. If services or eligible consumers are added to the Pennsylvania MA Program or HC program, or if covered services or eligible consumers are expanded or eliminated, implementation by the BH-MCO must be on the same day as Department's unless the BH-MCO is notified by the Department of an alternative implementation date.

2. The Primary Contractor and its BH-MCO must require that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to MAFFS, if the Provider serves only MA Members. Hours of operation should be flexible in order to accommodate the particular scheduling needs of Members (i.e. inclusion of evening and/or weekend hours). In addition, Providers must have services available 24 hours a day, seven days a week when medically necessary.

3. The Primary Contractor or its BH-MCO must have procedures for authorization and payment for State Plan Services, which are required but not available within the Provider network and for providing Emergency Services for Members who are temporarily out of the HealthChoices Zone.

4. Member Liability

   a. Members will not be held liable for:

      i. State Plan Services provided to the Member for which the Department does not pay the Primary Contractor.

      ii. State Plan Services provided to the Member for which the Department does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement.

      iii. State Plan Services to the extent that those payments are in excess of the amount that the Member would owe if the Primary Contractor or its BH-MCO provided the services directly.

   b. The Primary Contractor and its BH-MCO must coordinate with and make timely payments to Out-of-Network and Out-of-State Providers for medically necessary covered services as otherwise provided for in this Agreement, including, but not limited to, when:

      i. Services were rendered to treat an Emergency Medical Condition;

      ii. Services were prior authorized;

      iii. Services were not available in network;

      iv. The Primary Contractor and its BH-MCO denied Prior

Authorization of services but the Department determined, after a hearing, that the services should have been authorized.

c. The Primary Contractor and its BH-MCO may not impose any cost to the Member for using an Out-of-Network Provider that is greater than what the costs would have been if a Network Provider furnished the services.

5. The Primary Contractor or its BH-MCO must provide comprehensive Service Management, with clear access and lines of authority. Each Member's plan of care, including the commencement, course, and continuity of treatment and support services, must be documented in such a way as to permit effective review of care and demonstrate care coordination with services covered by the Primary Contractor or its BH-MCO.

6. For Priority Populations, a clearly defined program of care which incorporates longitudinal and disease state management is expected. In addition, evidence of a coordinated approach must be demonstrated for those persons with co-existing mental health and drug and alcohol conditions as well as for older adults with psychiatric and substance use disorders, particularly those with co-existing physical impairments, and other Special Needs Populations who experience mental health and/or drug and alcohol disorders (e.g., persons with intellectual disabilities, homeless persons, persons diagnosed with Autism Spectrum Disorder (ASD), persons discharged from correctional facilities, persons with HIV/AIDS and physical disabilities).

7. The Primary Contractor and its BH-MCO must ensure that the SUD providers in its network comply with program standards in the ASAM Criteria included but not limited to, admission criteria, discharge criteria, interventions,/types of services, hours of clinical care, and credentials of staff as set forth in the ASAM transition requirements found at https://www.ddap.pa.gov/Professionals/Pages/ASAM-Transition.aspx (ASAM transition requirements). The Primary Contractor and its BH-MCO must monitor SUD providers in order to ensure compliance with ASAM transition requirements. The monitoring process must follow guidelines that will be developed by OMHSAS. The Primary Contractor and its BH-MCO shall not impose any sanctions, financial or otherwise, upon SUD treatment Providers that are not in full compliance with the ASAM transition requirements prior to July 1, 2022.

8. The Primary Contractor or its BH-MCO must ensure that SUD providers in their network offer Medication Assisted Treatment (MAT) either on-site or facilitate access to MAT off-site. MAT is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. The Primary Contractor or its MH-MCO must ensure the coordination of care between therapeutic and pharmaceutical interventions so that individuals with SUD who have a disorder for which there is an FDA-approved medication treatment have access to those treatments based upon their individual needs and preferences.

   The Primary Contractor and its BH-MCO must:
   a. Ensure that Network Providers do not exclude individuals on MAT from being admitted into services;
   b. Ensure coordination of care after consent is obtained from the Member when a prescriber and the SUD treatment provider are not the same;
   c. Ensure Network Providers admit and provide services to individuals who use MAT for SUD;
   d. Ensure that the service access requirements in Section II.5.F. are met for providers of MAT for SUD.

9. The Primary Contractor or its BH-MCO is required to maintain 24-hour telephone accessibility, staffed at all times by qualified personnel, to provide information to Members and Providers, and to provide screening and referral, as necessary.

   a. There must be 24-hour capacity for service authorization.
   b. There must be 24-hour access to a physician for psychiatric and drug and alcohol clinical consultation and review.
   c. All Member and Provider calls must be answered within 30 seconds.
   d. Separate Member and Provider telephone lines are permitted.
   e. The Member line must be answered by a live voice at all times.
   f. BH-MCOs serving multiple counties in a HealthChoices Zone may establish a regional network with one telephone line for Member calls and one line for Provider calls.
   g. Separate record keeping must be established for tracking and monitoring of both Provider and Member phone lines.

10. The Primary Contractor or its BH-MCO must have procedures for reminders, follow-up, and outreach to Members including:

    a. Home visits and other methods to encourage use of needed services by Members who do not keep appointments, including notification of upcoming appointments.

b. Population groups with special needs and/or groups who under use needed Behavioral Health Services, such as older persons, persons who are homebound or homeless adults with intellectual disabilities, and persons diagnosed with ASD.

c. Administrative mechanisms for sending copies of information, notices and other written materials to an additional party upon the request and signed consent of the Member.

11. The Primary Contractor or its BH-MCO must have procedures to determine the EPSDT screen status for children receiving Behavioral Health Services. Referral to the child's PH-MCO PCP must be made for children whose EPSDT screens are not current, based on the American Academy of Pediatrics periodicity schedule. The BH-MCO must have procedures to collect and report EPSDT screen referral and status information.

12. A Primary Contractor or its BH-MCO that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service, is not required to do so if the BH-MCO objects to the service on moral or religious grounds.

    If the Primary Contractor or its BH-MCO elects not to provide, arrange for the provision of, or make payment for, a counseling or referral service because of an objection on moral and religious grounds, it must:

    a. Furnish information to the Department describing the service(s) it does not cover:

        i. include this information with its application for a Medicaid contract;
        ii. notify the Department whenever it adopts the policy during the term of the Agreement.

    b. Notify Members with the identity of the excluded services:

        i. within 90 days of adopting the policy with the projected effective date; but
        ii. at least 30 days before the effective date of the policy.

    c. Inform Members how they can obtain information from the Department about how to access the excluded services.

B. In Lieu Of and In Addition To Services

The Primary Contractor or its BH-MCO may develop or purchase in lieu of or in addition to services that are not State Plan Services. Information regarding the enrollment process for providers of in lieu of or in addition to services is included in Appendix Z.

1. In Lieu Of Services

   The Department may determine that certain in lieu of services, which are medically necessary and cost-effective alternatives to State Plan services or settings, may be provided by the Primary Contractor and its BH-MCO. The Primary Contractor and its BH-MCO are not required to provide in lieu of services but have the option to provide these approved services. If the Department approves the provision of in lieu services:

   a. The Primary Contractor and its BH-MCO may not require its Members to use the in lieu of services.

   b. The Department will take utilization and actual cost of in lieu of services into account when developing the relevant service component of the Capitation rate.

   c. In lieu of services must be authorized and approved by the Department. Annually, the Department will provide to the Primary Contractor a list of approved in lieu of services that will be taken into account in developing the relevant service component of the Capitation rate.

   e. The most commonly approved services include:
      i. Freestanding psychiatric facilities with more than 16 beds serving 21 – 64 year olds (Section 1.c does not apply).
      ii. Non-hospital drug and alcohol rehabilitation (Section 1.c does not apply)
      iii. Assertive Community Treatment
      iv. Psychiatric Rehabilitation Services

   Other approved in lieu of services, which may vary by Primary Contractor, may be provided in accordance with this section 1.a thru d. above.

2. In Addition To Services

   The Primary Contractor and its BH-MCO may voluntarily cover services that are in addition to those covered under the State Plan and in lieu of

services. The cost of these services will not be included when the payment rates are determined pursuant to 42 CFR §438.3.

C. Coordination of Care

1. The BH-MCO and the PHSS, operating in the county(ies) covered by the BH-MCO, are required to develop and implement written agreements regarding the interaction and coordination of services provided to Members. These agreements must be submitted to and approved by the Department. Complete agreements, including operational procedures, must be available for review by the Department at the time of On-Site Review. The agreements must be submitted for final review and approval to the Department at least 30 days prior to the implementation of the CHC Program in a new CHC Zone. The written agreements should include, but not be limited to:

    a. Procedures which govern referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, the provision of emergency department services, and other treatment issues necessary for optimal health and prevention of illness or disease. The PHSS and the BH-MCO must collaborate in relation to the provision of Emergency Services; however, Emergency Services provided in general hospital emergency departments are the responsibility of the Member's PHSS, regardless of the diagnosis or services provided. The only exception is for emergency department evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the BH-MCO. Responsibility for inpatient admission will be based upon the Member's Primary Diagnosis. Procedures must define and explain how payment will be shared when the Member's Primary Diagnosis changes during a continuous hospital stay.

    b. Procedures, including Prior Authorization, which govern reimbursement by the BH-MCO to the PHSS for HealthChoices Behavioral Health Services provided by the PHSS, or reimbursement by the PHSS to the BH-MCO for physical health services provided by the BH-MCO, and the resolution of any payment disputes for services rendered. Procedures must include provisions for assessment of persons with co-existing physical and behavioral health disorders, as well as provision for cost-sharing when both behavioral and physical health services are provided to a Member by a service Provider.

    c. Procedures for the exchange of relevant enrollment and health-related information among the BH-MCO, the PHSS, the PCP, and BH, PH, and LTSS service Providers in accordance with federal and state confidentiality laws and regulations (e.g., periodic treatment updates with identified primary and relevant specialty Providers).

d. Policy and procedures for obtaining releases to share clinical information and providing health records to each other as requested consistent with state and federal confidentiality requirements.
e. Procedures for training and consultation to each other to facilitate continuity of care and cost-effective use of resources.
f. A mechanism for timely resolution of any clinical and fiscal payment disputes; including procedures for entering into binding arbitration to obtain final resolution.
g. Procedures for serving on Interagency Teams, as necessary.
h. Procedures for the development of adequate Provider networks to serve Special Needs Populations and coordination of specialized service plans between the BH-MCO service managers and/or service Provider(s) and the PHSS PCP for Members with special health needs (e.g. children and adolescents in medical foster care, older Members with coexisting physical and behavioral health disorders such as asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure and a serious mental illness or ASD).
i. The BH-MCO is required to provide behavioral health crisis intervention and other necessary State Plan Services to Members with behavioral health Emergency Medical Conditions. The PHSS is responsible for payment of all emergency and medically necessary non-emergency ambulance services. The PHSS and BH-MCO must establish clear procedures for coordinating the transport and treatment of persons with behavioral health Emergency Medical Conditions who initially present themselves at general hospital emergency departments to appropriate behavioral health facilities.
j. Procedures for the coordination of laboratory services.
k. Mechanisms and procedures to ensure coordination between the BH-MCO service managers, Member services staff and Provider network with the PH-MCO special needs unit and CHC-MCO Coordinator. The effectiveness of these mechanisms shall be included as an area for review by the BH-MCO Quality Management program and the PHSS Quality Management program.
l. Procedures for the PHSS to provide physical examinations required for the delivery of Behavioral Health Services, within designated timeframes for each service.
m. Procedures for the interaction and coordination of pharmacy services to include:
    i. All pharmacy services are the payment responsibility of the Member's PHSS. All prescribed medications are to be dispensed through PHSS network pharmacies. This includes drugs prescribed by the PHSS and the Primary Contractor Providers. The only exception is that the Primary Contractor

is responsible for the payment of methadone when used in the treatment of substance use disorders and when prescribed and dispensed by Primary Contractor service Providers;

ii. Neither the PHSS nor the Primary Contractor and its BH-MCO are billed for medications administered during the course of an inpatient stay. Inpatient rates include the cost of all pharmaceuticals. Hospital inpatient rates are calculated to include ancillary costs, which are included in the per diem. Medications dispensed on an inpatient unit are an ancillary cost.

The PHSS may only restrict pharmacy services prescribed by a BH-MCO Provider if one of the following exceptions is demonstrated:

a. The drug is not being prescribed for the treatment of substance abuse/dependency/addiction or mental illness or to treat the side effects of psychopharmacological agents. Those drugs are to be prescribed by the PHSS PCP or specialists in the Member's physical care health network;
b. The prescribed drug does not conform to standard rules of the pharmacy services plan; e.g., use of generic or cost effective alternative(s), purchases from certain pharmacies, and quantity limited to a 30-day supply;
c. The drug is prescribed by a behavioral health Provider identified as not having a signed Provider Agreements with the BH-MCO; or
d. The prescription has been identified as an instance of fraud, abuse, gross overuse, or is contraindicated because of potential interaction with other medications.

iii. There must be BH-MCO representation on each HC PH-MCO's and CHC-MCO's panel of physicians and other clinicians selecting the PH-MCO formulary. The PH-MCOs and CHC-MCOs formularies or the reimbursable methods of administering drugs (e.g., use of injectables) must be reviewed and approved by OMAP, OLTL and OMHSAS prior to program implementation and for any subsequent change;

iv. procedures for monitoring behavioral health pharmacy services provided by the PHSS;

v. procedures for notifying each other of all prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete, up to

date medication records;

vi. procedures for the timely resolution of any disputes which arise from the payment for or use of pharmaceuticals (e.g., use of anticonvulsant medication as a mood stabilizer) including a mechanism for timely impartial mediation when resolution between the PHSS and BH-MCO does not occur;

vii. procedures for sharing independently developed Quality Management/Utilization Management information related to pharmacy services, as applicable;

viii. policies and procedures to collaborate in adhering to a drug utilization review (DUR) program approved by the Department. This system is based on federal statute/regulations [Section 4401(g) of OBRA 1990, Section 4.26, guidelines 1927(g), 42 CFR 456]; and

ix. procedures for the BH-MCO to collaborate with the PHSS in identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Members associated with specific drugs. Areas for particular attention include potential and actual adverse drug reactions; therapeutic appropriateness; over and under drug use; appropriate use of generic products; therapeutic duplication; drug/disease contraindications; drug to drug interactions; incorrect drug dosage or duration of treatment; drug allergy reactions; and clinical abuse/misuse.

x. The BH-MCO is required to provide the PHSS upon its request, a listing of the physicians in its initial Provider network and, on a quarterly basis, changes including terminations and additions.

2. The BH-MCO must ensure through its Provider Agreements that its Providers interact and coordinate services with the PHSS and their PCPs.

Behavioral health clinicians, LTSS Providers, and PCPs have the obligation to coordinate care of mutual patients. Consistent with state and federal confidentiality laws and regulations, both must:

a. Ascertain the Member's PCP, and/or relevant physical health specialist, or behavioral health clinician, and/or LTSS Providers and obtain applicable releases to share clinical information.
b. Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.
c. Provide health records to each other, as requested.
d. Comply with the agreement between the BH-MCO and the PHSS to

assure coordination between behavioral and physical health care including resolution of any clinical dispute.

e. Be available to each other for consultation.

3. HealthChoices Behavioral Health/Physical Health/LTSS Coordination

The Primary Contractor and its BH-MCO must work in collaboration with the PH-MCOs and CHC-MCOs through participation in joint initiatives to improve overall health outcomes of its Members and those activities that are prescribed by the Department.

4. Physical Health Medical Care

The Member's PHSS has a comprehensive benefit package provided in a manner comparable to the amount, duration, and scope set forth in the MA FFS program, unless otherwise specified by the Department. The comprehensive benefit package includes inpatient and outpatient hospital services, physician services, family planning services, prescription drugs, radiology, and other diagnostic and treatment services, outreach and follow-up, preventive care, home health services, and emergency transportation. Specific PHSS State Plan benefits include:
EPSDT services; emergency department services; physical examinations to determine abuse or neglect; AIDS Waiver program services for MA eligibles; HIV/AIDS targeted case management; medical foster care; medical services to HealthChoices Members, including Members placed in:

a. privately-operated ICF/IDs, and in ICF for persons with other related conditions;
b. mental health residential treatment facilities;
c. acute and extended acute psychiatric inpatient facilities;
d. non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence; and
e. juvenile detention facilities for up to 35 days.

All emergency department services in general hospitals are the responsibility of the Member's PHSS, regardless of the diagnosis or services provided except for evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act. Such evaluation is the responsibility of the BH-MCO pursuant to the terms of the written agreement described in Section II-4. C.1.a. Responsibility for ensuring admissions will be based on the Member's Primary Diagnosis.

All emergency and non-emergency medically necessary ambulance

transportation for both physical and Behavioral Health Services is the responsibility of the Member's PHSS even when the diagnosis is provided by the BH-MCO.

5. Community HealthChoices Coordinator

The Primary Contractor or its BH-MCO must appoint a behavioral health professional as a CHC Coordinator whose primary function includes:

- Coordinate Members' care needs with the CHC-MCO.
- Develop a process to coordinate behavioral healthcare between the BH-MCO and the CHC-MCO.
- Participate in the identification of best practices for behavioral health in a primary care setting.

6. Public Psychiatric Hospitalization

The Primary Contractor and its BH-MCO are not responsible for civil and forensic psychiatric hospitalizations at a state mental hospital are not covered by the Primary Contractor or its BH-MCO. However, the Primary Contractor and its BH-MCO shall coordinate with the state mental hospital and county mental health authority, as applicable, to develop and implement admission and discharge planning for the appropriate admissions and timely discharges and continuity of care for the Member.

7. Emergency Services: Coverage and Payment

The Primary Contractor and its BH-MCO may not deny payment for Emergency Services obtained when a representative of the entity instructs the Member to seek Emergency Services. Payment to an Out-of-Network Provider for emergency services must not be more than the amount that would have been paid if the services had been provided under the Department's MA FFS program.

The Primary Contractor and its BH-MCO may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

The Primary Contractor and its BH-MCO may not refuse to cover Emergency Services based on the emergency department Provider, hospital or fiscal agent not notifying the Member's BH-MCO of the Members screening and treatment within 10 calendar days of presentation for Emergency Services.

A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. Responsibility for inpatient admission will be based upon the Member's Primary Diagnosis.

The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and the determination is binding on the Primary Contractor and its BH-MCO.

The Primary Contractor and its BH-MCO must comply with the prior authorization, admission and documentation requirements for emergency inpatient admissions found in Appendix AA, Attachment 1.

8. The Primary Contractor or its BH-MCO must enter into a written agreement with the CCYA to include, at a minimum:

    a. Procedures for referral, authorization and coordination of care, including overall requirements for children and adolescents in substitute care and specific requirements for referral, review of Medical Necessity prior to admission to and coordination of care following discharge from accredited and non-accredited RTF services, and D&A non-hospital residential rehabilitation and detox programs.
    b. Liaison relationships for individual cases and administration.
    c. Release of records and BH-MCO representation in court.
    d. Procedures to assure continuity of behavioral health care for children in substitute care at the time of program start-up.
    e. Procedures to communicate denials of service by the BH-MCO.
    f. Provision of BH-MCO Provider directories, including electronic transmission where children and youth agency capacities exist.

9. For children and adolescents who are served by multiple child serving systems, the Primary Contractor or its BH-MCO must:

    a. Have well publicized written policies and procedures explaining the Primary Contractor or its BH-MCO is available to attend or convene Interagency Team meetings, at the request of or with the consent of the parent or custodian.
    b. At the parent/custodian's or agency's request, serve on an Interagency Team to develop a comprehensive interagency plan which identifies the service, the responsible agency to deliver the service, and the source of funding for the service.
    c. Coordinate specialized treatment plans for children and adolescents with special health needs, including early intervention.
    d. Ensure that a family with a child who has, or is at risk of, a developmental delay is referred to the county development disability/intellectual disability/early intervention program for a

determination of eligibility for home and community-based services or early intervention services.

10. The Primary Contractor or its BH-MCO is required to coordinate service planning and delivery with human services agencies. The Primary Contractor or its BH-MCO is required to have a letter of agreement with:

    a. Area Agency on Aging.
    b. County Juvenile Probation Office (including the same components as the agreement with the CCYA in Section II-4. C.8).
    c. County Drug and Alcohol Agency, including:
        i. A description of the role and responsibilities of the SCA.
        ii. Procedures for coordination with the SCA for placement and payment for care provided to Members in residential treatment facilities outside the HC Zone.
    d. County offices of MH and ID, including coordination with the Health Care Quality Unit (HCQU).
    e. Each school district in the county.
    f. County MH/ID Program, County Prisons, County Probation Offices, Department of Corrections and Pennsylvania Board of Probation and Parole to ensure continuity of care and enhanced services for individuals as they enter and leave the criminal justice system.
    g. Early intervention including:
        (i) Infant-toddler early intervention (0-3 years) administered by the County ID office.
        (ii) Pre-school intervention (3-5 years) administered by the local Mutually Agreed upon Written Arrangement .The Mutually Agreed upon Written Arrangement is most typically the Intermediate Unit.

11. The Primary Contractor or its BH-MCO must have in place written agreements with the other Primary Contractors or their BH-MCOs in the HC Zone to ensure continuity of care for Members who relocate from one HC county to another. The Primary Contractor or its BH-MCO must also have in place procedures to ensure continuity of care for Members who relocate to a county outside of the HC Zone or out-of-state on a temporary or permanent basis as well as disenrollment described below.

12. Certified Community Behavioral Health Clinics

    The Department has been awarded a federal demonstration grant under section 223 of the Protecting Access to Medicare Act of 2014 (H.R.4302). The grant is part of a comprehensive effort to integrate behavioral health with physical health. The Primary Contractor and its BH-MCO will comply with the

requirements contained in Appendix A.

The Primary Contractor and its BH-MCO will pay the CCBHC the Prospective Payment System payment rate, designated in the DHS-issued CCBHC Rate Letter, for individuals who are CCBHC members and who received a CCBHC-covered service during the Section 223 Demonstration program. The Primary Contractor and its BH-MCO will comply with the additional requirements contained in Appendix A when the CCBHC is located in the Primary Contractor's county(s) covered under their HC BH Agreement.

D. Member Services/Member Rights

1. The Primary Contractor and its BH-MCO must comply with any applicable federal and state laws that pertain to Members' rights and ensure that their staff takes those rights into account when furnishing services to Members.

2. Member Orientation

   a. In consultation with the Department, the Primary Contractor and its BH-MCO must develop and distribute culturally/disability sensitive materials to Members regarding program features, policies, and procedures.
   b. The Primary Contractor and its BH-MCO must conduct education sessions for Members and families to inform them of the benefits available and the access procedures. Such sessions must be in locations readily accessible and at times convenient for Members and families.
   c. The Primary Contractor and its BH-MCO must provide to Members, within five days of enrollment, the names, locations, telephone numbers of, and non-English languages spoken by, current Network Providers in the Member's service area, including identification of Providers that are not accepting new patients. In addition, the Primary Contractor and MCO its BH-MCO must provide a list of current State Plan behavioral health Network Providers to the Member upon the Member's request. The Primary Contractor and its BH-MCO must make a good faith effort to give written notice of terminated contracts within 15 days after receipt or issuance of a termination notice, to each Member who receives primary care from or was seen on a regular basis by the terminated Provider.
   d. The Primary Contractor and its BH-MCO must provide each Member the opportunity to talk to staff who can explain plan services and can assist the Member with accessing services.

.

   e. The Primary Contractor or its BH-MCO must provide a Member handbook using the Member handbook template developed by the

Department to all Members within five days of enrollment and make the handbook available to other interested parties, upon request (placeholder for link). The Primary Contractor or its BH-MCO may provide Members with the handbook in one of the following manners:

1. by mailing a printed copy of the information to the Member's mailing address;
2. by email after obtaining the Member's agreement to receive the information by email;
3. by posting a copy on its website and advising the Member in paper or electronic form that the information is available on the Internet and including the applicable internet address, provided that Members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
4. by any other method that can reasonably be expected to result in the Member receiving the information.

The Primary Contractor or its BH-MCO must inform Members what formats are available and how to access each format. The process for and method of distribution of the handbook must be submitted to the Department for prior approval. In addition, the Primary Contractor's BH-MCO must notify all Members of their right to request and obtain information related to the Provider network, benefits, Member rights and protections, and Complaint, Grievance, and DHS Fair Hearing procedures at least once a year. The Member handbook template will delineate the following responsibilities of the Primary Contractor and its BH-MCO and the Member's rights and responsibilities:

i. the amount, duration and scope of State Plan Services including EPSDT services and an explanation of any service limitations or exclusions;
ii. a specific statement that provides: "this managed care plan may not cover all your health care expenses. Read your contract (handbook) carefully to determine which health care services are covered;"
iii. how to contact Member Services and a description of its function;
iv. how to choose Providers within a level of care;
v. the counseling or referral services the Primary Contractor and its BH-MCO does not cover because of moral or religious objections. The Primary Contractor and its BH-MCO must inform Members on how they can obtain information from the Department about how and where to obtain the service;
vi. how to obtain emergency transportation and non-emergency

medically necessary transportation;

vii. the extent to which and how Members may obtain benefits from Out-of-Network Providers;

viii. how to obtain services when a Member moves or visits out-of-county/out-of-state;

ix. how to obtain emergency services;

x. how to obtain non-emergency services after hours

xi. explanation of the procedures for accessing Behavioral Health Services, including self-referred services and services that require prior authorization;

xii. confidentiality protections, including access to clinical records by oversight agencies and through the Quality Management/Utilization Management program;

xiii. information concerning methods for coordinating services for Members;

xiv. how to obtain Medical Assistance Transportation Program (MATP) services;

xv. phone numbers of the BH advocacy agencies;

xvi. phone number of the Department's Fraud and Abuse hotline;

xvii. the Primary Contractor, its BH-MCO and contracted Providers must not discriminate against staff, agents or Members receiving services regardless of their race, color, national origin, ethnicity, actual or perceived sexual orientation, age, gender identity, gender expression or disability;

xviii. information on Advance Directives (mental health power of attorney and mental health declarations) for adult Members, including:

a. The description of State law, if applicable.

b. The process for notifying the Member of any changes in applicable State law as soon as possible, but no later than 90 days after the effective date of the change.

c. Any limitation the Primary Contractor or its BH-MCO has regarding implementation of Advanced Directives as a matter of conscience.

d. The process for Members to file a Complaint concerning noncompliance with the advanced directive requirements with the Primary Contractor, its BH-MCO and DOH.

e. How to request written information on Advance Directive policies.

xix. information to adult Members regarding Member rights.

xx. explanation of the operation of the BH-MCO.

xxi. explanation of how Members are assisted in making appointments and obtaining services including the explanation of procedures for accessing self-referred services and

services that require prior authorization.

xxii. explanation of how Members are assisted to obtain transportation through MATP.

xxiii. explanation of how Member Complaints and Grievances are handled.

xxiv. explanation of rights, which must include the following:

a. each Member will be treated with respect and with due consideration for his or her dignity and privacy;

b. each Member will receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

c. each Member will participate in decisions regarding his or her health care, including the right to refuse treatment unless the individual meets criteria for involuntary treatment under the Mental Health Procedures Act, as amended 1978;

d. each Member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of seclusion and restraint;

e. each Member may request and receive a copy of his or her medical records and request that they be amended or corrected in accordance with the Federal Privacy Law;

f. each Member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Primary Contractor, its BH-MCO, Providers or and state agency treats the Member. Specifically, Members are given the opportunity to file a Complaint related to their race, national origin, ethnicity, age, sexual orientation, gender identity and gender expression;

g. each Member has the right to request a second opinion from a qualified health care professional within the Provider network. The Primary Contractor's BH-MCO must provide for a second opinion from a qualified health care professional within the network or arrange for the ability of the Member to obtain one outside the network, at no cost to the Member.

xxv. restrictions on the Member's freedom of choice among Providers.

xxvi explanation of the continuity of care requirements.

f. The Primary Contractor and/or its BH-MCO must send written notice, approved by the Department, to directly affected Members and directly affected Provider at least thirty (30) days prior to the effective date of the change in covered benefits and must simultaneously amend all written materials describing its covered benefit or Provider Network. A change in covered benefits includes any reduction in benefits or a substantial change in the Provider Network which would negatively affect a Member's access to service.

g. In addition to including the following information in the Member handbook, the Primary Contractor and its BH-MCO must provide each Member written notice of any Department-approved change in the following information at least thirty (30) days before the intended date of the change:

i. Complaint, Grievance, and DHS Fair Hearing procedures and timeframes (as provided in Appendix H) that must include the following:
   a. For DHS Fair Hearings.
      i. the right to hearing.
      ii. the method for obtaining a hearing.
      iii. the rules that govern representation at the hearing.
   b. The right to file Complaints and Grievances.
   c. The requirements and timeframes for filing a Complaint or Grievance.
   d. The availability of assistance in the filing process.
   e. The toll-free numbers that the Member can use to file a Complaint or Grievance by phone.
   f. The fact that, when requested by the Member, benefits will continue if the Member files a Complaint (one of the five types of Complaints that allow for continuation of benefits, as specified in Appendix H), Grievance or request for DHS Fair Hearing within the timeframes specified for filing.
   g. Any appeal rights that the Department chooses to make available to Providers to challenge the failure of the organization to cover a service.

ii. Instructions for obtaining care in an emergency, including;
   a. locations of any emergency settings and other location at which Providers and hospitals furnish Emergency Services;
   b. the use of the 911-telephone system or its local equivalent;
   c. what constitutes an Emergency Medical Condition, Emergency Services;
   d. the fact that Prior Authorization is not required for Emergency Services;

e. the fact that the Member has a right to use any hospital or other setting for Emergency Services.

3. The Primary Contractor and its BH-MCO must develop and implement programs for public education and prevention including behavioral health education materials and activities.

Public education programs shall focus on prevention, available services, leading causes of relapse, hospitalization and emergency department use, utilization of advance directives, and shall address initiatives which target high risk population groups.

4. If the Primary Contractor and its BH-MCO use any of the terms included in Appendix DD in a written communication with a potential Member or a Member, the Primary Contractor's and BH-MCO's use of the term must be consistent with the definition included in Appendix DD.

E. Member Disenrollment

1. General Authority

The Department has sole authority for terminating a HealthChoices Member from a HealthChoices BH-MCO, subject to the conditions described below.

2. Reasons for Disenrollment

The Department may terminate a Member from the BH-MCO on the basis of:

a. Member's loss of Medical Assistance eligibility.
b. Placement of the Member in a nursing facility for more than 30 consecutive days.
c. Placement of the Member in any state facility, including a state psychiatric hospital.
d. Placement of the Member in a Juvenile Detention Center for more than 35 consecutive days.
e. Change in permanent residence of the Member which places the Member outside the BH-MCO's service area.
f. Change in Member's status to a recipient group which is exempt from the HC Program.
g. Determination by the Department that the Member is eligible for the Health Insurance Premium Payment Program (HIPP).
h. Member is disenrolled 30 days after enrollment in the Aging Waiver (also known as the Pennsylvania Department of Aging (PDA) Waiver).
i. Member residing in PA Veterans Administrative Home for more than

30 consecutive days.

3. The Primary Contractor or its BH-MCO shall not terminate any Member from the HC-BH Program.

4. A Member's termination from enrollment becomes effective on a date specified by the Department. The Primary Contractor and its BH-MCO must have policies and procedures to comply with any Department enrollment termination and for the Member's continuity of care as described in Section II-4. C.

F. Complaint and Grievance System

1. General

The Primary Contractor's BH-MCO must establish Complaint and Grievance mechanisms through which Members and Providers can seek redress against the BH-MCO. The Primary Contractor or its BH-MCO may not take any adverse action against a Provider for assisting a Member in the understanding of or filing of a Complaint or Grievance under the Member Complaint and Grievance system. Primary Contractors may impose additional requirements on its BH-MCO as are deemed appropriate for effective management.

2. Member Complaint and Grievance System

The Primary Contractor's BH-MCO must develop, implement, and maintain a Complaint and Grievance system which provides for settlement of Member Complaints and Grievances at the most efficient administrative level. The Complaint and Grievance system must conform to the conditions set forth in Appendix H.

a. The Primary Contractor's BH-MCO must provide Members and Parents/custodians of children and adolescents for CISC, both Parents, if whereabouts are known, and county CCYA must receive information) with documents that plainly and clearly outline rights and responsibilities as Members, including the right to file a Complaint or Grievance and/or to request a DHS Fair Hearing. This information must include a toll-free telephone number for Members to facilitate the communication of a Complaint or Grievance.
b. The Primary Contractor and its BH-MCO must ensure that any Subcontractor, with authority to approve and disapprove service requests, complies with the Complaint and Grievance procedures and reporting requirements established by the Primary Contractor or its BH-MCO.
c. Denials of service or coverage must be in writing, notifying the Member or parent/custodian of a child or adolescent of the reason for

the denial, alternative treatments available, the right to file a Grievance and/or request a DHS Fair Hearing and the process for doing so.

d. The Primary Contractor's BH-MCO must integrate its Complaint and Grievance system with the QM process in terms of review, corrective action, resolutions, and follow-up.

e. The Primary Contractor's BH-MCO must have a data system in place capable of processing, tracking, and aggregating data to discern trends in Complaints and Grievances.

f. The Primary Contractor's BH-MCO must provide all required Member Complaint and Grievance information to the Enrollment Assistance Program as requested.

g. The Primary Contractor's BH-MCO's Grievance system may not be a prerequisite to or replacement for the Member's right to request a Fair Hearing (in accordance with 42 CFR Part 431, Subpart E) when the Member is adversely affected by an administrative decision rendered by the Primary Contractor's BH-MCO. The Primary Contractor and its BH-MCO must cooperate with and adhere to the Department's procedures and decisions.

h. Complaints or Grievances resulting from any action taken by oversight agencies responsible for fraud, abuse, and prosecution activities must be directed to the respective agency. Oversight agencies include the Department's Office of Medical Assistance Programs, Bureau of Program Integrity, the Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, and HHS/CMS's Office of Inspector General, and the United States Justice Department.

3) Denial of Services

The Primary Contractor's BH-MCO must have a procedure that allows Members to grieve denials of requests for authorization for services. Individuals responsible for denying services or reviewing Grievances of denials must have the necessary and appropriate clinical training and experience. All denials must be made by a physician or, in some cases, by a licensed psychologist. Prior to denying services requested for an individual under 21, a peer-to-peer review must be conducted. Denials of inpatient care must be approved by a physician. Qualifications of individuals must be consistent with Appendix AA, and all applicable Commonwealth laws and regulations.

The BH-MCO may not deny or reduce the amount, duration, or scope of a required service solely because of a Member's diagnosis, type of illness or condition. If a service for which the request for authorization is denied is viewed by the prescriber and the Member as an Urgent or Emergency Service,

the Primary Contractor's BH-MCO must have a process for expedited review of such Grievances to occur within 24 hours of the request. Any time the Primary Contractor's BH-MCO denies a request for authorization for service, the Primary Contractor's BH-MCO must notify the Member or the parent/custodian of a child or adolescent, in writing. The written notification must include:

a. Specific reasons for the denial with references to the program provisions;
b. A description of alternative services recommended on the basis of placement criteria, e.g., Adult Placement Criteria for Drug and Alcohol services.
c. A description of the Member's right to file a Grievance and/or request a DHS Fair Hearing.

d. Information for the Member describing how to file a Grievance and/or request a DHS Fair Hearing.
e. An offer by the BH-MCO to assist the Member in filing a Grievance and/or DHS Fair Hearing.

4. Provider Complaint System

The Primary Contractor's BH-MCO must develop, implement and maintain a Provider Complaint system which provides for informal mediation and settlement of Provider Complaints at the lowest administrative level and a formal Complaint process when informal resolution is not possible.
The Provider Complaint system must demonstrate a fundamentally fair process for Providers; adequate disclosure to Providers of Provider rights and responsibilities at each step of the process; and sound and justified decisions made at each step.

The Department's Bureau of Hearings and Appeals is not an appropriate forum and shall not be used by Providers to appeal decisions of the Primary Contractor or its BH-MCO.

II-5. REQUIREMENTS

The Primary Contractor is responsible for administering a behavioral health managed care program which meets, at a minimum, the requirements outlined below. The standards allow flexibility in the approach to meeting program objectives, while ensuring the needs of Members are met.

A. General

Participation will be limited to Primary Contractors who are either counties or Multi-

County Entities. A County Operated BH-MCO established as an arm or branch of county government is not subject to licensure, so long as the county maintains responsibility for all financial risk. A County Operated BH-MCO established as an arm or branch of county government must be certified by the Commonwealth as a Utilization Management entity under Act 68 if it directly performs Utilization Management functions. In the event a Multi-County Entity submits a single proposal, each county must be separately responsible for financial risk. One county may not assume the financial risk of the other county(ies) covered by the proposal; nor may a remaining county(ies) assume responsibility for the membership of a terminating county.

B. Executive Management

1. The development of the behavioral health managed care program is a broad-based process. The Primary Contractor must have documentation of the participation of consumers, persons in recovery and family members, including Parents of children and adolescents, as well as county drug and alcohol, mental health and intellectual disabilities, children and youth, juvenile justice, and Area Agency on Aging programs and school districts in the development of the behavioral health managed care program. Participation must include the involvement of consumers, persons in recovery, and family members in the selection of a BH-MCO Subcontractor if one is used and development of the proposal in response to the Department's document. Consumers, persons in recovery and family members must also be involved in ongoing program oversight.

2. In the event a county or MCE is the Primary Contractor, the county (separate from the BH-MCO) must establish an administrative structure for management and program oversight of the behavioral health managed care program. The management structure must include clearly defined and assigned responsibility for monitoring the BH-MCO's fiscal, program/Quality Management and management information systems. The Primary Contractor oversees and is accountable for any functions and responsibilities it delegates to the BH-MCO or any Subcontractor.

3. Subcontractual Relationships and Delegation

   For each Subcontract, the Primary Contractor and its BH-MCO must ensure that:

   a. The Subcontractor has been evaluated and determined competent to perform the activities to be delegated.

   b. The Subcontractor has been engaged pursuant to a written agreement between the Primary Contractor and/or its BH-MCO and the Subcontractor that specifies the activities and reporting responsibilities

delegated to the Subcontractor and provides for revoking delegation or imposing other remedies and sanctions if the Subcontractor's performance is inadequate.

c. Performance monitoring will be conducted on an ongoing basis, and the Subcontractor and will be subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State MCO laws and regulations.

d. Deficiencies or areas for improvement will be identified, and corrective action is required.

e. The Subcontractor has not been excluded from the participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

4. Primary Contractors and their BH-MCOs are required to place all HealthChoices Capitation payments in a separate, restricted account(s).

5. The Primary Contractor is required to contract with C/FST services in the counties served or establish such teams if they do not exist.

6. If the Primary Contractor is a county, the Primary Contractor is required to place Reinvestment Funds in a separate restricted account. A plan for expenditures from that account must be prior approved by DHS. Primary Contractors must have prior approval from DHS to carryover Reinvestment Funds from one Agreement period into a subsequent Agreement period; however, DHS approved reinvestment plan funds must continue to be tracked separately. Counties can maintain Reinvestment Funds, for DHS approved reinvestment plans, up to six months after the time period delineated in their approved reinvestment plan, unless such date is otherwise extended by the Department. This includes reinvestment plans that cover more than one period. After that time, unexpended Reinvestment Funds must be returned to the Department. Any funds remaining in the reinvestment account at the time of Agreement termination must be returned to DHS.

7. The Primary Contractor and its BH-MCO may combine functions or assign responsibility for a function across multiple departments, as long as it demonstrates the following duties and functions are carried out:

a. A Chief Executive Officer with clear authority over the entire operation of the BH-MCO.

b. A Medical Director who is a board-certified psychiatrist licensed in the

Commonwealth with at least five years combined experience in mental health and substance abuse services. The responsibilities of the Medical Director include:

i. development of clinical practice standards, policies, procedures, and performance;
ii. review and resolution of quality of care problems;
iii. participation in Complaint and Grievance processes related to service denials and clinical practice;
iv. development, implementation, and review of the internal Quality Management and Utilization Management programs;
oversight of the BH-MCO's referral process for specialty and in lieu of and in addition to services;
v. oversight and management of the BH-MCO's behavioral health rehabilitation, intensive behavioral health and residential services for children and adolescents, in collaboration with the HealthChoices PH-MCO's Medical Directors;
vi. leadership and direction in the BH-MCO's clinical staff recruitment, credentialing, and privileging activities;
vii. leadership and direction in the BH-MCO's prior authorization and utilization review processes, including examination of inter-rater reliability and setting a standard of at least 90% reliability among care managers for consistency in the prior authorization and utilization review process;
viii. leadership and direction of policies and procedures relating to confidentiality of clinical records; and
ix. participation in any meetings called by the Department.

c. A Chief Financial Officer (or governmental equivalent) to oversee the budget and accounting system.

d. A full-time BH-MCO Director of Quality Management who is a Pennsylvania-licensed RN, physician, physician's assistant or a licensed or certified MH Professional or is a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Healthcare Quality or is Certified in Healthcare Quality and Management (HCQM) by the American Board of Quality Assurance and Utilization Review Physicians. The Director of Quality Management must be located in Pennsylvania and have experience in quality management and quality improvement. The primary functions of the Director of Quality Management position are:

i. Evaluate individual and systemic quality of care
ii. Integrate quality throughout the organization
iii. Implement process improvements
iv. Resolve, track, and trend quality of care complaints
v. Involvement in the development and maintenance of a credentialed

Provider network

vi. Ensure that there are sufficient staff in the locations where services are being provided to enable the Primary Contractor and its BH-MCO to comply with quality management requirements included in this Agreement.

e. Utilization Management

f. Management Information Systems

g. Prior Authorization to include:
   i. assessment and substantiation of need for psychiatric and behavioral services provided by a mental health professional;
   ii. assessment and substantiation of need for drug and alcohol treatment services provided by a Drug and Alcohol Addictions Professional.

h. Member Services to communicate with Members, act as Member advocates, and coordinate Members' use of the Complaint and Grievance processes.

i. Provider Services to coordinate communications between the BH-MCO and its Providers.

8. The Primary Contractor's BH-MCO must organize and deliver services in accordance with principles established through the Child and Adolescent Service System Program (CASSP), the Community Support Program (CSP); and DDAP's Principles of Effective Treatment and OMHSAS' Cultural Competency Principles; see Appendices I, J, and CC respectively.

9. The Primary Contractor or its BH-MCO must have written agreements with the county mental health, intellectual disabilities and drug and alcohol authorities assuring availability and access to State Plan Services. Agreements must include provisions for the integration of crisis intervention services and the admission of any Member to a state mental hospital consistent with the established state mental hospital bed allocation assigned to the county as well as provisions for appropriate, coordinated response and dispute resolution processes related to court orders for behavioral health involuntary treatment services.

C. Administration

1. Administrative duties related to the daily operation of the program and interaction with Providers and Members such as those related to Member services, Provider services, Quality Management and Utilization Management, must be

conducted in an administrative office in close geographic proximity to the county in which services are provided.

2. The HealthChoices Program, through the EAP, provides Enrollment Specialists to assist Members with enrollment in a PHSS, and to provide Members with information regarding the PH-MCO and BH-MCO programs.

   The EAP is responsible for pre-implementation outreach and education for Members and families to explain the fundamental concepts of managed care and for providing information on benefit packages.

   The Primary Contractor or its BH-MCO must have policies and procedures for coordination with the EAP. The Primary Contractor or its BH-MCO must have informational materials; e.g., pamphlets and brochures, which can be used by the EAP to assist the Member's access to Behavioral Health Services. Any informational materials developed for this program by the Primary Contractor or its BH-MCO must have the Department's prior, written approval. The Primary Contractor or its BH-MCO will be required to print and provide the EAP with an adequate supply of approved materials on a continual basis.

   The Primary Contractor or its BH-MCO must have mechanisms to receive information electronically, as needed, from the EAP regarding the special needs and special services required by Members, identified at the time of enrollment.

3. Training and Professional Development

   The Primary Contractor or its BH-MCO must provide an ongoing process of training and professional development for BH-MCO Member services, Service Management, Quality Management and Utilization Management staff. Training topics should include but not be limited to: CSP and CASSP principles and DDAP treatment philosophy, Member rights, Complaint and Grievance process, Provider network access, human services, current clinical practice needs of special populations including persons with co-occurring mental health drug & alcohol conditions, persons with intellectual disabilities, children in substitute care and/or in juvenile probation, persons diagnosed with ASD, school intervention services, and Medical Necessity criteria including ASAM.

4. The BH-MCO must monitor the performance and quality of service of any BH Services Provider to which work is delegated to assure conformance with the terms of the Agreement.

5. The BH-MCO must work in partnership with the designated county/municipal

health department, and primary care practitioner as applicable, to ensure that conditions identified in accordance with the Disease Prevention and Control Law of 1955 (35 P.S. § 521.1 et. seq.) are reported (e.g., tuberculosis, hepatitis).

6. Records Retention

a. General

The Primary Contractor, its BH-MCO, Subcontractors and BH Services Providers must agree to maintain books and records relating to the HealthChoices Program services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records, and prescription files.
The Primary Contractor, its BH-MCO, Subcontractors and BH Services Providers also must agree to comply with all standards for record keeping specified by the Commonwealth. Operational data and medical record standards are described below.

The Primary Contractor, its BH-MCO, Subcontractors or BH Services Providers must, at their own expense, make all records available for audit, review or evaluation by the Commonwealth, including the Office of Attorney General Medicaid Fraud Control Section, its designated representatives, or federal agencies. Records required for this purpose include, but are not limited to books, records, contracts, computer or other electronic systems of the Primary Contractor, its BH-MCO, Subcontractors and BH Services Providers. Access shall be provided either on-site, during regular business hours, or through the mail. During the contract and record retention period, these records shall be available at the Primary Contractor's chosen location(s), subject to approval of the Department. All mailed records shall be sent to the requesting entity in the form of accurate, legible, paper copies, unless otherwise indicated, within 15 calendar days of such request and at no expense to the requesting entity.

The Primary Contractor, its BH-MCO, Subcontractors and BH Service Providers shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to the Agreement as well as to all required programmatic activity and data pursuant to the Agreement. Records, other than medical records, may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a form acceptable by the Department.

The Department, CMS, the Office of the Inspector General, the Comptroller General, and their designee may, at any time inspect and audit any records or documents of the Primary Contractor, its BH-MCO, Subcontractors or Behavioral Health Services Providers and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit exists for a 10-year period from the final date of the contract period or from the date of completion of any audit, whichever is later.

b. Digital Records

The Primary Contractor, its BH-MCO, Subcontractors and BH Services Providers shall develop policies and procedures for the transformation of hard-copy originals to digitally stored record-keeping copies. These policies and procedures must be authorized and approved by the Board of Directors and the CEO or President. Staff involved with the generation and authentication and storage of records should be trained and a log of those trained including date, trainer and the individuals trained should be maintained and the training should be provided periodically to staff to remind them of the process and the importance of engaging the process with fidelity.

An image must be verified as an exact copy of the original paper document and certified as the "record-keeping copy," by someone other than the originator of the document and at a supervisory level. Once certified, only then can the original paper document be destroyed. Ensuring that the "record-keeping copy" is an exact copy of the original paper document, requires that the following standards, at a minimum be in the policies and procedures developed by BH-MCO providers:

1. The Provider must be able to demonstrate the imaged version is an exact copy of the paper document;
2. The Provider must establish and implement a certification/quality assurance process to ensure the imaged information is an identical replication of the paper document in every way, including identifying the individual authorizing the original and the process. This should include their signature (this includes use of a valid electronic signature);
3. The Provider must retain the scanned image as the "recordkeeping copy" for the required retention period; and
4. As technological advances occur and are put into practice, the Provider must ensure continued accessibility to documents stored using earlier technologies.

c. Operational Data Reports

The Primary Contractor and its BH-MCO must agree to retain the source records for its data reports for a minimum of ten years and must have written policies and procedures for storing this information.

d. Clinical Records

The Primary Contractor or its BH-MCO must have written policies and procedures to maintain the confidentiality of and provide Member and other requesting entities access to the record, consistent with applicable state and federal confidentiality requirements. The Commonwealth, including the Office of Attorney General Medicaid Fraud Control Section, must be afforded prompt access to all Members' clinical records whether electronic or paper.

The Primary Contractor or its BH-MCO must have written policies and procedures for the maintenance of clinical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

The Department considers the clinical record as an important component of good patient care, for use in evaluating the quality of care rendered to Members. Therefore, the Primary Contractor or its BH-MCO must have written standards for clinical record documentation which reflect legibility, accuracy, completeness, and that chronologically reflect the evaluation, appropriateness of treatment, and Medical Necessity within the plan of care for the Member. A complete list of standards to follow is contained in 55 Pa. Code, Chapter 1101.

Clinical records must be legible, signed, dated, preserved, and maintained for a minimum of ten years from expiration of the Agreement. Clinical records must be maintained in the original form before conversion to any other form and records in all forms must be readily available for review.

The Department and the Office of Attorney General Medicaid Fraud Control Section are not required to obtain written approval from a Member before requesting the Member's clinical record from the Primary Contractor or its BH-MCO or any Provider, consistent with state and federal confidentiality requirements.

D. Provider Network/Relations

1. The Primary Contractor and its BH-MCO must provide access to all covered services for Members through a network of qualified professionals and facilities. The Provider’s network must have the following features in place

and the Primary Contractor and it BH-MCO must submit documentation that the Provider's network has the following features in place at the time it enters into a contract with the Department; on an annual basis; and at any time the Department determines that there has been a significant change in the Primary Contractor's and its BH-MCO's operations that would affect the adequacy of capacity and services, including changes in services, benefits, geographic service area, composition of or payments to the Provider network; or when a new population enrolls in the BH-MCO:

a. Sufficient Provider capacity and expertise for all covered services, for timely implementation of services, and for reasonable choice by Members of a Provider(s) within each level of care.

b. Represent the cultural and ethnic diversity of Members and their neighborhoods.

c. Clinical expertise and Cultural Competency in responding to Members with special needs.

d. Timely access to covered services and needed specialists including but not limited to the evaluation and treatment of: child and adolescent psychiatric, substance abuse and behavioral disorders; including disorders arising out of psychological and sexual abuse; co-existing psychiatric and substance use disorders; psychiatric or substance use disorders among older adults (particularly those with co-existing medical conditions); persons with intellectual disabilities with co-existing substance use or mental health disorders; persons with psychiatric or substance use disorders who are also homeless, pregnant or have HIV/AIDS, or persons diagnosed with ASD.

e. Providers must commit to ensuring access to and quality treatment and care for LGBTQI Members as well as racial and ethnic groups by providing a culturally affirmative environment of care.

f. Inclusion of Providers trained and experienced in working with the priority and Special Needs Populations covered under the plan.

g. Evidence of a cooperative relationship between the BH-MCO and its Provider network, for example, inclusion of Providers by the BH-MCO in the development of clinical protocols and Provider profiling.

h. The numbers of Network Providers who are not accepting new Members.

i. The anticipated MA enrollment.

j. The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the BH-MCO.

k. The number and types, in terms of training, experience, and specialization of Providers required to furnish the contracted MA services.

l. The geographic location of Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

2. In order to participate as a Network Provider that a) provides services to, b) orders, prescribes, refers or c) certifies eligibility for services for Members, the Provider must enroll with the Department's MA Program. Provider enrollment shall include identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, federal taxpayer identification number, and the Department license or certification number of the provider.

3. The Primary Contractor or its BH-MCO must ensure management of the Provider network through agreements which include the following provisions:

a. Maintenance of clinical records which conform to program specific regulations and release of clinical records in conformance with applicable federal and state confidentiality laws and regulations.

b. Criteria for Provider's clinical privileges, as applicable.

c. Clinical performance standards and data reporting requirements.

d. Financial performance standards and data reporting requirements.

e. Complaint procedures for Providers.

f. Requirements for referral, coordination of treatment planning, and consultation (including participation during Interagency Team meetings) in the diagnosis and treatment of psychiatric, substance abuse and behavioral disorders.

g. Requirements for coordination and continuity of care of Behavioral Health Services with social services; e.g., intellectual disabilities, area agencies on aging, juvenile probation, housing authorities, schools, child welfare, juvenile and county and state criminal justice.

h. Requirements for coordination, credentialing, and continuity of care with PHSS and PCPs or prior approved specialist (in accordance with the Department of Health Technical Advisory #95-1 or most current reference).

i. Procedures for approving demonstration projects for State Plan Service and treatment alternatives/innovations.

j. Compliance with The Child Protective Services Law, 23 Pa.C.S. § 6301-6385.

k. Compliance with The Older Adults Protective Services Law, 35 P.S. § 10225.101 et. seq..

l. Authorization of State Plan Services in accordance with DHS approved Medical Necessity criteria and Prior Authorization procedures.

m. Assurance that Providers delivering State Plan Services to Members via a subcontractual arrangement with a Network Provider, meet the same requirements and standards as a Network Provider.

n. Procedure to provide access to client records for quality of care and access reviews.

o. Prohibition against the use of prone restraints by Child Residential and Day Treatment Providers (both in and out of network).

p. Provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.

4. The Primary Contractor or its BH-MCO must have policies and procedures to monitor that the access standards are met by each Provider in each level of care. The BH-MCO must monitor the network to assure that Providers conform to expected referral and utilization patterns, conditioned upon accepted local and national practice, and deliver services that result in expected treatment outcomes based upon empirical data.

5. The Primary Contractor or its BH-MCO must maintain procedures for response, reporting, and monitoring of significant Member incidents for trend and case analysis. The Primary Contractor or its BH-MCO must make incident records and reports immediately available to the Department upon request.

6. The Primary Contractor or its BH-MCO must maintain procedures for

immediate response and appropriate reporting of any suspected or substantiated fraud or abuse to the Department's OA, Bureau of Program Integrity as required by 42 CFR §438.608(a)(7).

7. The Primary Contractor or its BH-MCO must notify the Department promptly of any changes to the composition of its Provider network that affect the Primary Contractor or its BH-MCO's ability to make available all State Plan Services or respond to the special needs of a Member or population group in a timely manner.

   a. The Primary Contractor (PC)/BH-MCO shall develop a policy and procedure for considering Provider rate setting for review and approval by OMHSAS. The policy shall include the opportunity of Providers to request a rate increase, summarize information the Provider must submit to justify a rate increase, describe the finance strategies the PC/BH-MCO may use in rate setting such as performance incentives, preferred Provider network, or other strategies. The policy will include a statement that the PC/BH-MCO shall not institute an across the board rate decrease for all Providers or a specific Provider type or group of Providers unless the PC or its BH-MCO has: (i) notified the Department of its intention to impose such an across the board rate decrease at least 45 days prior to the imposition of such a rate decrease; (ii) provided the Department with the justification for instituting such an across the board rate decrease (iii) discussed the proposed action with all affected Providers, and (iv) provided justification that such action will not adversely affect compliance with HealthChoices access and choice requirements.

   b. No payments will be made by the Primary Contractor and/or its BH-MCO for Provider-preventable conditions, as identified in the State Plan and will require that all Providers agree to comply with reporting requirements in 42 CFR § 447.26(d) as a condition of payment from the Primary Contractor. The Primary Contractor and/or its BH-MCO will comply with such reporting requirements to the extent the Primary Contractor and/or its BH-MCO directly furnishes services.

8. The Primary Contractor or its BH-MCO must maintain a plan of orientation and ongoing training for Network Providers. Training shall include but not be limited to:

   CASSP and CSP principles and DDAP treatment philosophy; priority and Special Needs Population issues such as children in substitute care and/or juvenile probation; Prior Authorization of services; continuity of care; payment procedures; Complaint and Grievance rights and procedures; coordination requirements with PHSS and PCPs; coordination requirements with county behavioral health and human services systems; current clinical

best practice and community service resources and advocacy organizations.

9. The Primary Contractor or its BH-MCO must make directories of network Providers for all State Plan Services and IBHS. The Primary Contractor or its BH-MCO must comply with the Department's directions for determining the Providers identified in the directory of IBHS Providers. The Provider directory must be made available on the website of the Primary Contractor or its BH-MCO in a machine-readable file and format as specified by CMS.

   The Primary Contractor or its BH-MCO must make available a paper Provider directory upon request, within five business days, and must utilize a web-based Provider directory. The Primary Contractor or its BH-MCO must establish a process to ensure the accuracy of electronically posted content, including a method to monitor and update changes in Provider information. The Primary Contractors or its BH-MCO must update the paper Provider directory at least monthly and electronic Provider directories must be updated no later than 30 calendar days after the Primary Contractor or its BH-MCO receives updated Provider information.

   The Provider directory must provide the following information as required in 42 CFR § 438.10(h) about its Network Providers:

   - Provider's name as well as any group affiliation
   - Street address(es)
   - Telephone number(s)
   - Website URL, as appropriate
   - Specialty, as appropriate
   - Whether the provider will accept new enrollees
   - The Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the Provider or a skilled medical interpreter at the Provider's office and whether the Provider has completed cultural competency training.
   - Whether the Provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

10. Primary Contractor and/or its BH-MCO must provide information required in 42 CFR § 438.10 to enrollees electronically, and the information:

    - Must be in a format that is readily accessible.
    - Must be placed in a location on the website that is prominent and readily accessible.
    - Must be provided in an electronic form which can be electronically retained and printed.

- Is consistent with content and language requirements.
- Must notify the enrollee that the information is available in paper form without charge upon request.

11. Health Information Organization

The Primary Contractor and its BH-MCO must contract with at least one Health Information Organization (HIO) that is capable of connecting to the PA Patient and Provider Network, or P3N. Information about certified regional networks of HIOs can be found at: https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Information%20Technology/HIO-Connection.aspx. Contracting efforts must be documented to demonstrate the Primary Contractor's and its BH-MCO's efforts to comply with this requirement. The Primary Contractor and its BH-MCO must work with the Department and HIOs to establish a resource and referral tool.

E. Provider Enrollment - Credentialing/Recredentialing

1. In maintaining the Provider network, the Primary Contractor or its BH-MCO must establish written credentialing and recredentialing policies and procedures. The Primary Contractor or its BH-MCO must adhere to credentialing requirements under the Pennsylvania Department of Health regulations, 28 Pa. Code §§ 9.761 and 9.762 for all State Plan Services Provider types as well as for Providers of in lieu of and in addition to services in the BH-MCO Provider network. Provider types interested in participating as a Provider within the network must obtain credentialing from the Primary Contractor or its BH-MCO (who will ensure the service is within the Provider's scope of practice) and approval from a county who wishes to offer the service. Credentialing policies and procedures must include, but not be limited to, the following criteria:

   a. Applicable license or certification as required by Pennsylvania law, including the Department's license or certification number of the Provider.

   b. Verification of enrollment in good standing with Medicaid (Providers of in lieu of and in addition to services must be enrolled in the MA program).

   c. Verification of an active MA Provider Agreements.

   d. Evidence of malpractice/liability insurance.

   e. Disclosure of any past or pending lawsuits/litigations.

   f. Board certification or eligibility, as applicable.

2. Except as provided by 42 CFR 438.12(b), the Primary Contractor or its BH-MCO may not discriminate for the participation, reimbursement or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Primary Contractor or its BH-MCO declines to include individual or groups or Providers in its network, it must give the affected Providers written notice of the reason for its decision.

3. The Provider credentialing policies and procedures must not discriminate against Providers that serve high risk populations or specialize in conditions that require costly treatment.

    a. A Primary Contractor or its BH-MCO may not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:
        i. any information the Member needs in order to decide among all relevant treatment options;
        ii. for the risk, benefit and consequences of treatment and non-treatment;
        iii. for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or
        iv. for Member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.

4. The Primary Contractor, its BH-MCO or Subcontractors may not employ or contract with Providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

5. A Primary Contractor or its BH-MCO shall have a process in place, approved by the Department, for consulting with the counties served regarding Providers to be enrolled in the network and those recredentialed.

6. Any Provider that has been terminated from the Medicare program or from another State's Medicaid program will be terminated from participation in the HC BH Medical Assistance program.

7. If a Centralized Credentialing Verification Organization (CVO) vendor is selected by the Department, the Primary Contractor and its BH-MCO must utilize the CVO as follows:

a. The CVO vendor will:
    i. facilitate the gathering of administrative materials needed for provider credentialing and recredentialing,
    ii. perform primary source verifications and provide the results of the primary source verification to the BH-MCO.

b. The Primary Contractor and its BH-MCO will
    i. evaluate the information provided by the CVO vendor and make the final determination of whether a provider will be credentialed or recredentialed with the BH-MCO and added to the BH-MCO's Network.

c. The Primary Contractor and its BH-MCO must establish agreements with the Commonwealth-procured CVO vendor, to cooperate and support the activities of the vendor, including but not limited to:
    i. data exchange,
    ii. receipt of verified application materials and other information,
    iii. marketing, and
    iv. notification of the outcome of the BH-MCO's credentialing or recredentialing decisions.

d. The Primary Contractor and its BH-MCO will continue to be responsible for meeting the credentialing and recredentialing requirements in this Agreement unless otherwise specified by the Department.

F. Service Access

1. The Provider network must provide face-to-face treatment intervention, including services provided in IMDs providing substance use disorder treatment, for all Members within one hour for emergencies, within 24 hours for Urgent situations, and within seven days for routine appointments and for specialty referrals. Upon the initial face-to-face intervention, the implementation of treatment services must adhere to the prescribed treatment plan, including the Start Date and frequency of treatment services. Prior Authorization of emergency services is not permitted. (See Appendix AA, Attachment 1. "Emergency Inpatient: Prior Authorization, Admission and Documentation.")

   The Primary Contractor or its BH-MCO must have a notification process in place with Providers for the referral of a Member to another Provider, if a selected Provider is not able to schedule the referred Member within the access standard.

2. The Primary Contractor and its BH-MCO must maintain a Provider network for all Members which is geographically accessible to Members. All levels of

care must be accessible in a timely manner. Members must have a choice of at least two Providers for all state plan services except crisis intervention services. A minimum of one provider must be available for crisis intervention services (telephone and mobile).

For ambulatory services to which the Member travels, the Providers must be:
a. Within 30 minutes travel time in Urban areas.

b. Within 60 minutes travel time in Rural areas.

For inpatient and residential services at least one of the two Providers must be:
a. Within 30 minutes travel time in Urban areas.

b. Within 60 minutes travel time in Rural areas.

Access standards including requirements for time and distance and minimum number of providers are subject to change in accordance with CMS requirements.

The Primary Contractor and its BH-MCO must comply with additional access standards for Network Providers if CMS determines that it will promote the objectives of the Medicaid program for a level of care to be subject to an access standard.

The Primary Contractor and its BH-MCO must make all reasonable efforts to honor a Member's choice of Network Provider. If the Primary Contractor and its BH-MCO are unable to provide a Member access to a Network Provider for a state plan service within the travel times set forth above, the Primary Contractor and its BH-MCO must make all reasonable efforts to ensure the Member's access to services within the travel times set forth above through an Out-of-Network Provider. If a Primary Contractor and its BH-MCO is unable to contract with an Out-of-Network Provider it must provide evidence that it made all reasonable efforts to contract with an Out-of-Network Provider, by providing verification that there is no Out-of-Network Provider that could serve the Member within the travel times set forth above. If a Primary Contractor and its BH-MCO are unable to contract with an Out-of-Network Provider, the BH-MCO must work with the Member to offer reasonable provider alternatives.

Network Providers are not required to be located within the county covered by the Agreement. Adherence to the travel time requirements may be facilitated by the Primary Contractor or its BH-MCO's inclusion of out-of-county BH Services Providers in its network.

The Primary Contractor or its BH-MCO must obtain DHS approval for network exception requests to cover situations in which the Primary Contractor or its BH-MCO determines that a Member is in need of a specialized State Plan Service and a Network Provider is not available within the travel timeframes. The network exception request must provide for the appropriate delivery of services and the availability of local supports for the Member. The Department will review and approve network exception requests based on the number of Network Providers in that specialty practicing in the service area.

3. The Primary Contractor's BH-MCO must have a service authorization system that includes verification of eligibility and a coordinated, expedited decision-making process in accordance with Appendix T for admission, continued stay and discharge for all State Plan Services. The Primary Contractor or its BH-MCO's service authorization system must include procedures for informing Providers and Members of authorization decisions.

4. The Primary Contractor or its BH-MCO must have written policies and procedures which comply with MA Bulletin 99-03-13 and Appendix V, to authorize care and transition Members to Network Providers for Members who are in care at the time of the Agreement implementation. Policies and procedures must specifically address priority and Special Needs Populations. Protocols for authorization, denial of authorization, and transfer to alternative facilities or Providers must also be included. Where disruption of services would have a significant negative impact on the Member, the Primary Contractor and its BH-MCO must have provisions for the authorization and payment of services delivered by Out-of-Network Providers. A transition monitoring plan must be developed to ensure that procedures and protocols governing transition into service are being followed and that transition problems are identified and corrected. The transition plan should also address the Primary Contractor or its BH-MCO staff recruitment and training prior to start-up and supervisory support during initial implementation. Planning must also address Network Provider credentialing, contracting and training; the Primary Contractor or its BH-MCO telephone capacity related to both Member services and Service Management functions; and MIS backup.

5. The Primary Contractor and its BH-MCO must have procedures for accessing Out-of-Network Providers, including procedures that allow for the submission of requests by telephone or electronically for an Out-of-Network Provider, to provide State Plan Services. The Primary Contractor and its BH-MCO can only request information that is required to determine medical necessity and authorize services. An Out-of-Network Provider is not required to sign or submit a Single Case Agreement for services to be authorized. In the event that the BH-MCO requires a Single Case Agreement, that must not delay authorization of services.

The Out-of-Network Policies and Procedures must be reviewed and updated annually by the Primary Contractor and its BH-MCO and be consistent with changes in Commonwealth and federal requirements as well as internal operations.

6. The Primary Contractor and its BH-MCO must have procedures to assure continuity of care for Members affected by Provider termination.
7. The Primary Contractor and its BH-MCO are required to provide the Member the option of continuity of care when:
   a. The BH-MCO terminates a contract with a Network Provider for reasons other than for cause and the Member is in an ongoing course of treatment with the Provider. The Member shall be allowed to continue course of treatment with the same Provider, for a transition period of up to sixty (60) days from the date the Member was notified by the BH-MCO of the termination or pending termination, provided that the Provider is enrolled in the PA MA program.
   b. A new Member is in an ongoing course of treatment with an Out-of-Network Provider shall be allowed to continue services with the Out-of-Network Provider, for a transitional period of up to sixty (60) days from the effective date of enrollment with the BH-MCO as long as the Provider is enrolled in the PA MA program. The BH-MCO, in consultation with the Member and Provider, may extend the transitional period if determined to be clinically appropriate.

   The Primary Contractor and its BH-MCO must require Out-of-Network and terminated Providers to agree to the same terms and conditions as are applicable to the BH-MCO's Network Providers.

8. If 5% or more of the MA Recipients in a County Assistance Office or a district office within the county speak a language other than English as a first language, the Primary Contractor or its BH-MCO must make available in that language all information that is disseminated to English speaking Members. This information includes, but is not limited to, Member handbooks, hard copy Provider directories, education and outreach materials, marketing materials, website access and digital materials available on the BH-MCO's website, written notifications, etc. All materials that are essential to service delivery, including at a minimum, provider directories, enrollee handbooks, appeal and Grievance notices, and denial and termination notices, must include taglines in the prevalent non-English language(s) explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TYD telephone number of the Primary Contractor or its BH-MCO's member/customer service unit. Interpreter services must be available, as practical and necessary, by toll-free telephone or in person to

ensure Members are able to communicate with the Primary Contractor or its BH-MCO and Providers and receive covered benefits in a timely manner. The Primary Contractor must have policies and procedures for ensuring language assistance services for people who have limited proficiency in English.

In addition, the Primary Contractor and its BH-MCO must comply with the ADA (42 U.S.C. §§ 12101 et. seq.) concerning the availability of appropriate alternative methods of communication for Members who are visually impaired, deaf or hard of hearing. Such appropriate alternative methods include, but are not limited to, Braille, audio tapes, large print, compact disc, DVD and/or electronic communication. The Primary Contractor or its BH-MCO must provide Text Telephone Typewriter (TTY) and/or Pennsylvania Telecommunication Relay Services for communicating with Members who are deaf or hard of hearing and comply with the ADA concerning access for Members with physical disabilities. These services must be made available upon request to the Member at no cost, in an appropriate manner that takes into consideration the special needs of the Member with disabilities or limited English proficiency.
The Primary Contractor or its BH-MCO must comply with 45 CFR §92.8. The term "significant publications and significant communications" referenced in 45 CFR §92.8(f) and 45 CFR §92.8(g) includes written notices requiring a response from an individual and notices to an individual, such as those pertaining to rights or benefits.

The information required for prevalent non-English speakers, as outlined above, must include at a minimum, Member handbooks, Provider directories, education and outreach materials, marketing materials, appeal and grievance notices, and denial and termination notices. The Primary Contractor or its BH-MCO must make oral interpretation available in all languages, and written translations in each prevalent non-English language as identified above, as well as Large Print as necessary, at no cost to the Member. Large print means printed in a font size no smaller than 18 points.

All written materials must use easily understood language in a font size no smaller than 12 point. All written materials must include taglines in the prevalent non-English languages as identified above, as well as in large print, explaining the availability of written translation or oral interpretation to understand the information provided, explaining how to request auxiliary aids and services and the provision of materials in alternative formats, and the toll-free and TTY/TDY telephone number of the Primary Contractor or its BH-MCO's member/customer service unit. The Primary Contractor or its BH-MCO must provide written materials in alternative formats upon request of the Member at no cost.

8. The Primary Contractor or its BH-MCO is expected to refer any Member in

need of any routine and specialized medical and/or social service not provided by the BH-MCO to an appropriate agency/organization.

9. The Primary Contractor or its BH-MCO and its Provider network are required reporters for suspected instances of child abuse pursuant to 23 Pa.C.S. § 6311.

10. The Primary Contractor or its BH-MCO must assure that Members are provided reasonable access to Behavioral Health Services provided by FQHC, wherever FQHC Behavioral Health Services are available, within travel of 30 minutes (Urban) and 60 minutes (Rural).

11. In all agreements with health care professionals, the Primary Contractor or its BH-MCOs must comply with the requirements specified in 42 CFR 438.12 and 438.214 which includes selection and retention of Providers, credentialing and recredentialing requirement and nondiscrimination.

G. Utilization Management and Quality Management (UM/QM)

1. General

The Primary Contractor or its BH-MCO must adhere to Department of Health Regulation 28 Pa. Code Chapter 9, Subchapter G. The Primary Contractor or its BH-MCO must have written policies and procedures to monitor use of services by its Members and to assure the quality, accessibility, and timely delivery of care being provided by its network. Such policies and procedures must:

a. Conform to state Medicaid plan QM requirements.

b. Assure a UM/QM committee meets on a regular basis.

c. Provide for regular UM/QM reporting to the Primary Contractor or its BH-MCO management and its Provider network (including profiling of Provider utilization patterns) as well as reports of joint UM/QM activities/studies conducted with the PHSS.

d. Provide opportunity for consumer (including representation for consumers in Special Needs Populations), persons in recovery and family (including Parents/custodians of children and adolescents) participation in program monitoring.

2. Utilization Management (UM)

The Primary Contractor and its BH-MCO must have Department approved written UM policies and procedures that include protocols for prior approval

(in accordance with Appendix AA), determination of Medical Necessity, Concurrent Review, Denial of Services, hospital discharge planning, Provider profiling, and Retrospective Review of claims. The timeframe for authorization of services provided by an Out-of-Network Provider or an out-of-state Provider must be the same as the timeframe for authorizing services provided by a Network Provider.

The UM policies and procedures may include provision for Retrospective Review for services provided due to emergencies and also for inpatient admission to an Out-of-Network facility following an emergency stabilization when there is uncertainty regarding the Medicaid eligibility status of the individual. For delayed request for authorization caused by such situations, the UM policies and procedures must include the provision that requests for authorization must occur within 7 days of the emergency stabilizing intervention or the eligibility issue being resolved, but no later than 180 days of the service date. As part of its UM function, the Primary Contractor and its BH-MCO must have processes to identify over, under, and type of service utilization problems and undertake corrective action.

UM practices should focus on the evaluation of the necessity, level of care, appropriateness, and effectiveness of Behavioral Health Services, procedures, and use of facilities. The Primary Contractor and its BH-MCO must also examine inter-rater reliability and set a standard of at least 90% reliability among care managers for consistency in the prior authorization and utilization review process.

The Primary Contractor must have criteria and review procedures. Mental health review criteria must be compatible with guidelines provided in Appendix T. All drug and alcohol reviews for children, adolescents and adults, , must be conducted in accordance with criteria compatible with the ASAM criteria.

The Primary Contractor or it's BH-MCO must use the guidelines of Appendix S, *Medical Necessity Guidelines for Intensive Behavioral Health Services (IBHS) Delivered Through Individual Services, ABA Services and Group Services*, when reviewing requests for prior authorization of ABA using BSC-ASD services and TSS services for children and adolescents under age 21 with ASD including the documentation that must be submitted for the BH-MCOs to determine the medical necessity of ABA using BSC-ASD services and TSS services.

The Primary Contractor will distribute the review and UM criteria to all Providers in its Provider network and to any new Provider who signs a Provider Agreement with the Primary Contractor. The Primary Contractor must also provide the criteria to Members, upon request.

3. Quality Management

a. The Primary Contractor or its BH-MCO agrees to implement a Quality Management program that includes a Continuous Quality Improvement (CQI) process. The Primary Contractor or its BH-MCO agrees to fully comply with the Department's Quality Management and Utilization Management standards. The Primary Contractor or its BH-MCO must ensure that compensation to individuals or entities that conduct Utilization Management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member. In the event that CMS specifies performance measures and topics for performance improvement projects to be required by the Department in their contracts with the Primary Contractor, its BH-MCO and its Subcontractors must agree to cooperate fully in implementing these performance measures and projects.

b. The Primary Contractor and its BH-MCO must contract directly with NCQA or with an NCQA-certified HEDIS® vender to verify the measure logic used for HEDIS® specifications, and must achieve certification for HEDIS® MY 2022 no later than October 1, 2022. The Primary Contractor and its BH-MCO are responsible for assessing and completing all necessary related steps and must plan appropriately to ensure compliance with this requirement for HEDIS® MY 2022.

c. Performance Improvement Projects

The Primary Contractor or its BH-MCO is required to conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. The performance improvement projects must involve the following:

i. Measurement of performance using objective quality indicators.
ii. Implementation of system interventions to achieve improvement in quality.
iii. Evaluation and initiation of activities for increasing or sustaining improvement.

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year. The Primary

Contractor is required to report the status and results of each project to the Department, as requested.

The BH-MCO must have a written QM plan that complies with 42 CFR Part 438, Subpart E and includes quality assessment and performance improvement processes designed to monitor, assure, and improve the quality of care delivered over a range of clinical and health service delivery areas. The continuous quality improvement process places emphasis on but need not be limited to, high volume and high-risk services and treatment and IBHS for children and adolescents, and care furnished to Members with special health care needs.

As a part of the QM plan, the BH-MCO should address, at a minimum, the effectiveness of the services received by Members, the quality and effectiveness of internal processes, and the quality of the Provider network. Among those areas to be considered in service delivery are access to services, the appropriateness of service manager authorizations, the authorization appeal process, adverse incidents, and the quality of service manager planning. Internal processes include but are not limited to telephone responsiveness; overall utilization patterns and trends; treatment outcomes; and Complaint, Grievance and fair hearing tracking processes. Provider monitoring includes but is not limited to utilization patterns, treatment outcomes, cooperation, and Member satisfaction. The QM plan shall also include mechanisms to incorporate recommended enhancements resulting from the Department's monitoring and external evaluations and audits.

4. Confidentiality

The Primary Contractor or its BH-MCO must have written policies and procedures which comply with federal and state law and regulations for maintaining the confidentiality of data, including clinical records/Member information.

5. Member Satisfaction

The Primary Contractor, its BH-MCO or Subcontractor must have systems and procedures to routinely assess Member satisfaction. These systems and procedures should include but not be limited to the use of ongoing consumer/family satisfaction teams (C/FST) (in accordance with Appendix L).

The Primary Contractor or its BH-MCO shall contract with existing C/FST, or establish such teams if they do not exist, to conduct satisfaction surveys for Members. The Subcontract shall ensure technical support of the C/FST for

report writing and conducting interviews and include funds for travel expenses and staff development of the C/FST. The Department will approve the C/FST Subcontracts established.

An annual report must be submitted to the Department on the activities and findings of the C/FST and Member satisfaction survey. Members and their families, including Parents of children and adolescents who are seriously emotionally disturbed and/or who abuse substances, or have been diagnosed with ASD, are to participate on the consumer/family satisfaction teams and in the design and implementation of the survey process. Such participation is to include: serving on C/FST, the review of C/FST and annual survey findings, and the determination of quality improvements to be undertaken based on the findings. The Primary Contractor and its BH-MCO should also have mechanisms which ensure that Member comments concerning Provider performance can be tracked in aggregate and be used as a component of Provider profiling. In addition, the Primary Contractor and its BH-MCO must cooperate in Member satisfaction assessments which may be performed by the Department, independent of the Primary Contractor's or its BH-MCO's internal process.

6. Provider Satisfaction

The Primary Contractor, either directly or via its BH-MCO or Subcontractor, must have systems and procedures to assess Provider satisfaction with network management. The systems and procedures must include, but not be limited to, an annual Provider satisfaction survey. Areas of the survey must include claims processing, Provider relations, credentialing, Prior Authorization, Service Management and Quality Management.

7. Department Review

The Primary Contractor, its BH-MCO and BH Services Providers must agree to make available to the Department and/or its authorized agents, on a periodic basis, clinical and other records for review of quality of care and access issues.

8. Performance-Based Contracting

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year.

9. External Independent Assessment

On at least an annual basis, the Primary Contractor or its BH-MCO must provide necessary documentation in order to comply with independent

external quality review organization (EQRO) activities. The review shall include:

a. Validation of the Primary Contractor's quality improvement projects.

b. Validation of the Primary Contractor's performance measures.

The Primary Contractor or its BH-MCO must provide, as necessary, a review of its compliance with state structural and operational standards. Information included in the EQRO must be derived from an assessment of compliance with standards that occurred within the last three years.

10. Pay for Performance - BH-MCO and PH-MCO Integrated Care Plan

The Department implemented a Pay for Performance program with financial incentives for integration and coordination of behavioral health and physical health services to improve the quality of healthcare and reduce expenditures. The targeted membership for this incentive program will be members with SMI. Information regarding this incentive program is found in Appendix E – Pay for Performance – Integrated Care Plan Program.

11 Pay for Performance – Behavioral Health

The Department implemented a Pay for Performance program that provides financial incentives for Primary Contractors that meet behavioral health performance measures. Information regarding the Pay for Performance Program is found in Appendix GG- Pay for Performance.

12. NCQA Multicultural Health Care Distinction/Health Equity Accreditation

The Primary Contractor and its BH-MCO must comply with the NCQA's requirements for multicultural health care and attain NCQA Multicultural Health Care Distinction/Health Equity Accreditation. The Primary Contractor and its BH-MCO must submit a workplan that includes a timeline to the Department annually that shows the Primary Contractor's and its BH-MCO's progress in achieving NCQA Multicultural Distinction/Health Equity Accreditation.

13. Use of Algorithms

The Primary Contractor and its BH-MCO must determine whether algorithms used for case management, disease management, quality management, or decisions about which Members receive additional services from the BH-MCO, contain

inadvertent racial bias. If any racial bias is identified, the BH-MCO must take steps to eliminate that bias to the satisfaction of the Department. As part of the determination of whether the algorithms contain racial bias and the elimination of racial bias, the BH-MCO will work with entities designated by the Department to identify bias and the actions that can be taken to eliminate or mitigate bias.

H. Advanced Directives

The Primary Contractor and its BH-MCO must have written policies and procedures for Advanced Directives that include the following: a description of State law; the process for notifying the Member of any changes in applicable State law as soon as possible, but no later than 90 days after the effective date of the change; any limitation the Primary Contractor or its BH-MCO has regarding implementation of Advanced Directives as a matter of conscience; the process for Members to file a Complaint concerning noncompliance with the Advanced Directive requirements with the BH-MCO and DOH; and how to request written information on Advance Directive policies. The Primary Contractor and its BH-MCO must educate staff concerning its policies and procedures on Advanced Directives. The policies and procedures must include that the Primary Contractor and its BH-MCO may not condition the provision of care or otherwise discriminate against a Member based on whether or not the Member has executed an Advanced Directive.

I. Fraud, Waste, and Abuse

1. Compliance Program

The Primary Contractor and its BH-MCO must develop a written compliance program that is consistent with 42 CFR § 438.608(a) and includes the following:

a. Written policies, procedures and standards of conduct that articulate the Primary Contractor's and its BH-MCO's commitment to comply with all Federal and State standards under this Agreement and all applicable Federal and State requirements;
b. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this agreement and who reports directly to senior management;
c. The establishment of a Regulatory Compliance Committee at the senior management level that is charged with overseeing the organization's compliance program and its compliance with the requirements under this agreement;
d. A system for training and education for the Compliance Officer, senior management, and the Primary Contractor's and BH-MCO's employees for

the Federal and state standards and requirements under this agreement;

e. Effective lines of communication between the Compliance Officer, the Primary Contractor's and its BH-MCO's employees;
f. Enforcement of standards through well publicized disciplinary guidelines; and
g. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.
h. Prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
i. Prompt notification to the Department when it receives information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence and the death of a member.
j. Notification to the Department when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the BH-MCO.
k. A method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by members and the application of such verification processes on a regular basis.
l. In the case of Primary Contractors or BH-MCOs that make or receive annual payments under the contract of at least $5,000,000, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
m. Prompt referral of any potential fraud, waste, or abuse that the BH-MCO identifies to the Department's Bureau of Program Integrity and the Pennsylvania Office of Attorney General Medicaid Fraud Control Section.
n. The BH-MCO's suspension of payments to a Network Provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR § 455.23.

2. Managing Fraud, Waste and Abuse Requirements

a. The Primary Contractor may designate the BH-MCO to fulfill the function of

managing the s Fraud, Waste and Abuse requirements and, in this event, the Primary Contractor will submit policies and procedures to the Department for approval describing the measures taken to ensure that the BH-MCO complies with all requirements related to Fraud, Waste and Abuse including but not limited to disclosures required by 42 CFR § § 455.104, 105, 106 and 107. In this instance the Primary Contractor must provide oversight of the BH-MCO and will require the BH-MCO to report all cases of suspected Fraud, Waste or Abuse to the Primary Contractor, the Department and the Pennsylvania Office of Attorney General Medicaid Fraud Control Section..

b. Corporate Integrity / Compliance / Fraud, Waste and Abuse Staff

The Primary Contractor and its BH-MCO must have Fraud, Waste and Abuse staff in sufficient numbers that will prevent, detect, investigate, and report suspected Fraud, Waste and Abuse that may be committed by Network Providers, Members, employees, and Subcontractors.

The Primary Contractor and its BH-MCO must designate a full-time Fraud Waste and Abuse Coordinator who will be dedicated to preventing, detecting, investigating, and referring suspected Fraud, Waste and Abuse in the HealthChoices Behavioral Health program to the Department and the Pennsylvania Office of Attorney General Medicaid Fraud Control Section. The Fraud, Waste and Abuse Coordinator will act as a direct contact with the Department and the Pennsylvania Office of Attorney General Medicaid Fraud Control Section in matters relating to Fraud, Waste and Abuse. The Primary Contractor shall submit the title, address, and contact information of the Coordinator to the Department.

3. Provider Screening and Federal Database Checks

The Primary Contractor and its BH-MCO must ensure that Network Providers comply with MA Bulletin #99-11-05 "Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation."

Pursuant to 42 C.F.R. § 455.436, the Primary Contractor and its BH-MCO must check the exclusion status of providers, persons with an ownership or control interest in the provider, and agents and managing employees of the provider through the following databases upon enrollment and reenrollment: the National Plan and Provider Enumeration System (NPPES) (effective for rating periods starting on or after July 1, 2017), the Social Security Death Master File (SSADMF), the System for Award Management (SAM) at www.sam.gov; the List of Excluded Individuals and Entities (LEIE) and PA Medicheck. After the initial enrollment or reenrollment, the LEIE, SAM and PA Medicheck

database checks must be repeated on an ongoing basis no less frequently than monthly.

4. Written Policies

The Primary Contractor and its BH-MCO must create, maintain, and comply with written policies and procedures for the prevention, detection, investigation, reporting, and referral of suspected Fraud, Waste and Abuse. The written policies and procedures must be approved by the Department's Bureau of Program Integrity.

The Department will require policies and procedures and an annual review of policies and procedures during the course of the Agreement period. The policies and procedures must contain the following:

a. The title and contact information of the Fraud, Waste and Abuse Coordinator and staff.
b. A description of specific controls in place for Fraud, Waste and Abuse detection, including an explanation of the technology used to identify aberrant billing patterns, procedures for claims edits and post processing review of claims, review of Complaints and Grievances, and other means of identifying Fraud, Waste and Abuse.
c. A description of the methodology and standard operating procedures used to investigate Fraud, Waste and Abuse, such as on-site visits and record reviews.
d. An explanation of the process for referring suspected Fraud, Waste and Abuse to the Department and the Pennsylvania Office Of Attorney General Medicaid Fraud Control Section within thirty (30) business days of identification of the problem/issue. This explanation must state that the Primary Contractor and its BH-MCO will gather and send to BPI and the Pennsylvania Office Of Attorney General Medicaid Fraud Control Section any and all documentation supporting the referral as set forth in Appendix F.
e. A methodology for recovering overpayments or otherwise sanctioning Providers.
f. A process for immediately reporting in writing any Providers who are suspended, resign, or voluntarily withdraw after initiation of Fraud, Waste and Abuse review.
g. A statement outlining an educational plan for staff relating to Fraud, Waste and Abuse.
h. A statement ensuring full cooperation with State and Federal oversight agencies including, but not limited to, the Department's Bureau of Program Integrity, the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section (MFCS), The Pennsylvania Office of the

Inspector General, the Department of Health and Human Services' Centers for Medicare and Medicaid Services and Office of Inspector General, and the US Justice Department.

i. A statement that the Department's Medicheck List and LEIE, and SAM are used to verify that Providers that are excluded from receiving contracts or are sanctioned by the State or Federal government are not participating in HealthChoices.
j. A method to verify whether services reimbursed by the Primary Contractor and its BH-MCO were actually furnished to Recipients.
k. A statement that provide for the imposition of payment suspension at the request of the Department and/or the MFCS.
l. A statement that requires compliance with MA Bulletin 99-11-05 upon hire and monthly screening thereafter to ensure all Providers in the network are eligible to participate.
m. A certification that the policies and procedures were reviewed and approved by the Primary Contractor and its BH-MCO.

5. Duty to Cooperate with Oversight Agencies

The Primary Contractor and its BH-MCO must cooperate fully with State detection and prosecution activities. Such agencies include, but are not limited to, the Department's Bureau of Program Integrity, Governor's Office of the Budget, the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, the US Department of Health and Human Services Office of Inspector General, CMS, DHHS-OIG and the United States Justice Department.

Such cooperation must include providing access to all necessary case information, computer files, and appropriate staff. In addition, such cooperation will include participating in periodic Fraud, Waste and Abuse training sessions, meetings, and joint reviews of Providers or Members.

The Primary Contractor and its BH-MCO must immediately notify the Department's Bureau of Program Integrity, when a Provider, as well as other parties associated with the Provider entity, has disclosed information regarding a criminal conviction related to Medicare, Medicaid, or Title XX when seeking to be credentialed or recredentialed as a Network Provider, or is identified due to required monthly screening. The Primary Contractor and its BH-MCO must also notify the Department's Bureau of Program Integrity of an adverse action, such as convictions, exclusions, revocations, and suspensions, taken on Provider applications, including denial of initial enrollment. Disclosure includes the following information:

a. Identity of any person or entity having an ownership or control interest in

the Provider and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

b. Identity of any person who is a managing employee of the Provider and who has been convicted of a crime related to Federal health care programs. Identity of any person who is an agent of the Provider and who has been convicted of a crime related to Federal health care programs. The Primary Contractor and/or its BH-MCO must supply updated disclosure to the Department within fifteen (15) days upon request.

6. Fraud and Abuse Hotline

The Primary Contractor and its BH-MCO must ensure that the Department's toll-free Fraud and Abuse hotline and accompanying explanatory statement (Appendix F, Attachment 3) is distributed Providers through Provider handbooks. Notwithstanding this requirement, the Primary Contractor and its BH-MCO will not be required to re-print handbooks for the sole purpose of revising them to include Fraud and Abuse hotline information. The Primary Contractor and its BH-MCO must, however, include such information in any new version of these documents to be distributed to Members and Providers.

7. Duty to Notify

i. Department's Responsibility

The Department will notify the Primary Contractor and its BH-MCO when it takes an action to suspend or terminate a behavioral health Provider from participation in the Medical Assistance Program. The notification will not include the basis for the departmental action, due to confidentiality issues. Upon notification from the Department that a Provider is suspended or terminated from participation in the Medical Assistance Program, the BH-MCO shall immediately act to terminate the Provider from participation in its network. When the Medical Assistance Program terminates the participation of a Provider based on a criminal conviction, disciplinary action taken or entered against the provider in the records of the State licensing or certifying agency, or a Medicare termination or suspension, the BH-MCO's effective date must be the same as the MA effective date of the action

ii. Primary Contractor and BH-MCO Responsibilities

The Primary Contractor and its BH-MCO must immediately notify the Department in writing if a Provider or Subcontractor is suspended, terminated, decredentialed or voluntarily withdraws from participation in the network after a review or investigation has commenced or as a result of suspected or confirmed Fraud, Waste or Abuse. The Primary Contractor or BH-MCO must

also immediately notify the Department, in writing, if it terminates or suspends an employee as a result of suspected or confirmed Fraud, Waste, or Abuse. The notification must contain the reason for the action. Failure to provide this notification will result in sanctions, penalties, or other actions.

Provider agreements shall include notification of the prohibition and sanctions for submission of false claims and statements.

8. Audit Protocol

The BH-MCO must inform all Network Providers of the Pennsylvania Medical Assistance Provider Self Audit Protocol which allows Providers to voluntarily disclose overpayments or improper payments of MA Funds.

The protocol is available on the Department's website at www.dhs.pa.gov under "About DHS-Fraud and Abuse".

9. Corrective Actions

The Department may take corrective actions, including but not limited to the corrective actions set forth in Part II-3, Section H.2 of this Agreement if it determines that a Primary Contractor, BH-MCO, Network Provider, employee, or Subcontractor has committed Fraud, Waste or Abuse or has otherwise violated applicable law.

10. Subcontracts and Provider Agreements

The Primary Contractor and its BH-MCO will require via written agreements that all Network Providers and all Subcontractors take such actions as are necessary to permit the Primary Contractor and its BH-MCO to comply with the Fraud, Waste and Abuse requirements listed in this Agreement as well as federal regulations including but not limited to 42 C.F.R. §438.608. ii.

To the extent that the Primary Contractor or its BH-MCO PH-MCO delegates oversight responsibilities to a third party, the Primary Contractor and its BH-MCO must require that such third party complies with the applicable provisions of this Agreement relating to Fraud, Waste and Abuse.

The Primary Contractor and its BH-MCO will require, via its Provider Agreement, that Network Providers comply with MA regulations and any enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions.

The Primary Contractor and its BH-MCO must suspend payment to a Network Provider when the Department determines there is a credible allegation of

fraud, waste or abuse against that Network Provider, unless the Department determines there is good cause for not suspending such payments pending the investigation.

The Primary Contractor and its BH-MCO shall require its Subcontractors to comply with the requirements set forth at 42 C.F.R. 438.230(c)(3).

The Primary Contractor and its BH-MCO's subcontractor agreement must specifically state that the subcontractor will grant the Department, CMS, the Pennsylvania Office of Attorney General Medicaid Fraud Control Section, HHS OIG, the Comptroller General, or their designees access to audit, evaluate, and inspect books, records, etc., which pertain to the delivery of or payment for Medicaid services under this Agreement. Subcontractor must make such books, records, premises, equipment, staff etc. all available for an audit at any time. Right to inspect extends for ten (10) years after termination of the Agreement, or conclusion of an audit, whichever is later.

II-6. PROGRAM OUTCOMES AND DELIVERABLES

A. Outcome Reporting

To measure the program's performance in the areas of access to care, outcomes, and satisfaction, the Primary Contractor and its BH-MCO must comply with the Department's program performance reporting requirements as delineated in Appendix K. The Primary Contractor or its BH-MCO must establish all coordination agreements and procedures necessary to collect the required data elements from the Providers, Members, etc.

The Primary Contractor or its BH-MCO must provide quarterly reports summarizing the findings, and actions taken in response to the findings of the consumer/family satisfaction teams as well as an annual report summarizing the findings and follow-up actions taken pursuant to the annual Member satisfaction survey conducted pursuant to Appendix L.

The Primary Contractor or its BH-MCO must have a plan in place to review the DDAP CIS data for accuracy and completeness and a plan to work with their Providers to that end.

B. Deliverables

Deliverables submitted by the Primary Contractor include, but are not limited to:

1.	Member Services	Marketing materials; Member handbooks; educational materials; Complaint and Grievance policies and procedures; Prior Authorization and access policies and procedures; listing of Providers.
2.	Administration	Letters of agreement; Provider contracts/Subcontracts; Provider Complaint system procedures; Provider network; staff development plan; Provider directory; Provider enrollment procedures; reimbursement methodology and rates; billing instructions and forms; encounter/referral form; coordination agreements; Complaint and Grievance data; clinical records; work space for evaluation teams; procedures and monitoring mechanisms for adhering to confidentiality laws and regulations.
3.	Quality Management /Utilization Management	QM plan; reports of QM activities; procedures for sharing independently developed QM/UM information related to pharmacy services; UM criteria and review procedures; clinical records and Member information; and corrective action plan(s).
4.	Data	Descriptions of management reports; QM/UM data; monthly performance reports; person-level encounter; fiscal reports; aggregate encounter; Complaint and Grievance reports; performance outcome management reports, including the consumer registry and quarterly status; transition monitoring and monitoring reports.
5.	Other	Organization chart listing key staff/functions; management information system; management and financial data system; identification and location of service sites; plan for coordination with county mental health and drug and alcohol authorities, as applicable; coordination agreement including procedures for clinical dispute resolution between the PH-MCO and BH-MCO; DUR policies and procedures; incident reports and trend analyses.

A. Financial Standards

To measure the program's capacity to assume and manage risk as well as meet fiscal requirements related to account management and claims processing, the Primary Contractor and its BH-MCO must provide the Department with financial reports as required or upon request. It must also cooperate with any Department or external, independent assessment of performance under the Agreement, including any federally required cost-effectiveness review or other audit.

1. General

   The Insurance Department (ID) regulates the financial stability of licensed BH-MCOs in Pennsylvania. Any licensed BH-MCO, therefore, must comply with applicable Insurance Department standards in addition to standards described in this document.

2. Risk Protection for High Cost Cases

   The Department seeks to minimize risks that valid claims, submitted to BH MCOs by Providers, for costs incurred by a Member above a certain monetary threshold, might not be paid. Each Primary Contractor must have a risk protection arrangement in place until the Agreement expires. This risk protection arrangement must include individual stop loss reinsurance that covers, at a minimum, eighty percent (80%) of inpatient costs incurred by one Member during one year in excess of $75,000. The Department may alter or waive the reinsurance requirement if the Primary Contractor submits an alternative risk protection arrangement that the Department determines is acceptable.

   The Department reserves the right to institute a different reinsurance threshold amount, to be determined by the Department if, upon review of financial and encounter data or other information, fiscal concerns arise that such a change in reinsurance threshold is deemed warranted by DHS. A review will occur annually, so that any change in reinsurance thresholds can be imposed or withdrawn as the financial situation of the Primary Contractor warrants a change.

   The Primary Contractor must submit its plan for risk protection for high cost cases 60 days prior to the beginning of each Agreement period. The Department will determine the acceptability of the reinsurance or alternate risk protection arrangement.

   The Primary Contractor may not change or discontinue the risk protection arrangement without prior approval from DHS. The Primary Contractor must

notify DHS 45 days prior to any change in the risk protection arrangement. The Department reserves the right to review such risk protection arrangements and require changes based on the Department's assessment of the Primary Contractor's overall financial condition.

3. Insolvency Arrangement/Secondary Liability

Each Primary Contractor must submit its plan 60 days prior to the beginning of each Agreement period to provide for payment to Providers by a secondarily liable party after a default in payment to Providers resulting from bankruptcy or insolvency. The secondarily liable party must insure payment to Providers for all services performed by the BH-MCO's Providers through the last day for which DHS paid a Capitation premium to the Primary Contractor. The insolvency arrangement must be at a minimum, the equivalent of two months' worth of paid claims, when determinable, or two months of expected Capitation revenue, in the absence of claims history. The requirement may be met by submitting one or more of the following arrangements:

a. insolvency insurance;
b. an irrevocable, unconditional and automatically renewable letter of credit for the benefit of DHS, or the county or Multi-County Entity, as applicable, to be determined on a case-by-case basis, which is in place for the entire term of the Agreement;
c. a guarantee from an entity, acceptable to the Department, with sufficient financial strength and credit worthiness to assume the payment obligations of the Primary Contractor in the event of a default in payment resulting from bankruptcy or insolvency; or
d. other arrangements, satisfactory to the Department, that are sufficient to ensure payment to Providers in the event of a default in payment resulting from bankruptcy or insolvency.

The financial instrument(s) submitted for consideration must clearly reflect that the instrument(s) is to be attached only in the event of a bankruptcy or insolvency. DHS must approve all such arrangements prior to the signing of the Agreement. Such approval will include approval of the financial strength of the secondarily liable parties and approval of all legal forms for secondary liability.

The Primary Contractor is required to submit its insolvency arrangement to DHS annually. Any proposed changes must be submitted to DHS for approval at least 45 days prior to any change becoming effective.

The Department, at its discretion, reserves the right to temporarily waive this requirement, in full or in part, if the insolvency requirement is being met by

funds held in an approved Risk and Contingency account. The Department will provide written notification of any temporary waiver.

4. Equity and Other Requirements

The following section applies only if the Primary Contractor is a County or Multi-County Entity operated BH-MCO:

a. The Primary Contractor is required to meet and maintain minimum equity requirements throughout the life of the Agreement. The purpose of the standard is to assure payment of the Primary Contractor's BH-MCO's obligations to Providers and to assure performance by the BH-MCO of its obligations under the Agreement.

The Primary Contractor is required to submit a quarterly report (refer to Appendix P, Report #17) that states whether or not it is in compliance with the equity requirements. If not in compliance with the requirements of this section, the Primary Contractor will supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve its fiscal health and to meet the equity requirements under this Agreement.

Each Primary Contractor must maintain minimum equity equal to the greater of $250,000 or 5% of annual HealthChoices Capitation revenue net of the Gross Receipts Tax, HIPF and MCO Assessment obligations paid or accrued as of the end of each reporting quarter. Annual HealthChoices Capitation revenue refers to amounts paid or accrued by DHS to the Primary Contractor, as shown on Report #17. During the first year after implementation, the equity may be phased in over the first four quarters of the Agreement. The phase-in requirement is 2% at the end of the first quarter; 3% at the end of the second quarter; 4% at the end of the third quarter and 5% at the end of the fourth quarter.

No later than 45 days prior to the effective date of this Agreement, the Primary Contractor must provide documentation that the equity requirement is being met, or will be met, by the effective date of the Agreement. The Primary Contractor must provide DHS with a Statement of Revenues and Expenses, balance sheet, and a Statement of Cash Flows, not later than 45 days after the end of each month (See Appendix P, Reports #13, 14, and 15). Statements must be consistent with Generally Accepted Accounting Principles (GAAP). These financial statements must include only information applicable to this Agreement. Each quarter, the balance sheet that provides information as of the last day of a calendar quarter must be accompanied by a certification, by an

independent actuary, of the liabilities shown on the balance sheet (See Appendix P, Report #13).

Equity requirements will be determined at the end of each quarter, based on the contract-specific balance sheet. Assets held to meet the minimum equity requirements must be in a form accepted by the ID as an "admitted asset." Assets held to meet the equity requirements must be maintained in a Restricted Reserve Account up to a maximum of 105% of the equity requirement as calculated on quarterly Report #17. This account must be established by applicable municipal ordinance or similar authority and will maintain funds for the exclusive use as a reserve under the Agreement. Withdrawals from this account will be made only with express written approval by DHS. Copies of the bank statements verifying deposits must be mailed monthly directly from the banking institution to the Department. The amounts held in the Restricted Reserve Account as of the last day of the calendar quarter will be compared to the minimum equity requirement amounts in order to determine compliance with this standard.

Within 15 days of identification of equity funds in excess of 105% of the requirement as shown on quarterly Report #17, funds must be:

- moved to funds designated for reinvestment; or
- moved to a Risk and Contingency account, up to the allowable DHS-calculated limit, after receiving written approval from the Department; or
- used to provide State Plan Services and administrative functions required by this document, due to fluctuations in enrollment, revenue or utilization which have caused costs to exceed available Capitation payments; or
- be returned to the Department.

The Department, at its discretion, reserves the right to temporarily waive this requirement, in full or in part, if the equity requirement is being met by the funds held in an approved Restrictive Reserve account. The Department will provide written notification of any temporary waiver.

If the Primary Contractor fails to comply with the requirements of this section, the Department may take any or all of the following actions:

- Discuss fiscal situation with the Primary Contractor's management;
- Require the Primary Contractor to submit and implement a corrective action plan to address fiscal problems;

- Suspend enrollment of some or all Members into the Primary Contractor's BH-MCO;
- Terminate the Agreement effective the last day of the calendar month after the Department notifies the Primary Contractor of termination.

b. The Primary Contractor shall account for its HealthChoices transactions in an Enterprise Fund.

c. Except as otherwise approved by the Department, the Primary Contractor may not use State and Federal funds allocated to the County MH and D&A programs pursuant to the 1966 MH/MR Act and the 1972 Drug and Alcohol Act (71 P.S. § 1690.101 et. seq.) to pay for HealthChoices Program costs.

5. Equity and Other Requirements

The following requirements apply if the Primary Contractor is a county or a Multi-County Entity and the Primary Contractor contracts with a Private Sector BH-MCO and one of the following conditions applies:

- the cost of the BH-MCO contract is at least 80% of the revenue the county receives from DHS under this Agreement; or

- the contract between the Primary Contractor and the BH-MCO provides that the BH-MCO contractor is substantially at risk to provide services without financial recourse to the county.

a) The requirements of Sections 2), 3), and 4)a. above also apply to the Private Sector BH-MCO contractor if the contract between the Primary Contractor and the Private Sector BH-MCO requires that the Private Sector BH-MCO meet and maintain the risk protection, equity and insolvency arrangement requirements stated in Sections 2), 3), and 4)a.

b) The Primary Contractor shall account for its HealthChoices transactions in a Special Revenue Fund.

c) Except as otherwise approved by the Department, the Primary Contractor may not use State and Federal funds allocated to the County MH and D&A programs pursuant to the 1966 MH/MR Act and the 1972 Drug and Alcohol Act (71 P.S. § 1690.101 et. seq.) to pay for HealthChoices Program costs.

6. Equity and Other Requirements

The following requirements apply if the Primary Contractor is a Private Sector BH-MCO:

a) The requirements of Sections 2) and 3)

b) Equity Requirements – Private Sector BH-MCO

In addition to the Primary Contractor's responsibility to meet requirements of the Insurance Department, the Primary Contractor is required to meet and maintain minimum equity requirements throughout the life of the Agreement. The purpose of the standards is to assure payment of the Primary Contractor's obligations to Providers and to assure performance by the Primary Contractor of its obligations under the Agreement.

Each Primary Contractor must maintain minimum SAP-based equity equal to the greater of $250,000 or 5% of annual HealthChoices Capitation revenue net of the Gross Receipts Tax, HIPF, and MCO Assessment obligations paid or accrued as of the end of each reporting quarter. Annual HealthChoices Capitation revenue refers to amounts paid by DHS to the Primary Contractor.

The Primary Contractor's equity as of the last day of the most recent Calendar quarter will be determined in accordance with SAP-based equity, as reported to the Insurance Department, and compared to the minimum equity requirement amounts in order to determine compliance with this standard.

The Primary Contractor will be required to submit a quarterly report (refer to Appendix P, Report #17) that states whether or not it is in compliance with the equity requirements. If equity is not in compliance with the requirements of this section, the Primary Contractor will supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve its fiscal health and to meet the equity requirements of its Agreement.

If the Primary Contractor fails to comply with the requirements of this section, the Department may take any or all of the following actions:

- Discuss fiscal situation with Primary Contractor management;
- Require the Primary Contractor to submit and implement a corrective action plan to address fiscal problems;
- Suspend enrollment of some or all Recipients into the Primary Contractor’s HC-BH Program;
- Terminate the Agreement effective the last day of the calendar month after the Department notifies the Primary Contractor of

termination.

7. The Primary Contractor must maintain revenues paid by the Department under the Agreement in a contract-specific bank account or accounts. These accounts will not contain funds unrelated to the Agreement. The Primary Contractor may prudently invest funds in the account and retain any interest or dividend for use in funding the costs of the Agreement.

8. The Primary Contractor must maintain separate fiscal accountability for Medicaid funding under the Waiver apart from mental health and substance abuse programs funded by state, county, and/or other federal program moneys, or any other lines of business. The Primary Contractor must maintain procedures for accurately recording, tracking and monitoring HealthChoices revenues and expenses separately from other lines of business, and by county, if the Primary Contractor has an Agreement in more than one (1) HealthChoices county.

9. DHS' obligation to make payments is limited to the Capitation payments provided by the Agreement. If DHS is obligated as a result of litigation to pay a Provider for a service rendered under the Agreement, the Primary Contractor will have an obligation to DHS in the same amount. DHS may offset an obligation it has to the Primary Contractor by this amount, or DHS may demand payment from the Primary Contractor.

10. Limitation of Liability

    In accordance with 42 CFR 434.20, the Primary Contractor must assure that Members will not be liable for the Primary Contractor or its BH-MCO's debts if the Primary Contractor or its BH-MCO becomes insolvent.

    The Primary Contractor and its BH-MCO must also include in all of its Provider Agreements a continuation of benefits clause, which states that the Provider agrees that in the event of the BH-MCO's insolvency or other cessation of operations, the Provider will continue to provide benefits to the BH-MCO Members through the period for which the premium has been paid, including Members in an inpatient facility.

11. Behavioral Health Service Cost Accruals

    The Primary Contractor must have actuarial services available to provide rate and other support services needed under the Agreement. The Primary Contractor must provide DHS with an actuarial certification of liabilities quarterly, if a county-operated BH-MCO, and at least annually, if a licensed, risk-bearing entity. As part of its accounting and budgeting function, the

Primary Contractor or its BH-MCO must establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The Primary Contractor or its BH-MCO must reserve funds by major categories of service (e.g., inpatient; outpatient) to cover both IBNRs and received but unpaid claims (RBUCs). As part of its reserving methodology, the Primary Contractor or its BH-MCO should conduct annual reviews and reconciliations to assess its reserving methodology and make adjustments as necessary.

12. Financial Performance

The Department will monitor the financial performance of the Primary Contractor, its BH-MCO and its major Subcontractors. Monitoring will include, but not be limited to, financial viability, profit, and appropriateness of medical and administrative expenditures.

13. Reporting Penalty

If the Primary Contractor fails to provide any report, audit, or file that is specified by the Agreement by the applicable due date, or if the Primary Contractor provides any report, audit, or file specified by the Agreement that does not meet established criteria, a subsequent payment to the Primary Contractor may be reduced by the Department. The reduction shall equal the number of days that elapse between the due date or any extension due date granted by the Department, and the day that the Department receives a report, audit, or file that meets established criteria, multiplied by the average PMPM Capitation rate that applies to the first month of the Agreement period. If the Primary Contractor provides a report, audit, or file on or before the due date, and if the Department notified the Primary Contractor after the 15th calendar day after the due date that the report, audit, or file does not meet established criteria, no reduction in payment will apply to the 16th day after the due date through the date that the Department notified the Primary Contractor.

See Appendix R, Encounter Data Submission Requirements and Liquidated Damages for Noncompliance, for sanctions related to noncompliance.

B. Capitation Payment

The following requirements apply to the final Capitation rate and the receipt of Capitation payments under the contract:

1. The final Capitation rate for each Primary Contractor must be:

i. Specifically identified in the review and approval by CMS of the rate certification package.

ii. The final Capitation rates must be based only upon services covered under the State Plan and additional services deemed by the Department to be necessary to comply with the requirements of subpart K of §438.900 (applying parity standards from the Mental Health Parity and Addiction Equity Act), and represent a payment amount that is adequate to allow the Primary Contractor to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.

2. Capitation payments may only be made by the Department and retained by the Primary Contractor for Medicaid eligible enrollees.

C. Acceptance of Department Capitation Payments

The Department's payment to a Primary Contractor is capitated for all State Plan Services. The obligation of the Department to make payments is limited to Capitation payments. The Department shall make Capitation payments to the Primary Contractor on a monthly basis in the following manner:

On the first day of each month, the Department will identify Members, whose enrollment in the BH-MCO is effective the previous month, as indicated in CIS. By the 15th day of the month, the Department shall make a Capitation payment to the Primary Contractor, for each Member enrolled in the BH-MCO, that constitutes payment in full for any and all covered services provided to the Member for the first day of the previous month that the Member is enrolled in the BH-MCO and for each subsequent day, through and including the last day of the previous month. This payment will be limited to those days for which the Department has not previously made payment to the Primary Contractor. The Department, however, at its sole discretion, reserves the right to:

1. delay all Capitation payments that would otherwise be made in the months of May and June, until July of the same year.

2. make a Capitation payment by the 15th of the month, for those months specified by the Department and upon notice to the Primary Contractor by the Department, for each Member enrolled in the BH-MCO, that constitutes payment in full for any and all covered services provided to the Member for the first day of the current month that the Member is enrolled in the BH-MCO and for each subsequent day, through and including the last day of the month. This payment will be limited to those days for which the Department has not previously made payment to the Primary Contractor.

For Members whose enrollment is effective at any time after the first day of the month, Capitation will be prorated and paid at a later date.

Appendix V, the HealthChoices Behavioral Health Recipient Coverage Document, provides for adjustments to the Department's obligation to make Capitation payments. Appendix V is subject to revision by the Department in its sole discretion and without the need to amend the Agreement.

The Capitation payment will be equal to the amount awarded the Primary Contractor through the rate setting process. Monthly Capitation rates will be changed to equivalent per diem amounts for the purpose of payments.

The Agreement will provide for rates for SSI Members who have Medicare Part A benefits that are distinct from rates for SSI Members who do not have Medicare Part A benefits. If the Department's TPL file is updated to indicate Medicare Part A coverage within four months prior to the current month for a Member at an SSI without Medicare rate, the Department will adjust the payment to reflect the rate cell appropriate to the Members, provided the TPL file indicates Part A coverage as of the first day of coverage by the Primary Contractor for this Member during the program month for which payment was made. If the Department's TPL file is updated to adjust or delete indication of Medicare Part A coverage within four months of a payment to the Primary Contractor for a Member at an SSI with Medicare or Healthy Horizons rate, the Department will adjust the payment to reflect the rate cell appropriate to the Member, provided the TPL file does not indicate Part A coverage as of the first day of coverage by the Primary Contractor for this Member during the program month for which payment was made. The Department will provide information to the Primary Contractor on this type of payment adjustment on an electronic file. The Primary Contractor will utilize this information to adjust its payments to Providers and instruct its Providers to bill Medicare.

The Department will recover Capitation payments made for the Members who were later determined to be ineligible or deceased. (See Appendix V, HealthChoices BH Recipient Coverage Document.)

The Primary Contractor must agree to accept Capitation payments in this manner and must have written policies and procedures for receiving, reconciling and processing Capitation payments.

By executing this Agreement, the Primary Contractor has reviewed the rates set forth in Appendix 3, Rates, and accepts the rates.

1. Payments for Members that are patients in an IMD

    a. The Department will make a monthly capitation payment for a Member

receiving inpatient or residential treatment services in an IMD so long as the facility is a hospital or a residential facility providing psychiatric or substance use disorder treatment.

i. IMDs providing substance use disorder treatment: Capitation payment will be made for stays in an IMD providing substance use disorder treatment.

ii. IMDs providing psychiatric treatment:
- For individuals under 21 years of age or 65 years of age or older, capitation payment will be made.
- For individuals 21-64 years of age, the Primary Contractor can retain the capitation payment only if the length of stay in the IMD is for a short term stay of no more than 15 cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in an IMD must meet the requirements for *in lieu of* services in 42 CFR § 438.3(e)(2)(i) through (iii). For stays longer than 15 cumulative days, the entire capitation payment for the month will be recouped by the Department and the Primary Contractor and its BH-MCO will receive a separate pro-rated capitation payment for the days of the month in which the Member was not in the psychiatric IMD facility.

b. For purposes of rate setting, the Department will use the utilization of services provided to an enrollee under 42 CFR § 438.6 when developing the inpatient psychiatric or substance use disorder component of the capitation rate but must price utilization at the cost of the same services through Providers included under the State Plan.

c. The Primary Contractor, and/or its BH-MCO, will comply with the Department's request for information regarding individuals in an IMD on a monthly basis, or as requested.

2. Automated Clearing House

The Department will make Capitation payments through the Automated Clearing House (ACH) Network. Within 10 days of the contract award, the Primary Contractor must submit or have already submitted its ACH information within its user profile in the Commonwealth's procurement system (PA Supplier Portal). At the time of submitting ACH information, the Primary Contractor will also be able to enroll to receive remittance advice via electronic addenda.

It is the responsibility of the Primary Contractor to ensure that the ACH

information contained in SRM is accurate and complete. Failure to maintain accurate and complete information may result in delays in payments.

D. Physician Incentive Arrangements

The Primary Contractor may operate a physician incentive plan only in accordance with Federal requirements for physician incentive plans and must provide reports to CMS or the Department upon request. The Primary Contractor contracts must provide for compliance with the requirements set forth in §§ 422.208 and 422.210 of 42 CFR, Chapter 438. In applying the provisions of § 422.208 and § 422.210 of 42 CFR, references to ‘‘MA organization,’’ ‘‘CMS,’’ and ‘‘Medicare beneficiaries’’ must be read as references to the Primary Contractor ‘‘State,’’ and ‘‘Medicaid beneficiaries,’’ respectively.

E. Claims Payment and Processing

1. Payments to Providers

The Department believes that one of the advantages of a behavioral health managed care system is that it permits Primary Contractors and their BH-MCOs to enter into creative payment arrangements intended to encourage and reward effective Utilization Management and quality of care. The Department therefore intends to give Primary Contractors and BH-MCOs as much freedom as possible to negotiate mutually acceptable payment rates. However, regardless of the specific arrangements made with Providers, the Primary Contractor and its BH-MCO must agree to make timely payments to both Networkand Out-of-Network Providers, subject to the conditions described below. The Primary Contractor and its BH-MCO must also agree to abide by special reimbursement provisions for FQHCs described below.

The Primary Contractor and its BH-MCO agree to negotiate and pay rates to IHCPs, FQHCs, and RHCs comparable to other Providers who provide comparable services in the Primary Contractor’s and its BH-MCO’s Provider network. The Primary Contractor and its BH-MCO cannot pay annual cost settlement or prospective payment. If the Primary Contractor and its BH-MCO do not negotiate a rate with an IHCP, the Primary Contractor and its BH-MCO must pay the IHCP a rate that is not less than the level and amount of payment that it would have made for the services to a Network Provider which is not an IHCP.

The Primary Contractor and its BH-MCO may require that an FQHC comply with case management procedures that apply to other entities that provide similar benefits or services.

The Primary Contractor and its BH-MCO must provide Members access to FQHCs and RHCs within the Provider Network. The Primary Contractor and its BH-MCO must pay FQHC and RHC rates no less than Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by the Department. The Primary Contractor and its BH-MCO must include in its Provider Network every FQHC and RHC that is willing to accept PPS rates as payment in full.

If a FQHC or RHC elects not to receive the PPS rate from the Primary Contractor and its BH-MCO, upon notification from the Department of the date that the FQHC or RHC elects not to receive the PPS rate, the Primary Contractor and its BH-MCO is no longer required to make payment at the PPS rate, as noted above. Effective with the date the FQHC or RHC elects not to receive the PPS rate, the Primary Contractor and its BH-MCO must negotiate and pay the FQHC or RHC at rates that are no less than what the Primary Contractor and its BH-MCO pays to other providers who provide comparable services within the Primary Contractor's and its BH-MCO's Provider Network.

The Primary Contractor and its BH-MCO shall not be obligated to pay Providers of authorized Behavioral Health Services unless bills for such services are submitted within 180 days from the date of service.

BH-MCOs may include a requirement in its Provider Agreements and Subcontracts that require that submission of Claims or Encounter records to be submitted within 180 days, or less, from the date of services. Claims adjudicated by a third-party vendor must be provided to the BH-MCOs by the end of the month following the month of adjudication.

The Primary Contractor and its BH-MCO shall follow state law on invoicing requirements on uniform claims, including the CMS 1500 and UB92, and HIPAA regulations for electronic billing via the 837 I and 837 P.

When an IHCP is not enrolled in the MA Program as an FQHC it may receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Department's MA FFS program.

2. The Department will not make payments to a Network Provider, for services covered under the Agreement between the Department and the Primary Contractor except when these payments are specifically required to be made by the Department in Title XIX of the Act, in 42 CFR Chapter IV, or when the Department makes direct payments to Network Providers for graduate medical education, costs approved under the State Plan.

3. The Primary Contractor and its BH-MCO shall adjudicate 90% of all Clean Claims within 30 days, 100% of Clean Claims within 45 days, and 100% of all claims within 90 days. The Primary Contractor shall provide the Department with a monthly report that supplies summary information on claims processed. This reporting requirement applies to claims processed by the Primary Contractor, its BH-MCO, or a Subcontractor, as well as capitation payments to Providers or Subcontractors of Behavioral Health Services. The specific report contents and claims processing timeliness standards are detailed in the HealthChoices Behavioral Health Financial Reporting Requirements (See Appendix P, Report #8).

4. **Payments for ASAM Service Providers**

Effective with dates of services beginning January 1, 2022, the Primary Contractor and its BH-MCO must pay rates for certain Drug and Alcohol services that are not less than the amounts directed by the Department:

ASAM Level of Care 2-Withdrawal Management
ASAM Level of Care 2.1
ASAM Level of Care 2.5
ASAM Level of Care 3.1
ASAM Level of Care 3.5
ASAM Level of Care 3.7
ASAM Level of Care 3.7-Withdrawal Management

This requirement applies to any Subcontractor of the Primary Contractor and its BH-MCO.

F. Retroactive Eligibility Period

The Primary Contractor and its BH-MCO will not be responsible for any payments owed to Providers for services that were rendered prior to a Member's effective date of enrollment.

G. (Member) Copays

The Primary Contractor and its BH-MCO are not allowed to impose co-pays for services.

H. Financial Responsibility for Dual Eligibles

The Commonwealth enters into a Coordination of Benefits Agreement with Medicare for the Medical Assistance populations. Consistent with 42 C.F.R. §438.3(t), the Primary Contractor or its BH-MCO must enter into individual Coordination of Benefits Agreements with Medicare for members dually eligible for Medicaid and Medicare and participate in the automated claims crossover process.

The Primary Contractor must ensure that a Member who is eligible for both Medicaid and Medicare benefits has the right to access a Medicare product or service from the Medicare Provider of his/her choice, regardless of whether that Provider is enrolled in the BH-MCO network. BH-MCOs may establish policies and procedures for their networks that maximize opportunities for consumers to have a choice of Medicare Providers.

The Primary Contractor and its BH-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries up to the contracted BH-MCO rate for the service billed by Network Providers. The Primary Contractor, its BH-MCO and Providers are prohibited from balance billing Members for Medicare deductibles or coinsurance. If the service is a covered Medicare service, the Primary Contractor is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the BH-MCOs Provider Network, and whether or not the Medicare Provider has complied with the authorization requirements of the Contractor. Since Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Providers enrolled in Medicaid , Medicare Providers seeking payment must be enrolled in Medicaid.

If no contracted BH-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the Primary Contractor must pay deductibles and coinsurance up to the applicable Medical Assistance fee schedule amount for the service.
For Medicare services that are not covered by either MA or the BH-MCO, the Primary Contractor must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the BH-MCO do not exceed 80% of the Medicare-approved amount.

In the event that Medicare does not cover a service, the Primary Contractor's BH-MCO may require Prior Authorization as a condition of payment for the service.

I. Risk and Contingency Funds (Does not apply to a Private Sector BH-MCO as the Primary Contractor)

1. The Primary Contractor shall submit a written request to the Department prior to designating funds as Risk and Contingency Funds. The request must include why funds should be designated as Risk and Contingency Funds instead of reinvested.

2. The amount approved by the Department must be placed in a risk and contingency account within 30 days of receiving a written approval letter from the Department.

3. The Primary Contractor is permitted to utilize without approval from the Department its Risk and Contingency Funds to make payments to its BH-MCO or Subcontractors if there is a delay of more than 31 days in a Capitation Payment from the Department. The Primary Contractor must return any funds used to its risk and contingency account within 60 days of their withdrawal from the risk and contingency account.

4. With prior written approval from the Department, the Primary Contractor may use Risk and Contingency Funds for the following purposes:

    a. To provide State Plan Services and administrative functions required by this document, due to fluctuations in enrollment, revenue and utilization which have caused costs to exceed available Capitation Payments;

    b. To meet the Primary Contractor's insolvency arrangement plan under Part II-7 A. of this document. Those Risk and Contingency Funds held for insolvency protection purposes will be restricted and only available in the event of a bankruptcy or insolvency; or for 3) above; or

    c. To meet the Primary Contractor's reinvestment plan.

5. Risk and Contingency (R&C) Funds shall at no time exceed the equivalent of 45 days' worth of paid claims, as determined by the Department, unless the Primary Contractor is holding funds in its risk and contingency account in order to meet the Department's insolvency arrangement requirements in Part II-7 A. as follows:

    a. If Risk and Contingency Funds are being used to fully meet the Department's insolvency arrangement requirement (equal to 60 days' worth of paid claims), the Department will inform the Primary Contractor of how many days of paid claims the Primary Contractor must maintain, which may include up to 90 days' worth of paid claims.

    b. If Risk and Contingency Funds are being used to partially meet the Department's insolvency arrangement requirement (less than 60 days' worth of paid claims), the Department will inform the Primary

Contractor of how many days of paid claims the Primary Contractor must maintain, which may include up to 75 days' worth of paid claims.

c. If Risk and Contingency Funds are being used to fully or partially meet the Department's insolvency arrangement requirement, the Department will inform the Primary Contractor of how many days of paid claims the Primary Contractor must maintain which may include up to 75 or 90 days' worth of paid claims. The Risk and Contingency Fund would then need to be funded, at a minimum, at the amount agreed upon by the Department, at all times.

d. In the event a Primary Contractor is meeting the insolvency arrangement requirement via Risk and Contingency Funds and changes the method in which the insolvency arrangement requirement is met, the days' worth of paid claims permitted to be maintained as Risk and Contingency Funds must change accordingly.

   Funds designated in a reinvestment plan submitted to the Department will not be included in the calculation of the 45, 75 or 90 days' worth of paid claims, as applicable. If the Risk and Contingency Funds exceed the equivalent of 45, 75 or 90 days' worth of paid claims, as applicable, at the end of any Agreement period, the Primary Contractor shall return the excess portion to the Department within 15 days of written notification from the Department.

6. The Risk and Contingency Funds shall be held in a bank account that is separate from any other HealthChoices bank accounts. Copies of the bank statements must be mailed monthly to the Department.

7. The Risk and Contingency Funds shall be reported as a separate line item on the monthly financial report and audited balance sheet submitted for the annual Agreement audit, including a statement of cash flow.

8. Within 14 months from the termination of the Agreement, any Risk and Contingency Funds remaining in the Primary Contractor's HealthChoices Special Revenue or Enterprise Fund for the HealthChoices Behavioral Health Program shall be returned to the Department.
9. In the event that the Department enters into another agreement with the Primary Contractor for the provision of HealthChoices Behavioral Health Services subsequent to a current Agreement's termination, the Department reserves the right, in its sole discretion, to allow the Primary Contractor to retain all, or a portion thereof, of Risk and Contingency Funds otherwise owed to the Department.

10. The Department reserves the right to revise the Risk and Contingency Fund requirements at its discretion. Any revisions will be implemented in compliance with timelines defined in the Agreement.

J. Return of Funds

Sections 1. and 2. below do not apply to a Private Sector BH-MCO as the Primary Contractor)

1. The Primary Contractor must return any unexpended Reinvestment Funds to the Department within six months from the time period approved for such expenditure unless such date is otherwise extended by the Department.

2. In the event that the Agreement with the Department ends and is not renewed, all funds, except for those in DHS approved reinvestment plans, or Reinvestment Funds in a plan submitted to DHS but which DHS has not taken a positive or negative action, remaining in the Primary Contractor's Special Revenue Fund or Enterprise Fund, or held by any Subcontractor, inclusive of Risk and Contingency Funds, not expended for HC-BH transactions, must be returned to the Department within 14 months from the expiration of the Agreement.

K. Payment for Services

1. Network Providers

The Primary Contractor and its BH-MCO are responsible for making timely payment for medically necessary, State Plan Services rendered by -Network Providers when:

a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency department; or

b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or

c. Services were rendered under the terms of the BH-MCO's contract with the Provider; or

d. Services were prior authorized.

Under these terms, the Primary Contractor will not be financially liable for services rendered in a hospital emergency department other than for emergency department evaluations for voluntary or involuntary

commitments pursuant to the Mental Health Procedures Act of 1976 which will be the responsibility of the BH-MCO.

2. Out-of-Network Providers

The Primary Contractor and its BH-MCO are responsible for making timely payments to Out-of-Network Providers for medically necessary, State Plan Services when:

a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency department; or

b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or

c. Services were prior authorized by the BH-MCO; or

d. Medically necessary services were rendered during an emergency placement by the child welfare agency.

The Primary Contractor is not financially liable for services rendered in a hospital emergency department other than for voluntary or involuntary commitments pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the BH-MCO. The BH-MCO must assure that cost to Members is no greater than it would be if services were provided within the Provider network.

An Out-of-Network Provider which bills the BH-MCO for covered HealthChoices State Plan Services, shall not balance bill the Member.

However, if the BH-MCO is referring a Member to an Out-of-Network Provider, the BH-MCO must pay deductibles and co-insurance up to the applicable Medical Assistance fee schedule amount for the service. In these circumstances, the Member cannot be subject to balance billing by the Provider.

The Primary Contractor and its BH-MCO must permit a Member who is an Indian as defined at 25 USC §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian under 42 CFR § 136.12, to obtain services from out-of-network IHCPs from whom the Member would otherwise be eligible to receive such services. The Primary Contractor and its BH-MCO must permit an out-of-network IHCP to refer a Member who is an Indian to a Network Provider.

3. Liability During an Active Provider Complaint

The Primary Contractor or its BH-MCO will not be liable to pay claims to Providers if the validity of the claim is being challenged by the BH-MCO through a Complaint process or appeal, unless the BH-MCO is obligated to pay the claim or a portion of the claim through its contract with the Provider.

4. Prohibited Payments

The Primary Contractor and its BH-MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency department of a hospital) that is furnished:

a. by, or at the medical direction or prescription of, any individual or entity during any period when the individual or entity is excluded from participation in Medicare, Medicaid, the federal Maternal and Child Health Services Block Grant program, the federal Social Services Block Grant program, SCHIP, or other federal healthcare program; or
b. by any individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the Department determines in accordance with then- applicable federal regulations there is good cause not to suspend such payments in whole or in part.

The Primary Contractor and its BH-MCO must not pay any amount for which funds may not be used under the federal Assisted Suicide Funding Restriction Act of 1997 (P.L. 105-12, 111 Stat. 23 (April 30, 1997)), including payments for items or services furnished for the purpose of causing, the death of any individual, such as by assisted suicide, euthanasia or mercy killing. The Primary Contractor and its BH-MCO must not pay for any item or service for road bridges, stadiums, or any other item or service not provided for under this Agreement.

L. Third Party Liability (TPL)

The Primary Contractor must comply with the TPL procedures defined by Section 1902(a)(25) of the Social Security Act, 42 U.S.C.A. § 1396 (a)(25) and implemented by the Department. Under the Agreement, the Third-Party Liability responsibilities of the Department will be allocated between the parties as indicated below.

1. Cost Avoidance Activities

    a. The Primary Contractor and its BH-MCO has primary responsibility for cost avoidance through the Coordination of Benefits (COB) relative to federal and private health insurance-type resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.A. § 1396a(a)(25) plans, and workers compensation. Except as provided in subparagraph 2, the Primary Contractor/ BH-MCO must attempt to avoid initial payment of claims, whenever possible, where federal or private health insurance-type resources are available. All cost-avoided funds must be reported to the Department via encounter data submissions and financial report 11. The use of the appropriate HIPAA 837 Loop(s) for Medicare, and Other Insurance Paid (OIP) shall indicate that TPL has been pursued and the amount which has been cost-avoided. The Primary Contractor shall not be held responsible for any TPL errors in the Department's EVS or the Department's TPL file.

    b. The Primary Contractor and its BH-MCO agree to pay, and to require that its Subcontractors pay, all Clean Claims for preventive pediatric care including EPSDT services to children, and services to children having medical coverage under a Title IV-D child support order to the extent the Primary Contractor and its BH-MCO is notified by the Department of such support orders or to the extent they become aware of such orders, and then seek reimbursement from liable third parties. The Primary Contractor and its BH-MCO shall communicate and require Providers to bill other primary insurance first, prior to submitting the claim to Medicaid. The Primary Contractor and its BH-MCO recognize that cost avoidance of these claims is prohibited.

    c. The Primary Contractor and its BH-MCO may not deny or delay approval of otherwise covered treatment or services based upon Third Party Liability considerations. The Primary Contractor and its BH-MCO may neither unreasonably delay payment nor deny payment of claims unless the existence of Third-Party Liability is established at the time the claim is adjudicated.

2. Post-Payment Recoveries

    a. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) other resources. Health-related insurance resources are ERISA health benefit plans, Blue

Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts. The term “other resources” means all other resources and includes, but is not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance and accident indemnity insurance.

b. The Department's Division of TPL retains the sole and exclusive right to investigate, pursue, collect, and retain all "other resources" as defined in paragraph 2) a. above. The Department is assigned the Primary Contractor’s subrogation rights to collect the “other resources” covered by this provision. Any correspondence or inquiry forwarded to the Primary Contractor or its BH-MCO (by an attorney, Provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the Recipient and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The Primary Contractor or its BH-MCO may neither unreasonably delay payment nor deny payment of claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by the Commonwealth under the scope of these "other resources" shall be retained by the Commonwealth.

c. Due to potential time constraints involving cases subject to litigation, the Department must ensure that it identifies these cases and establishes its claim before a settlement has been negotiated. Should the Department fail to identify and establish a claim prior to settlement due to the Primary Contractor's/BH-MCO’s untimely submission of notice of legal involvement where the Primary Contractor/BH MCO has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the Primary Contractor/BH-MCO The Department's actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by the Department.

d. The Primary Contractor or its BH-MCO has the sole and exclusive responsibility and right to pursue, collect and retain all health-related insurance resources for a period of 12 months from the date of payment. Notification of intent to pursue, collect and retain health-related claims not recovered by the Primary Contractor within the 12 months from the date of payment will become the sole and exclusive right of the Department to pursue, collect and retain. The Primary Contractor is responsible to notify the Department of

all cases recovered within the 12-month period.

e. Should the Department lose recovery rights to any claim due to late or untimely filing of a claim with the liable third party, and the untimeliness in billing that specific claim is directly related to untimely submission of encounter data, additional records under special request, or inappropriate denial of claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable claim shall be assessed against the Primary Contractor/BH-MCO.

f. Encounter data that is not submitted to the Department in accordance with the data requirements and/or timeframes identified in this Agreement can possibly result in a loss of revenue to the Department. Strict compliance with these requirements and timeframes shall therefore be enforced by the Department and could result in the assessment of liquidated damages against the Primary Contractor.

g. The Primary Contractor and its BH-MCO are responsible for pursuing, collecting, and retaining recoveries of 1) a claim involving Workers' Compensation, 2) health-related insurance resources where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The Primary Contractor and its BH-MCO are required to develop and implement cost-effective procedures to identify and pursue cases that are susceptible to collection through either legal action or traditional subrogation and collection procedures.

3. HIPP Program

The HIPP Program pays for employment-related health insurance for Members when it is determined to be cost effective. The cost effectiveness determination involves the review of group health insurance benefits offered by employers to their employees to determine if the anticipated expenditures in MA payments are likely to be greater than the cost of paying the premiums under a group plan for those services. The Department shall not purchase Medigap policies for equally eligible Members in the HealthChoices zone.

4. Requests for Additional Data

The Primary Contractor/BH-MCO must provide, at the Department's request, such information not included in the encounter data submissions that may be necessary for the administration of TPL activity. The Primary Contractor/

BH-MCO shall use its best efforts to provide this information within 15 calendar days of the Department's request. There are certain Urgent requests involving cases for minors that require information within 48 hours. Such information may include, but is not limited to, individual medical records for the express purpose of determining TPL for the services rendered. Confidentiality of the information shall be maintained as required by federal and state regulations.

5. Accessibility to TPL Data

The Department shall provide the Primary Contractor with accessibility to data maintained on the TPL file.

6. Third Party Resource Identification

Third party resources identified by the Primary Contractor and/or its BH-MCO, which do not appear on the Department's TPL database, must be supplied to the Department's TPL Division by the Primary Contractor and or its BH-MCO. In addition to newly identified resources, coverage for other household members, addition of coverage type, changes to existing resources, including termination of coverage and changes to coverage dates, must also be supplied to the Department's TPL Division. The method of reporting shall be via electronic process or manual submission or by any alternative method approved by the Department. TPL resource information must be submitted within two weeks of its receipt by the Primary Contractor and/or its BH-MCO. A manual document is only to be submitted in the following instances: the BH-MCO is no longer the Recipient's MCO, the Contract/Policy ID number is longer than 12 digits or for HIPP referrals. For electronic submissions, the Primary Contractor must follow the required report format, data elements, and specifications supplied by the Department. For manual submissions, the Primary Contractor must use an exact replica of the TPL resource referral form supplied by the Department. As the office responsible for the maintenance and quality assurance of the records stored on the TPL database, the Department's TPL Division will use these submissions for subsequent updates to the system.

The Department will contact the Primary Contractor and/or its BH-MCO when the validity of a resource is in question. The Primary Contractor and/or its BH-MCO shall verify inconclusive resource information within two (2) business days of notification by the Department that the resource information is in dispute. Unless the verification notification is requested on the last business day of the week, then the Primary Contractor and/or its BH-MCO must respond by the close of business that day to avoid a potential access to care issue for the Member.

The Primary Contractor shall use the Department's EVS and secured services on the internet (previously known as POSNET) to assure detailed information is provided for insurance carriers when a resource is received that does not have a unique carrier code.

7. Damage Liability

Liability for damages is identified in this section due to the large dollar value of many claims which are potentially recoverable by the Department's Division of TPL.

8. Estate Recovery

Section 1412 of the Human Services Code, 62 P.S. 1412, requires the Department to recover MA costs paid on behalf of certain deceased individuals. Individuals age 55 and older who were receiving MA benefits for any of the following services are affected:

a. Public or private nursing facility services;

b. Residential care at home or in a community setting; or

c. Any hospital care and prescription drug services provided while receiving nursing facility services or residential care at home or in a community setting.

The applicable MA costs are recovered from the assets of the individual's probate estate. The Department's Division of TPL is solely responsible for administering the Estate Recovery Program.

M. Performance Management Information System and Reporting

1. General

The requirement that the Primary Contractor and its BH-MCO provide the requested data is a result of the terms and conditions established by CMS. CMS specified that the state define a minimum data set and require all Primary Contractors and their BH-MCOs to submit the data.

To measure the Primary Contractor and its BH-MCO's accomplishments in the areas of access to care, behavioral health outcomes, quality of life, and Member satisfaction, the Primary Contractor and its BH-MCO must provide the Department with uniform service utilization, Quality Management, and

Member satisfaction/Complaint/Grievance data on a regular basis. The Primary Contractor and its BH-MCO also must cooperate with the Department in carrying out data validation steps. The Department intends to use this information as part of a collaborative effort with the Primary Contractor and its BH-MCOs to effect continuous quality improvement.

This data will include components specified by the Department and also problem areas targeted by the continuous quality improvement program, both of which may change from time to time.
The Primary Contractor and its BH-MCO will manage the program in compliance with the Department's standards and requirements and will provide data reports to support this management.

The Primary Contractor must, at its expense, arrange for a background check for each of its employees, as well as for the employees of its Subcontractors, who will have access to Commonwealth Information Technology (IT) facilities, either through on site or remote access. Background checks are to be conducted via Obtain a Criminal History Check procedure found at http://www.psp.state.pa.us/portal/server.pt/community/psp/4451/how_to/452779. The background check must be conducted prior to initial access by an IT employee and annually thereafter.

Before the Commonwealth will permit an IT Employee access to Commonwealth facilities, the Primary Contractor must provide written confirmation to the office designated by the agency that the background check has been conducted. If, at any time, it is discovered that an IT Employee has a criminal record that includes a felony or misdemeanor involving terroristic threats, violence, use of a lethal weapon, or breach of trust/fiduciary responsibility; or which raises concerns about building, system, or personal security, or is otherwise job-related, the Primary Contractor shall not assign that employee to any Commonwealth facilities, shall remove any access privileges already given to the employee, and shall not permit that employee remote access to Commonwealth facilities or systems, unless the agency consents, in writing, prior to the access being provided. The agency may withhold its consent at its sole discretion. Failure of the Primary Contractor to comply with the terms of this paragraph may result in default of the Primary Contractor under its Agreement with the Commonwealth.

The Department's detailed report formats are available on the Department’s websites.

It is the Department's right to request medical records directly from BH-

MCO's and BH Services Providers for issues related to quality of care, behavioral health outcome measures, TPL, and fraud and abuse.

2. Management Information System

The Department requires an automated MIS. There are numerous components required for the complete system. They are service authorization, Member Complaint and Grievance, Provider Complaint, Provider profiling, claims processing including TPL identification, Member enrollment, financial reporting, Utilization Management, encounter data, performance outcomes, Quality Management, and suspected/substantiated fraud and abuse. Of these components, service authorization, Provider profiling, claims processing (including TPL) encounter data and Member enrollment must be integrated.

The Primary Contractor and its BH-MCO's MIS must have the capability to electronically transfer data files with the Department and the EAP broker. The Primary Contractor and its BH-MCO must use a secure FTP connection that is compatible with the Department's product.

The Primary Contractor and its BH-MCO must comply with all applicable business and technical standards available on the DHS Internet site at the following link: http://www.dhs.pa.gov/provider/busandtechstandards/index. htm. This includes compliance with the standards for connectivity to the Commonwealth's network. The Primary Contractor and its BH-MCO's MIS must be compatible with the Department's MIS. The Primary Contractor and its BH-MCO must also comply with the Department's SeGovernment Data Exchange Standards. In addition, the Primary Contractor and its BH-MCO must comply with any changes made to the Commonwealth's Business and Technical Standards. Whenever possible, the Department will provide advance notice of at least 60 days prior to the implementation of changes. For more complex changes, every effort will be made to provide additional notice.

The Primary Contractor or its BH-MCO must maintain an automated Provider directory that meets the requirements of Section II-5. D.9. Upon request, the Primary Contractor or its BH-MCO is required to provide this directory to the Department via secure email or other portable storage device.

The MIS must include mechanisms to incorporate recommended enhancements resulting from the Department's monitoring and external evaluations and audits.

3. Encounter and Alternative Payment Arrangements Data

The Department requires the Primary Contractor or its BH-MCO to submit a separate record, or "pseudo claim," each time a Member has an encounter with a Provider. This includes encounters with Providers which are reimbursed on a Fee-for-Service or Alternative Payment Arrangement basis. An encounter is a service provided to a Member. This would include, but not be limited to, a professional contact between a Member and a Provider and will result in more than one encounter if more than one service is rendered. For services provided by BH-MCO contractors and Subcontractors, it is the responsibility of the Primary Contractor or its BH-MCO to take appropriate action to provide the Department with accurate and complete encounter data. The Department's point of contact for encounter data will be the Primary Contractor or its BH-MCO and not other Subcontractors or Providers.

The Department requires the Primary Contractor or its BH-MCO to submit a separate Alternative Payment Arrangement record for each advance payment made to a contractor or Provider responsible for all or part of a Member's behavioral health care. If the payment is an Alternative Payment Arrangement reimbursement, a separate record is required to report the amount paid on behalf of each Member. It is the responsibility of the BH-MCO to take appropriate action to provide the Department with accurate and complete data for payments made by BH-MCO to its contractors and Providers; the Department's point of contact for Alternative Payment Arrangement data will be the Primary Contractor or its BH-MCO and not other Subcontractors or Providers.

The Department will validate the accuracy of data on the encounter and Alternative Payment Arrangement data files. Validation criteria are included for each data element in the Requirements and Specifications Manual for Encounter Data/Alternative Payment Arrangement Data and in the Encounter and Complaint and Grievance Reporting Manuals.

a. 837 Transaction.

The 837 Transaction must include, at a minimum, the data elements listed in the HIPAA Implementation Guides and PROMISe Companion Guides.

b. Encounter Data.

The encounter data submittal must include, at a minimum, the data elements/reports listed in the Encounter Data and Complaint and Grievance Reporting Manuals.

c. Data Format.

The Primary Contractor and its BH-MCO must agree to submit Encounter and Alternative Payment Arrangement data electronically to the Department through PROMISe using the FTP. Data file content must conform to the requirements specified in the HIPAA Implementation Guides and PROMISe Companion Guides and the Aggregate Encounter and Complaint and Grievance Reporting Manuals.

d. Timing of Data Submittal

An encounter must be submitted and pass PROMISe edits on or before the last calendar day of the third month after the Primary Contractor paid/adjudicated the encounter.

Acceptable Alternative Payment Arrangement (formerly known as subcapitation) data must be submitted and found acceptable to the Department within 30 days after the period or case for which the payment applies.

The Primary Contractor must adhere to the file size specifications provided by the Department. A file submission schedule will be developed and provided to the Primary Contractor.

e. Member Medical Information

When requested, the Primary Contractor or its BH-MCO must provide a Member's medical records within 15 days of the Department's request.

f. Data Validation

The Primary Contractor and its BH-MCO must agree to assist the Department in its validation of utilization data by making available medical records and its claims data. The validation may be completed by Department staff and independent, external review organizations.

N. Audits

All costs incurred under the Agreement are subject to audit by the Department or its designee for final approval and acceptability, in accordance with industry standards, applicable accounting principles, and Federal and State regulations and

policy. Additional information on auditing is contained in Appendix W and the HealthChoices Financial Reporting Requirements (Appendix P). The Primary Contractor is responsible to comply with audit requirements as specified in the HealthChoices Audit Clause (Appendix W).

O. Restitution

The Primary Contractor must report to the Department within 60 days when it has identified overpayment of Capitation payments or other payments in excess of the amount specified in the Agreement. The Primary Contractor shall make full and prompt restitution to the Department, as directed by the Department, for overpayments received in excess of amounts due to the Primary Contractor under this Agreement whether such overpayment is discovered by the Primary Contractor, the Department, or other third party.

P. Claims Processing and MIS

The Primary Contractor or its BH-MCO must have a comprehensive automated MIS that is capable of meeting the requirements listed below and throughout this document. The Primary Contractor or its BH-MCO MIS must comply with the requirements listed in the latest version of the MIS and System Performance Review Standards. The Department will provide data support for the Primary Contractor and its BH-MCO as listed in Appendix O and described in the "Managed Care Data Support Overview for Behavioral Health".

- The Membership management system must have the capability to receive, update and maintain the BH-MCO's Membership files consistent with information provided by the Department.
- The claims processing system must have the capability to process claims consistent with timeliness and accuracy requirements identified in this document. Claims history must be maintained with sufficient detail to meet all Department reporting and encounter requirements.
- The Provider file management system must have the capability to store information on each Provider sufficient to meet the Department's reporting requirements.
- The Primary Contractor or its BH-MCO must have sufficient telecommunication, including electronic mail, capabilities to meet the requirements of this document.
- The Primary Contractor or its BH-MCO must have the capability to electronically transfer data files with the Department.
- The Primary Contractor or its BH-MCO must be compliant with the Health

Insurance Portability and Accountability Act (HIPAA) of 1996, Administrative Simplification Rule for the eight electronic transactions and for the code sets used in these transactions.

. Primary Contractor or its BH-MCO must have a procedure for maintaining Recipient enrollment and eligibility data, including a procedure for reconciliation of data discrepancies between their eligibility database and the Department's EVS, CIS and daily and monthly eligibility file transfers. The BH-MCO must process and load the daily files in their entirety within twenty-four (24) hours of receipt.

The BH-MCO must reconcile all components of the files against its internal membership information and notify the Department within thirty (30) in order to resolve problems.

The Primary Contractor or its BH-MCO's information system shall be subject to review and approval by the Department at any time.

Q. Data Support

The Department will make files available to the Primary Contractor or its BH-MCO on a routine basis that will allow them to effectively meet their obligation to provide services and record information consistent with Agreement requirements (See Appendix O). The Department expects to provide daily and monthly eligibility files, TPL monthly files, monthly payment reconciliation and summary payment files, MCO Provider Error File, ARM 568 File, MA Provider File, Procedure Code, Diagnosis Code Files and quarterly DDAP CIS files.

INTEGRATED COMMUNITY WELLNESS CENTERS

A. OVERVIEW

The Department of Human Services (DHS) defines Integrated Community Wellness Centers (ICWC) as a service delivery model that requires coordinated, comprehensive and quality care. Additional requirements include the provision of nine (9) core services; common data collection and reporting on quality measures; and a payment system that reimburses providers for the prospective cost of delivering services.

Each ICWC will offer care that is person-centered and family-centered in accordance with the requirements of section 2402(2) of the Affordable Care Act (ACA), trauma-informed, and recovery-oriented, and that the integration of physical and behavioral health care will serve the "whole person".

The ICWC populations to be served are adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders.

B. CORE SERVICES

The Primary Contractor and/or its BH-MCO must contract with each ICWC to deliver the following nine core services:

- Crisis Mental Health Services, including 24- hour mobile crisis team, emergency crisis intervention, and crisis stabilization
- Targeted case management
- Outpatient mental health and substance use services
- Patient-centered treatment planning, including risk assessment and crisis planning
- Screening, assessment, and diagnosis, including risk assessment
- Psychiatric rehabilitation services
- Peer support and counselor services and family support
- Intensive, community-based mental health care for veterans and members of the military
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk

C. PROSPECTIVE PAYMENT SYSTEM

Each ICWC will be paid via a monthly Prospective Payment System (PPS) rate. The Primary Contractor and/or its BH-MCO must pay each ICWC in its network the PPS rate for its enrolled ICWC members for the nine core services during the contract year. The PPS rates will be

incorporated into the Capitation rates. The Primary Contractor will be notified of each participating ICWC and the PPS rate to be paid in full via separate correspondence.

The Primary Contractor and/or its BH-MCO must ensure its provider agreement with each ICWC in its network reflects the new payment methodology (PPS).

D. DESIGNATED COLLABORATING ORGANIZATIONS

An ICWC is permitted to have a sub-contractual arrangement with one (1) or more Designated Collaborating Organizations (DCO) to provide one (1) or more of the required services. The DCO is not under the direct supervision of the ICWC but is engaged in a formal relationship with the ICWC and delivers services under the same requirements as the ICWC. However, the ICWC is financially and clinically responsible for the services provided by the DCO as defined by the sub-contractual arrangement.

Payment for the DCO is included within the scope of the ICWC PPS, and qualifying DCO rendered services will be reported through claims submitted by ICWCs to the BH-MCO. DCOs will receive payment for qualifying services through the ICWC in accordance with the sub-contractual arrangement.
Services of a DCO are distinct from *referred* service in that the ICWC is not financially and clinically responsible for referred services.
The Primary Contactor and/or its BH-MCO must ensure there are no duplicative payments to either the ICWC or its DCO.

E. DATA COLLECTION, REPORTING AND TRACKING

1. The Primary Contractor or its BH-MCO must provide ICWC-level Medicaid encounter data on all prescribed measures.

2. The Primary Contractor or its BH-MCO must ensure that there are no duplicative encounters for all prescribed measures submitted by the DCO and the ICWC.

3. All encounters must be submitted and approved in PROMISe (i.e., pass PROMISe edits) on or before 60 days following the date that the BH-MCO paid/adjudicated the provider's claim or encounter. The Primary Contractor and its BH-MCO and subcontractor(s) shall be responsible for maintaining appropriate systems and mechanisms to obtain all necessary data from its health care providers to ensure its ability to comply with encounter data reporting requirements; including checks for encounter duplications. In addition, all encounters must be timely, accurate and complete in accordance with Appendix R.

4. The Department has the right to request ICWC data at any time from the Primary Contractor, their BH-MCO, and/or ICWC providers.

5. Data reporting on all prescribed ICWC quality measures as established by the Department will be required.

Appendix B
STANDARD GRANT TERMS AND CONDITIONS FOR SERVICES

1. TERM OF GRANT

The term of the Agreement shall commence on the Effective Date and shall end on the Expiration Date identified in the Agreement, subject to the other provisions of the Agreement. The Agreement shall not be a legally binding Agreement until fully executed by the Grantee and by the Commonwealth and all approvals required by Commonwealth and federal procurement procedures have been obtained. No agency employee has the authority to verbally direct the commencement of any work under this Agreement. The Commonwealth may, upon notice to the Grantee, extend the term of the Agreement for up to three (3) months upon the same terms and conditions, which will be utilized to prevent a lapse in Agreement coverage and only for the time necessary, up to three (3) months, to enter into a new Agreement.

2. COMPLIANCE WITH LAW

The Grantee shall comply with all applicable federal and state laws, regulations and policies and local ordinances in the performance of the Agreement. If existing laws, regulations or policies are changed or if any new law, regulation or policy is enacted that affects the services provided under this Agreement, the Parties may modify this Agreement as may be reasonably necessary.

3. ENVIRONMENTAL PROVISIONS

In the performance of the Agreement, the Grantee shall minimize pollution and shall strictly comply with all applicable environmental laws and regulations, including the Clean Streams Law, Act of June 22, 1937 (P.L. 1987, No. 394), as amended, 35 P.S. § 691.601 et seq; the Pennsylvania Solid Waste Management Act, Act of July 7, 1980 (P.L. 380, No. 97), as amended, 35 P.S. § 6018.101 et seq; and the Dam Safety and Encroachment Act, Act of November 26, 1978 (P.L. 1375, No. 325), as amended, 32 P.S. § 693. .

4. POST-CONSUMER RECYCLED CONTENT; RECYCLED CONTENT ENFORCEMENT.

Except as waived in writing by the Department of General Services, any products that are provided to the Commonwealth as a part of the performance of the Agreement must meet the minimum percentage levels for total recycled content as specified by the Environmental Protection Agency in its Comprehensive Procurement Guidelines, which can be found at https://www.epa.gov/smm/comprehensive-procurement-guideline-cpg-program.

5. COMPENSATION/EXPENSES

The Grantee shall perform the specified services at the prices provided for in the Agreement. All services shall be performed within the time periods specified in the Agreement. The Grantee shall be compensated only for work performed to the satisfaction of the Commonwealth. The Grantee shall not be allowed or paid travel or per diem expenses.

6. PAYMENT

The Commonwealth shall put forth reasonable efforts to make payment by the required payment date. Payment should not be construed as acceptance of the service performed. The Commonwealth may conduct further inspection after payment, but within a reasonable time after performance, and reject the service if such post payment inspection discloses a defect or a failure to

meet specifications. The Grantee agrees that the Commonwealth may set off the amount of any state tax liability or other obligation of the Grantee or its subsidiaries to the Commonwealth against any payments due the Grantee under any Agreement with the Commonwealth.

7. TAXES – FEDERAL, STATE AND LOCAL

The Commonwealth is exempt from all excise taxes imposed by the Internal Revenue Service and has registered with the Internal Revenue Service to make tax free purchases under Registration No. 23740001-K. With the exception of purchases of the following items, no exemption certificates are required and none will be issued: undyed diesel fuel, tires, trucks, gas guzzler emergency vehicles, and sports fishing equipment. The Commonwealth is also exempt from Pennsylvania state sales tax, local sales tax, public transportation assistance taxes and fees and vehicle rental tax. The Department of Revenue regulations provide that exemption certificates are not required for sales made to governmental entities and none will be issued. Nothing in this paragraph is meant to exempt a construction contractor from the payment of any of these taxes or fees that are required to be paid with respect to the purchase, use, rental, or lease of tangible personal property or taxable services used or transferred in connection with the performance of a construction contract.

8. WARRANTY

The Grantee warrants that all services performed by the Grantee, its agents and subcontractor shall be performed in a professional and workmanlike manner and in accordance with prevailing professional and industry standards using the utmost care and skill. Unless otherwise stated in the Agreement, all services are warranted for a period of one year following completion of performance by the Grantee and acceptance by the Commonwealth. The Grantee shall correct any problem with the service without any additional cost to the Commonwealth.

9. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The Grantee warrants that it is the sole owner or author of, or has entered into a suitable legal agreement for: a) the design of any product or process provided or used in the performance of the Agreement that is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law and b) any copyrighted matter provided to the Commonwealth. The Grantee shall defend any suit or proceeding brought by a third party against the Commonwealth, its departments, offices and employees for the alleged infringement of United States or foreign patents, copyrights, trademarks or misappropriation of trade secrets arising out of the performance of the Agreement. The Commonwealth will provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, the Commonwealth may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by the Commonwealth at the Grantee's written request, it shall be at the Grantee's expense, but the responsibility for such expense shall be only that within the Grantee's written authorization. The Grantee shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the Grantee or the Commonwealth may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights. If any of the products provided by the Grantee in such suit or proceeding are held to constitute infringement and the use is enjoined, the Grantee shall, at its own expense and at its option, either procure the right to continue use of such products, replace them with non-infringing equal performance products or modify them so that they are no longer infringing. If the Grantee is unable to do any of the preceding, the Grantee shall remove all the equipment or software, which are obtained contemporaneously with the infringing product, or, at the option of the Commonwealth, only those items of equipment or software that are held to be infringing, and to pay the Commonwealth: 1) any amounts paid by the Commonwealth towards the purchase of the product, less straight line depreciation; 2) any license fee paid by the Commonwealth for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee representing the time remaining in any period of maintenance paid for. The obligations of the Grantee under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the Grantee without its written consent.

10. OWNERSHIP RIGHTS

The Commonwealth shall have unrestricted authority to reproduce, distribute, and use any submitted report, document, data, or material, and any software or modifications and any associated documentation that is designed or developed and delivered to the Commonwealth as part of the performance of the Agreement.

11. ASSIGNMENT OF ANTITRUST CLAIMS

The Grantee and the Commonwealth recognize that in actual economic practice, overcharges by the Grantee's suppliers resulting from violations of state or federal antitrust laws are in fact borne by the Commonwealth. As part of the consideration for the award of the Agreement, and intending to be legally bound, the Grantee assigns to the Commonwealth all right, title and interest in and to any claims the Grantee now has, or may acquire, under state or federal antitrust laws relating to the products and services that are the subject of this Agreement.

12. HOLD HARMLESS PROVISION

The Grantee shall indemnify the Commonwealth against any and all third party claims, demands and actions based upon or arising out of any activities performed by the Grantee and its employees and agents under this Agreement provided the Commonwealth gives the Grantee prompt notice of any such claim of which it learns. The Office of Attorney General ("OAG") has the sole authority to represent the Commonwealth in actions brought against the Commonwealth. The OAG may, however, in its sole discretion and under such terms as it deems appropriate, delegate its right of defense. If OAG delegates the defense, the Commonwealth will cooperate with all reasonable requests of the Grantee made in the defense of such suits. Neither party shall enter into any settlement without the other party's written consent, which shall not be unreasonably withheld. The Commonwealth may, in its sole discretion, allow the Contractor to control the defense and any related settlement negotiations.

13. AUDIT PROVISIONS

In addition to audit requirements of the Agreement, the Commonwealth shall have the right, at reasonable times and at a site designated by the Commonwealth, to audit the books, documents and records of the Grantee to the extent that the books, documents and records relate to costs or pricing data for the Agreement. The Grantee shall maintain records that support the prices charged and costs incurred for the Agreement. The Grantee shall preserve books, documents, and records that relate to costs or pricing data for the Agreement for a period of five (5) years from date of final payment or such longer period as required by the Agreement. The Grantee shall give full and free access to all records to the Commonwealth and state and federal oversight agencies and their authorized representatives.

14. DEFAULT

a. The Commonwealth may, subject to the provisions of Paragraph 15, Force Majeure, and in addition to its other rights under the Agreement, declare the Grantee in default by written notice to the Grantee, and terminate (as provided in Section XI of the Agreement and Paragraph 16, Termination Provisions) the whole or any part of this Agreement for any of the following reasons:

    1) Failure to begin services within the time specified in the Agreement or as otherwise specified;
    2) Failure to perform the services with sufficient labor, equipment, or material to complete the specified work in accordance with the Agreement terms;
    3) Unsatisfactory performance of services;
    4) Discontinuance of services without approval;
    5) Failure to resume discontinued services within a reasonable time after notice to do so;
    6) Insolvency or bankruptcy;

7) Assignment made for the benefit of creditors;
8) Failure or refusal within 10 days after written notice, to make payment or show cause why payment should not be made, of any amounts due for materials furnished, labor supplied or performed, for equipment rentals, or for utility services rendered;
9) Failure to protect, to repair, or to make good any damage or injury to property;
10) Failure to comply with the representations made in its application; or
11) Breach of any provision of the Agreement.

b. In the event that the Commonwealth terminates this Agreement in whole or in part, the Commonwealth may procure, upon such terms and in such manner as it determines, services similar or identical to those so terminated, and the Grantee shall be liable to the Commonwealth for any reasonable excess costs for such similar or identical services included within the terminated part of the Agreement.

c. If the Agreement is terminated as provided in Subparagraph a. above, the Commonwealth, in addition to any other rights provided in this paragraph, may require the Grantee to transfer title and deliver immediately to the Commonwealth in the manner and to the extent directed by the Department, such partially completed work, including, where applicable, reports, working papers and other documentation, as the Grantee has specifically produced or specifically acquired for the performance of such part of the Agreement as has been terminated. Except as provided below, payment for completed work accepted by the Commonwealth shall be at the Agreement price. Except as provided below, payment for partially completed work including, where applicable, reports and working papers, delivered to and accepted by the Commonwealth shall be in an amount agreed upon by the Grantee and the Department. The Commonwealth may withhold from amounts otherwise due the Grantee for such completed or partially completed works, such sum as the Department determines to be necessary to protect the Commonwealth against loss.

d. The rights and remedies of the Commonwealth provided in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Agreement.

e. The Commonwealth's failure to exercise any rights or remedies provided in this paragraph shall not be construed to be a waiver of its rights and remedies in regard to the event of default or any succeeding event of default.

15. FORCE MAJEURE

Neither party will incur any liability to the other if its performance of any obligation under this Agreement is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but are not limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, general strikes throughout the trade, and freight embargoes.

The Grantee shall notify the Commonwealth orally within five (5) days and in writing within ten (10) days of the date on which the Grantee becomes aware, or should have reasonably become aware, that such cause would prevent or delay its performance. Such notification shall (i) describe fully such cause(s) and its effect on performance, (ii) state whether performance under the Agreement is prevented or delayed and (iii) if performance is delayed, state a reasonable estimate of the duration of the delay. The Grantee shall have the burden of proving that such cause delayed or prevented its performance despite its diligent efforts to perform and shall produce such supporting documentation as the Commonwealth may reasonably request. After receipt of such notification, the Commonwealth may elect to cancel the Agreement or to extend the time for performance as reasonably necessary to compensate for the delay.

In the event of a declared emergency by competent governmental authorities, the

Commonwealth by notice to the Grantee, may suspend all or a portion of the Agreement.

16. TERMINATION PROVISIONS

In addition to the reasons set forth in the Agreement, the Commonwealth may terminate the Agreement for any of the following reasons. Termination shall be effective upon written notice to the Grantee and in accordance with the Agreement terms.

a. TERMINATION FOR CONVENIENCE: The Commonwealth may terminate the Agreement, in whole or part, for its convenience if the Commonwealth determines termination to be in its best interest. The Grantee shall be paid for services satisfactorily completed prior to the effective date of the termination and all actual and reasonable costs incurred as a result of the termination. The Grantee will not be entitled to recover anticipated profit, loss of use of money or administrative or overhead costs.

b. NON-APPROPRIATION: The Commonwealth's obligation to make payments during any Commonwealth fiscal year succeeding the current fiscal year shall be subject to availability and appropriation of funds. When funds (state, federal or both) are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal year period, the Commonwealth may terminate the Agreement, in whole or part. The Grantee shall be reimbursed in the same manner as described in subsection a to the extent that appropriated funds are available.

c. TERMINATION FOR CAUSE: In addition to other rights under the Agreement, the Commonwealth may terminate the Agreement for default under Paragraph 14, Default, upon written notice to the Grantee. The Commonwealth shall also have the right, upon written notice to the Grantee, to terminate the Agreement for other cause as specified in the Agreement or by law. If it is later determined that the Commonwealth erred in terminating the Agreement for cause, then, at the Commonwealth's discretion, the Agreement shall be deemed to have been terminated for convenience under the Subparagraph 18.a.

17. ASSIGNABILITY AND SUBCONTRACTS

a. Subject to the terms and conditions of this section, this Agreement shall be binding upon the parties and their respective successors and assigns.

b. The Grantee may subcontract with third parties approved by the Department to perform all or any part of the services to be performed, which approval may be withheld at the sole and absolute discretion of the Department. The existence of any subcontract shall not change the obligations of Contractor to the Commonwealth under this Contract. The Commonwealth may, for good cause, require that the Grantee remove a subcontractor from the Project. The Commonwealth will not be responsible for any costs incurred by the Grantee in replacing the subcontractor if good cause exists

c. The Grantee may not assign, in whole or in part, the Agreement or its rights, duties, obligations, or responsibilities without the prior written consent of the Department, which consent may be withheld at the sole and absolute discretion of the Department.

d. The Grantee may, without the consent of the Department, assign its rights to payment to be received under the Agreement, provided that the Grantee provides written notice of such assignment to the Department together with a written acknowledgement from the assignee that any such payments are subject to all of the terms and conditions of the Agreement.

e. For the purposes of this Agreement, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the Grantee; however, that the term shall not apply to the sale or other transfer of stock of a

publicly traded company.

f. Any assignment consented to by the Department shall be evidenced by a written assignment agreement executed by the Grantee and its assignee in which the assignee agrees to be legally bound to all of the terms and conditions of the Agreement and to assume the duties, obligations, and responsibilities being assigned.

g. A change of name by the Grantee, following which the Grantee's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. The Grantee shall give the Department written notice of any such change of name.

18. NONDISCRIMINATION/SEXUAL HARASSMENT CLAUSE

In addition to any other nondiscrimination provision of the Agreement, the Grantee shall:

a. In the hiring of any employee(s) for the manufacture of supplies, performance of work, or any other activity required under the Agreement or any contract, or subcontract, the Grantee, subgrantee, contractor, subcontractor, and any person acting on behalf of the Grantee shall not discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the Pennsylvania Human Relations Act ("PHRA") and applicable federal laws, against any citizen of this Commonwealth who is qualified and available to perform the work to which the employment relates.

b. The Grantee, and any subgrantee, contractor, subcontractor and any person on their behalf shall not in any manner discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the PHRA and applicable federal laws, against or intimidate any of their employees.

c. Neither the Grantee nor any subgrantee, contractor, and subcontractor nor any person on their behalf shall in any manner discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the PHRA and applicable federal laws, in the provision of services under the Agreement, or any subgrant, contract or subcontract.

d. Neither the Grantee nor any subgrantee, contractor, subcontractor nor any person on their behalf shall in any manner discriminate against employees by reason of participation in or decision to refrain from participating in labor activities protected under the Public Employee Relations Act, Pennsylvania Labor Relations Act or National Labor Relations Act, as applicable and to the extent determined by entities charged with such Acts' enforcement, and shall comply with any provision of law establishing organizations as employees' exclusive representatives.

e. The Grantee, and any subgrantee, contractor and subcontractor shall establish and maintain a written nondiscrimination and sexual harassment policy and shall inform their employees in writing of the policy. The policy must contain a provision that sexual harassment will not be tolerated and employees who practice it will be disciplined. Posting this Nondiscrimination/Sexual Harassment Clause conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where services are performed shall satisfy this requirement for employees within an established work site.

f. The Grantee, and any subgrantee, contractor and subcontractor shall not discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the PHRA and applicable federal laws, against any subgrantee, contractor, subcontractor or supplier who is qualified to perform the work to which the Agreement relates.

g. The Grantee and each subgrantee, contractor and subcontractor represent that it is presently in compliance with and will maintain compliance with all applicable federal, state, and local laws and regulations relating to nondiscrimination and sexual harassment. The Grantee and each subgrantee, contractor and subcontractor further represent that it has filed a Standard Form 100 Employer Information Report ("EEO-1") with the U.S. Equal Employment Opportunity Commission ("EEOC") and shall file an annual EEO-1 report with the EEOC as required for employers' subject to Title VII of the Civil Rights Act of 1964, as amended, that have 100 or more employees and employers that have federal government contracts or first-tier subcontracts and have 50 or more employees. The Grantee, and any subgrantee, contractor or subcontractor shall, upon request and within the time periods requested by the Commonwealth, furnish all necessary employment documents and records, including EEO-1 reports, and permit access to their books, records, and accounts to the agency and the DGS Bureau of Diversity, Inclusion and Small Business Opportunities for the purpose of ascertaining compliance with the provisions of this Nondiscrimination/Sexual Harassment Clause.

h. The Grantee, and any subgrantee, contractor and subcontractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subgrant agreement, contract or subcontract so that those provisions applicable to subgrantees, contractors or subcontractors will be binding upon each subgrantee, contractor or subcontractor.

i. The Grantee's and each subgrantee's, contractor's and subcontractor's obligations pursuant to these provisions are ongoing from and after the effective date of the Agreement through its termination date. The Grantee and each subgrantee, contractor and subcontractor shall have an obligation to inform the Commonwealth if, at any time during the term of the Agreement, it becomes aware of any actions or occurrences that would result in violation of these provisions.

j. The Commonwealth may cancel or terminate the Agreement and all money due or to become due under the Agreement may be forfeited for a violation of the terms and conditions of this Nondiscrimination/Sexual Harassment Clause. In addition, the agency may proceed with debarment or suspension and may place the Grantee, subgrantee, contractor, or subcontractor in the Contractor Responsibility File.

19. INTEGRITY PROVISIONS

It is essential that those who have agreements with the Commonwealth observe high standards of honesty and integrity and conduct themselves in a manner that fosters public confidence in the integrity of the Commonwealth contracting and procurement process.

1. **DEFINITIONS.** For purposes of these provisions, the following terms have the meanings found in this Section:

a. **"Affiliate"** means two or more entities where (a) a parent entity owns more than fifty percent of the voting stock of each of the entities; or (b) a common shareholder or group of shareholders owns more than fifty percent of the voting stock of each of the entities; or c) the entities have a common proprietor or general partner.

b. **"Consent"** means written permission signed by a duly authorized officer or employee of the Commonwealth, provided that where the material facts have been disclosed, in writing, by prequalification, bid, proposal, or contractual terms, the Commonwealth shall be deemed to have consented by virtue of the execution of this contract.

c. **"Contractor"** means the individual or entity, that has entered into this Agreement with the Commonwealth.

d. **"Contractor Related Parties"** means any Affiliates of the Contractor and the Contractor's executive officers, officers and directors, or owners of 5 percent or more interest in the Contractor.

e. **"Financial Interest"** means either:

(1) Ownership of more than a five percent interest in any business; or

(2) Holding a position as an officer, director, trustee, partner, employee, or holding any position of management.

f. **"Gratuity"** means tendering, giving, or providing anything of more than nominal monetary value including, but not limited to, cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. The exceptions set forth in the *Governor's Code of Conduct, Executive Order 1980-18*, the *4 Pa. Code §7.153(b)*, shall apply.

g. **"Non-bid Basis"** means an agreement awarded or executed by the Commonwealth with Contractor without seeking applications, bids or proposals from any other potential bidder or offeror.

2. In furtherance of this policy, Contractor agrees to the following:

a. Contractor shall maintain the highest standards of honesty and integrity during the performance of this Agreement and shall take no action in violation of state or federal laws or regulations or any other applicable laws or regulations, or other requirements applicable to Contractor or that govern procurement with the Commonwealth.

b. Contractor shall establish and implement a written business integrity policy, which includes, at a minimum, the requirements of these provisions as they relate to the activity with the Commonwealth and Commonwealth employees and beneficiaries and which is made known to all Contractor employees. Posting these Integrity Provisions conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or

near where services are performed shall satisfy this requirement.

c. Contractor, its Affiliates, agents, employees and anyone in privity with Contractor shall not accept, agree to give, offer, confer, or agree to confer or promise to confer, directly or indirectly, any gratuity or pecuniary benefit to any person, or to influence or attempt to influence any person in violation of any federal or state law, regulation, executive order of the Governor of Pennsylvania, statement of policy, management directive or any other published standard of the Commonwealth in connection with performance of work under this Agreement except as provided in this Agreement.

d. Contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material under this Agreement, unless the financial interest is disclosed to the Commonwealth in writing and the Commonwealth consents to Contractor's financial interest prior to Commonwealth execution of the Agreement. Contractor shall disclose the financial interest to the Commonwealth at the time of proposal submission, or if no bids or proposals are solicited, no later than Contractor's submission of the Agreement signed by Contractor.

e. Contractor certifies to the best of its knowledge and belief that within the last five (5) years Contractor or Contractor Related Parties have not:

(1) been indicted or convicted of a crime involving moral turpitude or business honesty or integrity in any jurisdiction;

(2) been suspended, debarred or otherwise disqualified from entering into any contract with any governmental agency;

(3) had any business license or professional license suspended or revoked;

(4) had any sanction or finding of fact imposed as a result of a judicial or administrative proceeding related to fraud, extortion, bribery, bid rigging, embezzlement, misrepresentation or anti-trust; and

(5) been, and is not currently, the subject of a criminal investigation by any federal, state or local prosecuting or investigative agency or civil anti-trust investigation by any federal, state or local prosecuting or investigative agency.

If Contractor cannot so certify the above, it must submit along with its application a written explanation of why such certification cannot be made and the Commonwealth will determine whether an Agreement may be entered into with the Contractor. The Contractor's obligation pursuant to this certification is ongoing from and after the effective date of the Agreement through its termination date. The Contractor shall have an obligation to immediately notify the Commonwealth in writing if at any time during the term of the Agreement it becomes aware of any event that would cause the Contractor's certification or explanation to change. Contractor acknowledges that the Commonwealth may, in its sole discretion, terminate the Agreement for cause if it learns that any of the certifications

made are currently false due to intervening factual circumstances or were false or should have been known to be false when entering into the Agreement.

Contractor shall comply with the requirements of the *Lobbying Disclosure Act (65 Pa.C.S.§13A01 et seq.)* regardless of the method of award. If this Agreement was awarded on a Non-bid Basis, Contractor must also comply with the requirements of the *Section 1641 of the Pennsylvania Election Code (25 P.S. §3260a).*

f. When Contractor has reason to believe that any breach of ethical standards as set forth in law, the Governor's Code of Conduct, or these Integrity Provisions has occurred or may occur, including but not limited to contact by a Commonwealth officer or employee which, if acted upon, would violate such ethical standards, Contractor shall immediately notify the project officer or the Office of the State Inspector General in writing.

g. Contractor, by submission of its application and execution of this Agreement and by the submission of any requests for payment pursuant to the Agreement, certifies and represents that it has not violated any of these Integrity Provisions in connection with the submission of the application, during any negotiations or during the term of the Agreement, to include any extensions. Contractor shall immediately notify the Commonwealth in writing of any actions for occurrences that would result in a violation of these Integrity Provisions. Contractor agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of the State Inspector General for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the Commonwealth that results in the suspension or debarment of the Contractor. Contractor shall not be responsible for investigative costs for investigations that do not result in the Contractor's suspension or debarment.

h. Contractor shall cooperate with the Office of the State Inspector General in its investigation of any alleged Commonwealth agency or employee breach of ethical standards and any alleged Contractor non-compliance with these Integrity Provisions. Contractor agrees to make identified Contractor employees available for interviews at reasonable times and places. Contractor, upon the inquiry or request of an Inspector General, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Office of the State Inspector General to Contractor's integrity and compliance with these provisions. Such information may include, but shall not be limited to, Contractor's business or financial records, documents or files of any type or form that refer to or concern this Agreement. Contractor shall incorporate this paragraph in any agreement, contract or subcontract it enters into in the course of the performance of this Agreement solely for the purpose of obtaining subcontractor compliance with this provision. The incorporation of this provision in a subcontract shall not create privity of contract between the Commonwealth and any such subcontractor, and no third-party beneficiaries shall be created thereby.

i. For violation of any of these Integrity Provisions, the Commonwealth may terminate this and any other Agreement with Contractor, claim liquidated damages in an amount equal to the value of anything received in breach of these Provisions, claim damages for all

additional costs and expenses incurred in obtaining another contractor to complete performance under this Agreement, and debar and suspend Contractor from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or non-use of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.

20. Grantee RESPONSIBILITY PROVISIONS

a. The Grantee certifies, for itself and all subgrantees and subcontractors, that as of the date of its execution of this Agreement, that neither it, nor any subgrantees, subcontractors nor any suppliers are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority and, if the Grantee cannot so certify, then it shall submit, along with its application, a written explanation of why such certification cannot be made.

b. The Grantee also certifies, that as of the date of its execution of the Agreement, it has no tax liabilities or other Commonwealth obligations.

c. The Grantee's obligations pursuant to these provisions are ongoing from and after the effective date of the Agreement through its termination date. The Grantee shall inform the Commonwealth if, at any time during the term of the Agreement, it becomes delinquent in the payment of taxes, or other Commonwealth obligations, or if it or any of its subgrantees or subcontractors are suspended or debarred by the Commonwealth, the federal government, or any other state or governmental entity. Such notification shall be made within 15 days of the date of suspension or debarment.

d. The failure of the Grantee to notify the Commonwealth of its suspension or debarment by the Commonwealth, any other state, or the federal government shall constitute an event of default.

e. The Grantee agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of State Inspector General for investigations of the its compliance with the terms of this or any other agreement between the Grantee and the Commonwealth, which results in the suspension or debarment of the Grantee. Such costs shall include, but shall not be limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Grantee shall not be responsible for investigative costs for investigations that do not result in the Grantee's suspension or debarment.

f. The Grantee may obtain a current list of suspended and debarred Commonwealth entities by either searching the internet at **htfp://www.dgs.state.pa.us** or contacting the:

Department of General Services
Office of Chief Counsel
603 North Office Building
Harrisburg, PA 17125
Telephone No. (717) 783-6472
FAX No. (717) 787-9138

21. AMERICANS WITH DISABILITIES ACT

a. Pursuant to federal regulations promulgated under the authority of The Americans With Disabilities Act, 28 C.F.R. § 35.101 et seq., the Grantee understands and agrees that no individual with a disability shall be excluded from participation in this

Agreement or from activities provided for under the Agreement on the basis of the disability. As a condition of accepting and executing this Agreement, the Grantee agrees to comply with the "General Prohibitions Against Discrimination," 28 C.F.R. § 35.130, and all other regulations promulgated under Title II of The Americans With Disabilities Act, which are applicable to all benefits, services, programs, and activities provided by the Commonwealth of Pennsylvania through Agreements with outside entities.

b. The Grantee shall be responsible for and agrees to indemnify and hold harmless the Commonwealth from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the Commonwealth of Pennsylvania as a result of the Grantee's failure to comply with the provisions of subparagraph a above.

22. COVENANT AGAINST CONTINGENT FEES

The Grantee warrants that no person or selling agency has been employed or retained to solicit or secure the Agreement upon an agreement or understanding of a commission, percentage, brokerage, or contingent fee, except bona fide employees or bona fide established commercial or selling agencies maintained by the Grantee for the purpose of securing business. For breach or violation of this warranty, the Commonwealth shall have the right to terminate the Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

23. GOVERNING LAW

This Agreement shall be governed by and interpreted and enforced in accordance with the laws of the Commonwealth of Pennsylvania without giving effect to conflict of law provisions and the decisions of the Pennsylvania courts. The Grantee consents to the jurisdiction of any court of the Commonwealth of Pennsylvania and any federal courts in Pennsylvania, waiving any claim or defense that such forum is not convenient or proper. The Grantee agrees that any such court shall have in personal jurisdiction over it, and consents to service of process in any manner authorized by Pennsylvania law.

24. INTEGRATION

The Agreement, including all referenced documents, constitutes the entire agreement between the parties. No agent, representative, employee or officer of either the Commonwealth or the Grantee has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with the Agreement, which in any way can be deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of the Agreement. No modifications, alterations, changes, or waiver to the Agreement or any of its terms shall be valid or binding unless accomplished by a written amendment signed by both parties.

25. CHANGES

The Commonwealth may issue change orders at any time during the term of the Agreement or any renewals or extensions thereof: 1) to increase or decrease the quantities resulting from variations between any estimated quantities in the Agreement and actual quantities; 2) to make changes to the services within the scope of the Agreement; 3) to notify the Grantee that the Commonwealth is exercising any renewal or extension option; and 4) to modify the time of performance that does not alter the scope of the Agreement to extend the completion date beyond the Expiration Date of the Agreement or any renewals or extensions thereof. Any such change order shall be in writing signed by the Project Officer. The change order shall be effective as of the date appearing on the change order, unless the change order specifies a later effective date. Such increases, decreases, changes, or modifications will not invalidate the Agreement, nor, if performance

security is being furnished in conjunction with the Agreement release the security obligation. The Grantee agrees to provide the service in accordance with the change order.

26. RIGHT TO KNOW LAW 8-K-1580

a. The Grantee and its subgrantees and subcontractors understand that this Agreement and records related to or arising out of the Agreement are subject to requests made pursuant to the Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, ("RTKL"). For the purpose of these provisions, the term "the Commonwealth" shall refer to the Department.

b. If the Commonwealth needs the Grantee, subgrantee or subcontractor's assistance in any matter arising out of the RTKL request related to this Agreement, it shall notify the Grantee, subgrantee, or subcontractor using the legal contact information provided in the Agreement. The Grantee, subgrantee, or subcontractor at any time, may designate a different contact for such purpose upon reasonable prior written notice to the Commonwealth.

c. Upon written notification from the Commonwealth that it requires assistance in responding to a RTKL request for information related to this Agreement that may be in the Grantee, a subgrantee or subcontractor's possession, constituting, or alleged to constitute, a public record in accordance with the RTKL ("Requested Information"), Grantee shall:
   1. Provide the Commonwealth, within ten (10) calendar days after receipt of written notification, access to, and copies of, any document or information in the Grantee, subgrantee or subcontractor's possession that the Commonwealth reasonably believes is Requested Information and may be a public record under the RTKL; and
   2. Provide such other assistance as the Commonwealth may reasonably request, in order to comply with the RTKL with respect to this Agreement.

d. If the Grantee, subgrantee or subcontractor considers the Requested Information to include a request for a Trade Secret or Confidential Proprietary Information, as those terms are defined by the RTKL, or other information that the Grantee, subgrantee or subcontractor considers exempt from production under the RTKL, the Grantee, subgrantee or subcontractor must notify the Commonwealth and provide, within seven (7) calendar days of receiving the written notification, a written statement signed by a representative of the Grantee, subgrantee or subcontractor explaining why the requested material is exempt from public disclosure under the RTKL.

e. The Commonwealth will rely upon the written statement in denying a RTKL request for the Requested Information unless the Commonwealth determines that the Requested Information is clearly not protected from disclosure under the RTKL. Should the Commonwealth determine that the Requested Information is clearly not exempt from disclosure, the Grantee, subgrantee or subcontractor shall provide the Requested Information within five (5) business days of receipt of written notification of the Commonwealth's determination.

f. If the Grantee, subgrantee or subcontractor fails to provide the Requested Information within the time period required by these provisions, the Grantee shall indemnify and hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of the failure, including any statutory damages assessed against the Commonwealth.

g. The Commonwealth will reimburse the Grantee, subgrantee or subcontractor for any costs associated with complying with these provisions only to the extent allowed under the fee schedule established by the Office of Open Records or as otherwise provided by the RTKL if the fee schedule is inapplicable.

h. The Grantee, subgrantee or subcontractor may file a legal challenge to any Commonwealth decision to release a record to the public with the Office of Open Records, or in the Pennsylvania Courts; however, the Grantee, subgrantee or subcontractor shall indemnify the Commonwealth for any legal expenses incurred by the Commonwealth as a result of

such a challenge and shall hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of the Grantee, subgrantee or subcontractor's failure, including any statutory damages assessed against the Commonwealth, regardless of the outcome of such legal challenge. As between the parties, the Grantee, subgrantee and subcontractor waive all rights or remedies that may be available to it as a result of the Commonwealth's disclosure of Requested Information pursuant to the RTKL.

i. The Grantee, subgrantee and subcontractor's duties relating to the RTKL are continuing duties that survive the expiration of this Agreement and shall continue as long as the Requested Information in its possession.

27. ENHANCED MINIMUM WAGE

a. Enhanced Minimum Wage. The Grantee shall pay no less than $12.00 per hour to its employees for all hours worked directly performing the services required by this Agreement, and for all hours performing ancillary services necessary for the performance of the Agreement services when an employee spends at least twenty per cent (20%) of their time performing ancillary services for the Agreement in a given work week.

b. Adjustment. Beginning July 1, 2019, and annually thereafter, the Grantee shall increase the enhanced minimum wage rate required by subsection a. by $0.50 until July 1, 2024, when the minimum wage reaches $15.00. Thereafter, the Grantee must increase the required enhanced minimum wage rate by the annual cost-of-living adjustment using the percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) for Pennsylvania, New Jersey, Delaware, and Maryland. The applicable adjusted amount shall be published in the Pennsylvania Bulletin by March 1 of each year to be effective the following July 1.

c. Exceptions. These Enhanced Minimum Wage Provisions shall not apply to employees:

(i) exempt from the minimum wage under the Minimum Wage Act of 1968;

(ii) covered by a collective bargaining agreement;

(iii) required to be paid a higher wage under another state or federal law governing the services, including the Prevailing Wage Act and Davis-Bacon Act; and

(iv) required to be paid a higher wage under any state or local policy or ordinance.

d. Notice. The Grantee shall post these Enhanced Minimum Wage Provisions for the entire period of the Agreement in conspicuous easily-accessible and well-lighted places customarily frequented by employees at or near where the services are performed.

e. Records. The Grantee must maintain and, upon request and within the time periods requested by the Commonwealth, furnish all employment and wage records necessary to document compliance with these Enhanced Minimum Wage Provisions.

f. Sanctions. Failure to comply with these Enhanced Minimum Wage Provisions may result in the imposition of sanctions, which may include, but shall not be limited to, termination of the Agreement, nonpayment, debarment or referral to the Office of General Counsel for appropriate civil or criminal referral.

g. Subcontractors. The Grantee shall include the provisions of these Enhanced Minimum Wage Provisions in every Subcontract so that these provisions will be binding upon Subcontractors**.**

DEPARTMENT OF HUMAN SERVICES
ADDENDUM TO
STANDARD CONTRACT TERMS AND CONDITIONS

A. APPLICABILITY

This Addendum is intended to supplement the Standard Terms and Conditions. To the extent any of the terms contained herein conflict with terms contained in the Standard Contract Terms and Conditions, the terms in the Standard Contract Terms and Conditions shall take precedence. Further, it is recognized that certain terms contained herein may not be applicable to all the services which may be provided through Department contracts.

B. CONFIDENTIALITY

The parties shall not use or disclose any information about a recipient of the services to be provided under this contract for any purpose not connected with the parties' contract responsibilities except with written consent of such recipient, recipient's attorney, or recipient's parent or legal guardian.

C. INFORMATION

During the period of this contract, all information obtained by the Contractor through work on the project will be made available to the Department immediately upon demand. If requested, the Contractor shall deliver to the Department background material prepared or obtained by the Contractor incident to the performance of this agreement. Background material is defined as original work, papers, notes and drafts prepared by the Contractor to support the data and conclusions in final reports, and includes completed questionnaires, materials in electronic data processing form, computer programs, other printed materials, pamphlets, maps, drawings and all data directly related to the services being rendered.

D. CERTIFICATION AND LICENSING

Contractor agrees to obtain all licenses, certifications and permits from Federal, State and Local authorities permitting it to carry on its activities under this contract.

E. PROGRAM SERVICES

Definitions of service, eligibility of recipients of service and other limitations in this contract are subject to modification by amendments to Federal, State and Local laws, regulations and program requirements without further notice to the Contractor hereunder.

F. **CHILD PROTECTIVE SERVICE LAWS**

In the event that the contract calls for services to minors, the contractor shall comply with the provisions of the Child Protective Services Law (Act of November 26, 1975, P.L. 438, No. 124; 23 P.S. SS 6301-6384, as amended by Act of July 1, 1985, P.L. 124, No. 33) and all regulations promulgated thereunder (55Pa. Code, chapter 3490).

G. **PRO-CHILDREN ACT OF 1994**

The Contractor agrees to comply with the requirements of the Pro-Children Act of 1994; Public Law 103- 277, Part C-Environment Tobacco Smoke (also known as the Pro-Children Act of 1994) requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health care services, day care and education to children under the age of 18, if the services are funded by Federal programs whether directly or through State and Local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for impatient drug and alcohol treatment.

H. **MEDICARE/MEDICAID REIMBURSEMENT**

1. To the extent that services are furnished by contractors, subcontractors, or organizations related to the contractor/subcontractor and such services may in whole or in part be claimed by the Commonwealth for Medicare/Medicaid reimbursements, contractor/subcontractor agrees to comply with 42 C.F.R.,Part 420, including:

a. Preservation of books, documents and records until the expiration of four (4) years after the services are furnished under the contract.

b. Full and free access to (i) the Commonwealth, (ii) the U.S. Comptroller General, (iii) the U.S. Department of Health and Human Services, and their authorized representatives.

2. Your signature on the proposal certifies under penalty of law that you have not been suspended/terminated from the Medicare/Medicaid Program and will notify the contracting DHS Facility or DHS Program Office immediately should a suspension/termination occur during the contract period.

I. **TRAVEL AND PER DIEM EXPENSES**

Contractor shall not be allowed or paid travel or per diem expenses except as provided for in Contractor's Budget and included in the contract amount. Any reimbursement to the Contractor for travel, lodging or meals under this contract shall be at or below state rates

as provided in Management Directive 230.10, Commonwealth Travel Policy, as may be amended, unless the Contractor has higher rates which have been established by its offices/officials, and published prior to entering into this contract. Higher rates must be supported by a copy of the minutes or other official documents and submitted to the Department. Documentation in support of travel and per diem expenses will be the same as required of state employees.

J. INSURANCE

1. The contractor shall accept full responsibility for the payment of premiums for Workers' Compensation, Unemployment Compensation, Social Security, and all income tax deductions required by law for its employees who are performing services under this contract. As required by law, an independent contractor is responsible for Malpractice Insurance for health care personnel. Contractor shall provide insurance Policy Number and Provider'' Name, or a copy of the policy with all renewals for the entire contract period.

2. The contractor shall, at its expense, procure and maintain during the term of the contract, the following types of insurance, issued by companies acceptable to the Department and authorized to conduct such business under the laws of the Commonwealth of Pennsylvania:

    a. Worker's Compensation Insurance for all of the Contractor's employees and those of any subcontractor, engaged in work at the site of the project as required by law.

    b. Public liability and property damage insurance to protect the Commonwealth, the Contractor, and any and all subcontractors from claim for damages for personal injury (including bodily injury), sickness or disease, accidental death and damage to property, including loss of use resulting from any property damage, which may arise from the activities performed under this contract or the failure to perform under this contract whether such performance or nonperformance be by the contractor, by any subcontractor, or by anyone directly or indirectly employed by either. The limits of such insurance shall be in an amount not less than $500,000 each person and $2,000,000 each occurrence, personal injury and property damage combined. Such policies shall be occurrence rather than claims-made policies and shall name the Commonwealth of Pennsylvania as an additional insured. The insurance shall not contain any endorsements or any other form designated to limit or restrict any action by the Commonwealth, as an additional insured, against the insurance coverage in regard to work performed for the Commonwealth.

Prior to commencement of the work under the contract and during the term of the contract, the Contractor shall provide the Department with current certificates of insurance. These certificates shall contain a provision that the coverages afforded under the policies will not be cancelled or changed until at least thirty
(30) days' written notice has been given to the Department.

K. PROPERTY AND SUPPLIES

1. Contractor agrees to obtain all supplies and equipment for use in the performance of this contract at the lowest practicable cost and to purchase by means of competitive bidding whenever required by law.

2. Title to all property furnished in-kind by the Department shall remain with the Department.

3. Contractor has title to all personal property acquired by the contractor, including purchase by lease/purchase agreement, for which the contractor is to be reimbursed under this contract. Upon cancellation or termination of this contract, disposition of such purchased personal property which has a remaining useful life shall be made in accordance with the following provisions.

    a. The contractor and the Department may agree to transfer any item of such purchased property to another contractor designated by the Department. Cost of transportation shall be born by the contractor receiving the property and will be reimbursed by the Department. Title to all transferred property shall vest in the designated contractor. The Department will reimburse the Contractor for its share, if any, of the value of the remaining life of the property in the same manner as provided under subclause b of this paragraph.

    b. If the contractor wishes to retain any items of such purchased property, depreciation tables shall be used to ascertain the value of the remaining useful life of the property. The contractor shall reimburse the Department in the amount determined from the tables.

    c. When authorized by the Department in writing, the contractor may sell the property and reimburse the Department for its share. The Department reserves the right to fix the minimum sale price it will accept.

4. All property furnished by the Department or personal property acquired by the contractor, including purchase by lease-purchase contract, for which the contractor is to be reimbursed under this contract shall be deemed "Department Property" for the purposes of subsection 5, 6 and 7 of this section.

5. Contractor shall maintain and administer in accordance with sound business practice a program for the maintenance, repair, protection, preservation and insurance of Department Property so as to assure its full availability and usefulness.

6. Department property shall, unless otherwise approved in writing by the Department, be used only for the performance of this contract.

7. In the event that the contractor is indemnified, reimbursed or otherwise compensated for any loss, destruction or damage to Department Property, it shall use the proceeds to replace, repair or renovate the property involved, or shall credit such proceeds against the cost of the work covered by the contract, or shall reimburse the Department, at the Department's direction.

L. DISASTERS

If, during the terms of this contract, the Commonwealth's premises are so damaged by flood, fire or other Acts of God as to render them unfit for use; then the Agency shall be under no liability or obligation to the contractor hereunder during the period of time there is no need for the services provided by the contractor except to render compensation which the contractor was entitled to under this agreement prior to such damage.

M. SUSPENSION OR DEBARMENT

In the event of suspension or debarment, 4 Pa Code Chapter 60.1 through 60.7, as it may be amended, shall apply.

N. COVENANT AGAINST CONTINGENT FEES

The contractor warrants that no person or selling agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee (excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business). For breach or violation of this warranty, the Department shall have the right to annul this contract without liability or, in its discretion, to deduct from the consideration otherwise due under the contract, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

O. CONTRACTOR'S CONFLICT OF INTEREST

The contractor hereby assures that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The contractor further assures that in the performance of this contract, it will not knowingly employ any person having such interest. Contractor hereby certifies that no member of the Board of the contractor or any of its officers or directors has such an adverse interest.

P. INTEREST OF THE COMMONWEALTH AND OTHERS

No officer, member or employee of the Commonwealth and no member of its General Assembly, who exercises any functions or responsibilities under this contract, shall participate in any decision relating to this contract which affects his personal interest or the interest of any corporation, partnership or association in which he is, directly or indirectly, interested; nor shall any such officer, member or employee of the Commonwealth or member of its General Assembly have interest, direct or indirect, in this contract or the proceeds thereof.

Q. CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS

(Applicable to contracts $25,000 or more)

1. The contractor, within 10 days of receiving the notice to proceed, must contact the Department of Human Services' Contractor Partnership Program (CPP) to present, for review and approval, the contractor's plan for recruiting and hiring recipients currently receiving cash assistance. If the contract was not procured via Request for Proposal (RFP); such plan must be submitted on Form PA-778. The plan must identify a specified number (not percentage) of hires to be made under this contract. If no employment opportunities arise as a result of this contract, the contractor must identify other employment opportunities available within the organization that are not a result of this contract. The entire completed plan (Form PA-778) must be submitted to the Bureau of Employment and Training Programs (BETP)**:** Attention CPP Division. (Note: Do not keep the pink copy of Form PA-778). The approved plan will become a part of the contract.

2. The contractor's CPP approved recruiting and hiring plan shall be maintained throughout the term of the contract and through any renewal or extension of the contract. Any proposed change must be submitted to the CPP Division which will make a recommendation to the Contracting Officer regarding course of action. If a contract is assigned to another contractor, the new contractor must maintain the CPP recruiting and hiring plan of the original contract.

3. The contractor, within 10 days of receiving the notice to proceed, must register in the Commonwealth Workforce Development System (CWDS). In order to register the selected contractor must provide business, location and contact details by creating an Employer Business Folder for review and āpproval, within CWDS at HTTPS://WWW.CWDS.State.PA.US . Upon CPP review and approval of Form PA-778 and the Employer Business Folder in CWDS, the Contractor will receive written notice (via the pink Contractor's copy of Form PA-778) that the plan has been approved.

4. Hiring under the approved plan will be monitored and verified by Quarterly Employment Reports (Form PA-1540); submitted by the contractor to the Central Office of Employment and Training – CPP Division. A copy of the submitted Form PA-1540 must also be submitted (by the contractor) to the DHS Contract Monitor (i.e. Contract Officer). The reports must be submitted on the DHS Form PA- 1540. The form may not be revised, altered, or re-created.

5. If the contractor is non-compliant, CPP Division will contact the Contract Monitor to request corrective action. The Department may cancel this contract upon thirty (30) days written notice in the event of the contractor's failure to implement or abide by the approved plan.

R. TUBERCULOSIS CONTROL

As recommended by the Centers for Disease Control and the Occupational Safety and Health Administration, effective August 9, 1996, in all State Mental Health and Mental Retardation Facilities, all full-time and part-time employees (temporary and permanent), including contract service providers, having direct patient contact or providing service in patient care

areas, are to be tested serially with PPD by Mantoux skin tests. PPD testing will be provided free of charge from the state MH/MR facility. If the contract service provider has written proof of a PPD by Mantoux method within the last six months, the MH/MR facility will accept this documentation in lieu of administration of a repeat test. In addition, documented results of a PPD by Mantoux method will be accepted by the MH/MR facility. In the event that a contractor is unwilling to submit to the test due to previous positive reading, allergy to PPD material or refusal, the risk assessment questionnaire must be completed. If a contractor refuses to be tested in accordance with this new policy, the facility will not be able to contract with this provider and will need to procure the services from another source.

S. ACT 13 APPLICATION TO CONTRACTOR

Contractor shall be required to submit with their bid information obtained within the preceding one-year period for any personnel who will have or may have direct contact with residents from the facility or unsupervised access to their personal living quarters in accordance with the following:

1. Pursuant to 18 Pa.C.S. Ch. 91(relating to criminal history record information) a report of criminal history information from the Pennsylvania State Police or a statement from the State Police that their central repository contains no such information relating to that person. The criminal history record information shall be limited to that which is disseminated pursuant to 18 Pa.C.S. 9121(b)(2) (relating to general regulations).

2. Where the applicant is not, and for the two years immediately preceding the date of application has not been a resident of this Commonwealth, the Department shall require the applicant to submit with the application a report of Federal criminal history record information pursuant to the Federal Bureau of Investigation's under Department of State, Justice, and Commerce, the Judiciary, and Related Agencies Appropriation Act, 1973 (Public Law 92-544, 86 Stat. 1109). For the purpose of this paragraph, the applicant shall submit a full set of fingerprints to the State Police, which shall forward them to the Federal Bureau of Investigation for a national criminal history check. The information obtained from the criminal record check shall be used by the Department to determine the applicant's eligibility. The Department shall insure confidentially of the information.

3. The Pennsylvania State Police may charge the applicant a fee of not more than $10 to conduct the criminal record check required under subsection 1. The State Police may charge a fee of not more than the established charge by the Federal Bureau of Investigation for the criminal history record check required under subsection 2.

The Contractor shall apply for clearance using the State Police Background Check (SP4164) at their own expense. The forms are available from any State Police Substation. When the State Police Criminal History Background Report is received, it must be forwarded to the Department. State Police Criminal History Background Reports not received within sixty (60) days may result in cancellation of the contract.

T. LOBBYING CERTIFICATION AND DISCLOUSRE
(applicable to contracts $100,000 or more)

Commonwealth agencies will not contract with outside firms or individuals to perform lobbying services, regardless of the source of funds. With respect to an award of a federal contract, grant, or cooperative agreement exceeding $100,000 or an award of a federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000 all recipients must certify that they will not use federal funds for lobbying and must disclose the use of non-federal funds for lobbying by filing required documentation. The contractor will be required to complete and return a "Lobbying Certification Form" and a "Disclosure of Lobbying Activities form" with their signed contract, which forms will be made attachments to the contract.

U. AUDIT CLAUSE
(applicable to contracts $100,000 or more)

This contract is subject to audit in accordance with the Audit Clause attached hereto and incorporated herein.

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

The Commonwealth of Pennsylvania, Department of Human Services (DHS), distributes federal and state funds to local governments, nonprofit, and for-profit organizations. Federal expenditures are subject to federal audit requirements, and federal and state funding passed through DHS are subject to DHS audit requirements. If any federal statute specifically prescribes policies or specific requirements that differ from the standards provided herein, the provisions of the subsequent statute shall govern. DHS provides the following audit requirements in accordance with the Commonwealth of Pennsylvania, Governor's Office, Management Directive 325.9, as amended August 20, 2009.

Subrecipient means an entity that expends federal awards received from a pass-through entity to carry out a federal program, but does not include an individual that is a beneficiary of such a program. A subrecipient may also be a recipient of other federal awards directly from a federal awarding agency. For purposes of this audit clause, a subrecipient **is not** a vendor that receives a procurement contract to provide goods or services that are required to provide the administrative support to carry out a federal program.

A. Federal Audit Requirements – Local Governments and Nonprofit Organizations

A local government and nonprofit organization must comply with all federal audit requirements, including: the Single Audit Act, as amended; the revised Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Government, and Non-Profit Organizations*; and any other applicable law or regulation, as well as any other applicable law or regulation that may be enacted or promulgated by the federal government.

A local government or nonprofit organization that expends federal awards of $500,000 or more during its fiscal year, received either directly from the federal government, indirectly from a pass-through entity, or a combination of both, to carry out a federal program, **is required** to have an audit made in accordance with the provisions of OMB Circular A-133, as revised.

If a local government or nonprofit organization expends **total federal awards of less than $500,000** during its fiscal year, it is exempt from these **federal** audit requirements, but is required to maintain auditable records of federal or state funds that supplement such awards. Records must be available for review by appropriate officials. **Although an audit may not be necessary under the federal requirements, DHS audit requirements may be applicable.**

B. Department of Human Services Audit Requirements

A local government or nonprofit provider must meet the DHS audit requirements.

Where a Single Audit or program-specific audit is conducted in accordance with the federal audit requirements detailed above, such an audit will be accepted by DHS provided that:

1. A full copy of the audit report is submitted as detailed below; **and**

2. The subrecipient shall ensure that the audit requirements are met for the terms of this contract; i.e., the prescribed Attestation Report and applicable schedule requirement(s). The incremental cost for preparation of the Attestation Report and the schedule cannot be charged to the federal funding stream.

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

The local government or nonprofit organization must comply with all federal and state audit requirements including: the Single Audit Act Amendments of 1996; Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, as amended; and any other applicable law or regulation and any amendment to such other applicable law or regulation which may be enacted or promulgated by the federal government. **In the absence of a federally required audit**, the entity is responsible for the following annual audit requirements, which are based upon the program year specified in this agreement.

Institutions that **expends $500,000 or more in combined state and federal funds** during the program year is required to have an audit of those funds made in accordance with generally accepted *Government Auditing Standards* (The Yellow Book), revised, as published by the Comptroller General of the United States. Where such an audit is not required to meet the federal requirements, the costs related to DHS audit requirements may not be charged to federal funding streams.

If in connection with the agreement, a local government or nonprofit organization **expends $300,000 or more in combined state and federal funds** during the program year, the subrecipient shall ensure that, for the term of the contract, an independent auditor conducts annual examinations of its compliance with the terms and conditions of this contract, as well as applicable program regulations. These examinations shall be conducted in accordance with the American Institute of Certified Public Accountants' Statements on Standards for Attestation Engagements (SSAE), Section 601, *Compliance Attestation*, and shall be of a scope acceptable to DHS. The initial Section 601 compliance examination shall be completed for the program year specified in the contract and conducted annually thereafter. The independent auditor shall issue a report on its compliance examination as defined in SSAE, Section 601. The incremental cost for preparation of the SSAE cannot be charged to federal funding streams.

The subrecipient shall submit the SSAE, Section 601, audit report (if applicable) to DHS within 90 days after the program year has been completed. When SSAE, Section 601, audit reports are other than unqualified, the subrecipient shall submit to DHS, in addition to the audit reports, a plan describing what actions the subrecipient will implement to correct the situation that caused the auditor to issue a qualified report, a timetable for implementing the planned corrective actions, a process for monitoring compliance with the timetable, and a contact person who is responsible for the resolution of the situation.

If the subrecipient enters into an agreement with a subcontractor(s) for the performance of any primary contractual duties, the audit requirements are applicable to the subcontractor(s) with whom the subrecipient has entered into an agreement. Consequently, the audit requirements should be incorporated into the sub-contractual document as entered by the subrecipient.

A local government or nonprofit entity that **expends less than $300,000 combined state and federal funds** during the program year is exempt from DHS audit requirements but is

required to maintain auditable records for each contract year. Records must be available for review by appropriate DHS officials or a pass- through entity.

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

GENERAL AUDIT PROVISIONS

A local government or nonprofit organization is responsible for obtaining the necessary audit and securing the services of a certified public accountant or other independent governmental auditor. Federal regulations preclude public accountants licensed in the Commonwealth of Pennsylvania from performing audits of federal awards.

The Commonwealth reserves the right for federal and state agencies, or their authorized representatives, to perform additional audits of a financial and/or performance nature, if deemed necessary by Commonwealth or federal agencies. Any such additional audit work will rely on the work already performed by the subrecipient's auditor, and the costs for any additional work performed by the federal or state agency will be borne by those agencies at no additional expense to the subrecipient.

The Commonwealth reserves the right for state and federal agencies, or their authorized representatives, to perform financial and/or performance audits if deemed necessary. If it is decided that an audit of this contract will be performed, the subrecipient will be given advance notice. The subrecipient shall maintain books, records, and documents that support the services provided, that the fees earned are in accordance with the contract, and that the subrecipient has complied with the contract terms and conditions. The subrecipient agrees to make available, upon reasonable notice, at the office of the subrecipient, during normal business hours, for the term of this contract and the retention period set forth in this Audit Clause, any of the books, records, and documents for inspection, audit, or reproduction by any state or federal agency or its authorized representative.

The subrecipient shall preserve all books, records, and documents related to this contract for a period of time that is the greater of five years from the contract expiration date, until all questioned costs or activities have been resolved to the satisfaction of the Commonwealth, or as required by applicable federal laws and regulations, whichever is longer. If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any resulting final settlement.

Audit documentation and audit reports must be retained by the subrecipient's auditor for a minimum of five years from the date of issuance of the audit report, unless the subrecipient's auditor is notified in writing by the Commonwealth or the cognizant or oversight federal agency to extend the retention period. Audit documentation will be made available upon request to authorized representatives of the Commonwealth, the cognizant or oversight agency, the federal funding agency, or the Government Accountability Office.

Records that relate to litigation of the settlement of claims arising out of performance or expenditures under this contract to which exception has been taken by the auditors shall be retained by the subrecipient or provided to the Commonwealth at DHS's option

until such litigation, claim, or exceptions have reached final disposition.

Except for documentary evidence delivered pursuant to litigation or the settlement of claims arising out of the performance of the contract, the subrecipient may, in fulfillment of his obligation to retain records as required by this Audit Clause, substitute photographs, microphotographs, or other authentic reproductions of such records after the expiration of two years following the last day of the month of reimbursement to the contractor of the invoice or voucher to which such records relate, unless a shorter period is authorized by the Commonwealth.

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

SUBMISSION OF AUDIT REPORTS TO THE COMMONWEALTH

A. Federally Required Audit Reports

Submit an electronic copy of federally required audit reports to the Commonwealth, which shall include:

1. Auditor's reports

   a. Independent auditor's report on the financial statements, which expresses an opinion on whether the financial statements are presented fairly in all material respects in conformity with the stated accounting policies.

   b. Independent auditor's report on the supplementary Schedule of Expenditures of Federal Awards (SEFA), which should determine and provide an opinion on whether the SEFA is presented fairly in all material respects in relation to the subrecipient's financial statements taken as a whole. This report can be issued separately or combined with the independent auditor's report on the financial statements.

   c. Report on internal control over financial reporting, compliance and other matters based on an audit of financial statements performed in accordance with Government Auditing Standards.

   d. Report on compliance with requirements applicable to each major program and report on internal control in accordance with the circular.

   e. Schedule of findings and questioned costs.

2. Financial statements and notes to the financial statements

3. SEFA and notes to the SEFA

4. Summary schedule of prior audit findings

5. Corrective action plan (if applicable)

6. Data collection form

7. Management letter (if applicable)

In instances where a federal program-specific audit guide is available, the audit report package for a program-specific audit may be different and should be prepared in accordance with the audit guide and OMB Circular A-133.

Effective July 1, 2009, the Office of the Budget, Office of Comptroller Operations,

Bureau of Audits will begin accepting electronic submission of single audit/program-specific audit reporting packages. Electronic submission is required for the fiscal year ending December 31, 2008 and subsequent years. Instructions and information regarding submission of the single audit/program-specific audit reporting package are available to the public on Single Audit Submissions page of the Office of the Budget website (http://www.budget.state.pa.us). The

reporting package must be submitted electronically in single Portable Document Format (PDF) file to RA-BOASingleAudit@state.pa.us.

Steps for submission:

1. Complete the Single Audit/Program Specific Audit Reporting Package Checklist available on the Single Audit Submissions page of the Office of the Budget website (http://www.budget.state.pa.us). The Single Audit/Program Specific Audit Reporting Package Checklist ensures the subrecipient's reporting package contains all required elements.

2. Upload the completed Single Audit/Program-Specific Audit Reporting Package along with the Single Audit/Program Specific Audit Reporting Package Checklist in a single PDF file to an e-mail addressed to RA-BOASingleAudit@state.pa.us. In the subject line of the e-mail the subrecipient must identify the exact name on the Single Audit/Program-Specific Audit Reporting Package and the period end date to which the reporting package applies.

The subrecipient will receive an e-mail to confirm the receipt of the Single Audit/Program-Specific Audit Reporting Package, including the completed Single Audit/Program Specific Audit Reporting Package Checklist.

B. DHS Required Audit Reports and Additional Submission by Subrecipients

Submit **three copies** of the DHS required audit report package.

1. Independent Accountant's Report – on the Attestation of an entity's compliance with specific requirements during a period of time in accordance with the contract and the appropriate schedule, as required.

2. In addition, if OMB Circular A-133, §__.320 (e), *Submission by Subrecipients*, applies, please submit the audit requirements directly to:

U.S. Postal Service: Department of Human Services
Bureau of Financial Operations
Division of Financial Policy and Operations Audit Resolution Section
3rd Floor, Bertolino Building
P. O. Box 2675
Harrisburg, Pennsylvania 17102-2675

Special Deliveries: 3rd Floor, Bertolino Building
1401 North Seventh Street Harrisburg, Pennsylvania 17102
Phone: (717) 787-8890 Fax: (717) 772-2522

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

PERIOD SUBJECT TO AUDIT

A federally required audit, made in accordance with OMB Circular A-133, encompasses the fiscal period of the provider. **Therefore, the period of the federally required audit may differ from the official reporting period as specified in this agreement.** Where these periods differ, the required supplement schedule(s) and Independent Auditor's Report on the Attestation must be completed for the official annual reporting period of this agreement that ended during the period under audit and shall accompany the federally required audit.

CORRECTIVE ACTION PLAN

The provider shall prepare a corrective action plan (CAP) to address all findings of noncompliance, internal control weaknesses, and/or reportable conditions disclosed in the audit report. For each finding noted, the CAP should include: (1) a brief description identifying the findings; (2) whether the provider agrees with the finding; (3) the specific steps to be taken to correct the deficiency or specific reasons why corrective action is not necessary; (4) a timetable for completion of the corrective action steps; and (5) a description of monitoring to be performed to ensure that the steps are taken (6) the responsible party for the CAP.

REMEDIES FOR NONCOMPLIANCE

The provider's failure to provide an acceptable audit, in accordance with the requirements of the Audit Clause Requirements, may result in DHS not accepting the report and initiating corrective action against the provider that may include the following:

- Disallowing the cost of the audit.
- Withholding a percentage of the contract funding pending compliance.
- Withholding or disallowing administrative costs.
- Suspending subsequent contract funding pending compliance.

TECHNICAL ASSISTANCE

Technical assistance on DHS's audit requirements, and the integration of those requirements with the federal Single Audit requirements, will be provided by:

Department of Human Services Bureau of Financial Operations
Division of Financial Policy and Operations Audit Resolution Section
3rd Floor, Bertolino Building
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Phone: (717) 787-8890 FAX: (717) 772-2522

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations
ENCLOSURE I

The Department of Human Services (DHS) requires an Independent Accountant's Report on the Attestation to be in the format described by the American Institute of Certified Public Accountants (AICPA). The following is the form of report an Independent Accountant should use when expressing an opinion on an entity's compliance with specified requirements during a period of time. For further guidance, refer to the AICPA guidelines.

Independent Accountant's Report

[Introductory Paragraph]

We have examined [*name of entity*]'s compliance with [*list specific compliance requirement*] during the [*period*] ended [*date*]. Management is responsible for [*name of entity*]'s compliance with those-requirements. Our responsibility is to express an opinion on [*name of entity*]'s compliance based on our examination.

[Scope Paragraph]

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about [*name of entity*]'s compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on [*name of en*tity]'s compliance with specified requirements.

[Opinion Paragraph]

In our opinion, [*name of* entity] complied, in all material respects, with the aforementioned requirements for the year ended December 31, 20XX.

[DATE] [SIGNATURE]

LOBBYING CERTIFICATION AND DISCLOSURE OF LOBBYING ACTIVITIES

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his/her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employees of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any federal grant, the making of any federal loan, the entering into any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form- LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all times including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements, and that all sub- recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, and U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE: _____

TITLE: _____

DATE: _____

INSTRUCTIONS FOR COMPLETION OF DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether sub-awardee or prime federal client, at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31 U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an office or employee of any agency, a Member of Congress, an office or employee of Congress, or an employee of Member of Congress in connection with a covered federal action. Use the Standard Form-LLL-A, "Continuation Sheet," for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award client. Identify the tier of the sub-awardee, e.g., the first sub-awardee of the prime is the 1st tier. Sub-awards include but are not limited to subcontracts, sub-grants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Sub-awardee," then enter the full name, address, city, state, and zip code of the prime federal client. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1, e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency. Include prefixes, e.g., "RFP-DE-80-001."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award loan commitment for the prime entity identified in Item 4 or 5.

10. A. Enter the full name, address, city, state, and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered federal action.

B. Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the rate and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contract with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a Standard Form-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minute per reports, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.
Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing the burden, to the Office of Management and Budget, Paperwork Reduction Project (CC-48-004), Washington, D.C., 30603.

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

1. Type of Federal Action: Contract a. Grant b. Cooperative Agreement c. Loan d. Loan Guarantee e. Loan Insurance	2. Status of Federal Action: Bid/Offer Application a. Initial Award b. Post-Award	3. Report Type: a. Initial Filing b. Material Change For Material Change: Year _____ Quarter _____ Date of last report _____

4. Name and Address of Reporting Entity: Prime Subawardee Tier _____ if known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known: $
10. a. Name and Address of Lobbying Entity (if individual, last name, first name, MI):	b. Individuals Performing Services (including address if different from No. 10a) (last name, first name, MI) SF-LLL-A, if necessary
11. Amount of Payment (check all that apply): $ _____ actual planned	13. Type of Payment a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other; specify: _____
12. Form of Payment (check all that apply): a. Cash b. In-kind: Specify: Nature _____ Value	

14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employee(s) or Member(s) contacted, for payment indicated in Item 11:

(attach Continuation Sheet(s) SF-LLL-A, if necessary)

15. Continuation Sheet(s) SF-LLL-A attached: Yes No

16. Information required through this form is authorized by Title 31 U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and no more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL

DISCLOSURE OF LOBBYING ACTIVITIES
Continuation Sheet

Reporting Entry:_____Page _____of _____

PAY FOR PERFORMANCE PROGRAM: Integrated Care Plan (ICP) Program

This Appendix defines a potential payment obligation by the Department to the Primary Contractors for Quality Performance Measures achieved per HEDIS® and select Pennsylvania Performance Measures (PAPMs), as defined below.

This Appendix is effective only if the Primary Contractor operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022. If the Primary Contractor does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022, the Department has no payment obligation under this Appendix.

The Department will provide financial incentives to the Primary Contractors and the Physical Health Managed Care Organizations (PH-MCOs) for the Integrated Care Plan (ICP) Program. The Department will provide a funding pool from which dollars will be paid to the Primary Contractor based on shared BH/PH-MCO performance measures outlined in this Appendix. The Department expects this ICP Program to improve the quality of health care and reduce Medical Assistance (MA) expenditures through enhanced coordination of care between the BH-MCOs, PH-MCOs and providers.

The Primary Contractor shall require its BH-MCO to meet the below requirements.

A. **In order to be eligible for payments under the ICP**, the BH-MCO must provide an Annual Integrated Care Plan Program Report (AICPR) for Calendar Year (CY) 2022 that contains the following specific data requirements for individuals with serious persistent mental illness (SPMI).

B. The AICPR is subject to audit by the Department to verify the accuracy of the stratification, ICP and hospital notification information.

1. **Member stratification**- A stratification shall be conducted on all Members in the targeted SPMI population. New Members shall have an initial stratification level established within sixty (60) days of the date of enrollment and existing Members after having the initial stratification level established will have a stratification conducted at a minimum every six (6) month thereafter. The BH-MCO will report the Member ID, initial stratification level, and stratification level every six (6) months. By submitting the AICPR, the BH-MCO is representing that the dates the stratification was conducted included in the AICPR are accurate. For the Primary Contractor to receive the P4P payment the percentage of the Members having stratifications done at least every six (6) months must be equal to or greater than ninety percent. Members will be stratified as follows:

    a. Four (4) = high PH/high BH needs
    b. Three (3) = high PH/low BH needs
    c. Two (2) = low PH/high BH needs

d. One (1) = low PH/low BH needs

2. **Integrated Care Plan/Member Profile** - The Department will inform the Primary Contractor and its BH-MCO of its target ICP number. The total number of ICPs assigned each year for BH care management activity will equal the total number of ICPs assigned for PH care management activity in that same year. For purposes of this requirement, the Department considers an ICP to be the collection, integration and documentation of key physical and behavioral health information that is easily accessible in a timely manner to persons with designated access. The BH-MCO shall review and update the ICP annually and assign a review date in the AICPR submission. An ICP will count toward the Primary Contractor's assigned number if:
   a. the AICPR has an ICP date in the year reviewed; or
   b. the Member disenrolled during that CY but the ICP date is in the year reviewed.

   An ICP will not count towards the Primary Contractor's assigned number if the Member has been disenrolled from the BH-MCO and the ICP date is not in the year reviewed. In order to receive a P4P payment, the ICP target number must be met.

3. **Hospitalization Notification and Coordination**- Each BH-MCO and PH-MCO will jointly share responsibility for notification of all inpatient hospital admissions and will coordinate discharge and follow-up. This includes at a minimum the Member's identification, the date of inpatient admission and name of the acute care hospital. Additional information sharing is encouraged as appropriate per HIPAA and regulatory standards. Notification to the partner MCO of hospital admissions shall occur within one (1) business day of when the responsible MCO partner learns of the admission (e.g., if the BH-MCO knows of an admission, it will notify the PH-MCO within one (1) business day and vice versa). The BH-MCO will maintain documentation to support the attestation of 90% admissions notifications. By submitting the AICPR, the BH-MCO is representing that the admission notification dates included in the AICPR are accurate. The BH-MCO must maintain documentation of the date the BH-MCO notified the PH-MCO of the admission. The AICPR will be reviewed by the Department to determine how frequently the BH-MCO notified the PH-MCO within one (1) business day of the Member's hospitalization. For the Primary Contractor to receive the P4P payment the percentage of notifications occurring within one (1) business day must be equal to or greater than ninety percent.

For CY 2022, the Primary Contractor and its BH-MCO must create a process to share and discuss the ICP with the Member and the Member's behavioral health Provider. The Primary Contractor and its BH-MCO must record the date the ICP was shared in the AICPR. Beginning in CY 2023 sharing and discussing the ICP with both the Member and Member's behavioral health Provider will become an eligibility requirement for an incentive payout.

B. PERFORMANCE MEASURES

The performance measures for the 2022 ICP Program include the following:

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment *
   a. Initiation rate (IET-I)*
   b. Engagement rate (IET-E)*

2. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)*

3. Combined behavioral health and physical health Inpatient 30-Day Readmission Rate for Individuals with SPMI (REA)**

4. Emergency Department Utilization for Individuals with SPMI (ED Util)** defined in member months (MM)

5. Combined behavioral health and physical health Inpatient Admission Utilization for Individuals with SPMI (IP Util) ** defined in MM

6. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)*

7. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9/0%) (HPCMI)**

8. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)*

9. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)*

10. Follow-Up After Emergency Department Visit for Mental Illness (FUM)*

Note: The ICP P4P measures are subject to change due to changes in the specifications made by the measurement steward.

**CMS Core Measure /NCQA measure*

*** Pennsylvania Performance measure defined by EQRO*

C. PAYMENT FOR PERFORMANCE

The ICP P4P Program measures Benchmark Performance and Improvement Performance. Payments will be based on meeting a Benchmark/Goal and an incremental improvement calculated from the previous HEDIS/PAPM 2021/MY of 2020 to the HEDIS/PAPM 2022/MY 2021.

- **Benchmark Performance**: The Department will make a Benchmark Performance payout for performance relative to the HEDIS® MY 2021 (RY 2022) benchmarks for all measures excluding the measures below, which will have a goal assigned:
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement rate,
    - Emergency Room Utilization for Individuals with SPMI,
    - Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SMI,
    - Combined BH-PH Inpatient Admission Utilization for Individuals with SMI.

There is no Benchmark Performance payout for Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9/0%) and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia.

The Department will award a Benchmark Performance or Goal payout amount for each measure that will range from 0% up to and including 125% of the measure's value, defined as half of the Primary Contractor's Maximum Program Payout amount divided by 7 quality indicators.

The Department will distribute the payouts according to the following criteria:

a. All HEDIS® Measures
    - HEDIS® MY 2021 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
    - HEDIS® MY 2021 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
    - HEDIS® MY 2021 rate at or above the 50th percentile and below the 75th percentile benchmark: 75 percent of the measure value.

b. Emergency Department Utilization for Individuals with SMI
    - Performance goal at or below 142.00: 100 Percent of the measure value.
    - Performance goal above 142.00: No payout.

c. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SMI
    - Performance goal at or below 15.00%: 100 Percent of the measure value.
    - Performance goal above 15.00%: No payout.

d. Combined BH-PH Inpatient Admission Rate for Individuals with SPMI
    - Performance goal at or below 22.00: 100 percent of the measure value.
    - Performance goal above 22.00: No payout.

e. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement rate
   - Performance goal at or above 32.00%: 100 percent of the measure value.
   - Performance goal below 32.00%: No payout.

- **Improvement Performance:** The Department will award an Improvement Performance payout amount for each measure that will range from 0% up to and including 100% of the measure's value, defined as half of the Primary Contractor's Maximum Program Payout amount divided by eight (8) quality indicators.

  The measures below will only receive an incremental payout:
  - Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications
  - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9/0%)
  - Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

  NOTE: For Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia, if the denominator is small (<30) the payout may change to a Benchmark Performance payout from an Improvement Performance payout. For Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9/0%), if the denominator is small (<30), the Improvement Performance payout would change to a Goal payout.

  There is no Improvement Performance payout for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence and Follow-Up After Emergency Department Visit for Mental Illness.

  The Improvement Performance payout scales will be applied contingent on benchmark percentile performance for each HEDIS® MY 2021 measure.

  - If improvement is achieved and the benchmark performance for that measure is <50th percentile, Scale 1 will be applied.
  - If improvement is achieved and the benchmark performance for that measure is ≥50th percentile and <75th percentile, Scale 1 will be applied.
  - If improvement is achieved and the benchmark performance ≥75th percentile Scale 2 will be applied.

  a. Scale 1:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year's rate. Incremental performance improvements are measured comparing rates from HEDIS® MY 2020 (RY 2021) to HEDIS® MY 2021(RY 2022).

Scale 1 applies to Initiation and Engagement of Alcohol and Other Drug Dependence Treatment-Initiation rate and Adherence to Antipsychotic Mediations for Individuals with Schizophrenia

- ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 4 and < 5 Percentage Point Improvement: 80 percent of the measure value.
- ≥ 3 and < 4 Percentage Point Improvement: 60 percent of the measure value.
- ≥ 2 and < 3 Percentage Point Improvement: 40 percent of the measure value.
- ≥ 1 and < 2 Percentage Point Improvement: 20 percent of the measure value.
- < 1 Percentage Point Improvement: No payout.

b. Scale 2:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year's rate. Incremental performance improvements are measured comparing rates from MY 2020 (RY 2021) to MY 2021 (RY 2022) and PAPM MY 2020 (RY 2021) to PAPM MY 2021 (RY 2022).

Scale 2 applies to the following measures:

- Initiation and Engagement of Alcohol and Other Drug Dependence - Engagement rate,
- Emergency Department Utilization for Individuals with SPMI
- Combined BH-PH Inpatient Admission Utilization Rate for Individuals with SPMI
- Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SPMI
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications,
- Diabetes Care for People with SPMI: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia.

- ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 4 and < 5 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 3 and < 4 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 2 and < 3 Percentage Point Improvement: 85 percent of the measure value.
- ≥ 1 and < 2 Percentage Point Improvement: 75 percent of the measure value.
- ≥ 0.5 and < 1 Percentage Point Improvement: 50 percent of the measure value.
- < 0.5 Percentage Point Improvement: No payout.

NOTE: The payout structure is subject to change based on reporting restrictions as a result of a natural disaster, pandemic and other unforeseen events. The Department will share those changes with the Primary Contractor and its BH-MCO prior to making the changes.

D. Payment to the Primary Contractors

Ten million dollars ($10M) will be allocated for the ICP Program in RY 2022 for Behavioral Health. The funding will be allocated to each Primary Contractor according to its overall percent of HealthChoices Members from the previous calendar year.

If the Department has a payment obligation to the Primary Contractor under Section C above, pursuant to this Appendix, the Department will issue the payment by August 31, 2023.

Fraud, Waste and Abuse Reporting Requirements

Fraud, Waste, and Abuse reporting is governed by 62 P.S. §§ 1401 et seq., 55 Pa. Code §§ 1101.73 - 1101.75, and 42 C.F.R. §§ 438.608(a)(7)-(8) and 455.23. Member referrals are governed by 55 Pa. Code §§ 1101.91 and 1101.92.

Fraud, Waste, and Abuse Referrals

The Primary Contractor and its BH-MCO are required to report to the Department's Bureau of Program Integrity (BPI) any act by Providers, Members and their caregivers, or the employees of the Primary Contractor or its BH-MCO that may affect the integrity of the HealthChoices Program. If the Primary Contractor and its BH-MCO suspects Fraud, Waste or Abuse, the Primary Contractor or its BH-MCO must report the suspected Fraud, Waste or Abuse to BPI. The instructions and MCO Referral Form templates are located on the HealthChoices extranet website under Managed Care Programs/Fraud and Abuse.

Simultaneously with the referral to BPI, the Primary Contractor or its BH-MCO must in accordance with 42 C.F.R. § 438.608(a)(7) refer the suspected Fraud to the Pennsylvania Office of Attorney General Medicaid Fraud Control Section. BPI referrals shall be submitted using the Department's MCO Referral Form. Fraud referrals submitted to BPI using the MCO Referral Form will be automatically sent to the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section. After submitting the MCO Referral Form, the Primary Contractor or its BH-MCO must upload the supporting documentation using the Department's DocuShare. The Primary Contractor or its BH-MCO must also upload the supporting documentation using the Office of Attorney General, Medicaid Fraud Control Section ShareFile.

The Primary Contractor or its BH-MCO must notify BPI if it recovers any overpayments or improper payments related to Fraud, Waste or Abuse of Medical Assistance funds, or otherwise takes an adverse action against a Provider.

The Primary Contractor and its BH-MCOs are required to report quality issues to BPI for further investigation. Quality issues are issues which on an individual basis affect the Recipient's health (e.g. poor-quality services, inappropriate treatment, aberrant or abusive prescribing patterns, or withholding of Medically Necessary services from a Recipient).

All referrals as a result of Fraud, Waste or Abuse or related to quality issues must be made promptly, but no later than thirty (30) days of the identification of the problem/issue. The Primary Contractor or BH-MCO must conduct a preliminary investigation to determine if indicia of Fraud exists. The Primary Contractor or its BH-MCO may informally consult with other state agencies or law enforcement to reach this determination. The Primary Contractor or its BH-MCO must send to BPI all relevant documentation collected to support the fraud referral. Relevant documentation can include, but is not limited to, the materials listed on the "Checklist of Supporting Documentation for Referrals" located on the HealthChoices extranet website under Managed Care

Programs/Fraud and Abuse . The Primary Contractor or its BH-MCO must check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form to indicate the supporting documentation that is included with each referral. A copy of the completed checklist and all supporting documentation must accompany each referral. Any egregious situations or acts (e.g., those that are causing or imminently threaten to cause harm to a Member or significant financial loss to the Department or its agent) must be referred immediately to BPI for further investigation.

Once completed, the Primary Contractor or its BH- MCO must electronically submit the MCO Referral Form to BPI through the HealthChoices Extranet. Additionally, the following information must be submitted to BPI electronically using a DocuShare folder designated by BPI:

- Checklist of Supporting Documentation for Referrals, linked on the BH-MCO Referral Form, located on the HealthChoices Extranet, and
- A copy of the confirmation page (which will appear after the "Submit" button is clicked when submitting the BH-MCO Referral Form), and
- All supporting documentation. Referrals without all supporting documentation will not be processed and will be returned for further development if they are received without all supporting documentation.

If DocuShare is inaccessible for any reason, the BH MCO must notify the BPI contract monitor, then mail the required supporting information identified above to the below address:

Department of Human Services
Bureau of Program Integrity – DPPC/DPR
P.O. Box 2675
Harrisburg, PA 17105-2675

Failure to comply with this Appendix may result in sanctions or corrective action as specified in Appendix F.1 of the Agreement. Pursuant to 42 C.F.R. § 455.23(a), the Department will suspend all Medicaid payments to a Provider if it determines that there is a credible allegation of Fraud, Waste or Abuse for which an investigation is pending against the Provider y unless the Department has good cause not to suspend payments or to suspend payments in part. Upon notification from the Department of the imposition of a payment suspension, the Primary Contractor or its BH-MCO must at a minimum also suspend payments to the Provider.

Recipient Restriction

All suspected Member Fraud, Waste or Abuse should be reported directly to BPI's Recipient Restriction Section by the Primary Contractor or its BH-MCO's Restriction Coordinator using the established restriction referral process.

In the event Member Fraud, Waste or Abuse is suspected but the criteria for restriction is not met, the BH- MCO's Restriction Coordinator should forward all supporting documentation, including a narrative description of the alleged Fraud, Waste or Abuse to the Department's Recipient Restriction Section.

All additional information should also be sent to the Recipient Restriction Section at:

Department of Human Services
Bureau of Program Integrity
Recipient Restriction Program
Box 2675
Harrisburg, PA 17105-2675
717-772-4627 (office)
717- 214-1200 (fax)

Quarterly and Annual Compliance Reporting

The Primary Contractor's and its BH-MCO must submit to BPI quarterly and annually statistical reports which detail the Primary Contractor's and its BH-MCO's detection of Fraud, Waste or Abuse and sanctioning of Providers.

The "MCO Quarterly Compliance Report" and instructions for completion are located online at: https://pagov.sharepoint.com/:x:/r/sites/DHS-HC-Extranet/_layouts/15/Doc.aspx?sourcedoc=%7B03DB450C-BB31-4EC0-81C4-556ECAAAA866%7D&file=MCO%20Quarterly%20Compliance%20Report.xlsm&action=default&mobileredirect=true

The Primary Contractor and its BH-MCO must include the following information in all quarterly and annual reports (42 C.F.R. § 438.608(a)(2)):

- Information for all situations where a Provider's action caused an overpayment to occur
- Cases under review including approximate dollar amounts
- Providers terminated due to Medicare/Medicaid preclusion
- Providers terminated for good cause or best interest
- Overpayments recovered
- Cost avoidance issues related to identifying or identified Fraud, Waste, and Abuse

Upon completion of the Quarterly and annual Compliance Report, the Primary Contractor and its BH-MCO must submit the Report via Docushare. The Primary Contractor and its BH-MCO must provide a quarterly and annual certification statement signed by the Chief Executive Officer, the Chief Financial Officer or the Chief Operations Officer and the Special Investigation Unit (SIU) Manager/Compliance Officer with every reporting package being submitted. If revisions are made to any report, an additional quarterly certification statement must accompany the revised report being sent to the Department of Human Services.

Fraud and Abuse Hotline

Information for Inclusion in Provider Manuals

The following information must be included in Provider Handbooks:

The Department of Human Services has established a hotline to report suspected fraud, waste, and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is 1-866-DHS-TIPS (1-844-347-8477) and operates between the hours of 8:30 AM and 3:30 PM, Monday through Friday. Voice mail is available at all other times.
Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Some common examples of fraud and abuse are:

- Billing or charging Medical Assistance recipients for covered services
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand name drugs
- Falsifying records
- Performing inappropriate or unnecessary services

Suspected fraud and abuse may also be reported via the website at:

https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx

Information reported via the website or email can also be done anonymously. The website contains additional information on reporting fraud and abuse.

Appendix G

OPIOID USE DISORDER CENTERS OF EXCELLENCE

1) The Primary Contractor and its BH-MCO must contract with all behavioral health Opioid Use Disorder Centers of Excellence (OUD-COE) enrolled in the MA Program as Provider Specialty Type 232 – Opioid Center of Excellence within the HealthChoices counties in which the BH-MCO operates, unless the Primary Contractor and its BH-MCO demonstrates to OMHSAS's satisfaction that the Primary Contractor and its BH-MCO are not able to reach a contractual agreement with the OUD-COE, or that the OUD-COE is not compliant with the terms of this Appendix.

2) The Primary Contractor and its BH-MCO must pay the Department's per-member-per-month (PMPM) rate of $277.22 for community-based care management services rendered by an OUD-COE when the OUD-COE has appropriately submitted a claim using procedure code G9012 (other specified case management service not elsewhere classified). The PMPM payment is for a bundle of care management services rendered by the OUD-COE. Claims for procedure code G9012 may only be paid to providers enrolled in the MA Program as Provider Specialty Type 232 – Opioid Center of Excellence, as described in Medical Assistance Bulletin 01-20-08/08-2011/11-20-02/19-20-01/21-20-01/31-20-08. Payment of the PMPM for procedure code G9012 may only be made for provision of care management services. All clinical services, including Medication Assisted Treatment (MAT) and laboratory testing, must be billed for and paid separately. The BH-MCO must require that an OUD-COE provide care management services in accordance with the OUD-COE's service description approved by DHS and in accordance with the terms of this Appendix in order to receive payment for procedure code G9012. DHS will provide the Primary Contractor and its BH-MCO with approved services descriptions for OUD-COEs within the Primary Contractor and BH-MCO's county/counties upon approval.

   If a Member with an OUD receives services from an OUD-COE that is dually enrolled in the MA Program as a Federally Qualified Health Center (FQHC), the Primary Contractor and its BH-MCO must pay the Department's $277.22 PMPM rate to Provider Type 08, Clinic, when procedure code G9012 is billed on a claim for a four-digit Service Location Code that is enrolled as Provider Specialty 232, Opioid Center of Excellence, and the rate for procedure code G9012 is higher than the FQHC PPS rate. The MCO will make payment to the service location enrolled as Provider Specialty 080, FQHC, in accordance with Section II-7.E.1 of the Agreement. The Primary Contractor and its BH-MCO must coordinate with a Member's PH-MCO and any OUD-COE providing services to the Member in accordance with Section II-4.C of the Agreement to ensure that the Member's care is coordinated and not duplicated.

3) The following services, when provided as clinically appropriate and included or reflected in the Member's care plan, constitute community-based care management services covered by procedure code G9012.

   a) Screening and Assessment

i) Assessments to identify a Member's needs related to Social Determinants of Health, administered in home and community-based settings whenever practicable

ii) Level of care assessments, which may be completed either by the OUD-COE or through a referral. If a level of care assessment results in a recommendation of MAT, the OUD-COE must provide education related to MAT.

iii) Screenings for clinical needs that require referrals or treatment

b) Care Planning

i) Development of integrated, individualized care plans that include, at a minimum:

A) The Member's treatment and non-treatment needs
B) The Member's preferred method of care management, such as face-to-face meetings, phone calls, or through a secure messaging application
C) The identities of the Member's community-based care management team, as well as the members of the Member's support system

ii) Care coordination with a Member's PCP, mental health service provider, drug & alcohol treatment provider, pain management provider, obstetrician or gynecologist, and BH-MCO, as applicable

c) Referrals

i) Facilitating referrals to necessary and appropriate clinical services according to the Member's care plan, including:

A) Primary care, including screening for and treatment of positive screens for: HIV, Hepatitis A (screening only); Hepatitis B; Hepatitis C; and Tuberculosis.
B) Perinatal Care and Family Planning Services.
C) Mental Health Services.
D) Forms of medication approved for use in MAT not provided at the OUD-COE Provider's enrolled service location(s).
E) MAT for pregnant women, if the OUD-COE Provider does not provide MAT to pregnant women.
F) Drug and Alcohol Outpatient Services.
G) Pain Management

ii) Facilitating referrals to any ASAM Level of Care that is clinically appropriate according to a Level of Care Assessment

iii) Facilitating referrals to necessary and appropriate non-clinical services according to the results of the Member's needs identified through a Social Determinants of Health screening

d) Monitoring

i) Individualized follow-up with Members and monitoring of Members' progress per the Member's care plan, including referrals for clinical and non-clinical services

ii) Continued and periodic re-assessment of a member's Social Determinants of Health needs

iii) Performing urine drug screenings at least monthly

e) Making and receiving warm hand-offs. In the event of a warm hand-off from an overdose event, the OUD-COE must provide education related to overdose risk and naloxone.

4) Any member of an OUD-COE's care management team may provide the care management services described above if they are appropriately licensed or credentialed to do so. . A Primary Contractor and its BH-MCO may not require an OUD-COE to document provision of each of these services every month for every Member in order to receive the PMPM payment but may conduct a chart review for a Member to determine whether these services have been provided over time.

5) The Primary Contractor and its BH-MCO must pay a claim for procedure code G9012 when it determines that the OUD-COE has met the following requirements:

a) During the first calendar month a Member is engaged with the OUD-COE, the OUD-COE has provided and documented one face-to-face community-based care management service, as defined in Section 3 of this Appendix and one service for the treatment of a condition associated with an ICD-10 diagnosis code related to OUD.
b) During subsequent months a Member is engaged with the OUD-COE, the OUD-COE has provided and documented one face-to-face community-based care management service, as defined in Section 3 of this Appendix. If a Member does not receive a face-to-face care management service for two or more consecutive months, the OUD-COE must also provide a treatment service in addition to a face-to-face care management service to receive the PMPM for a subsequent month.
c) The OUD-COE has documented the care management service encounter within the Member's electronic health record, including the following information:

i) Date of encounter
ii) Location of encounter
iii) Identity of the individual employed by the OUD-COE with whom the Member met
iv) Duration of encounter
v) Description of service provided during the encounter
vi) Next planned activities that the OUD-COE and the Member will undertake

6) The community-based care management service for which the G9012 procedure code claim is being submitted is not duplicative, overlapping, or redundant of other care or case management services for which the BH-MCO has already paid on a Member's behalf.

7) The Primary Contractor and its BH-MCO may not pay multiple claims using procedure code G9012 to an OUD-COE for the same Member in the same calendar month. The Primary Contractor and its BH-MCO may require a claim using procedure code G9012 be submitted each time a Member receives a community-based care management service from an OUD-COE, but it may only pay one claim per month. The Primary Contractor and its BH-MCO may pay the PMPM to more than one OUD-COE for services provided to an individual Member during the same calendar month only during the Member's first two months of engagement with an OUD-COE.

8) The Primary Contractor and its BH-MCO may not require anything additional of the OUD-COEs in order to receive the PMPM, including data reporting. OUD-COEs will submit data to the Department monthly.

9) The Primary Contractor or its BH-MCO will perform a claims analysis on an annual basis and provide the analysis to the Department no later than July 31 of the calendar year following the year for which claims are being analyzed. The Primary Contractor or its BH-MCO will identify OUD-COE clients as those members for whom a G9012 procedure code claim was submitted during the previous year and will analyze the additional claims submitted for those members, focusing on the metrics defined below. The purpose of this analysis will be to monitor COEs for adherence with the terms of their provider contracts and to ensure quality services are being provided to the Primary Contractor's members.

10) The Primary Contractor or its BH-MCO will analyze the following metrics through claims analysis. The format for this analysis, along with instructions and a standard methodology to analyze the measures, will be designated by the Department through its Operations Reporting requirements found on the Pennsylvania HealthChoices Extranet. The Department will provide data to the Primary Contractor or its BH-MCO to support this analysis upon request.

    1. Percentage of Members who received a service rendered by a primary care provider. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who received a service rendered by a primary care provider during a COE service window.

    2. Percentage of Members who received a pain management service. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who received a pain management service during a COE service window.

    3. Percentage of Members who were prescribed a benzodiazepine while prescribed buprenorphine or methadone. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who were concurrently prescribed a benzodiazepine while prescribed buprenorphine or

methadone. This measure is based on the PQA measure "Concurrent Use of Opioids and Benzodiazepines (COB)" and has been updated to the latest value sets.

4. Percentage of Members who were prescribed an opiate while prescribed buprenorphine or methadone. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who were concurrently prescribed an opioid while prescribed buprenorphine or methadone. This measure is based on the PQA measure "Concurrent Use of Opioids and Benzodiazepines (COB)" and has been updated to the latest value sets.

5. Percentage of Members who are pregnant. The measure is calculated by determining the number of female enrollee-COE pairs where the enrollee can be identified as pregnant from a Medicaid-paid delivery during the reporting period. NOTE: the reporting period for this measure is from October 8 of the previous calendar year to October 7 of the reporting period (calendar year) of the other measures. This measure and other pregnancy related measures (measures 6, 7, and 8) include enrollee-COE pairs from both the current year and the previous year.

6. Percentage of pregnant Members who received a timely prenatal initial visit. The measure is calculated by first determining the number of female enrollee-COE pairs who were identified as pregnant in Measure 5 whose pregnancy overlapped for at least 42 days with a COE service window. The measure reports the percentage of these women who received timely prenatal care according to the HEDIS definition. NOTE: the reporting period for this measure is based on qualifying deliveries that occur between October 8 of the previous calendar year to October 7 of the reporting period (calendar year) of the other measures. This measure and other pregnancy related measures (measures 5, 7, and 8) include enrollee-COE pairs from both the current year and the previous year.

7. Percentage of pregnant Members who received a timely post-partum care visit. The measure is calculated by first determining the number of female enrollee-COE pairs who were identified as pregnant in measure 5 and had at least 1 day of overlap between their COE service window and the period from 7 to 84 days postpartum. The measure reports the percentage of these women who received timely postpartum care according to the HEDIS definition. NOTE: the reporting period for this measure is from October 8 of the previous calendar year to October 7 of the reporting period (calendar year) of the other measures. This measure and other pregnancy related measures (measures 5, 6, and 8) include enrollee-COE pairs from both the current year and the previous year.

8. Percentage of pregnant Members receiving post-partum contraception. The measure is calculated by first determining the number of female enrollee-COE pairs who were identified as pregnant in measure 5 and had at least 1 day of overlap between their COE service window and the period from delivery to 60 days postpartum. The measure reports the percentage of these women who received postpartum contraception according to the HEDIS definition for "Contraceptive Care – Postpartum Women".

NOTE: the reporting period for this measure is from October 8 of the previous calendar year to October 7 of the reporting period (calendar year) of the other measures. This measure and other pregnancy related measures (measures 5, 6, and 7) include enrollee-COE pairs from both the current year and the previous year.

9. Percentage of Members who received methadone. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who received methadone during the COE service window.

10. Percentage of Members who received buprenorphine. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who received buprenorphine during the COE service window.

11. Percentage of Members who received naltrexone. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who received naltrexone during the COE service window.

12. Duration of medication-assisted treatment. The measure determines the duration (90, 180, and 270 days) of medication for opioid use disorder (MOUD) treatment (defined by continuity of pharmacotherapy, NQF 3175) for enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who had at least one claim for MOUD in the COE service window. NOTE: For this measure, the reporting period is two (2) calendar years, the current year and the previous year.

13. Percentage of Members screened for Hepatitis B, Hepatitis C, or Tuberculosis. The two separate measures are calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who were screened for Hepatitis B, Hepatitis C, or Tuberculosis during the COE service window.

14. Percentage of female Members receiving contraception. The measure is calculated by determining the number of female enrollee-COE pairs (unique combinations of female enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who received any type of contraception during the COE service window.
15. Percentage of female Members who received long-acting reversible contraception (LARC). The measure is calculated by determining the number of female enrollee-COE pairs (unique combinations of female enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who received any LARC during a COE service window.

16. Percentage of Members with emergency department (ED) visits. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who had an ED visit during a COE service window.

17. Percentage of Members with inpatient acute care stays, excluding inpatient drug and alcohol stays. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or face-to-face management service from a COE during the reporting period) who had an inpatient acute care stay (excluding stays in an inpatient drug and alcohol treatment facility) after engaging in treatment from a COE during a COE service window.

APPENDIX H
Complaint, Grievance and Fair Hearing Processes

A. General Requirements

1. The BH-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances (at all levels) as they relate to the MA population.

2. All Complaint, Grievance, and Fair Hearing policies and procedures developed by a BH-MCO must be approved in writing by the Department prior to their implementation.

3. The Complaint and Grievance processes must be fair, easy to understand, easy to follow, easily accessible and respectful of the Member's rights.

4. The BH-MCO policies and procedures regarding Member Complaints and Grievances must be provided to Members in written form:

   a. Upon enrollment into the BH-MCO,
   b. Upon Member request, and
   c. At least 30 Days before a Department-approved change becomes effective.

5. The BH-MCO must require Network Providers to display information about how to file a Complaint or a Grievance and the Complaint and Grievance process at all Network Provider offices.

6. The BH-MCO may not charge Members a fee for filing a Complaint or Grievance.

7. The BH-MCO must require Network Providers to display a notification that Members will not incur a fee for filing Complaints or Grievances at any level of the process at all Network Provider offices.

8. The BH-MCO must operate a toll-free telephone service for Members to use to file Complaints and Grievances and to follow up on Complaints and Grievances filed by Members. The phone service must be operated 24 hours a day, 7 Days a week by appropriately trained staff. Voice mail or recorded messages are not allowed. The BH-MCO must provide Members with the number of the toll-free telephone service.

9. All BH-MCO staff that interact with Members must receive training on Complaints and Grievances that includes how to record a Complaint or

Grievance and how to provide the information staff receive to designated Complaint and Grievance staff for processing.

10. All County and BH-MCO staff involved in the Complaint and Grievance processes and all review committee members must receive training in the areas related to their responsibility at least annually or more frequently, if needed.

11. All County and BH-MCO staff involved in the Complaint and Grievance processes and all review committee members must have the necessary orientation, knowledge, and experience to make a determination about assigned issues and must analyze information and resolve disputed issues in a fair and nondiscriminatory manner.

12. All review committee proceedings shall be conducted in a manner that is informal and impartial to avoid intimidating the Member or the Member's representative.

13. The BH-MCO must identify a lead person responsible for overall coordination of the Complaint and Grievance processes, including the provision of information and instructions to Members.

14. The BH-MCO must maintain an accurate log of all Complaints and Grievances, which includes, at a minimum:

    a. Identifying information about the Member
    b. A description of the reason for the Complaint or Grievance
    c. The date the Complaint or Grievance was received
    d. The date of the review or review meeting (if applicable)
    e. The decision
    f. The date of the decision
    g. If the second level Complaint review committee or the Grievance review committee included a consumer representative

    The BH-MCO must provide the log to the Department or CMS upon request.

15. The BH-MCO must retain all Complaint and Grievance records, which must include a copy of any document reviewed by the Complaint or Grievance review committee and the Complaint or Grievance log, for 10 years from the date the Complaint or Grievance was filed.

16. The BH-MCO must allow the Member or the Member's representative if the Member has provided the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member's behalf access to all relevant documents pertaining to the subject of the Member's Complaint or Grievance, including any new or additional evidence considered, relied upon, or generated for the Complaint or Grievance review and, if an Investigator was assigned, any information obtained as part of the investigation. The BH-MCO may not charge Members or their representatives for copies of the documentation.

17. The BH-MCO must ensure that there is a link between the Complaint and Grievance processes and the Quality Management and Utilization Management programs.

18. The BH-MCO may not use the time frames or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Member from receiving medically necessary care in a timely manner.

19. The BH-MCO must accept Complaints and Grievances from Members who have disabilities which are in alternative formats including: TTD/TTY for telephone inquiries and Complaints and Grievances from Members who are deaf or hearing impaired; Braille; recording; or computer disk; and other commonly accepted alternative forms of communication. The BH-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitation of some Members who have disabilities so they treat these Members with patience, understanding, and respect.

20. The BH-MCO must provide Members who have disabilities assistance with preparing and presenting their case at Complaint or Grievance reviews at no cost to the Member. This includes, but is not limited to:

    a. Providing qualified sign language interpreters for Members who are deaf or hearing impaired;

    b. Providing information submitted on behalf of the BH-MCO at the Complaint or Grievance review in an alternative format accessible to the Member filing the Complaint or Grievance. The alternative format version must be supplied to the Member before the review and at the review, so the Member can discuss and/or refute the content during the review; and

    c. Providing personal assistance to Members with other physical limitations with copying and presenting documents and other evidence.

21. The BH-MCO must provide language interpreter services when requested by a Member at no cost to the Member.

22. The BH-MCO must offer Members the assistance of a BH-MCO staff member throughout the Complaint and Grievance processes at no cost to the Member. The BH-MCO staff member cannot have been involved in and cannot be a subordinate of anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

23. The BH-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not a subordinate of anyone who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

24. Upon receipt of a Complaint or Grievance, the BH-MCO must offer to provide Members with names and contact information of advocacy organizations available to assist Members.

25. If the decision on a Member's Complaint or Grievance indicates that a corrective plan of action or follow-up is needed to address quality of care concerns, the BH-MCO must implement the corrective plan of action or follow-up and document the actions taken in the Complaint or Grievance record or include in the record where documentation of the corrective action or follow-up can be found.

26. If a Member continued to receives services at the previously authorized level because the Member filed a Complaint, Grievance, or Fair Hearing to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving within one Day from the mail date on the written notice of decision if acute inpatient services were being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services were being discontinued, reduced, or changed, the BH-MCO must pay for the services pending resolution of the Complaint, Grievance, or Fair Hearing, unless the Member subsequently withdraws the Complaint, Grievance or Fair Hearing.

27. The BH-MCO must notify the Member when the BH-MCO fails to decide a first level Complaint or Grievance within the time frames specified in this Appendix, using the Notice for Failure of the BH-MCO to Meet Complaint or Grievance Time Frames template. The BH-MCO must mail this notice to the Member one Day following the date the decision was to be made.

28. The BH-MCO must notify the Member when it denies payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, using the Notice for Payment Denial Because the Service Was Provided Without Authorization by a Provider Not Enrolled in the Pennsylvania Medical Assistance Program template. The BH-MCO must mail this notice to the Member on the day that the decision is made to deny payment.

29. The BH-MCO must notify the Member when it denies payment after a service(s) has been delivered because the service(s) provided is not a covered service(s) for the Member, using the Notice for Payment Denial Because the Service Was Not a Covered Service for the Member template. The BH-MCO must mail this notice to the Member on the day that the decision is made to deny payment.

30. The BH-MCO must notify the Member when it denies payment after a service(s) has been delivered because the BH-MCO determined that the emergency room service(s) was not medically necessary, using the Notice for Denial of Payment After a Service(s) Has Been Delivered Because the Emergency Room Service(s) Was Not Medically Necessary template. The BH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

31. The BH-MCO must notify the Member when it denies the Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities, using the Notice for Denial of Request to Dispute Financial Liability template. The BH-MCO must mail this notice to the Member on the day the decision is made to deny the request to dispute a financial liability.

32. The BH-MCO must include the Non-Discrimination Notice and Language Assistance Services templates when sending a letter or notice to a Member and a Member's representative if the Member has provided the BH-MCO with written authorization that indicates that the representative may be involved and/or take action on the Member's behalf.

33. The BH-MCO must use the templates supplied by the Department, which are available in DocuShare. The BH-MCO may not modify the templates. The BH-MCO must also follow the instruction in the templates for including detailed, specific information related to the Complaint or Grievance.

B. Complaint Requirements

1. Definition**:** A Complaint is a dispute or objection regarding a Network Provider or the coverage, operations, or management of a BH-MCO, which has not been resolved by the BH-MCO and has been filed with the BH-MCO or with the Pennsylvania Insurance Department's (PID) Bureau of Managed Care (BMC), including, but not limited to:

    a. a denial because the requested service is not a covered service;

    b. the failure of the BH-MCO to meet the required time frames for providing a service;

    c. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

    d. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

    e. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member;

    f. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities; or

    g. a member's dissatisfaction with the BH-MCO or a Provider.

Note: Complaints do not include requests to reconsider a decision concerning the medical necessity and appropriateness of a covered health care service.

2. First Level Complaint Process

    a. A BH-MCO must permit a Member to designate a representative, which may include the Member's Provider, if the Member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member's behalf. Failure to provide written authorization that the representative may be involved and/or act on the Member's behalf may not delay the Complaint process.

    A Member or Member's representative (if designated) may file a

Complaint either orally or in writing.

b. If the Complaint disputes one of the following, the Member or Member's representative (if designated) must file a Complaint within 60 Days from the date of the incident complained of or the date the Member receives written notice of a decision:

   i. a denial because the requested service is not a covered service;

   ii. the failure of the BH-MCO to meet the required time frames for providing a service;

   iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

   iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

   v. a denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

   vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

   For all other Complaints, there is no time limit for filing a Complaint.

c. A Member who files a Complaint to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered service must continue to receive the disputed service at the previously authorized level pending resolution of the Complaint, if the Complaint is filed orally, hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced, or changed.

d. The BH-MCO must send the Member and Member's representative (if designated), an acknowledgment letter, using the appropriate acknowledgment letter template upon receipt of the Complaint, which can be no later than 5 business days after receipt of the

Complaint.

If the Complaint disputes one of the following:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities

the BH-MCO must use the Complaint Acknowledgement Letter template.

For all other Complaints, the BH-MCO must use the First Level Complaint Acknowledgement Letter template.

f. Upon receipt of the Complaint, the BH-MCO must assign an Investigator who was not involved in and is not the subordinate of anyone who was involved in any previous review or decision-making on the issue that is the subject of the Complaint and who will not benefit financially from the resolution of the Complaint. The Investigator is responsible for obtaining from the Member and any other individuals involved with the Complaint all relevant documents pertaining to the subject of the Complaint. The Investigator must treat the Member and any other individuals involved with the Complaint equally and with respect. The Investigator must provide to the first level Complaint review committee at least 2 Days prior to the Complaint review all information obtained as part of the investigation. The Investigator must attend the Complaint review and present the information obtained as part of the investigation to

the first level Complaint review committee. The Investigator cannot be involved in the Complaint review committee's decision.

g. The Complaint review for Complaints **not involving a clinical issue** must be performed by a Complaint review committee, which must include one or more employees of the BH-MCO who were not involved and are the not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

h. The Complaint review for Complaints **involving a clinical issue** must be performed by a Complaint review committee, which must include one or more employees of the BH-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. At least one individual on the committee must meet the qualifications described in Appendix AA, section C.3 for an individual that can deny a request for services based on medical necessity and this individual must decide the Complaint. Other appropriate individuals may participate in the review.

i. The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the Member's position to the Complaint review committee.

j. The Member must be provided the opportunity to appear before the Complaint review committee. The BH-MCO must be flexible when scheduling the Complaint review to facilitate the Member's attendance. The Complaint review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the Complaint review, the BH-MCO must provide an opportunity for the Member to communicate with the Complaint review committee by telephone or videoconference.

k. The Complaint review committee may ask individuals who attend the Complaint review in person, by telephone, or by videoconference questions related to the subject of the Complaint.

l. The Member may elect not to attend the Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

m. If the Member's Provider did not file the Complaint, the Member's

Provider may participate in the Complaint review only if the Member consents to the Provider being present at the Complaint review. The BH-MCO must document the Member's consent in the Complaint record.

n. County or BH-MCO staff may attend the Complaint review for training purposes if the Member consents to the staff person attending the Complaint review. The BH-MCO must document the Member's consent in the Complaint record.

o. The BH-MCO must maintain as part of the Complaint record a sign-in sheet that includes the date and time of the review meeting; who was present at the review meeting and why the individual was present at the review meeting; if the individual attended the review meeting in person, by phone, or by videoconference; the affiliation and job title of anyone present at the review meeting other than the Member; and documentation that all individuals present at the review meeting other than the Member have acknowledged that they will keep the information discussed during the review meeting confidential. All individuals that are present at the review meeting in person must sign the sign-in sheet.

p. The decision of the Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative (if designated) without regard to whether such information was submitted or considered previously. The decision of the Complaint review committee must be based solely on the information presented at the review.

q. The Complaint review committee must complete its review of the Complaint as expeditiously as the Member's health condition requires.

r. The Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.

s. The BH-MCO must send a written notice of the Complaint decision to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within 30 Days from the date the BH-MCO received the Complaint, unless the time frame for deciding the Complaint has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member's request for an extension in the Complaint record.

t. If the Complaint disputes the following the BH-MCO must use the Complaint Decision Notice template to send written notice of the Complaint decision:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

For all other Complaints, the BH-MCO must use the first level Complaint Decision Notice template to send written notice of the Complaint decision.

u. If the Complaint disputes one of the following, the Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:

i. a denial because the requested service is not a covered service;

ii. the failure of the BH-MCO to meet the required time frames for providing a service;

iii. the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) was provided without

authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member; or

vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

The Member or Member's representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's first level Complaint decision

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an external review in writing with PID's BMC within 15 Days from the date the Member receives written notice of the BH-MCO's first level Complaint decision.

For all other Complaints, the Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a second level Complaint either in writing, by fax, or orally within 45 Days from the date the Member receives written notice of the BH-MCO's first level Complaint decision.

3. Second Level Complaint Process

a. A BH-MCO must permit a Member to designate a representative, which may include the Member's Provider, if the Member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member's behalf. Failure to provide written authorization that the representative may be involved and/or act on the Member's behalf may not delay the Complaint process.

b. A second level Complaint must be filed within 45 Days from the date the Member receives written notice of the BH-MCO's first level Complaint decision.

c. The BH-MCO must send the Member and Member's representative (if designated) an acknowledgment letter using the Second Level

Complaint Acknowledgment Letter template upon receipt of the second level Complaint, which can be no later than 5 business days after receipt of the second level Complaint.

d. The second level Complaint review for Complaints not involving a clinical issue must be performed by a Complaint review committee made up of 3 or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

e. The second level Complaint review for Complaints involving a clinical issue must be conducted by a second level Complaint review committee made of up of three (3) or more individuals who were not involved in and or not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The second level Complaint review committee must include at least one individual who meets the qualifications described in Appendix AA, section C.3 for an individual that can deny a request for services based on medical necessity and this individual must decide the Complaint. Other appropriate individuals may participate in the review.

f. At least one-third of the second level Complaint review committee may not be an employee of the BH-MCO or a related subsidiary or Affiliate.

g. At least 20% of the second level Complaint review committees in a year must include a consumer representative on the review committee.

h. If the Complaint involves mental health services for an adult, the consumer representative must have received or is currently receiving mental health services. If the Complaint involves substance abuse services, the consumer representative must have received or is currently receiving substance abuse services.

i. If the Complaint involves mental health services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving mental health services or an individual who has received or is currently receiving mental health services. If the Complaint involves substance abuse services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving substance abuse services

or an individual who has received or is currently receiving substance abuse services.

j. The BH-MCO must provide to the second level Complaint review committee at least 2 Days prior to the second level Complaint review meeting the first level Complaint record, which must include a copy of any document reviewed by the first level Complaint review committee.

k. A committee member who does not personally attend the second level Complaint review meeting may not be part of the decision-making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review all information presented at the meeting.

l. The second level Complaint review committee may not discuss the Complaint prior to the review meeting.

m. The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the Member's position to the second level Complaint review committee.

n. The Member must be provided the opportunity to appear before the second level Complaint review committee. The BH-MCO must be flexible when scheduling the second level Complaint review to facilitate the Member's attendance. The second level Complaint review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the second level Complaint review, the BH-MCO must provide an opportunity for the Member to communicate with the second level Complaint review committee by telephone or videoconference.

o. The BH-MCO must give the Member at least 10 Days advance written notice of the second level Complaint review date. The BH-MCO must document in the Complaint record the date that it notified the Member of the review date.

p. The Member may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

q. A facilitator must attend the second level Complaint review meeting to ensure that the review meeting is conducted in accordance with the requirements set forth in this Appendix. The facilitator may not

contribute to the discussion of the second level Complaint review committee or be involved in the decision of the second level Complaint review committee.

r. A BH-MCO staff member that is prepared to provide information on the BH-MCO's position on the issue the Complaint is about must attend the second level Complaint review meeting. The BH-MCO staff member may not be present during the discussion of the decision and may not be involved in the decision of the second level Complaint review.

s. If the Member's Provider did not file the Complaint, the Member's Provider may participate in the Complaint review only if the Member consents to the Provider being present at the Complaint review. The BH-MCO must document the Member's consent in the Complaint record.

t. The second level Complaint review committee may ask individuals who attend the Complaint review meeting in person, by telephone, or by videoconferences question related to the subject of the Complaint.

u. County or BH-MCO staff may attend the Complaint review for training purposes if the Member consents to the staff person attending the Complaint review. The BH-MCO must document the Member's consent in the Complaint record.

v. The BH-MCO must maintain as part of the Complaint record a sign-in sheet that includes the date and time of the review meeting; who was present at the review meeting and why the individual was present at the review meeting; if the individual attended the review meeting in person, by phone, or by videoconference; the affiliation and job title of anyone present at the review meeting other than the Member; and documentation that all individuals present at the review meeting other than the Member have acknowledged that they will keep the information discussed during the review meeting confidential. All individuals that are present at the review meeting in person must sign the sign-in sheet.

w. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative (if designated) without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.

x. The second level Complaint review committee must complete its review of the Complaint as expeditiously as the Member's health condition requires.

y. The testimony taken by the second level Complaint review committee (including the Member's comments) must be either recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.

z. The BH-MCO must send a written notice of the second level Complaint decision to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), using the Second Level Complaint Decision Notice template, within 45 Days from the date the BH-MCO received the second level Complaint.

aa. The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file in writing a request for an external review of the second level Complaint decision with PID's BMC within 15 Days from the date the Member receives the written notice of the BH-MCO's second level Complaint decision.

4. External Complaint Process

a. If a Member files a request directly with PID's BMC for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a covered service, the Member must continue to receive the disputed service at the previously authorized level pending resolution of the external review, if the request for external review is filed orally, hand delivered, or post-marked within one Day from the mail date on the written notice of the BH-MCO's Complaint decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO's Complaint decision if any other services are being discontinued, reduced, or changed.

b. Upon the request of PID's BMC, the BH-MCO must transmit all records from the BH-MCO's Complaint review to PID's BMC within 30 Days from the request in the manner prescribed by PID's BMC. The Member, the Provider, or the BH-MCO may submit additional materials related to the Complaint.

5. Expedited Complaint Process

   a. The BH-MCO must conduct an expedited review of a Complaint if the BH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a Member or a Member's representative (if designated) provides the BH-MCO with written certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification must include the Provider's signature.

   b. A request for an expedited review of a Complaint may be filed either in writing or orally.

   c. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the Member of the right to present testimony and evidence and make legal and factual arguments, in person as well as in writing and of the limited time available to do so.

   d. If the Provider certification is not included with the request for an expedited review and the BH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, the BH-MCO must inform the Member that the Provider must submit a certification as to the reason why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within 72 hours from the Member's request for an expedited review, the BH-MCO must decide the Complaint within the standard time frames as set forth in this Appendix, unless the time frame for deciding the Complaint has been extended by up to 14 Days at the request of the Member. If the BH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the BH-MCO must make a reasonable effort to give the Member prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within 2 business days of the decision to deny expedited review, using the Notice of Failure to Receive Provider Certification for an Expedited Complaint template .

   e. A Member who files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving on the basis that the service is not a

covered service must continue to receive the disputed service at the previously authorized level pending resolution of the Complaint, if the request for expedited review is filed orally, hand delivered, or post-marked within one Day from the mail date on the written notice of the BH-MCO's decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO's decision if any other services are being discontinued, reduced, or changed.

f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes at least one individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity. Other appropriate individuals may participate in the review, but an individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity must decide the Complaint.

g. The members of the expedited Complaint review committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

h. The Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.

i. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable) within either 48 hours of receiving the Provider's certification or 72 hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Complaint has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member's request for an extension in the Complaint record. In addition, the BH-MCO must mail written notice of the decision to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within 2 business days of the decision using the Expedited Complaint Decision Notice template.

j. The Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the

Member's behalf, may file a request for an expedited external Complaint review with the BH-MCO within 2 business days from the date the Member receives the BH-MCO's expedited Complaint decision. A Member who files a request for an expedited external Complaint review that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the expedited external Complaint review if the request for expedited external Complaint review is filed orally, hand delivered, faxed, or post-marked within one business day from the mail date on the written notice of the BH-MCO's decision if acute inpatient services are being discontinued, reduced, or changed or within 2 business days from the mail date on the written notice of the BH-MCO's decision if any other services are being discontinued, reduced, or changed.

k. A request for an expedited external Complaint review may be filed either in writing or orally.

l. The BH-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external Complaint reviews.

m. The Member or the Member's representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's expedited Complaint decision.

n. The BH-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Member's request for expedited review of a Complaint.

C. Grievance Requirements

1. Definition: A Grievance is a request to have a BH-MCO or utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

   A Grievance may be filed regarding a BH-MCO's decision to:

   a. deny, in whole or in part, payment for a service;

   b. deny or issue a limited authorization of a requested service, including a determination based on the type or level of a service;

   c. reduce, suspend, or terminate a previously authorized service; and

   d. deny the requested service but approve an alternative service.

2. Grievance Process

   a. A BH-MCO must permit a Member to designate a representative, which may include the Member's Provider, if the Member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or act on the Member's behalf. Failure to provide written authorization that the representative may be involved and/or act on the Member's behalf may not delay the Grievance process.

   b. A Member or Member's representative (if designated) may file a Grievance either orally or in writing.

   c. The Member or Member's representative (if designated) must file a Grievance within 60 Days from the date the Member receives written notice of decision.

   d. A Member who files a Grievance to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Grievance, if the Grievance is filed orally, hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed.

   e. The BH-MCO must send the Member and Member's representative (if designated) an acknowledgment letter using the Grievance Acknowledgment Letter template upon receipt of the Grievance, which can be no later than 3 business days after receipt of the Grievance.

   f. In order for the Provider to represent the Member in the conduct of a Grievance, the Provider must obtain the written consent of the Member and submit the written consent with the Grievance. A Provider may obtain the Member's written permission at the time of treatment. The BH-MCO must assure that a Provider does NOT require a Member to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

      i. The name and address of the Member, the Member's date of birth, and identification number,

ii. If the Member is a minor, or is legally incompetent, the name, address, and relationship to the Member of the person who signed the consent,

iii. The name, address, and plan identification number of the Provider to whom the Member is providing consent,

iv. The name and address of the BH-MCO to which the Grievance will be submitted,

v. An explanation of the specific service which was provided or denied to the Member to which the consent will apply,

vi. The following statement: "The Member or the Member's representative may not submit a Grievance concerning the services listed in this consent form unless the Member or the Member's representative rescinds consent in writing. The Member or Member's representative has the right to rescind consent at any time during the Grievance process.",

vii. The following statement: "The consent of the Member or the Member's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.",

viii. The following statement: "The Member or the Member's representative, if the Member is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The Member or the Member's representative understands the information in the Member's consent form."; and

ix. The dated signature of the Member, or the Member's representative, and the dated signature of a witness.

g. The Grievance review must be performed by a Grievance review committee made up of 3 or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. The Grievance review committee must include at least one individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity. Other appropriate individuals may participate in

the review, but an individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity must decide the Grievance.

i. At least one-third of the Grievance review committee may not be an employee of the BH-MCO or a related subsidiary or Affiliate.

j. At least 20% of all Grievance review committees in a year must include a consumer representative on the review committee.

k. At least 2 Days prior to the Grievance review meeting the BH-MCO must provide to the Grievance review committee a copy of all documents reviewed to determine the medical necessity and appropriateness of the requested services.

l. If the Grievance involves mental health services for an adult, the consumer representative must have received or is currently receiving mental health services. If the Grievance involves substance abuse services, the consumer representative must have received or is currently receiving substance abuse services.

m. If the Grievance involves mental health services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving mental health services or an individual who has received or is currently receiving mental health services. If the Grievance involves substance abuse services for a child or adolescent, the consumer representative may be a parent or guardian of a child or adolescent who has received or is currently receiving substance abuse services or an individual who has received or is currently receiving substance abuse services.

n. A committee member who does not personally attend the Grievance review meeting may not be part of the decision-making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review all information presented at the meeting.

o. The Grievance review committee may not discuss the Grievance prior to the review meeting.

p. The BH-MCO must afford the Member a reasonable opportunity to present testimony and evidence and make legal and factual arguments, in person as well as in writing. The BH-MCO must allow the Member or anyone the Member chooses to present the

Member's position to the Grievance review committee.

q. The Member must be provided the opportunity to appear before the Grievance review committee. The BH-MCO must be flexible when scheduling the Grievance review to facilitate the Member's attendance. The Grievance review must be conducted at a time and place that is convenient for the Member. If the Member cannot appear in person at the Grievance review, the BH-MCO must provide an opportunity for the Member to communicate with the Grievance review committee by telephone or videoconference.

r. The BH-MCO must give the Member at least 10 Days advance written notice of the Grievance review date. The BH-MCO must document in the Grievance record the date that it notified the Member of the review date.

s. The Member may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

t. A facilitator must attend the Grievance review meeting to ensure that the review meeting is conducted in accordance with the requirements set forth in this Appendix. The facilitator may not contribute to the discussion of the Grievance review committee or be involved in the decision of the Grievance review committee.

u. A BH-MCO staff member that is be prepared to provide information on the BH-MCO's decision about the medical necessity and appropriateness of the requested services must attend the Grievance review meeting. The BH-MCO staff member may not be present during the discussion of the decision and may not be involved in the decision of the Grievance.

v. If the Member's Provider did not file the Grievance, the Member's Provider may participate in the Grievance review only if the Member consents to the Provider being present at the Grievance review. The BH-MCO must document the Member's consent in the Grievance record.

w. The Grievance review committee may ask individuals who attend the Grievance review in person, by telephone, or by videoconference questions related to the subject of the Grievance.

x. County or BH-MCO staff may attend the Grievance review for training purposes if the Member consents to the staff person attending the Grievance review. The BH-MCO must document the

Member's consent in the Grievance record.

y. The BH-MCO must maintain as part of the Grievance record a sign-in sheet that includes the date and time of the review meeting; who was present at the review meeting and why the individual was present at the review meeting; if the individual attended the review meeting in person, by phone, or by videoconference; the affiliation and job title of anyone present at the review meeting other than the Member; and documentation that all individuals present at the review meeting other than the Member have acknowledged that they will keep the information discussed during the review meeting confidential. All individuals that are present at the review meeting in person must sign the sign-in sheet.

z. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Member or Member's representative (if designated) without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of the Grievance review committee must be based solely on the information presented at the review.

aa. The Grievance review committee must complete its review of the Grievance as expeditiously as the Member's health condition requires.

bb. The testimony taken by the Grievance review committee (including the Member's comments) must be either recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Grievance record.

cc. The BH-MCO must send a written notice of the Grievance decision , to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within 30 Days from the date the BH-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member's request for an extension in the Grievance record.

dd. The BH-MCO must use the appropriate Grievance Decision Notice template to send written notice of the Grievance decision:

i. Overturned: The review committee determined that the evidence presented supports the reversal or alteration of a prior decision concerning the medical necessity and

appropriateness of the health care service.

ii. Partially Overturned: The review committee determined that the evidence presented supports the partial reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

iii. Upheld: The review committee determined that the evidence presented does not support the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

ee. The Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for external review.

The Member or Member's representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's Grievance decision.

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request with the BH-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed by PID's BMC. The request must be filed in writing or orally within 15 Days from the date the Member receives the written notice of the BH-MCO's Grievance decision.

3. External Grievance Process

a. The BH-MCO must process all requests for external Grievance review. The BH-MCO must follow the protocols established by PID's BMC to meet all time frames and requirements necessary for coordinating the request and notification of the decision to the Member, Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider.

b. A Member who files a request for external Grievance review that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is filed orally, hand delivered, or post-marked within one Day from the mail date on the written notice of the BH-MCO's Grievance decision if acute inpatient services are

being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO's Grievance decision if any other services are being discontinued, reduced, or changed.

c. Within 5 business days of receipt of the request for an external Grievance review, the BH-MCO must notify the Member, the Member's representative (if designated), the Provider, if the Provider filed the request for the external Grievance review, and PID's BMC that the request for an external Grievance review has been filed.

d. The external Grievance review must be conducted by a CRE not affiliated with the BH-MCO.

e. Within 2 business days from receipt of the request for an external Grievance review, PID's BMC will randomly assign a CRE to conduct the review. The BH-MCO and assigned CRE will be notified of this assignment.

f. Within two (2) business days of receipt of notice of the assignment of the CRE, the BH-MCO must notify the Member using the template provided by PID's BMC of the name and contact information of the assigned CRE.

g. If PID's BMC fails to select a CRE within 2 business days from receipt of a request for an external Grievance review, the BH-MCO may designate a CRE to conduct a review from the list of CREs approved by PID's BMC. The BH-MCO may not select a CRE that has a current contract or is negotiating a contract with the BH-MCO or its Affiliates or is otherwise affiliated with the BH-MCO or its Affiliates.

h. The BH-MCO must forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the CRE conducting the external Grievance review. The BH-MCO must transmit this information within 15 Days from receipt of the Member's request for an external Grievance review.

i. The BH-MCO must inform the Member that within 15 Days from receipt of the request for an external Grievance review by the BH-MCO, the Member, the Member's representative (if designated), or the Member's Provider may supply additional information to the CRE conducting the external Grievance review for consideration.

The BH-MCO must document in the Grievance record the date the Member was informed that the Member could supply additional information to the CRE conducting the external Grievance review for consideration. The BH-MCO must also inform the Member that the Member must provide the BH-MCO at the same time with copies of the additional information submitted so that the BH-MCO has an opportunity to consider the additional information.

j. Within 60 Days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to the BH-MCO, the Member, the Member's representative, PID's BMC, and the Provider (if the Provider filed the Grievance with the Member's consent) that includes the basis and clinical rationale for the decision. The standard of review must be whether the service was medically necessary and appropriate under the terms of the BH-MCO contract.

k. The external Grievance decision may be appealed by the Member, the Member's representative, or the Provider to a court of competent jurisdiction within 60 Days from the date the Member receives notice of the external Grievance decision.

4. Expedited Grievance Process

a. The BH-MCO must conduct an expedited review of a Grievance if the BH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or if a Member or a Member's representative (if designated) provides the BH-MCO with written certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the Provider's signature.

b. A request for an expedited review of a Grievance may be filed either in writing via mail or fax or be filed orally.

c. The expedited review process is bound by the same rules and procedures as the Grievance review process with the exception of time frames, which are modified as specified in this section.

d. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the Member of the right to present testimony and evidence and make legal and factual arguments, in person as well as in writing and of the limited time available to do so.

e. If the Provider certification is not included with the request for an expedited review and the BH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, the BH-MCO must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within 72 hours from the Member's request for an expedited review, the BH-MCO must decide the Grievance within the standard time frames as set forth in this Appendix, unless the time frame for deciding the Grievance has been extended by up to 14 Days at the request of the Member. If the BH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the BH-MCO must make a reasonable effort to give the Member prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within 2 business days of the decision to deny expedited review, using the Notice of Failure to Receive Provider Certification for an Expedited Grievance template.

f. A Member who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Grievance, if the request for expedited review is filed orally, hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of the BH-MCO's decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of the BH-MCO's decision if any other services are being discontinued, reduced, or changed.

g. Expedited review of a Grievance must be performed by a Grievance review committee made up of 3 or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. The Grievance review committee must include at least one individual who meets the qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity. Other appropriate individuals may participate in the review, but the individual who meets the

qualifications described in Appendix AA, Section C.3 for an individual that can deny a request for services based on medical necessity must decide the Grievance.

i. At least one-third of the Grievance review committee may not be an employee of the BH-MCO or a related subsidiary or Affiliate.

j. The Grievance review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Grievance record.

k. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within either 48 hours of receiving the Provider's certification or 72 hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for decided the expedited Grievance has been extended by up to 14 Days at the request of the Member. The BH-MCO must document a Member's request for an extension in the Grievance record.

l. The BH-MCO must send written notice of the Grievance decision to the Member, Member's representative (if designated), service Provider, and prescribing Provider (if applicable), within 2 business days of the decision using the appropriate Expedited Grievance Decision Notice template:

    i. Overturned: The review committee determined that the evidence presented supports the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

    ii. Partially Overturned: The review committee determined that the evidence presented supports the partial reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

    iii. Upheld: The review committee determined that the evidence presented does not support the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

m. The Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the

Member's behalf, may file a request for an expedited external Grievance review with the BH-MCO within 2 business days from the date the Member receives the BH-MCO's expedited Grievance decision. A Member who files a request for an expedited external Grievance review that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the expedited external Grievance review if the request for expedited external Grievance review is filed orally, hand delivered, faxed, or post-marked within one business day from the mail date on the written notice of the BH-MCO's decision if acute inpatient services are being discontinued, reduced, or changed or within 2 business days from the mail date on the written notice of the BH-MCO's decision if any other services are being discontinued, reduced, or changed

n. A request for an expedited external Grievance review may be filed either in writing or orally.

o. The BH-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external Grievance reviews.

p. The Member or the Member's representative may file a request for a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's expedited Grievance decision.

q. The BH-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Member's request for expedited review of a Grievance.

D. Department's Fair Hearing Requirements

1. Fair Hearing: A hearing conducted by the Department's Bureau of Hearings and Appeals or a Department designee.

2. Department's Fair Hearing Process

a. A Member must file a Complaint or Grievance with the BH-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the BH-MCO failed to provide written notice of a Complaint or Grievance decision within the time frames specified in this Appendix, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

b. The Member or the Member's representative may request a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's Grievance decision for any of the following:

i. The denial, in whole or in part, of payment for a requested service based on lack of medical necessity;
ii. The reduction, suspension, or termination of a previously authorized service;

iii. The denial of a requested service but approval of an alternative service.

c. A Member or the Member's representative may request a Fair Hearing within 120 Days from the mail date on the written notice of the BH-MCO's first level Complaint decision for any of the following:

i. The denial of a requested service because the service is not a covered service;

ii. The failure of the BH-MCO to meet the required time frames for providing a service;

iii. The failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. The denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

v. The denial of payment after a service(s) has been delivered because the service(s) is not a covered service(s) for the Member;

vi. The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

d. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the BH-MCO failed to provide a written notice of the Complaint or Grievance decision within the time frames specified in this Appendix.

e. Requests for Fair Hearings must be mailed or faxed to:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17105-2675
or
717-772-7827

f. A Member who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed. If the request for a Fair Hearing is not hand delivered or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed, services can be discontinued.

g. Upon the receipt of the request for a Fair Hearing, the Bureau of Hearings and Appeals or the Department's designee will schedule a hearing. The Member and the BH-MCO will receive notification of the hearing date by letter at least 10 Days before the hearing date, or a shorter time if requested by the Member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

h. The BH-MCO is a party to the hearing and must be present. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Bureau of Hearings and Appeals' decision is based solely on the evidence presented at the hearing. The absences of the BH-MCO from the hearing will not be reason to postpone the hearing.

i. The BH-MCO must provide Members, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

j. The Bureau of Hearings and Appeals will issue an adjudication within 90 Days of the date the Member filed the first level Complaint or the Grievance with the BH-MCO, not including the number of

Days before the Member requested the Fair Hearing. If the Bureau of Hearings and Appeals fails to issue an adjudication within 90 Days of receipt of the request for the Fair Hearing, the BH-MCO must comply with the requirements at 55 Pa. Code § 275.4 regarding the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process, the time limit by which the Bureau of Hearings and Appeals must issue the adjudication prior to interim assistance being afforded will be extended by the length of the delay attributed to the Member.

k. The Bureau of Hearings and Appeals' adjudication is binding on the BH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within 15 Days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within 30 Days from the date of the adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the BH-MCO.

3. Expedited Fair Hearing Process

a. A Member or the Member's representative may file a request for an expedited Fair Hearing with the Department either orally or in writing.

b. A Member must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.

c. The Bureau of Hearings and Appeals will conduct an expedited Fair Hearing if a Member or a Member's representative provides the Department with a signed written certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process or if the Provider provides testimony at the Fair Hearing which explains why using the usual time frame would place the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function in jeopardy

d. A Member who files a request for an expedited Fair Hearing that disputes a decision to discontinue, reduce, or change a service that the Member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is hand delivered, faxed, or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being

discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed If the request for an expedited Fair Hearing is not hand delivered or post-marked within one Day from the mail date on the written notice of decision if acute inpatient services are being discontinued, reduced, or changed or within 10 Days from the mail date on the written notice of decision if any other services are being discontinued, reduced or changed, services can be discontinued.

e. Upon the receipt of the request for an expedited Fair Hearing, the Bureau of Hearings and Appeals or the Department's designee will schedule a hearing.

f. The BH-MCO is a party to the hearing and must be present. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The absence of the BH-MCO from the hearing will not be reason to postpone the hearing.

g. The BH-MCO must provide the Member, at no cost, with records, reports, and documents, relevant to the subject of the Fair Hearing.

h. The Bureau of Hearings and Appeals will issue an adjudication within 3 business days from receipt of the Member's oral or written request for expedited review.

i. The Bureau of Hearings and Appeals' adjudication is binding on the BH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within 15 Days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within 30 Days from the date of adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the BH-MCO.

E. Provision of and Payment for Services Following Decision

1. If the BH-MCO, the Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny, limit, or delay services that were not furnished during the Complaint, Grievance, or Fair Hearing process, the BH-MCO must authorize or provide the disputed service as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice that the decision was reversed. If the BH-MCO requests reconsideration, the BH-MCO must authorize or provide the disputed service or item pending reconsideration unless the BH-MCO

requests a stay of the Bureau of Hearings and Appeals' decision and the stay is granted.

2. If the BH-MCO, the Bureau of Hearings and Appeals, or the Secretary reverses a decision to deny authorization of services, and the Member received the disputed services during the Complaint, Grievance, or Fair Hearing process, the BH-MCO must pay for those services that the Member received.

3. If the Bureau of Hearing and Appeals affirms a decision to deny authorization of services and the Member did not request reconsideration from the Secretary within 10 Days from the date of the adjudication or the Secretary affirms a decision to deny authorization of services, and the Member received the disputed services during the Complaint, Grievance, or Fair Hearing process, the services can be discontinued.

4. If a Member requests both an external review and a Fair Hearing, and the decisions rendered as a result of both the external review and Fair Hearing are in conflict with one another, the BH-MCO must abide by the decision most favorable to the Member. In the event of a dispute or uncertainty regarding which decision is most favorable to the Member, the BH-MCO must submit the matter to OMHSAS' Quality Assurance/Risk Management Coordinator for review and resolution.

F. Quality Review of Complaints and Grievances

1. The Primary Contractor is responsible for monitoring the Complaint and Grievance processes for compliance with this Appendix and the Program Evaluation Performance Summary (PEPS). The monitoring must include a review of the following:

   a. The Member Handbook to confirm that it describes the Complaint, Grievance, and Fair Hearing processes in accurate and easy to understand language;
   b. Complaint and Grievance decisions to determine if decisions were made within required time frames;
   c. Written notification letters;
   d. Investigations of the Complaint;
   e. When reviews are scheduled to ensure that the reviews are held in a time and place that is convenient for the Member;
   f. Complaint and Grievance trainings; and
   g. The adherence of members of the review committee to the requirements of this Appendix.

2. The Primary Contractor and BH-MCO must provide the Department with evidence of the BH-MCO's compliance with this Appendix. This evidence

must include the percentage of Complaint and Grievance cases, by level, reviewed by the Primary Contractor.

3. If as a result of the Primary Contractor's monitoring of the Complaint and Grievance processes for compliance with this Appendix and PEPS, the Primary Contractor discovers that corrective plans of action and/or follow up activities are needed, the BH-MCO must implement the corrective plans of action and/or follow up activities.

4. When reporting on Complaint decisions, the Primary Contractor must include the following classifications:

    a. Substantiated: The available information supported the Member's Complaint and a corrective plan of action is needed.
    b. Unsubstantiated: The available information did not support the Member's Complaint.

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of CASSP Principles

For County Mental Health Programs

Instructions: The Local CASSP Advisory Committee should receive a copy of the Indicators of the Application of the CASSP Principles Checklist from the County Administrator for completion. In the event that there is no functioning local CASSP Advisory Committee, a committee composed of equal representation of family members, consumers, and professionals should be convened for this purpose. The CASSP Advisory Committee shall then forward the completed document to the MH/MR Administrator's Office for inclusion in the County Plan for submission to OMHSAS.

Please complete the following checklist by denoting the presence of CASSP indicators in the county programs.

1. The first set of indicators address the county programs on a whole. Please indicate a "yes" or "no" response.

2. The second set is applicable to individual agencies. (They can also be found in the HealthChoices Southwest RFP, Appendix I). Please indicate the responses, "All", "Most", "Some", and "Few", that best describe the presence of the agency indicators in the county programs.

3. In addition to checking a response, please provide: a) any necessary explanation in the margins, especially for "no responses, b) any additional county program indicators that were not included in the checklist, and c) a one paragraph narrative summarizing how the principle will be strengthened in plan year 2001-2002.

I. Child-centered

The Principle:

Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

The Indicators for County Mental Health Program:

YES	NO	
[ ]	[ ]	Office staff are courteous, respectful, and willing to assist parents either in person or on the telephone.
[ ]	[ ]	CASSP Coordinator position is filled.
[ ]	[ ]	CASSP Coordinator has a Master's Degree or a minimum of 5 years experience with children's services.
[ ]	[ ]	CASSP Coordinator is a discrete position located in an administrative office, has administrative responsibility for children's services and provides no direct services.
[ ]	[ ]	Credentialing criteria for staff overseeing children's programs reflect personnel qualifications indicative of expertise in child and adolescent growth and development and therapeutic interventions, and experience in child-serving systems.
[ ]	[ ]	Orientation to CASSP values has become an integrated component for new staff in administrative, supervisory, and direct service positions.
[ ]	[ ]	A service plan format for CASSP meetings with a reading level understandable to a child or adolescent is used and is signed by the child or adolescent.
[ ]	[ ]	Adolescents are included in CASSP meetings.
[ ]	[ ]	The county has a Consumer Satisfaction Team and/or Family Satisfaction Team and an adolescent satisfaction survey is included in consumer/family satisfaction protocols.
[ ]	[ ]	When conducting program evaluations, data elements collected include child and adolescent factors identified in the performance outcome measures (POMS).
[ ]	[ ]	CASSP Coordinator is provided with opportunity for training in child/adolescent issues.

Other county level indicators:

[ ]	[ ]	**County staff are familiar with and utilize special communication tools such as qualified interpreters, TTY, large print, Braille, readers, etc. in assisting children and adolescents with special needs from initial intake, through assessment planning, intervention and after care services, and the communication tool of the child/adolescent's choice is utilized.**

All Most Some Few **All Most Some Few**

[ ] [ ] [ ] [ ] county funded agencies demonstrate **[ ] [ ] [ ] [ ]** of the following:

The Indicators for Agencies:

- Toys, children's literature, furniture for small children, and adolescent literature are available in the waiting rooms and offices.
- Credentialing criteria reflect personnel qualifications indicative of expertise in child and adolescent growth and development and therapeutic interventions, and experience in child-serving systems.
- Assessments include the use of tools that are age- and/or developmentally-appropriate.
- The strengths, interests and resources of the child are identified in assessments, treatment plans and progress notes.
- An individualized treatment plan format with a reading level understandable to a child or adolescent is used and is signed by the child or adolescent.
- An adolescent satisfaction survey is included in consumer satisfaction protocols.
- Adolescents are included in interagency team meetings.
- Data elements collected include child and adolescent factors identified in the performance outcome measures (POMS).
- Financial support is given to the training of staff in child and adolescent clinical specialty areas.

Narrative summarizing how the "child-centered" principle will be strengthened in plan year 2001-2002:

II. **Family-focused**

The Principle: *Services recognize that the family is the primary support system for the child. The family participates as full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.*

The Indicators for County Mental Health Programs:

YES NO

[ ] [ ] Information for families, including local family support/advocacy organizations, is available in the office; for example, the PIN newsletter, *Sharing*, Right to Education, etc.

[ ] [ ] Parents/guardians participate as team members in CASSP meetings, or records include documentation of efforts to include them.

[ ] [ ] Parents/guardians sign the CASSP service plan after they have been fully involved in the development of it.

[ ] **[ ]** Personnel work to ensure that office hours and CASSP meetings are available in the evenings and on weekends and at times convenient for the family.

CASSP Indicators for County Mental Health Programs, 1st Edition, 11/21/2017, Page 3.

[ ] [ ] The county has a Family Satisfaction Team and the satisfaction protocols include items specific for families of children and adolescents, such as whether parents perceive themselves to be respected as the primary caretakers for their children, are treated as resources, and are included in decision-making about their child.

[ ] [ ] A CASSP Advisory/Management Committee meets at least quarterly and includes families of children and/or adolescents.

[ ] [ ] A parent/professional co-chair model for the Advisory/Steering Committee has been adopted.

[ ] [ ] Families are included on the county MH Committee.

[ ] [ ] Parents have input into county plans.

[ ] [ ] Parent-led support group(s) meet regularly.

[ ] [ ] Parent leaders routinely participate on child-serving system planning meetings.

[ ] [ ] Parents provide training to professionals on the parent's perspective as a routine segment of orientation and agency training events.

[ ] [ ] Parents are invited to attend provider and administrative training on children's issues.

[ ] [ ] Parents are supported in becoming leaders through scholarships to attend state and national conferences.

[ ] [ ] When parents act as trainers for professionals, they are paid the same honorarium as professional trainers.

[ ] [ ] The county funds a family advocate position.

[ ] [ ] Proposals submitted to state offices for new service initiatives include support letters from parents.

[ ] [ ] Parent leaders or groups agree that the local CASSP project has addressed their concerns.

[ ] [ ] Parents are included in program reviews

[ ] [ ] The county reimburses families for transportation and child-care cots related to participation in county CASSP activities.

Other county level indicators:

[ ] [ ] County staff are familiar with and will provide for and utilize special communication tools such as qualified interpreters, TTY, large print, Braille, readers, etc. in involving families/caregivers with special needs to participate in all phases of planning and treatment for their special needs family member. The communication tool of family's/caregiver's choice is utilized.

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Information for families, including local family support/advocacy organizations, is in the waiting room; for example, the PIN newsletter, *Sharing*; CHADD; Right to Education, etc.
- Parents/guardians participate as team members on treatment teams or any interagency meetings, or records include documentation of efforts to include them.
- Parents/guardians sign the treatment plan after they have been fully involved in the development of it.
- Personnel work to ensure that appointments are available in the evenings and on weekends and at times convenient for the family.
- An agency handbook, which includes a grievance and appeals procedure, is written in clear and understandable language.
- Personnel ensure that families get copies of the agency handbook and understand who to call for help with questions.
- Consumer satisfaction protocols include items specific for families of children and adolescents.
- Families of children and/or adolescents are involved on the agency/management board or a family/community advisory committee to the agency.
- The agency handbook indicates that child and adolescent specialists can be requested by the family to provide treatment services for their child.
- The agency handbook contains information for families regarding the availability of training and education to assist them in supporting their child through the treatment process.

Narrative summarizing how the "family-focused" principle will be strengthened in plan year 2001-2002:

III. **Community-based**

The Principle: *Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.*

CASSP Indicators for County Mental Health Programs, 1st Edition, 11/21/2017, Page 5.

The Indicators for County Mental Health Programs:

YES NO

[ ] [ ] County office maintains a list of resources within the zip code or within 10 miles.

[ ] [ ] Local resource pamphlets - such as (but not limited to) the local library, the YMCA or YWCA, Boys and Girls Clubs - are available in the office.

[ ] [ ] Natural and community resources are used in the CASSP service plan, such as family, neighbors, school, work, leisure and church activities.

[ ] [ ] Orientation to and support for public transportation are available to families.

[ ] [ ] The data system tracks the use of local/community resources.

[ ] [ ] The county funds outreach programs.

[ ] [ ] The staff training schedule includes topics on community resources and understanding the community in which the staff works.

[ ] [ ] The county has identified gaps in the service system and has developed a plan to address them.

[ ] [ ] The county maintains records of community involvement and participation in activities including public meetings, hearings, and discussions.

Other county level indicators:

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Resources within the zip code or within 10 miles are used.
- Local resource pamphlets - such as (but not limited to) the local library, the YMCA or YWCA, Boys and Girls Clubs - are available in service management offices.
- Natural resources are used in each treatment plan, such as family, neighbors, school, work, leisure and church activities.
- Orientation to and support for public transportation are available to families.
- The data system tracks the use of local/community resources.
- There is a policy/procedure to reach out to families and their children when needed.
- The staff training schedule includes topics on community resources and understanding the community in which the staff works.
- If community-based resources are not available for a family, there is an administrative/financial plan to address the service gap.
- Records of community involvement and participation are maintained.

Narrative summarizing how the "community-based" principle will be implemented in plan year 2001-2002:

IV. **Multi-system**

The Principle: *Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.*

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	A CASSP Advisory/Management Committee meets at least quarterly and includes representatives of each of the child-serving systems.
[ ]	[ ]	Directors of MH/MR, Drug & Alcohol, Children and Youth, Special Education, Juvenile Probation, meet at least quarterly to discuss children's issues.
[ ]	[ ]	The CASSP Coordinator is responsible for assuring coordination among MH providers and child-serving systems in the county.
[ ]	[ ]	Intersystem children's needs assessment occurs on an annual basis with input from all CASSP participants.
[ ]	[ ]	Intersystem professionals have input into county plans.
[ ]	[ ]	CASSP projects provide input for annual plans which address local children's service gaps and priorities for agencies including Children and Youth, Education/Special Education, Drug & Alcohol, Juvenile Probation, Mental Health, and Mental Retardation.
[ ]	[ ]	Cross-system training occurs routinely, and/or agencies routinely invite other system staff to scheduled training.
[ ]	[ ]	An intersystem conflict resolution process is established and reviewed/revised as needed.
[ ]	[ ]	An intersystem release of information procedure is established and integrated into staff orientations.
[ ]	[ ]	An intersystem forum to develop/review treatment/service plans for children needing multi system support meets regularly with all major child-serving systems participating.
[ ]	[ ]	Child-serving system directors have formal or informal input into the CASSP Coordinator's performance evaluation.
[ ]	[ ]	Fiscal procedures to implement shared funding of children's services are developed.

[ ] **[ ]** The local ideal system of care for children has been described.

[ ] [ ] Proposals for new children's services to state offices routinely include support letters from each of the child-serving systems.

[ ] [ ] Procedures to coordinate discharge planning for children and adolescents returning from community inpatient units, residential treatment centers, mental retardation centers, youth development centers and forestry camps and/or other out-of-county group care settings are established with mechanisms to ensure continuity for the child, aftercare, and establishment of "lead" or joint case management.

[ ] [ ] A local Student Assistance Program coordinating mechanism is in place.

[ ] [ ] Each of the major child-serving systems agrees that the local CASSP project has addressed intersystem issues which affect their own target populations.

[ ] [ ] Shared funding of children's services based on an individualized service plan occurs routinely for children/adolescents requiring multi-system support.

[ ] [ ] Early Intervention issues and coordination have been addressed by the system directors.

Other county level indicators:

All	**Most**	**Some**	**Few**		**All**	**Most**	**Some**	**Few**	
[ ]	**[ ]**	**[ ]**	**[ ]**	county funded agencies demonstrate	**[ ]**	**[ ]**	**[ ]**	**[ ]**	of the following:

The Indicators for Agencies:

- Families and, if they choose, an advocate/support person participate in the interagency meeting as members of the team.
- Interagency team meetings are held in a convenient and comfortable room with access to blackboard/newsprint, etc.
- At a minimum, mental health and education personnel are involved in interagency team meetings for children and adolescents who are of school age.
- Child-serving systems and other persons/informal support systems involved with the child are included in the treatment process as documented in telephone calls, conferences and interagency meetings.
- Letters of agreement with each child-serving system are current (for each fiscal year) and include a conflict resolution protocol.
- Procedures are written for convening the interagency team, including when meetings are called, who calls them and who leads them.
- Each child's service plan reflects the contribution of each involved service system.
- The data system reports cross-system outcome measures.
- Individual practitioners/agency/MCO staff are knowledgeable and participate in the county child-serving system's collaborative structure.

CASSP Indicators for County Mental Health Programs, 1st Edition, 11/21/2017, Page 10.

- Progress notes reflect a summary of interagency team meetings and attendees, and are distributed to the team.

Narrative summarizing how the "multi-system" principle will be strengthened in plan year 2001-2002:

V. Culturally competent

The Principle: *Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, custom, language, rituals, ceremonies and practices characteristic of a particular group of people.*

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	A CASSP Advisory/Management Committee meets at least quarterly and includes persons representing the cultural diversity of the county.
[ ]	[ ]	The county office has resources and materials that reflect the cultural diversity of the county.
[ ]	[ ]	Persons of various cultural backgrounds representative of the county have input into county plans.
[ ]	[ ]	Cross-system training includes a component on cultural competence for administrators, supervisors, and direct service staff.
[ ]	[ ]	Orientation procedures to county staff include cultural competence values and issues.
[ ]	[ ]	Persons of color, ethnic and religious groups are provided the opportunity to comment on the cultural appropriateness of the service they or their child received.
[ ]	[ ]	Assessment of the cultural diversity and competencies of local staff and clients has promoted the development of strategies to move toward a culturally competent system of care.
[ ]	[ ]	Local CASSP network mailing list includes ministers, churches, cultural centers, and community leaders who represent/service African, Latino, Asian, or Native American cultures.

CASSP Indicators for County Mental Health Programs, 1st Edition, 11/21/2017, Page 12.

[ ] **[ ]** County administrative and direct care staff represent the cultural diversity of the county.

[ ] **[ ]** Consumer and family satisfaction protocols include questions tailored to ethnic communities.

Other county level indicators:

[ ] [ ] County staff are trained in Deaf Culture and other cultures, communication skills and the distinction related to language, syntax, and expression of feelings in the culture.

[ ] [ ] County staff are trained in the protocol and use of interpreters.

All Most Some Few **All Most Some Few**

[ ] [ ] [ ] [ ] county funded agencies demonstrate **[ ] [ ] [ ] [ ]** of the following:

The Indicators for Agencies:

- Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the cultural diversity of the people served by the agency.
- Waiting rooms and offices have literature reflecting the ethnic groups in the community.
- The schedule of regular staff training includes cultural competence development, and related topics.
- Introductory cultural competency trainings for staff incorporate the following elements:
  - overview of cultural competence including specifics on local cultural diversity
    - the principles of cultural competency development
    - conducting psychiatric and psychological assessments applicable to the individual's cultural context
    - treatment planning appropriate to the individual, family, and cultural context
    - integrating community supports and resources
    - considering and using non-traditional methods and services
    - direct service provision and effectively engaging minorities in treatment
    - more advanced trainings involve issues and related topics
- Service delivery reflects:
    - psychiatric assessments which incorporate an appreciation of the child's or adolescent's culture and level of acculturation
    - treatment plans/consultations which involve or reflect the family's cultural perspective
    - up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
    - recognition of the importance of religion, religious expression and religious institutions
    - services available from clinical staff who speak the language understood by children and families or who use interpreters
    - interagency meetings which welcome extended family members
    - recognition of culturally relevant holidays and traditions
    - tracking of completion rates for appointments by ethnicity, age, and gender
- Administrative and treatment staff represent the cultural diversity of the community the agency serves.
- Minority members participate at the policy-making and administrative/monitoring levels.
- Advisory boards include minority membership.

CASSP Indicators for County Mental Health Programs, 1st Edition, 11/21/2017, Page 14.

- Consumer satisfaction protocols include questions tailored to ethnic communities.

Narrative summarizing how the "culturally competent" principle will be strengthened in plan year 2002-2002:

VI. Least restrictive/least intrusive

The Principle: *Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.*

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	Review of service data over the past several years shows a decrease in out-of-state and out-of- county placements; a decrease in inpatient days; a decrease in residential treatment days; an increase in community-based utilization, especially use of natural supports.
[ ]	[ ]	The county maintains a list of available local resources.
[ ]	[ ]	County staff communicate with children and their families to ensure there is comfort with the intensity and frequency of services, especially those services that are provided in the home, the school, or other natural locations.
[ ]	[ ]	Family-friendly consolidation by county staff in the scheduling of appointments is apparent so that it is efficient for the family both in time and location.
[ ]	[ ]	In-home, in-school and in-community resources are considered by the county before out-of- home placement, or as part of a discharge plan when returning from placement.
[ ]	[ ]	Justification for each service or placement considered for children and adolescents is documented by the county.
[ ]	[ ]	The family has a voice in the process of identifying appropriate providers and staff for various in-home services.

Other county level indicators:

All	Most	Some	Few		All	Most	Some	Few

[ ] **[ ]** **[ ]** **[ ]** county funded agencies demonstrate **[ ]** **[ ]** **[ ]** **[ ]** of the following:

The Indicators for Agencies:

- Family-friendly consolidation in the scheduling of appointments is apparent so that it is efficient for the family both in time and location.
- The community integration questionnaire is used to ensure the use of least restrictive services.
- In-home, in-school and in-community resources are safely used first before out-of-home placement is considered or as part of a discharge plan when returning from placement.
- Justification for each service or placement considered is documented.
- The family has a voice in the process of identifying appropriate providers and staff for various in-home services.

Narrative summarizing how the "least restrictive/least intrusive" principle will be strengthened in plan year 2001-2002:

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF Human Services

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of CSP Principles

For County Mental Health Programs

Instructions: The Local CSP Advisory Committee should receive a copy of the Indicators of the Application of the CSP Principles Checklist from the County Administrator for completion. In the event that there is no functioning local CSP Advisory Committee, a committee composed of equal representation of family members, consumers, and professionals should be convened for this purpose. The CSP Advisory Committee shall then forward the completed document to the MH/MR Administrator's Office for inclusion in the County Plan for submission to OMHSAS.

Please complete the following checklist by denoting the presence of CSP indicators in the county programs.

1. The first set of indicators address the county programs on a whole. Please indicate a "yes" or "no" response.

2. The second set is applicable to individual agencies. Please indicate the responses "All", "Most", and "Some", or "Few", that best describe the presence of the agency indicators in the county program.

3. In addition to checking a response, please provide: a) any necessary explanation in the margins, especially for "no" responses, b) any additional county program indicators that were not included in the checklist, and c) a one paragraph narrative summarizing how the principle will be strengthened.

I. ***Consumer-center/Consumer-empowered***

The Principle:

Services are organized to meet the needs of each consumer, rather than the needs of the managed care program or needs of service providers. Services incorporate consumer self-help approaches and are provided in a manner that allows persons to retain the greatest possible control over their own lives.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	County office staff are courteous, respectful, and willing to assist consumers and family members either in person or on the telephone.
[ ]	[ ]	There is a county staff person designated as the CSP Liaison.
[ ]	[ ]	County staff overseeing adult mental health services reflect appropriate qualifications, including orientation to and training in CSP principles.
[ ]	[ ]	The county has integrated orientation to CSP values for all has become an integrated new county administrative, supervisory, and direct service staff.
[ ]	[ ]	County staff, including case managers, consider consumer choice and preference in the selection of services and treatment.
[ ]	[ ]	Consumers are included in CSP meetings.
[ ]	[ ]	Data elements collected by the county during program evaluations include factors identified in the state Performance Outcome Management System (POMS) and reflects outcomes important to consumers (e.g., employment, housing, transportation, and social supports).
[ ]	[ ]	The CSP Liaison is provided opportunity for training in adult mental health issues.
[ ]	[ ]	County staff encourage family members to participate in service and treatment decisions.
[ ]	[ ]	Consumers are integrally involved in planning, developing, and implementing new services and in the evaluation of services.
[ ]	[ ]	Consumers and families are involved in the county plan development.
[ ]	[ ]	Consumer and families participate in the budget meetings with county and state mental health staff.
[ ]	[ ]	The county program promotes and funds consumer self-help and consumer-run alternatives.

[ ] [ ] County personnel policies and practice encourage the hiring of consumers as staff, consultants, and trainers.

[ ] [ ] The county program uses people first language in all written materials (e.g., people with schizophrenia, not schizophrenics).

[ ] [ ] The county program makes information available to consumers on the self-help philosophy and statewide and local consumer organizations.

[ ] [ ] Notice of public/special hearings is widespread throughout the mental health community as well as in newspapers at least two weeks prior to the event.

[ ] [ ] Public/special hearings are held in locations accessible to public transportation, or transportation is arranged where no public transportation exists.

[ ] [ ] County staff are trained on consumer self-help approaches and the concept of recovery from mental illness.

[ ] [ ] Consumers are involved in all service and treatment decisions affecting their lives and given choice and preference in accessing/utilizing services.

Other county level indicators:

[ ] [ ] Consumers with special needs, including but not limited to persons who are deaf, hard of hearing, deafblind, elderly, etc and their families, are involved in county plan development, program assessment of need, implementation and evaluation of services, and participate in budget meetings with county and state mental health staff.

[ ] [ ] County staff are familiar with and utilize special communication tools such as qualified interpreters, TTY, large print, braille, readers, etc. in assisting consumers with special needs from initial intake, through assessment, planning, intervention and after care services, and that the communication tool of the consumer's choice is utilized.

All	**Most**	**Some**	**Few**		**All**	**Most**	**Some**	**Few**	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Consumers are integrally involved in designing and evaluating services.
- Consumer preferences are honored whenever possible (e.g., therapist/case manager, decor, living arrangements, programming, food selection, etc.).
- Consumer self-help and consumer-run alternatives are promoted and funded.
- Individual strengths, interests and resources are identified in assessments, treatment plans and progress notes.
- Treatment/service plans reflect consumer involvement in goal setting and decisions regarding services. Consumers' signatures appear on all treatment/service plans, or an explanation of why the consumer has not signed is noted.
- Personnel policies encourage the hiring of consumers as staff, consultants, trainers.
- Consumer confidentiality is honored.
- People First language is used in all written materials (e.g., people with schizophrenia not schizophrenics).

Information is available to consumers on self-help philosophy and statewide and local consumer organizations.

YES NO

- Data collection reflects outcomes important to consumers (e.g., employment, housing, social supports).
- Provider staff are trained on the concept of recovery from mental illness and promote recovery concepts to consumers

Narrative summarizing how the "consumer-centered/consumer-empowered" principle will be strengthened:

II. Culturally Competent

The Principle:
Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are designed and delivered to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices of an individual or a particular group of people.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	A County CSP Committee meets regularly and includes persons reflective of the county cultural/ethnic groups.
[ ]	[ ]	The county office has resources and materials that reflect the cultural diversity of the county.
[ ]	[ ]	Persons from minority cultures have input into county plans.
[ ]	[ ]	Training includes a component on cultural competence for administrators, supervisors, and direct service staff.
[ ]	[ ]	Training teams represent the ethnic groupings of the county.
[ ]	[ ]	Orientation procedures to county staff include cultural competence values and issues along with other CSP values.
[ ]	[ ]	Consumer satisfaction surveys include a request for persons of cultural minorities to comment on the cultural appropriateness of the service they received.
[ ]	[ ]	Assessment of the cultural diversity and competencies of local staff and clients are used in the development of strategies to move toward a culturally competent system of care.
[ ]	[ ]	Local CSP network mailing list includes ministers, churches, cultural centers, and community leaders who represent/serve African, Latino, Asian, Native American, or other local cultural groups.
[ ]	[ ]	Administrative staff represent the cultural diversity of the county.
[ ]	[ ]	Consumer and family satisfaction protocols include questions tailored to ethnic communities.

Other county level indicators:

[ ] [ ] County staff are trained in Deaf Culture and other cultures, communication skills and the nuances related to language, syntax, and expression of feelings in the culture.

[ ] [ ] County staff are trained in the protocol and use of interpreters.

All	**Most**	**Some**	**Few**		**All**	**Most**	**Some**	**Few**	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the diversity of the population the agency serves.
- Waiting room and offices have literature reflecting the ethnic groups in the community.

- The schedule of regular staff training includes cultural competency development, and related topics.
- Introductory cultural competency trainings for staff incorporate the following elements:
    - overview of cultural diversity
    - the principles of cultural competency development
    - conducting psychiatric and psychological assessments applicable to the individual's cultural context
    - treatment planning appropriate to the individual, family, and cultural context
    - integrating community supports and resources
    - considering and using non-traditional methods and services
    - direct service provision and effectively engaging minorities in treatment
- Service delivery reflects:
    - psychiatric assessments which incorporate an appreciation of the consumer's culture and level of acculturation
    - treatment plans/consultations which involve or reflect the family's cultural perspective
    - up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
    - recognition of the importance of religion, religious expression and religious institutions

  - services available from clinical staff who speak the language understood by the consumer or who use interpreters
  - interagency meetings which welcome extended family members
  - recognition of culturally relevant holidays
  - tracking of completion rate for appointments by ethnicity, age and gender
- Administrative and treatment staff represent the cultural diversity of the community the agency serves.
- Minority members participate at the policy-making and administrative/monitoring levels.
- Advisory boards include minority membership.
- Consumer satisfaction protocols include questions tailored to ethnic communities.

Narrative summarizing how the "culturally competent" principle will be strengthened:

III. Flexible

The Principle: *The development and delivery of services and supports are flexible as possible in order to meet the needs of a wide diversity of persons in the geographic area. Flexibility includes having a wide variety of services, of variable intensity available at a wide range of times, and delivered in a wide range of environments.*

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	The county, through its provider system, delivers a full array of services and treatment.
[ ]	[ ]	The county ensures consumer choice in treatment plans and support services.
[ ]	[ ]	County staff are accessible and available during non-business hours.
[ ]	[ ]	County staff credentialing standards support the provision of rehabilitative, self-help, and alternative treatment services, as well as traditional mental health approaches.

[ ] [ ] The county has an outreach team to identify people in need of mental health services.

Other county level indicators:

[ ] [ ] The county has an outreach team to identify elderly people and other people with special needs who are in need of mental health services.

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- A full array of treatment, rehabilitation and support services are available in accessible locations.
- Day, evening and weekend hours are available.
- Services are delivered at a variety of locations, including the consumer's home or community as appropriate.
- Type and duration of service is based on consumer need.
- Staff credentialing standards recognize expertise in rehabilitative, self-help and alternative treatment approaches.

Narrative summarizing how the "flexible" principle will be strengthened:

IV. **Meet Special Needs**

The Principle:
Services are adapted to meet the special needs of people with mental illness who are affected by one or more of such factors as old age, substance abuse, physical disability, loss of sight/hearing, mental retardation, homelessness, HIV/AIDS, and involvement in the criminal justice system.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	The county program actively collaborates with other human service agencies to meet the needs of consumers with special needs.

[ ] [ ] The county program supports creative inter-agency agreements, collaborative funding, and cross-system training of staff.

[ ] [ ] The county program tracks and/or coordinates outreach to special needs populations.

[ ] [ ] The county solicits input from other service agencies when planning, developing, or expanding services.

[ ] [ ] County staff training includes modules on special populations.

[ ] [ ] The county program has designated staff specialists for special populations.

Other county level indicators:

[ ] [ ] The county program actively seeks and utilizes input from persons with special needs, their family members and advocates, in the development of county plans.

[ ] [ ] The county program provides the necessary communication tools/qualified interpreters/large print materials/assistive hearing devices, etc. to enable persons with special needs to participate in the county plan development.

[ ] [ ] The county program ensures that a discharge plan for those being discharged from the criminal justice system involves networking with the criminal justice system and all systems which will enable a successful transition.

All Most Some Few **All Most Some Few**
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Representatives from other service systems are involved in developing/implementing the treatment/service plan of persons with special needs.
- Staff specialists are available/trained to meet the diverse needs of consumers, as outlined above.

- Timely mobile outreach is provided to specialty populations including persons who are elderly, homeless and involved in the criminal justice system.
- Data systems track service utilization and outcomes specific to special populations.
- TDD telephone access, sign language interpreters, Braille materials and other assistive devices are available, as needed.
- Creative interagency agreements and funding focus on the total needs of the individual (cross-training of staff, co-location of staff, etc.).

Narrative summarizing how the "meet special needs" principle will be strengthened:

V. **Accountable**

The Principle:
Service providers are accountable to the users of the services. Consumers and their families are involved in planning, implementing, monitoring and evaluating services.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	The county program supports CSP activities at local, regional, and state levels.
[ ]	[ ]	The county ensures consumers understand service options and how to access services.
[ ]	[ ]	County documents including county annual plans, reports, and newsletters are written in language that is understandable to consumers.
[ ]	[ ]	The county program provides a consumer-friendly complaint, grievance, and appeal system.
[ ]	[ ]	The county program collects consumer satisfaction data, and prepares and distributes reports to consumers, advocates, and providers.
[ ]	[ ]	The county maintains a continuous quality improvement plan for services, outcomes, and access.

[ ] [ ] The county has a consumer satisfaction team (which is independent of county providers, staffed by consumers/family members, and where members earn competitive wages.)

[ ] [ ] Consumer satisfaction data indicates that consumers and families are treated with respect and dignity.

Other county level indicators:

[ ] [ ] Consumer satisfaction data indicates that input has been sought from consumers with special needs, such as persons who are deaf, hard of hearing, deafblind, elderly, having HIV/AIDS, etc. and that the data indicates that consumers with special needs are treated with respect, dignity, and that they understand service options, and how to access services.

[ ] [ ] The county has open/closed captioned videos, large print materials, assistive hearing devices and other communication tools available to help consumers with special needs understand their rights, service options and how to access services.

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Consumers and families are integrally involved in the design, development and evaluation of services. This includes:
    - Consumer satisfaction teams.
    - Consumer/family membership on governing/advisory boards.
    - Information on services, diagnoses, medications, etc. is available and written in consumer friendly language.
- The member handbook/policies and procedures, which includes grievance and appeal procedures, is written in clear and understandable language.
- Personnel ensure that consumers receive copies of the member handbook/policies and procedures and understand who to call for help with questions.

- The agency has positive outcome measures aimed towards stabilization/growth in functioning, increased consumer satisfaction, etc.
- The agency has a balanced focus on cost, quality, outcome and access, when evaluating program success.
- Data and standards related to demographics, budgets/expenditures, criteria for service authorizations, complaints/appeals, outcomes, etc. are provided to consumers/families and advocates for review.

Narrative summarizing how the "consumer-centered/consumer-empowered" principle will be strengthened:

VI. **Strengths-Based**

The Principle:
Services build upon the assets and strengths of consumers to promote growth and movement toward independence.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	The county program promotes recovery from mental illness.
[ ]	[ ]	The county program facilitates opportunities for consumer growth and independence.
[ ]	[ ]	The county program assures that assessments, treatment/service plans, and progress notes highlight and capitalize on each individual's strengths, assets, skills and talents.
[ ]	[ ]	The county program assures that written materials support People First language and the role of the consumer as a key partner in the recovery process.
[ ]	[ ]	The county maintains a continuum of services allowing individuals to maintain the highest level of independence possible.

[ ] [ ] Self-help and consumer run services are funded and available.

Other county level indicators:

[ ] [ ] The county continuum of services allows individuals who have special needs to maintain the highest level of independence possible and the county networks with advocacy groups for persons with special needs to identify all resources available for the consumer to maintain the highest level of independence possible.

All	**Most**	**Some**	**Few**		**All**	**Most**	**Some**	**Few**	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Service interventions promote a wellness, not illness, focus.
- Assessments, treatment/service plans and progress notes highlight and capitalize on each individual's strengths, assets, skills and talents.
- Written materials support People First language and the role of consumer as a key partner in the recovery process.
- Staff are trained in the concept of recovery from mental illness.
- The concept of recovery is promoted by providers.

Narrative summarizing how the "strengths-based" principle will be strengthened:

VII. Community-Based/Natural Supports

The Principle:
Services are offered in the least coercive manner and most natural setting possible. Consumers are encouraged to use the natural supports in the community and to integrate into the living, working, learning, and leisure activities of the community.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	County office maintains a list of resources within the zip code or within 10 miles.
[ ]	[ ]	Local resource pamphlets describing natural community supports are available in the county office.
[ ]	[ ]	Natural and community resources are used in service plans, such as family, neighbors, work, leisure and church activities, and service and community organizations.
[ ]	[ ]	Orientation to and support for public transportation are available to families.
[ ]	[ ]	The data system tracks the use of local/community resources.
[ ]	[ ]	The county funds outreach programs.
[ ]	[ ]	The staff training schedule includes topics on community resources and understanding the community in which the staff works.
[ ]	[ ]	The county has identified gaps in the service system and has developed a plan to address them.
[ ]	[ ]	The county maintains records of community involvement and participation in activities including public meetings, hearings, and discussions.

Other county level indicators:

[ ]	**[ ]**	**The county office insures that its staff and the contract provider staff are knowledgeable of and utilize natural and community supports which benefit consumers with special needs. Staff training includes presentations from consumers with special needs, as well as their family members and advocates.**

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Community based resources/services within the zip code or within 10 miles are used.
- Pamphlets/information on local resources and services are made available through administrative entities and provider agencies.
- Training and support in finding and using transportation is available to consumers.
- Natural resources are used in each treatment plan, such as housing, work, leisure and church activities.
- Consumers are encouraged to develop advance directives in preparation for crises for staff/family to follow.
- Individuals identified by the consumer as supports should be incorporated into the treatment/service plan.
- The data system tracks the use of local/community resources.
- There is a policy/procedure to reach out to consumers and their families when needed.
- The staff training schedule includes topics on community resources and understanding the community in which the staff works.

Narrative summarizing how the "community-based/natural supports" principle will be strengthened:

VIII. **Coordinated**

The Principle:
Services and supports are coordinated on both the local system level and on an individual consumer basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Agencies must work in collaboration to meet the variety of needs that people with psychiatric disabilities have.

The Indicators for County Mental Health Programs:

County staff orientation and training includes an overview of various human services agencies.

YES NO

[ ] [ ] County program staff are designated as liaisons with other human service systems.

[ ] [ ] County staff are available to provide orientation to other agencies regarding mental health services.

[ ] [ ] The county program ensures that written agreements/plans for coordination are in place with providers and agencies including: state-hospitals, medical services providers, social services agencies, and police and corrections offices.

Other county level indicators:

[ ] [ ] The county staff and contracted provider staff receive and provide orientation to agencies serving persons who have special needs. These agencies include but are not limited to the Office for the Deaf and Hard of Hearing, The Department of Aging and the Area Agencies on Aging, the Coalition for the Homeless, etc.

All Most Some Few **All Most Some Few**
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Written agreements/plans for coordination are in place with the following:
  - State hospitals.
  - Medical services providers/insurers. (This should include a good baseline medical work-up, coordination in monitoring physical and neurobiological services, etc.)
  - Social service agencies (Offices of aging, vocational rehabilitation, housing authorities, drug and alcohol programs, homeless shelters, legal services, etc.)
  - Police departments, district justices, jails and prisons, etc.
- Staff are designated as liaisons to other service agencies in order to plan and facilitate services.

- Staff development/training involves overview of service agencies in area (e.g., policies, procedures, mission statement, regulations, etc.).

Narrative summarizing how the "coordinated" principle will be strengthened:

DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS
Principles of Effective Treatment

Background

Alcohol and other drug abuse and dependency treatment services must be provided by facilities licensed by the Department of Drug and Alcohol Programs, Division of Drug and Alcohol Licensure, to ensure that minimum standards are being maintained to protect the health, safety and welfare of the individual.

Philosophy

Substance abuse and dependence are primary diseases, not symptoms of other underlying conditions. Substance use disorders can be diagnosed, are responsive to treatment and are complex behavioral disabilities usually having chronic medical, social and psychological components, which result in multiple negative consequences. Substance abuse and dependence related problems affect not only the dependent individual, but other family members, particularly children. Denial is a central characteristic or symptom of substance abuse and dependence that complicates an individual's ability to acknowledge a problem.

Principles

- **Treatment needs to be readily available**. Because individuals diagnosed with a substance use disorder may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

- **No single treatment is appropriate for all individuals**. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

- **Effective treatment attends to multiple needs of the individual, not just his or her substance use**. To be effective, treatment must not only address the individual's substance use but any associated medical, psychological, social, vocational, and legal problems.

- **Individuals diagnosed with a substance use disorder and with a coexisting mental disorders should have both disorder treated in an integrated way**. Because addictive disorders and mental disorders often occur in the same individual, persons presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder. Both disorders are considered primary.

- **Treatment should be person specific** and guided by an individualized treatment plan based upon a face to face comprehensive biopsychosocial evaluation of the person and when possible, a comprehensive evaluation of the family as well.

- **Counseling (individual and group) and other behavioral therapies are critical components of effective treatment for substance use disorder**. In therapy, the person addresses issues of motivation, build skills to resist substance use, replace substance-using activities with constructive and rewarding nonsubstance-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

- **Self-help groups such as Alcoholics Anonymous, Narcotics Anonymous and Double Trouble are essential adjuncts to the treatment process**. Attendance should be encouraged when appropriate.

- **Medications are an important element of treatment for many individuals,** especially when combined with counseling and other behavioral therapies. Methadone and buprenorphine are very effective in helping individuals dependent upon opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some individuals diagnosed with opiate dependency as well as a co-occurring alcohol dependence. For persons dependent upon nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For individuals diagnosed with mental disorders, both behavioral treatments and medications can be critically important.

- **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases**, and counseling to help individuals modify or change behaviors that place themselves or others at risk of infection. Counseling can help individuals avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

- **Remaining in treatment for an adequate period of time is critical for treatment effectiveness**. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most people, the threshold of significant improvement is reached at about 3 months in treatment. Treatment may include Residential care followed by Intensive Outpatient care or Partial treatment followed by Outpatient care, or any movement through the level of care continuum. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep people in treatment.

- **Recovery from substance use disorders can be a long-term process and frequently requires multiple episodes of treatment**. As with other chronic illnesses, relapses to substance use can occur during or after successful treatment episodes. Individuals diagnosed with a substance use disorder may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining long-term abstinence.

- **Treatment does not need to be voluntary to be effective**. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of substance use treatment interventions.

- **Persons recovering from substance use disorders are viewed as important resources in the statewide service system**. As representatives of the recovering community, persons in recovery serve as an inspiration to the individuals struggling with a substance use disorder. As a practicing professional they provide an empathetic and knowledgeable approach to treatment philosophy, offer valuable input into the recovering community network, and serve as a voice for advocacy.

The majority of the above Principles are adapted from the National Institute of Drug Abuse (NIDA).

BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS (BH-MCOs)
PERFORMANCE/OUTCOME MANAGEMENT SYSTEM (POMS)

A. OVERVIEW

The POMS consists of a database that is updated on a periodic basis through batch data file extracts that are obtained from a variety of data sources (see attached table of outcome measures and data sources). The database, which is maintained and managed by the Department of Human Services (DHS), contains an extensive array of raw data concerning enrollees in the BH-MCOs. The primary purpose of the database is to serve as the basis for producing a set of performance measures/indicators. The Department will utilize the performance measures/indicators as its primary tool for continuously evaluating the effectiveness of the BH-MCO contractors in achieving a variety of systems level outcomes.

The POMS serves the following primary functions:

(1) Provides accountability for public funds expended through the Department's capitation payments to the BH-MCO contractors.

(2) Provides a fair and objective evaluation of the BH-MCOs that the Department can use for implementing outcome oriented incentives and sanctions.

(3) Supports the Department and the BH-MCO contractors to implement a collaborative continuous Quality Improvement process.

B. DATA COLLECTION PROCESSES

Raw data concerning BH-MCO enrollees, obtained from a variety of sources, will be transmitted via batch file extracts to the POMS central database (see attached flow chart). The data will be linked and integrated for each BH-MCO enrollee based on unique identifiers. The integrated database will provide the basis for DHS to derive quantitative performance indicators/measures that reflect systems level outcomes achieved by each BH-MCO primary contractor. The primary data sources and data collection processes are as follows:

(1) BH-MCO Encounter Data - BH-MCOs, through a process similar to what DHS required for the HealthChoices PH-MCOs, will submit data files on a regular schedule to DHS. The data will be edited and then loaded into DHS's Enterprise Data Warehouse. The Office of Mental Health and Substance Abuse Services (OMHSAS) will, on a regular schedule, receive a file of all DHS accepted encounter records and will perform additional edits before loading to the POMS central database.

(2) Enrollee Eligibility and Demographic Data - DHS will on a regular schedule move enrollee eligibility and demographic data from its Client Information System (CIS) into the Enterprise Data Warehouse. OMHSAS will subsequently pull a subset of eligibility and demographic data elements via data file extracts into the POMS central database.

(3) Secondary Data - OMHSAS will develop data exchange agreements with other state agencies, as feasible, to obtain regularly scheduled data file extracts that will be loaded into the POMS central database. Data exchanges with state agencies such as the Department of Corrections, State Police and the Department of Education are under development.

(4) Consumer/Family Satisfaction Reports - There will be standardized measures administered by the BH-MCO. A Co-occurring Disorder (COD) question must be included on the survey and a sampling of COD consumers must be surveyed. The BH-MCO will submit reports of findings to the DHS. A survey will be conducted annually.

(5) BH-MCO Consumer Registry File - BH-MCOs will maintain a computerized registry of their enrollees who have accessed behavioral health services. The registry is comprised of a minimum data set including clinical descriptions such as priority population and critical dates during the episode of care such as date of first service request, registration date and termination date. These data will be submitted by the BH-MCOs to the POMS central database.

(6) BH-MCO Quarterly Status File - BH-MCOs will maintain a computerized file concerning the status of priority populations. The file will be updated on a calendar quarter basis for each enrollee in the priority population. The quarterly status file is comprised of a minimum data set including outcome measures such as vocational/educational status and independence of living arrangement. These data will be submitted by the BH-MCOs to the POMS central database on a regular schedule.

(7) Performance Indicator Reports - On a regular schedule, DHS will produce from the POMS central database a set of performance indicators that measure the performance of each BH-MCO consistent with the outcome dimensions outlined in the attached table of outcome measures. The performance indicator reports will be issued by DHS on a regular schedule to all relevant DHS monitoring staff, the BH-MCOs and other stakeholder groups.

C. CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS

The Department encourages the BH-MCOs to implement a Continuous Quality Improvement (CQI) process based upon Deming's 14-point program for managed adapted to the health care industry, and Joint Commission on Accreditation of Health Care Organization (JCAHO) guidelines. The overall process should include:

- Delineating the scope of the services to be monitored and improved.
- Identifying the important aspects of the services whose quality should be examined and improved.

- Identifying indicators (including but not limited to the performance indicators established by DHS) that will be used to monitor the quality, accessibility and appropriateness of the important aspects of services.

- Establishing thresholds (including but not limited to the thresholds established by DHS) for the review of indicators that become "flags" signaling the need for further analysis of the causes for the data reported to DHS.

Collecting data pertaining to each indicator and comparing the aggregate level of performance with the threshold for analysis. If the threshold is not reached, further analysis may not be necessary.

- Initiating analyses of other important aspects of services when thresholds have been reached.

- Taking actions to improve the aspects of services.

- Reporting the findings to the organizations involved, including a report of findings to DHS on a regular schedule. Monitoring and analysis are continued in order to identify any future deficiencies in services and to improve quality.

DHS monitoring staff will review the CQI reports of findings submitted by the BH-MCOs. DHS monitoring staff will provide feedback to BH-MCOs indicating:

(1) Concurrence with the BH-MCOs explanation/cause of the performance indicator findings and actions proposed by the BH-MCOs to improve performance (and/or correct deficiencies); or

(2) Offer alternative explanations/causes for the performance indicator findings and/or recommended alternative actions to improve performance (and/or correct deficiencies).

BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS
PERFORMANCE/OUTCOME MANAGEMENT SYSTEM

OUTCOME DIMENSIONS	DATA SOURCE(S)
*1. Increase Community Tenure and Less Restrictive Services** ▪ Increase the appropriate use of behavioral health inpatient days. ▪ Decrease criminal incarcerations. ▪ Increase the appropriate use of MH residential care. ▪ Decrease out-of-home placements. ▪ Decrease homelessness. ▪ Increase residential stability. ▪ Decrease patient days in state mental hospitals. *To be reported/compiled only for priority group consumers by age group (under age 21, 21-64 and age 65+).	1. Quarterly Status File (QSF)[1] 2. Criminal incarceration data sets from state correctional institutions, county jails and juvenile court records. 3. BH encounter data and SMH data set (PCIS).
*2. Increase Vocational and Educational Status** ▪ Increase school attendance (full time regular classroom) ▪ Increase school retention. ▪ Increase school performance. ▪ Improve school behavior. ▪ Increase vocational status for adults. *To be reported/compiled only for priority group consumers by age group.	1. Quarterly Status File (QSF)[1] 2. Employment tax records.

OUTCOME DIMENSIONS	DATA SOURCE(S)
*3. Reduce Criminal/Delinquent Activity** ▪ Reduce number of arrests. ▪ Reduce positive drug screens. ▪ Improve probation/parole status. ▪ Reduce status offenses. (focus on truancy) *To be reported/compiled only for priority group consumers by age group.	1. Quarterly Status File (QSF)[1] 2. Arrest records (state police) 3. Probation and Parole records 4. Automated Health Systems 5. AOPC records
*4. Improve Health Care** ▪ Meet or exceed DHS' EPSDT screening targets. ▪ Increase % of consumers with annual physical exams. ▪ Reduce hospital medical ER use. *To be compiled only for priority group consumers by age group.	1. Encounter data from physical health HMOs. 2. 837I HIPAA Compliant Transaction Institutional. 3. 837P HIPAA Compliant Transaction Professional.
5. *Increase "Penetration Rates*" (i.e., percent of enrollees who received behavioral health treatment through the behavioral health contractor) ▪ Increase appropriate utilization by priority group and type of service. ▪ Increase appropriate utilization by age and type of service.	1. Consumer Registry File (CRF)[2] 2. 837I HIPAA Compliant Transaction Institutional. 3. 837P HIPAA Compliant Transaction Professional.
*6. Increase Consumer/Family Satisfaction** *To be reported/compiled only for priority group consumers.	1. Consumer Registry File (CRF)[1] 2. Consumer/Family Satisfaction Measurement Instruments

OUTCOME DIMENSIONS	DATA SOURCE(S)
7. Implement Continuous Quality Improvement (CQI) Actions	1. CQI Periodic Reports – Behavioral health contractor must submit to DHS periodic narrative reports detailing its CQI activities, delineating deficiencies and areas for improvement, actions taken to improve performance (or remedy deficiencies) and the effectiveness/outcome of actions taken. CQI reports must address performance indicator reports issued by OMH.
8. Increase Range of Services and Improve Utilization Patterns ▪ Improve/increase the array of treatment, support and rehabilitative service options. ▪ Decrease % of priority group consumers using only inpatient and/or ER services. ▪ Reduce inpatient re-hospitalization rate. ▪ Reduce rate of perinatal addictive disorders. ▪ Reduce "drop-out" rate.	1. 837I HIPAA Compliant Transaction Institutional. 2. 837P HIPAA Compliant Transaction Professional. 3. Encounter data from physical MCOs.
9. Implement co-occurring disorder (COD) Performance Indicator or QA measure ▪ *Improve/increase identification of co-occurring recipients* ▪ *Increase the percentage of network providers that routinely screen and assess for co-*	1. BH-MCO self reporting

[1]Reporting requirements and Data elements for QSF are in the Proposers' Library.
[2]Reporting Requirements and Data elements for CRF are in the Proposers' Library.

** *HIPAA Implementation Guides* and *Addenda* for the various types of transactions are available, free of charge, from the Washing Publishing Company at www.wpc-edi.com/hipaa/. These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.

*** *Pennsylvania PROMISe Companion Guides* for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The *Companion Guides* provide detailed information specific to the submittal of claims and encounter transactions to Pennsylvania's PROMIS*e* system.

HealthChoices COD Performance Indicators/QA Measures

Please use the following operational definitions and reporting specifications for required DHS COD performance indicators/QA measures referenced in Appendix K.2

Operational definitions:

Co-occurring disorder: Individuals with a co-occurring disorder have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

Screening: A formal process that is typically brief and occurs soon after the individual presents for services. The purpose of the screening process is to determine the likelihood that a person has a co-occurring disorder, not to establish the presence or specific type of disorder, but to determine the need for an assessment. (No mandated instrument)

Assessment: A formal process of gathering information and engaging with the individual that enables the provider to establish the presence or absence of a co- occurring disorder that may involve clinical interviews, administration of standardized instruments, and/or review of existing information. The purpose of the assessment is to establish the existence of a clinical disorder or service need and to work with the individual to develop a treatment plan. (No mandated instrument)

Specific reporting criteria:
(unduplicated count, quarterly review and annual report)

(1) Increase the percentage of network providers that routinely screen and assess for co-occurring mental health and substance use disorders:

Total number of network providers: _____
Number of network providers that have a written policy/procedure requiring individuals to be screened and assessed for co-occurring disorders: _____
Total number of individuals screened and/or assessed for a co-occurring disorder: ___

(2) Increase identification of co-occurring recipients (prevalence): Per Network provider:

Total number of individuals admitted to the program: _____
Total number of individuals determined to have a co-occurring disorder that have been admitted to the program: _____
Total number of individuals determined to have a co-occurring disorder referred to another treatment provider: _____

GUIDELINES FOR CONSUMER/FAMILY SATISFACTION TEAMS AND MEMBER SATISFACTION SURVEYS

The Department of Human Services (DHS) values and encourages the input of consumers and families in all aspects of the HealthChoices Program and expects that such input will be incorporated in quality improvement. In addition the Office of Mental Health and Substance Abuse Services (OMHSAS) encourages input from consumers, persons in recovery, and families regarding the services and supports received in the mental health and drug and alcohol service system. Consumer and family feedback helps inform Providers, counties and Behavioral Health Managed Care Organizations (BH-MCO) about how services can support recovery for adults, resilience in children and adolescents and be more effective. Consumers and families have specialized knowledge and sensitivity about how respect, dignity and responsiveness of services can affect the process of recovery and preserve resilience. Members are more likely to feel safe in describing their experience with someone who is not their service Provider. Soliciting feedback on satisfaction with services empowers consumers and families and allows them to have a greater role in determining the quality of behavioral health care and recommending system improvements DHS therefore requires Primary Contractors to implement a comprehensive approach for the measurement of consumer/family satisfaction, including but not limited to:

- A Consumer/Family Satisfaction Team (C/FST) Program
- An Annual Mailed/Telephonic Survey of Member Satisfaction

A. CONSUMER and FAMILY SATISFACTION TEAM PROGRAM

1. Purpose

The purpose of the C/FST Program is to determine whether adult behavioral health service recipients and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families are satisfied with services and to help ensure that problems related to service access, delivery and outcome are identified and resolved in a timely manner. Surveys should identify consumer and family member satisfaction with the services of a specific Provider as well as the level of satisfaction with the behavioral health system and all of the treatment, services and supports each consumer is receiving. This is primarily accomplished by gathering information through face-to-face discussions with Recipients of behavioral health services and the families of child and adolescent service Recipients, with follow-up reports, dialogue, and problem resolution feedback with the Primary Contractor.

It is the responsibility of the Primary Contractor (the Primary Contractor refers to the responsible party that holds the HealthChoices contract or agreement with DHS) to provide the support, encouragement, and resources necessary to build a strong, independent, conflict free C/FST Program. In a recovery oriented service system support and encouragement would be evidenced by a Primary Contractor that:

- Communicates the importance of listening to and acting upon the results of satisfaction feedback from C/FSTs;
- Supports and encourages C/FSTs so that they are considered a respected and valuable service;
- Requires timely Provider action in response to survey results;
- Has a Provider network that works in partnership with C/FSTs to continuously improve service responsiveness using survey results in their internal quality management program;
- Identifies system improvement needed based on survey results;
- Actively provides direction and feedback to C/FSTs about how to improve their program and acquire the skills needed to move toward the independent operation of a satisfaction survey program; and
- Provides the resources necessary to accomplish the requirements outlined in this document.

2. Organizational Requirements of Consumer/Family Satisfaction Team Programs

In order to determine whether or not behavioral health services are meeting the needs and expectations of adults, young adults, children and adolescents and their family members, the Primary Contractor shall ensure that the C/FST Program is organized and operates in compliance with the following:

The Primary Contractor either directly, or via a BH-MCO or other sub-contractor, must have systems and procedures to routinely assess service Recipient satisfaction. The C/FST Program may be either a single or a multi-county program based upon the nature of the contract between DHS and the Primary Contractors. The family satisfaction component may be accomplished either as a separate administrative entity or as a component of the C/FST Program that is specifically responsible for family satisfaction activities.

a. The Primary Contractor for HealthChoices and/or the BH-MCO must have a contract or a written and signed agreement with each C/FST Program and fiduciary, if applicable, that delineates roles and responsibilities of all parties. Designation of who holds the responsibility for advocacy and follow-up on behalf of Members should also be included.

b. Under the contract or written agreement, and consistent with the requirements of the Mental Health Procedures Act (Chapter 5100), the C/FST members will act as agents of the Primary Contractor, and are, therefore, to have the same access to consumers and family members as the Primary Contractor and service Providers, insofar as it is necessary to perform their responsibilities.

c. Each C/FST Program must have a Director who may be full or part time depending upon the size of the program. The Director must be a person who self-identifies as a consumer, person in recovery, or family member as stated in 3(a) and (b) as of January 1, 2005. If the current Director hired prior to January 1, 2005 does not meet this requirement, he or she may continue to serve until such time as the position is vacant and a new Director is hired.

d. C/FST members must be paid at least as much as other persons in the general workforce doing similar work in the same community.

e. C/FSTs must be independent from any Provider of behavioral health services or any other agency that might create a conflict of interest. C/FSTs that do not have accounting capabilities may contract with a provider as its fiduciary provided the contract safeguards the independence of the C/FST for program direction including budget priorities, satisfaction surveys, findings and recommendations.

f. The Primary Contractor shall work with the C/FST to establish an annual plan for conducting face-to-face interviews. The plan will include goals such as: the number of interviews to be completed, the levels of care to be surveyed and special focus surveys to address specifically identified special populations. If the C/FST Program identifies barriers to accessing Members to be surveyed, the Primary Contractor will assist to resolve the issue. Priority populations should be given priority for face-to-face interviews.

g. The Primary Contractor will ensure that the C/FST Program has adequate financial resources, training, support, and necessary equipment for the program to produce high quality quarterly reports.

3. Consumer and Family Satisfaction Team Minimum Requirements

a. Persons performing adult satisfaction activities must be, or have been, consumers of behavioral health services, persons in recovery, or family members.

b. Persons performing family satisfaction activities must include family members of children and adolescents with serious emotional disturbance and/or substance abuse disorders who are receiving or have received behavioral health services in the publicly funded system, and may also include older adolescents and/or young adults who are receiving or have received behavioral health services as a child or adolescent in the publicly funded system.

c. Family satisfaction team members must have child abuse and criminal history clearances in accordance with the Child Protective Services Law, Chapter 63, Sections 6303 and 6344, and are mandated reporters for child abuse.

d. The family satisfaction component may be a separate and distinct administrative entity, or may be at least one team of a C/FST Program or one member of a team dedicated to family satisfaction activities.

e. Young adults (18-22) may be interviewed by either consumer or family satisfaction team members, as appropriate, depending on the services being received.

4. Conducting Satisfaction Surveys

Consumer and family satisfaction interviews serve as a means for early identification and resolution of problems related to service access, and timeliness of service delivery, appropriateness of services and recovery and resilience outcomes. Face-to-face interviews afford Members the opportunity to communicate openly with peers on an on-going basis. Additionally, satisfaction surveys assist in determining the level of satisfaction with respect, dignity and hopefulness as integral components of the entire service delivery system. These activities also provide a further check to ensure that the service system is consistent with the principles of recovery in adults, resilience in children and adolescents, of the Community Support Program (CSP), the Child and Adolescent Service System Program (CASSP), cultural competence, and Drug and Alcohol (D&A) Treatment Principles. The Primary Contractor shall ensure:

a. Consumer/family satisfaction should be assessed through face-to-face interviews with adult behavioral health service Recipients; children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families. Interviews should be face-to-face whenever possible however, telephone or mailed surveys may be used if preferred by the Member.

b. The Primary Contractor shall establish mechanisms in their contract or written agreement to inform the C/FST Program of newly enrolled Members receiving behavioral health services and on-going Members who may wish to participate in satisfaction interviews. The first mechanism below is to be used when member names, addresses and telephone numbers are provided to the C/FST. The second mechanism describes the process if the Primary Contractor does not wish Member names to be provided to the C/FST without Member consent. It is the Primary Contractors responsibility to select the mechanisms for notifying Members about the C/FST Program as follows:

   i. The Primary Contractor periodically provides the names and addresses of Members newly enrolled in mental health services to the C/FST and at least annually updates the list for Members who continue to remain enrolled, and notifies Members receiving drug and alcohol services as stated in 4 (b) ii below; or
   ii. The Primary Contractor informs all newly enrolled Members receiving mental health and/or drug and alcohol services about the C/FST Program. The names of members receiving mental health services who wish to be interviewed can be provided to the C/FST without a release of information. Members receiving drug and/or alcohol services must sign a release of information in order for their name, address and telephone number to be provided to the C/FST. A mechanism must be established to provide an opportunity to be interviewed at least annually for Members that remain enrolled in mental health and drug and alcohol services.

c. Service Providers must provide C/FSTs with comfortable private space for interviews to ensure an environment in which behavioral health consumers and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families feel free to express any concerns they may have.

d. C/FSTs solicit input from Recipients of behavioral health services and the families of children and adolescents receiving behavioral health services in order that satisfaction and areas of concern can be identified and recommendations for systems improvement can be developed. This can be accomplished through individual and/or group discussions, upon discharge from a service, and as focus groups with behavioral health consumers, persons in recovery, children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families, including visits to programs where members receive their services or to their homes. Family members may be more easily accessed when interviews are conducted by telephone. Information about the C/FST Program is best shared in face-to- face presentation with individuals or groups, however, such methods as videotapes, telephone or written material may also be used.

e. Some of the C/FST survey questions should address satisfaction with the Provider(s) and the mental health and drug and alcohol service(s) the consumer is receiving. The findings of the C/FST shall be organized to identify the Provider, or special population in the case of a focused survey for three purposes: 1) to allow the managed care organization to include C/FST information in Provider profiling, 2) to provide feedback to the individual Provider about their program, and 3) to allow the Primary Contractor (County and/or Managed Care Organization) to direct the Provider to take corrective action to address a Member concern or concerns about the Provider operation or program. The face-to-face surveys and monthly problem solving process ensure action is taken on an on-going basis and resolution for the Member is timely and responsive. Both the on-going surveys and the annual survey described in Section B can be used to identify trends that may require system improvement.

f. The Primary Contractor will identify and request the C/FST to conduct outreach efforts to under-served or un-served groups of consumers and families in order to conduct satisfaction surveys and identify system improvements that will increase the access, engagement and retention of these individuals in needed behavioral health services.

5. <u>Areas for Consumer and Family Satisfaction Team Observation and Discussion with Recipients of Behavioral Health Services and the Families of Child and Adolescent Service Recipients</u>

Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. The survey tool should allow identification of the Provider(s) and the service(s) provided as well as general satisfaction with the service system. Satisfaction surveys shall include but not be limited to the following areas:

<u>BH-MCO Related Issues</u>:

- Knowledge of and satisfaction with member services
- Knowledge of benefits and treatment options
- Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
- Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff

Service Delivery:
- Interagency Team Process for children and adolescents and their families
- Choice of Providers
- Satisfaction with timeliness and convenience of the service delivery system
- Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient)

Treatment:
- Service Recipient involvement in treatment planning and decisions
- Child or adolescent and their family members involvement in treatment planning and decisions
- Interagency Team Process for children and adolescents and their families
- Perception of effectiveness/outcomes of treatment
- Perception of changes in quality of life as a result of treatment
- Satisfaction with dignity, respect and hopefulness offered during treatment
- Satisfaction with physical health care

Overall Satisfaction:
- Degree to which services were consistent with CSP**,** CASSP and D&A principles, and facilitate recovery and resilience
- Freedom from sense of coercion or fear of retribution for Recipients of mental health services
- Satisfaction and comfort level with physical environment of facility or site where services were provided.
- Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

DHS may from time to time require specific questions to be added to C/FST satisfaction surveys in order to conduct statewide quality assurance activities.

6. Confidentiality

All employees of C/FST Programs must comply with applicable state and federal laws, regulations, and rules regarding the confidentiality of mental health consumers and recipients of drug and alcohol treatment services. The contract or written agreement will address confidentiality requirements including the following:

a. All C/FST members must receive training in confidentiality regulations for mental health and substance abuse services. All family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services.

b. All C/FST members must sign a confidentiality agreement, and personnel policies must address disciplinary procedures relevant to violation of the signed confidentiality agreement.

c. Mental Health Confidentiality: For purposes of the HealthChoices program, C/FSTs are agents of the Primary Contractor, and have the delegated authority to collect and disseminate the needed information. C/FST members must be considered as equal to all other mental health professionals with regard to access to mental health consumers, children and adolescents with serious emotional disturbance and their families. There should be no special written permission required to engage consumers and families receiving mental health, whether in state hospitals or community programs.

d. Mental Health Confidentiality: If the Recipient of mental health services is a child (up to 14 years of age), he or she may be interviewed but only in the presence of a responsible family member or authorized caregiver, and the family member or caregiver must also be interviewed. If the Recipient of mental health services is an adolescent (14 to 18 years of age), the adolescent should be interviewed independently and responsible family members or an authorized caregiver could also be offered the opportunity to be interviewed. It is preferable but not necessary to receive the adolescent's consent before interviewing family members or caregivers.

e. Drug and Alcohol Confidentiality: A service agreement between the C/FST Program and each Drug and Alcohol Provider outlining Drug and Alcohol confidentiality rules, rights, regulations and laws that govern Drug and Alcohol Providers in Pennsylvania is also required. This is consistent with the current practice of Drug and Alcohol Providers to require such an agreement be signed by representatives of the Departments of Health and Human Services, Joint Commission on Accreditation of Healthcare Organizations, and Single County Authorities for Drug and Alcohol services.

f. Drug and Alcohol Confidentiality: Prior to a drug and alcohol service Provider contacting a C/FST Program to provide the name of a person who wishes to be surveyed, a consent to release information form must be signed by the Member requesting their name, address and telephone number be provided to the C/FST Program. A copy of the signed consent to release information form must be retained in the Member's treatment file and a copy given to the Member and the C/FST. Consent to release information forms for Members receiving drug and alcohol treatment services are not required when the C/FST conducts surveys without receiving the persons name and reports data in the aggregate

g. Drug and Alcohol Confidentiality: Recipients of drug and alcohol treatment services, regardless of age, must give their written consent for a parent or other family member to be interviewed, or to be present while the Recipient of services is being interviewed.

h. C/FSTs must be afforded the opportunity to meet with mental health consumers and Recipients of substance abuse services and the family members of child and adolescent service Recipients to describe and explain the purpose and function of C/FSTs.

7. Problem Identification and Recommendations for Action

C/FSTs must provide feedback to the Primary Contractor through written quarterly reports and monthly problem resolution meetings that allow for dialogue and review of findings. The Primary Contractor is responsible for timely reports back to the C/FST on specific actions and problem resolution resulting from identified issues, concerns and problems. The contract or written agreement shall identify the process the Primary Contractor will use to resolve problems and address suggestions identified by the C/FST including the following:

a. Process for problem identification and resolution that includes the C/FST Program, consumers, persons in recovery, parents, adolescents, children, designated county staff, staff of the managed care organization, and advocates as appropriate to the problem identified.

b. The problem resolution process must include how often problem resolution meetings will occur, with whom, and the responsibilities of all parties (County, C/FST, managed care organization, and Providers). This process will identify actions to be taken by the Primary Contactor if resolution is not reached. There must also be a process in place for responding to urgent matters identified by Members.

c. The Managed Care Organization sub-contracts with Providers of behavioral health services in their network shall include the timeframe in which the Provider must respond to the recommendations made by the C/FST as directed by the County, Managed Care Organization or the C/FST. Providers of behavioral health services should be required to use C/FST feedback in their quality management program.

d. The Primary Contractor must provide a timely response to the C/FST on actions taken in response to reported problems and concerns resulting from service Recipient interviews for inclusion in the next quarterly report.

e. Mechanisms must be in place to address identified trends or system changes that may require the Primary Contractor to study in more depth to understand the issue and resolve. This may include focus meetings on specific topics or collaboration with other involved service systems. The results of these focus studies will be provided to the C/FST for inclusion in their reports.

8. Knowledge, Training and Orientation of Consumer and Family Satisfaction Teams

The Primary Contractor will ensure that C/FST members have both an initial orientation to and on-going training in the following areas:

a. C/FST members must have basic knowledge of mental illness and addictive diseases and an understanding of the concept of recovery and resilience in relation to both for adults and children and adolescents. Persons performing Family Satisfaction activities must also have an understanding of serious emotional disturbance and substance abuse disorders in children and adolescents.

b. Training for C/FST members must include confidentiality regulations for mental health and substance abuse services. Family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services. Training must include an understanding of responsibilities, as applicable, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

c. C/FST members must also have an understanding of the cultural diversity of the individual and community being served in order to ensure culturally sensitive interactions. Training shall include the basic concepts of recovery and resilience.

d. Family satisfaction team members must have training in the responsibilities of being mandated reporters for child abuse.

e. The Primary Contractor shall arrange a minimum of two (2) hours orientation/training on the BH-MCO operations, policies and procedures for satisfaction team members.

9. Quarterly Reports

The Primary Contractor shall provide the Department with the C/FST Program's quarterly report summarizing consumer and family satisfaction findings, as well as improvement actions and system changes implemented by the Primary Contractor in response to those findings. The Primary Contractor shall provide support and direction to the C/FST to ensure the report contains not only the

numeric results of surveys conducted but also information about the actions taken in the previous quarter by the Primary Contractor or behavioral health service Provider, trends observed, and other relevant information that can be used by Providers and others about ways to improve treatment and supports.

10. DHS Annual Review of Consumer/Family Satisfaction Team Programs

DHS will conduct an annual review of the C/FST program that will include a review of the following:

a. Results of satisfaction surveys;

b. Actions taken to resolve identified issues and system changes;

c. Role and effectiveness of the Primary Contractor in problem resolution and direction to the C/FST program;

d. Adequacy of the budget, staff, and training opportunities to carry out the requirements of the program;

e. Role of the fiduciary, if applicable, in supporting the program and financial priorities established by the C/FST program; and

f. Progress on gaining skills and abilities of the C/FST program to move toward operating as an independent, conflict free, satisfaction program, as applicable

B. ANNUAL MEMBER SATISFACTION SURVEYS

1. Consumer and Family Satisfaction Annual Mailed/Telephonic Survey

The Primary Contractor is responsible for ensuring that an annual satisfaction survey of a representative sample of persons served by the behavioral health program is conducted by mail or telephonically. The purpose of the Annual Mailed/Telephonic Consumer and Family Member Satisfaction Survey is to determine the extent to which the BH-MCO adult Members and family members of children and adolescents are satisfied with overall BH-MCO operations and services, and to identify areas which need improvement. Surveys are developed and used by the BH-MCO to gather information to determine whether the BH-MCO adult Members and family members of children and adolescents are knowledgeable about and satisfied with the behavioral health program including core functions such as member services as well as to assess whether service availability, service access, and services provision and effectiveness are meeting the Member's needs and expectations.

a. Surveys of Recipients of substance abuse services, regardless of age, must be distributed by Providers at service delivery sites in order to protect the confidentiality of persons being surveyed.

b. A separate survey instrument must be developed for children and adolescent service Recipients and their families.

c. Findings and resulting recommendations from the survey and consumer/family satisfaction activities are to be incorporated into the Primary Contractor's ongoing quality management and improvement program.

d. The County may directly conduct the annual survey or direct the managed care organization, C/FST Program, or another entity that would be conflict free, to conduct the annual survey.

2. Areas Covered by the Consumer and Family Satisfaction Survey

Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. Satisfaction surveys shall include but not be limited to the following areas:

BH-MCO Related Issues:
- Knowledge of and satisfaction with member services
- Knowledge of benefits and treatment options
- Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
- Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff

Service Delivery:
- Interagency Team Process for children and adolescents and their families
- Choice of Providers
- Satisfaction with timeliness and convenience of the service delivery system
- Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient)

Treatment:
- Service Recipient involvement in treatment planning and decisions
- Child or adolescent and their family Members involvement in treatment planning and decisions
- Interagency Team Process for children and adolescents and their families
- Perception of effectiveness/outcomes of treatment
- Perception of changes in quality of life as a result of treatment
- Satisfaction with dignity, respect and hopefulness offered during treatment
- Satisfaction with physical health care.

Overall Satisfaction:

- Degree to which services were consistent with CSP**,** CASSP and D&A principles, and facilitate recovery and resilience
- Freedom from sense of coercion or fear of retribution for Recipients of mental health services
- Satisfaction and comfort level with physical environment of facility or site where services were provided.
- Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

Miscellaneous:

- Items required by the Department as a result of the Department's ongoing monitoring and program evaluation.
- Knowledge of and satisfaction with the Medical Assistance Transportation Program
- Satisfaction of consumers with special needs e.g. deaf and hard of hearing, older adults, people who are homeless, etc.
- Suggestions for improvement

3. Sampling Procedure

The Annual Mailed/Telephonic Consumer and Family Satisfaction Survey must be sent to, or conducted with, a representative sample of behavioral health service Recipients with a statistically valid sampling of Members in the adult priority population groups, family members of child and adolescent service Recipients, and special needs populations, as well as a sampling of Members who filed complaints and grievances. The survey of Members receiving drug and alcohol services must be anonymously distributed through service Providers.

4. Frequency of Survey and Reporting Results

A report of the survey findings and resulting recommendations for quality improvement must be submitted to the Department as part of the annual quality management summary report, quality management plan for the upcoming year. The Consumer and Family Satisfaction Mailed/Telephonic Survey will be conducted at least annually

HealthChoices Behavioral Health
Data Reporting Requirements
(Non-Financial)

File/Report Name	Description	Frequency	Data Format Transfer Mode Due Date
Transition Monitoring	Reports on data needed for OMHSAS monitoring of the transition to a new contractor or subcontractor.	Weekly, during start-up or transition to a new BH-MCO. Time-limited.	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due by close-of-business on Wednesday following the reporting week.
Quarterly Monitoring	Reports on data needed for on-going monitoring of the HealthChoices Behavioral Health contract.	Quarterly	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. File transfer via SeGOV data exchange. Due 45 days after the end of the reporting quarter.
837 Transactions	Reports each time a consumer has an encounter with a provider. Format/data based on HIPAA compliant 837 format.	Monthly (or more frequently, as scheduled by submitter)	File transfer via Secure eGOV data exchange. Each encounter record is due by the last calendar day of third month after the Primary Contractor paid/adjudicated the claim/encounter.
Alternative Payment Arrangement (APA) reporting	Reports any payment arrangement with a provider other than Fee For Service.	Varies	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 30 days after the end of a payment cycle.
Complaints and Grievances	Reports aggregate data on complaints, grievances and resolutions. Also includes detail records on grievances.	Monthly	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 30 days after the end of the reporting month.

Consumer Data: Consumer Registry/Quarterly Status (included in Performance Outcome Management System	Reports person-specific demographic/clinical data at registry and closure; i.e. birth date, priority group, service request date, independence of living. Reports status and outcome data on priority group consumers, i.e. independence of living, voc/ed, residential moves.	Quarterly	ASCII files via eGovernment Secure Data Exchange; due 30 days after the end of the reporting quarter.

HealthChoices Behavioral Health
Data Reporting Requirements
(Non-Financial)

File/Report Name	Description	Frequency	Data Format Transfer Mode Due Date
MCO Provider File	Reports all providers within the network.	Monthly	File transfer via SeGOV data exchange. Due by the second Monday of the month.
Monthly IBHS Services Report	Report tracks Behavioral Health Technician (BHT) hours and recipients authorized and BHT hours and recipients paid.	Monthly	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 4 months after the authorization month.
Denial Log	Reports each time a requested service was denied, as well as any alternatives approved.	Monthly	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 15 days after end of reporting month.

* Does not cover financial reporting requirements. The file specifications, formats, data elements and reporting requirements are subject to change by the Department.

** *Pennsylvania PROMISe Companion Guides* for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The *Companion Guides* provide detailed information specific to the submittal of claims and encounter transactions to Pennsylvania's PROMISe system.

HealthChoices Behavioral Health Program
Requirements for County Reinvestment Plans

Primary Contractors in the HealthChoices program, including those behavioral health managed care organizations (BH-MCOs) under direct contract with the Department of Human Services (DHS), are allowed to retain Capitation revenues and investment income that was not expended during the Agreement period to reinvest in programs and services in their County. These funds, called Reinvestment Funds, must be spent in accordance with a DHS, Office of Mental Health and Substance Abuse Services (OMHSAS) approved reinvestment plan.

Reinvestment Funds provide a unique opportunity for a financial incentive to reward sound financial management practices and allow the creative use of funds to fill identified gaps in the service system, test new innovative treatment approaches, and develop cost-effective alternatives to traditional services that may create cost offsets for State Plan Services. Reinvestment is one mechanism used to achieve the Commonwealth's expectation for the continuous quality improvement of a comprehensive treatment system that not only supports recovery for persons with mental health issues, including drug and/or alcohol treatment needs, but for the family support structure as well. This document refers to both the reinvestment plan and reinvestment plan priorities. The term "plan" refers to the entire reinvestment submission for the Agreement year. The "reinvestment plan priorities" are the individually named projects that are numbered in priority order and submitted with a program description.

This document describes the required planning process, allowable expenditures, financial reporting, and the approval process for Primary Contractors to use Reinvestment Funds. These requirements are detailed in the following documents: HealthChoices Behavioral Health Program Standards & Requirements (PSR), the HealthChoices Behavioral Health Agreement, and the Financial Reporting Requirements – HealthChoices Behavioral Health Program.

A. Planning for Reinvestment Funds

Involvement of Stakeholders

1. The planning process must include and document the involvement of members of the BH-MCO who have received or are currently receiving services, families (including families of children and adolescents), persons in recovery, MH/ID and Single County Authorities (SCA), and as appropriate, County Commissioners and local legislators.
2. In order for stakeholders to provide informed feedback about options for Reinvestment Funds, the County and BH-MCO should present the results of data analysis performed to document utilization trends, unmet needs, populations served, outcomes achieved by the HealthChoices program to date, etc. as part of the planning process in the development of the reinvestment plan.

3. Stakeholders must be involved at all stages of the planning and decision making process. Evidence of their involvement and feedback must be summarized as part of the plan submission.
4. Counties must document the planning process used at the local level to discuss behavioral health service needs.
5. Preliminary reinvestment plans should be discussed with the OMHSAS Field Office for input regarding planned use of funds prior to submission.

Timeframes for Submission and Approval

1. The timeframes for submission and approval are provided as approximate dates. The dates provided are the outside dates for when submission is required. Primary Contractors may submit plans prior to the completion of the audit using estimates of the Reinvestment Funds available. Submission timeframes are calculated from the beginning and ending dates of the annual Agreement. Dates for review and approval may vary depending on any additional information or clarification needed. The review process is summarized below, and detailed steps are provided in Attachment 1.
2. Plans for Reinvestment Funds are submitted annually based on the HealthChoices Agreement year.
3. Draft plans are submitted to the OMHSAS Field Office for review and comment once the amount of Reinvestment Funds are identified and confirmed by OMHSAS. This should be no later than the first day of the ninth (9th) month after the end of the Agreement year.
4. The OMHSAS Field Office provides written feedback to the Primary Contractor.
5. Final reinvestment plans are to be submitted within thirty (30) days of receiving OMHSAS feedback.
6. The Service System Review Committee (SSRC) reviews and approves final reinvestment plans. If there are questions, the questions are provided to the Primary Contractor. Once the Primary Contractor satisfactorily responds to the questions by providing the requested additional information and/or submitting a revised plan, written approval will be provided.
7. The Primary Contractor cannot begin implementing the approved reinvestment plan until written notification is received that the plan is approved and when the funds to support the plan have been deposited into a restricted account as required (within thirty (30) days of plan approval).
8. If Reinvestment Funds from a subsequent year are intended to be used to continue funding a previously approved reinvestment plan priority, the Primary Contractor must submit the previously approved plan with updated financial information related to the request for continuation funding. There should be evidence that stakeholders continue to support the plan priority and evidence of the benefit from implementing the priority. OMHSAS will expedite the review of the plan.

9. When additional funds are identified, plans must be submitted no later than twelve (12) months from the date additional Reinvestment Funds are identified. The new plans will be reviewed at the time they are received following the same process described above. Exceeding this timeframe for submission may result in the DHS recovery of these funds.

B. Identification of Reinvestment Funds

1. Primary Contractors confirms the amount of Reinvestment Funds available with OMHSAS. Written confirmation should be received, in order to meet the above timeframes, by the middle of the (8th) month after the end of the Agreement year, in order to meet the above timeframes. Confirmation of funds available should occur before the draft reinvestment plan is submitted. It is understood that the amount of reinvestment money available is subject to change based on future reconciliation.
2. For reinvestment purposes only, adjustments made to prior year available funds two (2) years after submission of the Agreement audit will be applied to the most recent audited Agreement year.
3. When the County is the Primary Contractor, funds that would otherwise be available for reinvestment, but are being proposed for Risk and Contingency, must be identified by the County and approved by OMHSAS. The County must submit a written request to OMHSAS for approval of Risk and Contingency Funds stating the rationale for the request prior to its letter confirming the amount of reinvestment available. A written request for approval to use Risk and Contingency Funds for reinvestment purposes must be submitted to OMHSAS and approved prior to the submission of a reinvestment plan.
4. A reinvestment plan must be submitted for approval within twelve (12) months of the time additional funds are identified for reinvestment.

C. Guidance on the Use of Reinvestment Funds

Allowable Uses for Reinvestment Funds

1. Start-up costs for State Plan Services, during capacity building, including provider assistance. Any unmet service access standards should be considered for reinvestment funds as a priority. Any billable State Plan Services must be submitted to the BH-MCO for payment during the start-up of the service.
2. Development and/or purchase of Medical Assistance (MA) eligible in lieu of or in addition to services.
3. Behavioral health supports that are not MA eligible (non-medical**)** such as purchase or renovation of a facility, employment supports, housing development, or rental subsidies.
4. Training and consultation that is required to implement a new service or support for MA eligible individuals.
5. Expenditures must be consistent with the conditions of the Center for Medicare and Medicaid Services (CMS) waiver, the HealthChoices PSR and Agreement.

Reinvestment Funds Cannot be used for:

1. Incentives payment to a BH-MCO.
2. Payment of State Plan Services.
3. Administrative costs such as medical management, quality management activities, outcome studies, etc.
4. Training not connected to the development of a specific service or program (see Allowable Expenditures for Training) detailed below.
5. Transportation costs that are available under the Medical Assistance Transportation Program (MATP).
6. Services targeted primarily for non-Medical Assistance (MA) eligible persons or to the community at large.
7. Expenditures that do not comply with the Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5).

Allowable Expenditures for Training

Training is an important component of any new service. In developing a budget as part of a reinvestment plan, the training component should be identified in the overall budget of the service. The training must be tied to a new service and not a stand- alone budget item. For example, if the Primary Contractor has determined that there is a need for a Mental Illness Substance Abuse (MISA) program, Reinvestment Funds could be allocated to cover the costs of training for the implementation of this program. However, if the Primary Contractor decided that they would like to train all County staff in MISA "best practice," the Primary Contractor would need to use administrative dollars to fund this training since it is not tied to a specific program developed to provide services targeted for MA eligible consumers.

Allowable Expenditures for Purchase, Renovation and Fixed Assets

1. The reinvestment plan must address additional information specified in the Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5) when a plan priority includes these Non-Medical services or supports. These guidelines specify the additional information that must be included in the reinvestment plan priority submitted and in the agreement entered into between the Primary Contractor and Subcontractor. These include:

    A. Additional areas that must be addressed in the reinvestment plan description regarding ownership, analysis of the need for Non-Medical Services, availability of an on-going revenue source, etc.

    B. A detailed budget of the costs associated with purchase of a facility or property, renovation, fixed assets, personnel, operating expenses, etc. must be submitted following the guidelines in Attachment 5.

C. The Primary Contractor/Provider Agreement should ensure that if the property is sold that any proceeds from the sale would be returned to the Primary Contractor. In this case a new reinvestment plan for these funds must be submitted within twelve (12) months or the funds will be considered Discretionary Funds which must be returned to the Department.

D. Costs for Non-Medical Services are not considered in the HealthChoices rate setting process and DHS has no obligation to continue to fund priorities that were approved as one-time expenditures for the purchase or renovation of a facility.

D. OMHSAS Plan Parameters

Format for Submission of Reinvestment Plans

1. The reinvestment plan must be submitted in accordance with OMHSAS established parameters.
2. A standardized format for submission of both the draft and final reinvestment plan is provided in Attachment 3. **Each reinvestment plan priority for the Agreement year must be numbered in priority order and must be submitted on a separate form using this format.** The same priority number based on the Agreement year must always be used on all reports to facilitate tracking. One (1) set of budget forms must be submitted listing each reinvestment plan by priority number (Attachment 4).
3. The reinvestment plan title is to include the Primary Contractor name and contract year from which the funds are identified as available for reinvestment.
4. The reinvestment plan priority format identifies the: Primary Contractor; the date of submission; the type of service to be funded (State Plan-start-up, In Lieu Of, In Addition To, or Non-Medical Only); indicate if it is a new, continuation, or amended plan and indicate the numeric priority assignment of the reinvestment plan.
5. Reinvestment plan priorities can include expenditures up to three (3) years, with a maximum of five (5) years, subject to SSRC approval, with the exception of State Plan Start-up which should be completed within six (6) months, up to a maximum of one (1) year.
6. Each reinvestment plan priority must state the Agreement years in which Reinvestment Funds will be spent. Primary Contractors should ensure the dates for expenditure are realistic to avoid requests for extensions.
7. When determining the Agreement year in which the reinvestment plan priority funds will be spent, the Primary Contractor should consider the time it will take to accomplish the plan priority and the date of OMHSAS approval. If the time to approve the plan priority was delayed, the final date for spending may need to be adjusted.
8. Expenditures for a reinvestment plan priority cannot be incurred until the effective date of the OMHSAS approval letter.
9. OMHSAS reserves the right to request additional information, if necessary, in order to approve a reinvestment plan priority.

Target Population

1. The reinvestment plan must identify that it is targeted for the unmet or under-met needs of mental health and drug and alcohol MA eligible individuals.
2. It is understood that some non-MA eligible consumers may receive services in a program established to target MA eligible members. DHS assures that the federal funds flowing to the counties under the HC BH Agreement will be used to provide services that primarily benefit MA beneficiaries. Reinvestment plan priorities must identify the priority populations to be served.
3. Describe the population that is targeted for the reinvestment plan priority, e.g. adults with serious mental illness, adolescents with drug and alcohol treatment needs, etc. Include an estimation of the number of persons to be served by the reinvestment plan priority.

Description of Program or Service

1. Reinvestment plans must include a detailed narrative description of each program or service that is consistent with and supports the definition of the service as being either State Plan start-up, Services in lieu of , in addition to or Non-Medical Only.
2. Describe the program or service to be funded by the reinvestment plan priority and why this service or approach is expected to improve the health outcomes for the persons targeted. Evidenced Based Practice Models should be considered for inclusion in a reinvestment plan.
3. If a Primary Contractor is requesting the approval of a new MA eligible in lieu of services, identify the service or services that are expected to generate cost offsets once the in lieu of service is available.

Description of Fund Expenditures

1. Provide a brief summary of what the reinvestment plan priority will fund.
2. Each reinvestment plan priority must contain a description of the major budgeted items (personnel, equipment, operational costs, etc.) and the cost associated with each item. The qualifications of both training and experience for staff and a break out of each position being funded should be included in the plan.
3. If the reinvestment plan priority is funding start-up costs for an State Plan Service, list the specific start-up costs expenditures that will be funded, and the length of time start-up costs will be required e.g. six months, with a maximum of one year, of staff salaries, staff training, etc. Include an offset for estimated billable services.
4. Identify how the reinvestment plan priority will be financed for continuation once Reinvestment Funds have been expended. Sustainability must be discussed with some detail as to the funding options in the future and a description of how the service will continue or a justification as to why the services will end.
5. Reinvestment plan priorities with requests for Non-Medical facility, land or property purchase and/or fixed asset expenditures require submission of the specific information outlined in Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5).

Data Analysis Supporting Request

1. Include a summary of the data analysis that supports why the target population has been chosen and why the specific service has been chosen for Reinvestment Funds. Identify the number of HC members in the target population.
2. Identify the outcomes to be achieved by the service and the data to be collected to measure the outcomes.
3. For continuation or expansion requests the outcome data and any findings need to be included with the submission as well as any updates or changes to the services being implemented.

Description of Stakeholder Involvement in Decision Making

1. Requests must summarize stakeholder involvement in the planning and decision making process for each request.
2. It is expected that stakeholders will be provided information about the outcomes achieved by the HealthChoices program to date. This might include the current strengths and opportunities for improvement as seen by the County and BH- MCO. Such information will allow stakeholders to provide informed feedback about priorities for Reinvestment Funds**.**

Reinvestment Budget Forms

1. Four (4) budget forms must be submitted which break out costs based on eligibility category for HealthChoices recipients, MA recipients, Non-MA recipients and total expenditures. One set of budget forms is to be completed, listing each reinvestment plan priority submitted (Attachment 4).
2. Primary Contractors should use their best estimates to determine the number of clients in each of these three (3) categories. It is understood that members move in and out of eligibility categories.

E. Financial Requirements for Reinvestment Funds

1. Primary Contractors must place Reinvestment Funds in a separate restricted account. Bank statements for the account must be submitted monthly. Bank statements are to be reconciled monthly.
2. Reinvestment Funds can be deposited when identified, but must be placed in a restricted account within **thirty (**30) days of the OMHSAS written approval of the reinvestment plan(s).
3. Report #12 Reinvestment Report is the format used for the monthly report as outlined in the Financial Reporting Requirements-HealthChoices Behavioral Health Program document (Attachment 6, updated annually).
4. Report #12 must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected in this report.
5. A separate report is required for HealthChoices recipients and for Other, non-HealthChoices or non-identifiable recipients.
6. Expenses are to be reported based on HealthChoices recipients and for Other, non-HealthChoices or non-identifiable recipients. To the extent that is not

possible and the expenses must be allocated, then an allocation methodology will need to be submitted and received before written approval from DHS will be generated

7. If Reinvestment Funds from more than one (1) Agreement year are being utilized, a separate set of reports must be filled out for each Agreement year's Reinvestment Funds.
8. Interest earned from the reinvestment account must be reported on Report #12. Expenditures of interest earned must be consistent with an approved plan.
9. Funds are withdrawn from the reinvestment account in accordance with a plan approved by OMHSAS. No funds can be distributed, or expenditures incurred, prior to the date of the OMHSAS approval letter.
10. Primary Contractors must return any unexpended Reinvestment Funds to DHS within six (6) months of the date by which funds were approved to be spent, unless the timeframe for expenditure of these funds was extended by OMHSAS. After that time, unexpended Reinvestment Funds must be returned to DHS.
11. In the event the Agreement with the Department ends and is not renewed, all funds, except for those in DHS approved reinvestment plans, or Reinvestment Funds in a plan submitted to DHS but which DHS has not taken a positive or negative action, remaining in the Primary Contractor's Special Revenue Fund or Enterprise Fund, or held by any Subcontractor, inclusive of Risk and Contingency Funds, not expended for the HC BH transaction, must be returned to the Department within fourteen (14) months from the expiration of the Agreement. Funds identified in a reinvestment plan submitted to DHS, but on which DHS has not taken a positive or negative action, are not considered Discretionary Funds.

F. Modifications to Approved Reinvestment Plans

1. Proposed changes or modifications to an approved reinvestment plan priority must be submitted in writing. Written confirmation of approval of a change will be issued by OMHSAS within the approval timelines described below.
2. Changes may include a request to: extend the timeframe for expenditure of funds, revise the approved program, withdraw an approved plan and propose a new plan for use of the funds, or change the amount of expenditure when approval of such a change is required.
3. A request for an extension of an approved reinvestment plan (numbered by priority) must be received forty-five (45) days prior to the end of the final contract expenditure year stated on the OMHSAS reinvestment approval letter and must indicate the reason extension. OMHSAS will provide a written response to a request for extension. Failure to meet this 45-day requirement may result in DHS's recovery of these funds**.**
4. If program or service plan modifications are requested after a reinvestment plan priority has been approved by OMHSAS, the Primary Contractor must use this same format (Attachment 3) to submit a request for change. Stakeholder involvement, and documentation of such, must occur if a new reinvestment plan priority is being proposed to substitute for a previously approved priority.

5. Any revisions to the amount approved for an individual reinvestment plan priority which is the greater of twenty-five percent (25%) or $50,000 for the priority being revised, must be approved by OMHSAS in advance. Examples include:
   a. A plan has been approved for $100,000. The Primary Contractor wishes to decrease the plan by $40,000. This change could be made without approval since the greater of 25% or $50,000 has not been exceeded, or;
   b. A plan is approved for $1M. The county wishes to increase the plan by $300,000. This change would have to be approved since the change is the greater than 25% (25% equals $250,000).
6. The Reinvestment Report-Budget forms (Attachment 4) will be used to track approved changes for expenditures and reinvestment plan priorities from a contract year.

G. Annual Report on HealthChoices Reinvestment Plans

1. Submission of an Annual Report on HealthChoices Reinvestment Plans for approved reinvestment plans from the previous contract year and those plan priorities that continue to be funded with reinvestment dollars is required. The annual report of Reinvestment Funds is to include a program summary for each reinvestment plan priority that continues to be funded with reinvestment dollars.
2. The Annual Report on HealthChoices Reinvestment Plans is due on the last day of the thirteenth (13th) month from the end of the contract year. The required format for submission is attached (Attachment 7). An updated budget is required to be submitted annually.
3. OMHSAS provides a summary of all approved reinvestment plans to stakeholders. The summary is published in the OMHSAS HealthChoices Behavioral Health Program Annual Report.
4. A summary of the Annual Report on HealthChoices Reinvestment Plans is also distributed to stakeholders.

Step #	Responsible Entity	Step Description	Due Date
1	Contractor	HealthChoices Contract Audit Completed	CY May 15 SFY November 15
2	Contractor	Identifies amount of reinvestment funds available	CY August 15 SFY February 15
3	Contractor	Confirm with OMHSAS amount of reinvestment funds available. Submit draft reinvestment plans to OMHSAS Field Office.	CY September 1 SFY March 1
4	OMHSAS Field Office	Provide feedback to Contractor on draft plans	
5	Contractor	Submit final reinvestment plans to OMHSAS Field Office	30 days after receiving OMHSAS feedback on draft plan
6	OMHSAS/BPPD	Distribute plans to DHS Reinvestment Review Team	
7	DHS Reinvestment Review Team	Identifies any additional information needed **or** approves if no additional information is required	
8	OMHSAS Field Office	Provides feedback on final plans	
9	OMHSAS Field Office	Prepares summary of County responses received. Prepares draft approval letter.	
10	OMHSAS	Sends final approval letter to County	
11	Contractor	Implementation begins when approval letter is received and funds have been deposited	
12	Contractor	Annual Report on HC Reinvestment Plan for approved plan	CY January 31 SFY July 31

Example

Date
County MH/ID Administrator Dear

Administrator:

The _____County HealthChoices reinvestment plan for funds generated during calendar year _____has been approved. Acceptance of the following initiatives is confirmed.

Type of Service	**Budget Amount**	**In-Plan-Start-up, In Lieu Of, In Addition To Or Non-Medical**	**Contract Expenditure Year(s)**
Priority 1 Continuation of Funding for Community Treatment Teams	$600,000	In Lieu Of	2002 – 2003
Priority 2 Psychiatric Rehabilitation Services	$400,000	In Lieu Of**	2002 – 2003

HealthChoices reinvestment funds need to be kept in a separate, restricted bank account and statements for the account must be submitted to the Department each month. Funds must be deposited no later than 30 days after the date of this approval. Also, an annual report on the use of reinvestment funds during _____will be due on _____.

[Note: Plans that contain Bricks and Mortar will be annotated with two asterisks and will include the following statement: "**The County reinvestment plan submission is in compliance with the DHS requirements as stated in the Review and Approval Guidelines for Reinvestment Plans that Provide Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets. The HealthChoices reinvestment funds are one-time only funds and start-up costs of these services are not considered in the HealthChoices rate setting process. The Department of Public Welfare has no obligation to continue to fund services approved for this reinvestment plan."]

Reinvestment plans should be implemented in accordance with the approved timeframes. Any delay in implementing the plan should be communicated to OMHSAS. The monitoring of HealthChoices reinvestment funds will be discussed during monthly HealthChoices monitoring meetings. However, if you have questions or concerns that require immediate attention, please be in contact with your Monitoring Team leader or Community Program Manager.

Sincerely,

Director

HEALTHCHOICES REINVESTMENT PLAN PRIORITY

County_____

Reinvestment Plan from contract year_____ Date of Submission_____

Name of Service_____

New Plan_____ Continuation Plan_____ Amended Plan _____

Reinvestment Service or Program – (check all categories that apply)

In-Plan Start-up TOTAL Reinvestment $ Requested:	**Non-Medical Only** TOTAL Reinvestment $ Requested:
In Lieu Of _____ Approved Procedure Code Newly Proposed _____ Budget a. Clinical/Operating $ _____ Budget b. One-time costs $ _____ TOTAL Reinvestment $ Requested:	**In Addition To** _____ Budget a. Clinical/Operating $ Budget b. One-time costs _____ TOTAL Reinvestment $ Requested: _____

Priority of submitted **Year(s) in which funds are to be spent**

Target Population: (MA eligible target population, population characteristics, number people served annually)

Description of Program or Service: (Describe program, for: In-Plan start up- under one year. Indicate service is to be licensed; In Lieu Of- why service is a cost effective alternative, staffing FTEs/qualifications; Children's Services requires IBHS program exception application; In Addition To – why expected to be cost effective or appropriate but not cost effective, staffing FTEs/qualifications; and Non-Medical Only- used when all costs are non-medical)

Description of Fund Expenditures: (Narrative identifying major budgeted items for clinical and operating expenses and total costs. Identify on-going funding source for program/services. Provide Attachment 5 information as applicable).

Clinical Costs* – Narrative and major budgeted items, includes personnel and benefits

Operating Costs** – Narrative and major budgeted items, includes operating costs incurred during the course of normal business, rent, travel, telephone, office supplies, etc.

Facility or land Purchase or Renovation**:** (Attachment 5: Summarize what is being purchased/ renovated and ownership arrangement including who owns title. Indicate agreement for disposal of assets upon sale.)

Fixed Assets: (Identify fixed assets to be purchased - vehicles, computers, furniture, equipment, etc. Indicate County Code for purchasing will be followed for items requiring competitive bid. See Attachment 5, if applicable.)

Data Analysis and Expected Outcomes: (Identify number of HC members in target population, describe unmet or under-met needs, what is expected to be achieved by the service and data to be collected to measure outcomes. For In Lieu Of services, identify the service from which cost offsets will be achieved.)

Stakeholder Involvement in Decision Making: (Stakeholder participation summarized and demonstrated support)

Instructions for Completing the Reinvestment Budget Form (Initial Budget Submission and Revisions):

The HealthChoices reinvestment plan must include a budget form. It is understood that adjustments to IBNRs, interest, and other items may impact the amounts available. Changes to the amount available and the corresponding budget should be handled as follows:

The **initial budget submission** should be included with the reinvestment plan and should reflect the exact amounts specified in the reinvestment plan. These amounts should be shown in the "Initial/Previous Budget" column.

Subsequent to the initial budget submission, **revisions** to the budget must be submitted as follows:

- An updated budget **must** be submitted with the annual reinvestment update.
- If a change is being proposed to any item within the budget, approval must be given by OMHSAS for the change if it is greater than 25% of the current priority amount or $50,000, whichever is higher. The request for approval must include a revised budget reflecting the proposed changes.
- Any changes due to IBNR adjustments or interest earned since the last budget was submitted should be reflected in the "Revision Amount" column.

Anytime revisions to the budget are being submitted, the most recent budget amounts should be reflected in the "Initial/Previous Budget" column.

When reporting actual reinvestment expenditures on Financial Report #12, the budget amounts should reflect the most recent budget amounts submitted.

County – The County HealthChoices Behavioral Health program for which the reinvestment budget is being submitted.

Date – The date the budget form is being prepared.

Reinvestment Funds from – The contract year that the reinvestment funds are applicable to.

Category of Eligibility – There are four separate forms:

HealthChoices Recipients – provide amounts that will be targeted to individuals who are enrolled in the HealthChoices Behavioral Health program.

MA Recipients – provide amounts that will be targeted to individuals who are eligible for medical assistance benefits but NOT enrolled in the HealthChoices Behavioral Health program.

Non-MA Recipients – provide amounts that will be targeted to individuals who are not eligible for medical assistance benefits.

Total – provide totals for amounts provided on individual forms.

Allocations/Contributions – Indicate the amount anticipated to be available.

Investment/Interest Income – Indicate an estimate of any interest to be earned over the course of the reinvestment spending period. This line item cannot be $0; an estimate **must** be provided.

Total Available – Add Allocations/Contributions and Investment/Interest Income.

Reinvestment Services (Identify) – List each reinvestment plan item, along with the specific budget amount. Please use the same description and amount used in the reinvestment plan.

Total Reinvestment Services – Sum of the individual reinvestment services.

Remaining Balance – Allocations/Contributions plus Investment/Interest Income minus Total Reinvestment Services.

Reinvestment Funds from_____
(Contract Year)

Category of Eligibility - ___HealthChoices Recipients

Reinvestment Account	Initial/Previous Budget	Revision Amcunt*	Revised Budget
Allocations/contributions			
Investment/interest income			
TOTAL AVAILABLE			
Less: Approved distributions for:			
Reinvestment Services (Identify)			
TOTAL REINVESTMENT SERVICES			
REMAINING BALANCE			

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306 Prepared by OMHSAS /DMFR

Reinvestment Funds from_____
(Contract Year)

Category of Eligibility - MA Recipients

Reinvestment Account	Initial/Previous Budget	Revision Amount*	Revised Budget
Allocations/contributions			
Investment/interest income			
TOTAL AVAILABLE			
Less: Approved distributions for:			
Reinvestment Services (Identify)			
TOTAL REINVESTMENT SERVICES			
REMAINING BALANCE			

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306 Prepared by OMHSAS /DMFR

Reinvestment Funds from_____
(Contract Year)

Category of Eligibility - Non-MA Recipients

Reinvestment Account	Initial/Previous Budget	Revision Amcunt*	Revised Budget
Allocations/contributions			
Investment/interest income			
TOTAL AVAILABLE			
Less: Approved distributions for:			
Reinvestment Services (Identify)			
TOTAL REINVESTMENT SERVICES			
REMAINING BALANCE			

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306 Prepared by OMHSAS /DMFR

Reinvestment Funds from_____
(Contract Year)

Category of Eligibility -____Total

Reinvestment Account	Initial/Previous Budget	Revision Amcunt*	Revised Budget
Allocations/contributions			
Investment/interest income			
TOTAL AVAILABLE			
Less: Approved distributions for:			
Reinvestment Services (Identify)			
TOTAL REINVESTMENT SERVICES			
REMAINING BALANCE			

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306 Prepared by OMHSAS /DMFR

Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets

All reinvestment plan priorities containing costs for facility or real estate purchase, renovation, housing development, vehicle acquisition, and/or purchase of fixed assets must adhere to these Reinvestment Plan Guidelines and applicable provisions of the local County Code.

Reinvestment Plan Submission:

Conditions that apply to reinvestment plan priorities that contain costs for facility or real estate purchase, renovation, housing development, vehicle acquisition, and or purchase of fixed assets are:

1. Primary purpose of the reinvestment plan priority must be to serve MA eligibles with mental health and/or drug and alcohol treatment service needs.

2. The reinvestment plan priorities must contain a statement of the rationale for the development of the program and related capital costs.

3. The reinvestment plan priority must explain the financial strategy for acquiring the property, facility or vehicle and why that method is cost effective. Identify whether the facility/vehicle will be purchased or leased or will facility costs be built into the service rate.

   Each County will describe the housing capital development strategy and why acquisition by a housing organization is cost effective from a housing finance perspective. The housing development strategy shall also specify the following: amount of reinvestment resources budgeted, types of rental housing (e.g. new construction or rehabilitation), and plan to administer the housing development funds.

4. The reinvestment plan priority must summarize the ownership arrangement between the County and provider and specify the party that holds title to fixed assets. Identify related parties when there is common ownership. Provide a detailed data analysis supporting the request as part of the reinvestment plan. The data analysis must support the need for the project proposed. The analysis should include, for example, analysis of the provider network demonstrating a gap in service, rationale for cost effectiveness of the purchase, description of underserved target population to be served, etc.

5. The County may enter an agreement to provide capital resources with a qualified housing organization in exchange for the set-aside of specific number of rental units for MA eligible consumers protected by a long term use restriction. The ownership arrangement for any capital development for supportive housing should identify the property to be acquired or replaced, number of set-aside units within the overall development that the county will have priority access over a specified period of time, how consumer access will be assured, the affordability of the rents to be paid by the MA eligible consumer, how the county will be reimbursed or be assured that the use restriction for these set-aside units remains in place in the event the property goes into foreclosure or the owner violates the terms of the agreement or the use restriction. Rental subsidies assigned to these set-aside rental units to ensure affordability for a specified period of time can be considered in exchange for investment based on a financial analysis that the exchange is of like or greater value.

6. The reinvestment plan priority must include a budget in sufficient detail to demonstrate how the amount identified in the reinvestment plan priority request was determined. This should include budgeted items (e.g. personnel, equipment, operating costs, transportation, repairs, etc.) and associated costs as well as any pertinent assumptions.

7. The reinvestment plan priority must contain information about the source of operating funds for the continuation of the program or service after one-time reinvestment plan funds are expended.

   For housing development plans, identify the number of units that will be available for a specified period of time. If the County intends to retain a housing agency to administer the housing development funds on their behalf, the reinvestment plan must include detailed information on the County's selection process, the selection criteria to be used, the administrator's duties/responsibilities, and the expected administrative fee to be paid to the administrator.

8. Purchase of vehicles is not permitted for transportation to MA services of MA eligible members otherwise served by the Medical Assistance Transportation Program (MATP).

County-Provider Reinvestment Plan Agreement:

Any agreement entered into between the County and a provider for the purpose of implementing a reinvestment plan priority, which contains costs for facility or real estate purchase, renovation, vehicle acquisition, and/or purchase of fixed assets, must:

1. Be reduced to writing

2. Be targeted to Medical Assistance eligibles with mental health and/or drug and alcohol service needs. For a housing development strategy the eligibles must be included as a priority population for housing services.

3. Assure that the acquisition or renovation is likely to be used in the HC program for at least five years and be subject to specified disposition requirements.
4. Identify any related parties and the relationship of the related parties regarding the accomplishment of the reinvestment plan.

5. Specify ownership rights, use of the facility, and the process for disposition of fixed assets in the event a sale should occur.

   For housing development funds, the funds must be secured by legally binding documents that are in acceptable forms. Such forms include but are not limited to: mortage, promissory note, loan agreement and restrictive covenant.

   These legally binding housing documents will address how the restriction of use will be passed on to the future owner in the event of property transfer as well as how the County will be reimbursed or be assured the use restriction for the set-aside units will stay in place in the event the property goes into foreclosure or the owner violates the terms of the agreement or the use restriction.

6. In the event of a sale, proceeds from the sale are to be returned to the County HealthChoices program for reinvestment in programs or services for MA eligible members**.** This provision is not applicable to housing development plans.

7. Specify the accounting method to be used in expensing, depreciating or amortizing costs. This provision is not applicable to housing development plans

8. Require maintenance, repair and insurance of fixed assets.

   In the case of a facility being purchased for housing, the County should specify the required maintenance and insurance of fixed assets. To ensure a property is maintained, the County or its designee will require or conduct periodic inspections to ensure compliance with HUD's Housing Quality Standards (HQS). Failure of inspection may trigger foreclosure or other actions as specified by the County. The County should be named on the insurance of fixed assets to order

for the County to be notified if coverage ceases and failure to maintain insurance of fixed assets can also trigger foreclosure or other action as specified by the County.

9. Require competitive bidding or written estimates as required by County Code or prudent business practices.

10. Be reviewed and approved by the County Solicitor and/or other appropriate County official (e.g. MH/MR legal counsel) to ensure compliance with these Reinvestment Plan Guidelines and applicable County Code provisions.

11. Contain a budget that details the costs associated with the facility renovation or purchase of fixed assets as submitted in the County's reinvestment plan priority. This provision is not applicable to housing development plans

12. Report #12 - Reinvestment Report

The purpose of this report is to monitor reinvestment activity. All approved allocations to and distributions from the reinvestment account are to be shown on this report. This report must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected on this report.

Reinvestment funds can be deposited when identified, but **must** be placed in a restricted account within thirty (30) days of the OMHSAS written approval of the County's reinvestment plan(s).

IMPORTANT NOTE: The services reported on this report should NOT be reported on Report #9. Report #9 should only reflect those medical services being provided under the current year's capitation revenue.

Columns are provided for reporting the number of unduplicated recipients served, current month units of service provided and dollar amount paid for those services, as well as cumulative year to date and contract to date units of service provided and dollar amount paid. A separate report must be provided for each of the following categories of aid:

1. All HealthChoices(all HealthChoices eligible recipients)
2. Other (non-HealthChoices recipients or non-identifiable recipients)
3. Total (total of the two categories above)

A methodology for allocating costs that are not attributable to a specific category of aid must be submitted and approved by DHS prior to implementation.

In addition, if reinvestment funds from more than one contract year are being utilized, a separate set of reports must be filed for each contract year's reinvestment funds.

The count of unduplicated recipients should be unduplicated by each individual reinvestment service and should reflect unduplicated recipients on a contract to date basis.

The Prior Period Balance is the reinvestment account balance as of the last day of the prior calendar month for the "Current Period" column; the reinvestment account balance as of the last day of the prior year for the "Year to Date" column; and $0 for the "Contract to Date" column.

Allocations/contributions are funds transferred into the reinvestment account.

Investment Revenue is income generated by the undistributed funds retained in the reinvestment account. Reinvestment revenue represents earnings on prior year funds and should appear on Report #12 only.

Approved Distributions are funds withdrawn from the reinvestment account in accordance with the DHS-approved Reinvestment Plan. A written plan for reinvestment must be submitted to and approved by DHS prior to making any distribution. Administrative costs, such as bank fees, should be reported on a separate line. Any administrative costs reported **must** be disclosed in detail in the footnotes to these reports.

Ending Balance is the reinvestment account balance as of the end of the last day of the calendar month.

The Budgeted Amount column should reflect the amounts and services contained in the DHS-approved reinvestment plan. Budgeted Investment/Interest Income should reflect either estimated interest to be earned on HealthChoices funds deposited in the reinvestment bank account and included in the Budget Forms submitted with your reinvestment plans to DHS for approval or interest earned on funds deposited in the reinvestment bank account and allocated to approved reinvestment plans.
Budgeted Amounts are not required to be allocated by rating group and can be reported only on the Total page. For electronic reporting, Budgeted Amounts may be reported in total as "Other".

The HealthChoices Behavioral Health Program Requirements for County Reinvestment Plans requires that revisions to an individual reinvestment plan priority, which are the greater of twenty-five percent (25%) or $50,000 for the priority being revised, be approved by OMHSAS in advance. Revisions less than the preceding requirements can be made without OMHSAS approval. All revisions to budget amounts made without OMHSAS approval must be included in the footnotes to the reports.

The bank statements for the reinvestment account, as well as the bank reconciliation that reconciles the general ledger to the reinvestment account bank statements, must be submitted with each month's report. The Department reserves the right to request additional documentation.

Reinvestment Report Form

Statement as of: _____(Reporting Date)

County: _____(County Name)

Reported By: _____(Reporting Entity)

For: _____(Year of Reinvestment Funds) Rating Group: _____(Rating Group)

Reinvestment Account Activity	Unduplicated Recipients	Current Period Units of Service	Current Period $ Amount	Contract to Date Units of Service Provided	Contract to Date $ Amount	Budget Amount
1. Prior Period Balance						
2. Allocations/contributions						
3. Investment/interest income						
4. SUBTOTAL (Lines 2 & 3)						
5. TOTAL (Lines 1 & 4)						
Less: Approved distributions for Reinvestment Services (identify):						
6. TOTAL						
7. Ending Balance (Line 5 minus Line 6)						

THIS REPORT FORMAT SHOULD BE USED FOR REPORTING MONTHS BEGINNING WITH 1/03.

COUNTY ANNUAL REPORT ON HEALTHCHOICES REINVESTMENT PLANS

COUNTY

Name of Service: _____ In-Plan-Start-up In Lieu Of In Addition To_____ Non-medical Bricks and Mortar____
Description of Program Service:
Progress in Implementing the Program or Service Including Expenditure of Funds:
Impact on Target Population:
Describe how the Program or Service is meeting the goals of HealthChoices (access, quality of life, improved health outcomes, cost effectiveness, etc.)

Note: An updated budget (Attachment 4) must be submitted with this report**.**

Prepared by: _____ Date:

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

ON-LINE INQUIRY ACCESS:

Each Behavioral Health Managed Care Organization (BH-MCO) will be required to connect to the Pennsylvania Open System Network (POSNet) for the purpose of on-line inquiries and file transfers. Specifications and limited technical assistance will be made available through the Department's Business Partner Help Desk. No information made available to the BH-MCO is to be used for any purpose other than supporting their work program under HealthChoices.

OMHSAS will provide hands-on training on the use and interpretation of Inquiry information found on the system.

- Client Information System (CIS)
  The Department will make available to each BH-MCO access to the Department's CIS database. This database provides eligibility history and demographic information to support the BH-MCO in meeting their obligations.

- Provider Database System
  Each BH-MCO has access to provider base information, including provider number, location, enrollment status, provider type and specialty.

- Reference Transactions System
  This system allows BH-MCO inquiry into drug, procedure code and diagnosis code information.

ELIGIBILITY VERIFICATION:

The Department provides the BH-MCO with an option for verifying Medical Assistance and HealthChoices eligibility, other than CIS inquiry.

- Eligibility Verification System (EVS)
  Each BH-MCO will be provided access to the Department's EVS. Telephone, Personal computer and Point of Sale device methods can be used to access the system. EVS can be used to verify Medical Assistance Eligibility, PH- MCO and BH-MCO coverage, primary care practitioner, TPL resources and other information.

DATA SUPPORT FILE TRANSMISSIONS:

The Department provides the BH-MCO with many data files for use in managing their program. These files are critical to the effective management of the program. Additional files, other than those listed as follows, may be made available by the Department as business needs evolve. The Department will transfer files via Secure eGOV. The file formats are subject to change by the Department and by HIPAA mandates.

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

Capitation Payment/Reimbursement Files:

File Description	File Name	Purpose	Frequency	From	To
820 Capitation	PMMRCCSS.MM.zip (P=constant; MM=Plan Code; R=Capitation; CC=Financial Cycle Number; SS=Sequence number	File of actual recipients paid for by DHS.	Monthly; Sent by the 5th of the month	PROMISe	BH-MCOs
MCO Payment Summary File	MPSMYJJJ.MM.zip (MPSM=Constant; YJJJ=Last Digit Year Julian Year; MM=Plan Code)	Summary file of capitation payments by county group rate cell and date of service up to 36 months.	Monthly; Sent by the end of the 2nd week of the month	PROMISe	BH-MCOs

Data Files:

File Description	File Name	Purpose	Frequency	From	To
PH/BH Pharmacy File	BHPHpharmMMDDYY.txt (BH=receiving BH-MCO; PH=submitting PH-MCO; pharm=pharmacy data; MM=Month; DD=Day; YY=Year)	Pharmacy data from physical health plans to the behavioral health plans.	Sent according to schedule developed by PH- MCO; at least twice a month.	PH-MCOs	BH-MCOs
FFS Pharmacy File	XX80pharmMMDDYY.txt (XX = Receiving PH-MCO, 80= indicates information is coming from FFS, pharm = pharmacy data, MM = Month, DD=Day, YY=Year, .txt = file extension for ASCII)	Pharmacy data from FFS to the physical health and behavioral health plans.	Weekly; Wed.	PROMISe	BH-MCOs

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

Eligibility Files/CIS-Related Files:

File Description	File Name	Purpose	Frequency	From	To
ARM568 File	xxARM568.ddd (XX=MCO Code; ARM568=Constant; ddd=Julian Date)	Report file of CIS eligibility statistics by county/ district.	Monthly; Sent on the Monday following the first full weekend of the month	DHS	BH-MCOs
834 Daily Eligibility File	FDXXJJJS.MM.zip (F=Constant; D=Daily; XX=Plan Code; JJJ=Julian Day; S=Sequence Number)	File of any change affecting address, category of assistance, county and district indicators, and plan coverage that day for a managed care recipient.	Daily; sent every state work day.	HP Translator	BH-MCOs
834 Monthly Eligibility File	FMXXJJJS.MM.zip (F=Constant; M=Monthly; XX=Plan Code; JJJ=Julian Day; S=Sequence Number; X12=Constant)	File of all MA eligible recipients who are covered by the plan at some point in the next month only. One record per recipient (most recent).	Monthly; created on the next to the last Saturday of the month.	HP Translator	BH-MCOs
TPL File	xxTPL766 (xx=MCO Code; TPL766=Constant)	TPL data for each MCO's members.	Monthly; Sent by the 25th of the month, regardless of holidays or weekends.	DHS	BH-MCOs

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

Provider Files:

File Description	File Name	Purpose	Frequency	From	To
List of Active and Closed Provider files	PRV414W.MM.zip PRV415M.MM.zip (PRV414 or PRV415=Constant; M=Monthly, W=Weekly; MM=Plan Code)	File of statewide MA providers.	Weekly; Tuesdays Monthly; Sent on the 1st of the month	PROMISe	BH-MCOs
Quarterly Network Provider File	PRV640Q.MM.zip (PRV640= Constant; Q=Quarterly; MM = Plan Code	File of MCO's providers, as returned to the MCO.	Quarterly; Sent on the 1st of the following months – January, April, July and October.	PROMISe	BH-MCOs
Response to the PRV640M Provider File	PRM640M.MM.rpt (PRM640=Constant; M=Monthly; MM=Plan Code)	Report of MCO provider records returned by DHS due to error.	Monthly; Sent within 48 hrs. of receiving the PRV640M. MM.zip	PROMISe	BH-MCOs
NPI Crosswalk	PRV430W	File of all active NPI records.	Weekly; Fridays	PROMISe	BH-MCOs
Special Indicator File	PRV435W	File of provider/service locations and special indicators.	Weekly; Fridays	PROMIS*e*	BH-MCOs

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

Reference Files:

File Description	File Name	Purpose	Frequency	From	To
Reference Diagnosis Code File	DIAGYJJJ.MM.zip (DIAG=Constant; YJJJ =Last Digit Year; MM=Plan Code)	ICD-9	Monthly; Sent on the 1st of the month.	PROMISe	BH-MCOs
Procedure Code Extract	PROCYJJJ.MM.zip (There are 5 files within this file.) They are: mcmod01.dat mcproc01.dat mctype01.dat mcprst01.dat mcprel01.dat (PROC=Constant; YJJJ=Last Digit Year Julian Day; MM=Plan Code)	The procedure Code File contains 5 files within the zip file: Modifier Max Fee, Procedure Code, Provider Type, Restricted, and Related.	Monthly; Sent on the 1st of the month	PROMISe	BH-MCOs

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

HIPAA Transaction Reports/Files:

File Description	File Name	Purpose	Frequency	From	To
ZZZ Full File Reject Report	Original File Name.zzz.zip	This report is sent from the translator in response to incoming HIPAA transaction files from the MCOs.	Daily	HP Translator	BH-MCOs
997 Full File Reject Report	Original File Name.997.zip	This report is sent from the translator in response to incoming HIPAA transaction files from the MCOs.	Daily	HP Translator	BH-MCOs
Record Accept/Reject Report	Original File Name.txn.zip	This report is sent from the translator in response to incoming HIPAA transaction files from the MCOs.	Daily	HP Translator	BH-MCOs
Record Accept/Reject File	Original File Name.ext.zip	This report is sent from the translator in response to incoming HIPAA transaction files from the MCOs.	Daily	HP Translator	BH-MCOs

HealthChoices Behavioral Health Data Support Files and Resources for Behavioral Health Managed Care Organizations

Notes:

*The Department reserves the right to occasionally modify the transmission schedule of data support files, based on operational need. Advance notice will be provided to business partners. Primary Contractors must refer to the Pennsylvania HealthChoices Managed Care website for the latest file specifications and file transfer schedules. https://dpwintra.dpw.state.pa.us/HEALTHCHOICES/custom/schedule/dpwfilespecs/dpwfi lespecs.asp

**HIPAA Implementation guides and Addenda for the various types of transactions are available from the Washington Publishing Company at http://www.wpc-edi.com. These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.

***Pennsylvania PROMISe Companion Guides for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The Companion Guides provide detailed information specific to the elements within the 834 and 820 files from the PROMISe system.

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM
PROGRAM STANDARDS AND REQUIREMENTS
PRIMARY CONTRACTOR

APPENDIX P

HealthChoices Behavioral Health
Financial Reporting Requirements (FRR's)

The current FRR is located at:

http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_226810.pdf

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES

PRIORITY POPULATIONS

MENTAL HEALTH *Reference: Mental Health Bulletin, OMH-94-04*
Adult *Serious Mental Illness: Adult Priority Group*

In order to be in the Adult Priority Group, a person: must meet the federal definition of serious mental illness[1]; must be age 18+, (or age 22+ if in Special Education); must have a diagnosis of schizophrenia, major affective disorder, psychotic disorder NOS or borderline personality disorder (DSM-IV or its successor documents as designated by the American Psychiatric Association, diagnostic codes 295.xx, 296.xx, 298.9x or 301.83); and must meet at least one of the following criteria: A. (Treatment History), B. (Functioning Level) or C. (Coexisting Condition or Circumstance).

A. Treatment History

1. Current residence in or discharge from a state mental hospital within the past two years; or

2. Two admissions to community or correctional inpatient psychiatric units or residential services totaling 20 or more days within the past two years; or

3. Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years; or

4. One or more years of continuous attendance in a community mental health or prison psychiatric service (at least one unit of service per quarter) within the past two years; or

5. History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services; or

6. One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician, (e.g., Area Agency on Aging) within the past two years.

[1] Adults with serious mental illness are persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. (See Reference for additional detail)

B. Functioning Level

Providers must perform an assessment of an individual's functionality utilizing an appropriate instrument and determine if the individual is appropriate for inclusion into Adult Priority Group.

The DSM identifies the WHODAS 2.0 or any subsequent version for individuals 18 years of age or older as a good instrument from the WHO. Other nationally recognized instruments appropriate to the individual's presenting condition are also acceptable.
Providers will also need to complete assessments for individuals under 18 years of age using appropriate clinical instruments to measure functioning for children, youth and young adults.

C. Coexisting Condition or Circumstance

1. Coexisting Diagnosis:

   a. Psychoactive Substance Use Disorder; or
   b. Intellectual Disabilities; or
   c. HIV/AIDS; or
   d. Sensory, Developmental and/or Physical Disability; or

2. Homelessness[2]; or

3. Release from Criminal Detention[3].

In addition to the above, any adult who met the standards for involuntary treatment (as defined in Chapter 5100 Regulations - Mental Health Procedures) within 12 months preceding the assessment is automatically assigned to the high priority group.

MENTAL HEALTH
Child and Adolescent

Reference: "Child and Adolescent Target Groups 1, 2, &3" in 1994 Community Mental Health Services Block Grant Application

I. The Child and Adolescent Priority Group 1 includes persons who meet all four criteria below:

A. Age: birth to less than 18 (or age 18 to less than 22 and enrolled in special education service).

[2] Homeless persons are those who are sleeping in shelters or in places not meant for human habitation, such as cars, parks, sidewalks or abandoned buildings.

[3] Applicable categories of release from criminal detention are jail diversion; expiration of sentence or parole; probation or Accelerated Rehabilitation Decision (ARD).

B. Currently or at any time in the past year have had a DSM-V diagnosis (excluding those whose sole diagnosis is intellectual disabilities or psychoactive substance use disorder or a "V" code) that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school or community activities.

C. Receive services from mental health and one or more of the following:

1. Intellectual Disabilities
2. Children and Youth
3. Special Education
4. Drug and Alcohol
5. Juvenile Justice
6. Health (the child has a chronic health condition requiring treatment)

D. Identified as needing mental health services by a local interagency team, e.g., CASSP Committee, Cordero Workgroup.

In addition to the above, any child or adolescent who met the standards for involuntary treatment within the 12 months preceding the assessment (as defined in Chapter 5100 - Mental Health Procedures) is automatically assigned to this priority group.

II. Second priority[4] is associated with children at-risk of developing a serious emotional disturbance by virtue of :

A. A parent's serious mental illness.
B. Physical or sexual abuse.
C. Drug dependency.
D. Homelessness.
E. Referral to the Student Assistance Programs.

DRUG AND ALCOHOL *Reference: Pennsylvania Department of Drug and Alcohol Programs Treatment Manual*

Providers which serve an injection drug use population shall give preference to treatment as follows:

- Pregnant injection drug users
- Pregnant substance users
- Injection Drug Users
- Overdoes survivors
- Veterans

[4] See reference for additional detail.

Encounter Data Submission Requirements and Application of Liquidated Damages for Noncompliance

I. CERTIFICATION REQUIREMENT

Each Behavioral Health Managed Care Organization (BH-MCO) or other entity intending to submit encounter data on behalf of a HealthChoices Behavioral Health Primary Contractor (Primary Contractor) must be certified through the Pennsylvania Reimbursement Operations and Management Information System in electronic format (PROMISe™) prior to the submission of production encounter data. The Department of Human Services (Department) will work with each submitter to ensure that the submitter can successfully create, submit, process, receive, and reconcile HIPAA-compliant file transactions that meet Pennsylvania's requirements.
Information on the certification process can be obtained by contacting the Department at: OMHSAS-837Issues@pa.gov

II. SUBMISSION REQUIREMENTS

A. HIPAA Compliance and MMIS Timeliness and Acceptance

All encounters must be HIPAA Compliant and submitted and approved in PROMISe™ (i.e., pass PROMISe™ edits) within 90 days following the date that the BH-MCO paid/adjudicated the provider's claim or encounter. The Primary Contractor and its subcontractor(s) shall be responsible for maintaining appropriate systems and mechanisms to obtain all necessary data from its health care providers to ensure its ability to comply with the Department's encounter data reporting requirements.

Failure to maintain a 98% Professional and 95% Institutional encounter timeliness and/or acceptance rates may result in liquidated damages.

Encounters will be evaluated using the Department's monthly timeliness and acceptance report.

Timeliness:

- Timeliness is calculated as the number of days between the adjudication date and the date accepted into PROMISe™.

Acceptance:

- Acceptance is based on the number of approved and denied ICN's submitted for the month.

Encounter submissions adversely affected by the HIPAA translator or PROMISe™ system deficiencies will not be included by the Department in the calculation of compliance percentages. Primary Contractors, BH-MCOs and other HealthChoices Behavioral Health business partners will be notified by the Department of the specific types of encounters which will be excluded from penalty consideration under the timeliness and acceptance performance measures.

B. Accuracy and Completeness

Accuracy and completeness are primarily based on the consistency between encounter information submitted to the Department and information for the same service maintained by the BH-MCO in their claims/service history database.

Accuracy and completeness will be determined through a series of analyses applied to BHMCO claims history data and encounters received and processed through PROMISe™. These analyses will be conducted at least annually by the Department, or the Department's contractor.

III. LIQUIDATED DAMAGES PROVISIONS

Non-compliance with Department requirements, followed by a failure to submit and fully implement a Department approved corrective action plan, may result in the Department imposing liquidated damages on the Primary Contractor

A. Timeliness and Acceptance

B. Failure to comply with the encounter data timeliness and/or acceptance requirements may result in the imposition of liquidated damages of up to of 2% of monthly paid administrative revenue (or $2,000, whichever is greater), to a maximum of $25,000 per month.

C. Accuracy and Completeness

Errors in accuracy and/or completeness requirements that are identified by the Department, or the Department's contractor, in the data analysis may result in the imposition of liquidated damages. An error in accuracy, an error in completeness, or an error in both areas, within the same claim/encounter record, will count as one error toward the total count of records contained within the reviewed sample. The percentage of the sample that includes an error is calculated by dividing the total number of records within the sample that includes an error by the total number of records in the sample.

Percentage of the sample that includes an error	Liquidated Damages
Less than 1.00%	None
1.00% – 4.99%	Up to 1.00% of monthly paid Administrative revenue (or $2,000, whichever is greater), to a maximum of $10,000 per month.
5.00% – 7.49%	Up to 2.00% of monthly paid administrative revenue (or $2,000, whichever is greater), to a maximum of $25,000 per month.
7.50% - 9.99%	Up to 2.50% of monthly paid administrative revenue (or $2,000, whichever is greater), to a maximum of $50,000 per month.
10.00% or higher	Up to 5.00% of monthly paid administrative revenue (or $2,000, whichever is greater), to a maximum of $75,000 per month.

Medical Necessity Guidelines for Intensive Behavioral Health Services (IBHS) Delivered Through Individual Services, ABA Services and Group Services

DESCRIPTION OF INDIVIDUAL SERVICES

Individual services are intensive therapeutic interventions and supports that are used to reduce and manage identified therapeutic needs, increase coping strategies and support skill development to promote positive behaviors with the goal of stabilizing, maintaining or maximizing functioning of a child, youth or young adult in the home, school or community setting.

Individual services can be delivered using behavior consultation (BC), mobile therapy (MT) or behavioral health technician (BHT) services. BC services consist of clinical direction of services to a child, youth or young adult, development and revision of the individual treatment plan (ITP), oversight of the implementation of the ITP, and consultation with a child's, youth's or young adult's treatment team regarding the ITP. MT services consist of individual and family therapy, development and revision of the ITP, assistance with crisis stabilization, and assistance with addressing problems the child, youth or young adult has encountered. BHT services consist of implementing the ITP.

INITIATION REQUIREMENTS FOR INDIVIDUAL SERVICES

A written order that complies with 55 Pa. Code § 1155.32(a)(1) is required for BC, MT or BHT services to be initiated. If services are to begin prior to completion of an assessment and ITP, a treatment plan is also required.

MEDICAL NECESSITY GUIDELINES FOR INITIATION OF INDIVIDUAL SERVICES

When evaluating whether the order contains clinical information to support the need for an assessment and ITP to be completed or the medical necessity of the BC, MT or BHT services ordered, the following must be taken into account:

A 1. The use of BC, MT or BHT services is reasonably expected to reduce or ameliorate the child's, youth's or young adult's identified therapeutic needs and increase the child's, youth's or young adult's coping strategies.

or

The use of BC, MT or BHT services is necessary to support skill development to promote positive behaviors that will assist the child, youth or young adult with achieving or maintaining maximum functional capacity.

2. The child's, youth's or young adult's behaviors do not pose a risk to the safety of the child, youth or young adult or others that cannot be managed while in the

community and the child, youth or young adult does not require a more restrictive level of care, such as inpatient treatment or a psychiatric residential treatment facility.

3. The number of hours of services prescribed are necessary for an assessment to be conducted and an ITP completed or are reasonably expected to reduce or ameliorate the behavioral or developmental effects of the child's, youth' or young adult's behavioral health disorder diagnosis; enable the child, youth or young adult to achieve or maintain maximum functional capacity; or acquire the skills needed to maximize functioning within the child's, youth's or young adult's home, school or community.

OR

B. If the written order does not support the above BC, MT, or BHT services must be otherwise medically necessary to meet the behavioral health needs of the child, youth or young adult.

CONTINUED CARE REQUIREMENTS FOR INDIVIDUAL SERVICES

The following documentation is required for BC, MT or BHT services to continue:

1. A written order that complies with 55 Pa. Code § 1155.32(a)(6).

2. An updated assessment that complies with 55 Pa. Code § 5240.21(b)-(d).

3. An updated ITP that complies with 55 Pa. Code § 5240.22(b)-(e) and (g).

MEDICAL NECESSITY GUIDELINES FOR CONTINUATION OF INDIVIDUAL SERVICES

An evaluation of the medical necessity of continued BC, MT or BHT services must take into account whether the required documentation indicates the following:

A. 1. The child, youth or young adult shows measured improvement and/or demonstrates alternative/replacement behaviors.

or

There is a reasonable expectation that continuation of BC, MT or BHT services will reduce or ameliorate the child's, youth's or young adult's identified therapeutic needs and increase the child's, youth's or young adult's coping strategies.

or

There is a reasonable expectation that continuation of BC, MT or BHT services is necessary to support skill development to promote positive behaviors that will assist the child, youth or young adult with achieving or maintaining maximum functional capacity.

2. The child's, youth's or young adult's behaviors do not pose a risk to the safety of the child, youth or young adult or others that cannot be managed while in the community and the child, youth or young adult does not require a more restrictive level of care, such as inpatient treatment or a psychiatric residential treatment facility.

3. The BC, MT or BHT services are needed to maintain the child's, youth's or young adult's maximum functional capacity and the benefit of continuing the BC, MT or BHT services is not outweighed by the risk that continuing the services will impede the child's, youth's or young adult's progress toward achieving his or her highest functional level.

4. The number of hours of services prescribed are reasonably expected to reduce or ameliorate the behavioral or developmental effects of the child's, youth' or young adult's behavioral health disorder diagnosis; enable the child, youth or young adult to achieve or maintain maximum functional capacity; or acquire the skills needed to maximize functioning within the child's, youth's or young adult's home, school or community.

OR

B. If the required documentation does not support the above, continued BC, MT or BHT services must be otherwise medically necessary to meet the behavioral health needs of the child, youth or young adult.

DESCRIPTION OF APPLIED BEHAVIOR ANALYSIS SERVICES

Applied Behavior Analysis (ABA) includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. ABA services are used to develop needed skills (behavioral, social, communicative, and adaptive functioning) through the use of reinforcement, prompting, task analysis, or other appropriate interventions in order for a child, youth or young adult to master each step necessary to achieve a targeted behavior.

Intensive Behavioral Health Services (IBHS) can be delivered through ABA services, which can be delivered through Behavior Analytic (BA), Behavior Consultation–ABA (BC-ABA), Assistant Behavior Consultation–ABA (Asst. BC-ABA) or Behavioral Health Technician–ABA (BHT-ABA) services. BA and BC-ABA services consist of clinical direction of services to a child, youth or young adult; development and revision of the individual treatment plan (ITP); oversight of the implementation of the ITP and consultation with a child's, youth's or young adult's treatment team regarding the ITP BA services also include functional analysis. Asst. BC-ABA services consist of assisting the individual who provides BA or BC–ABA services and providing face-to-face behavioral interventions. BHT-ABA services consist of implementing the ITP.

INITIATION REQUIREMENTS FOR ABA SERVICES

A written order that complies with 55 Pa. Code § 1155.33(a)(1) is required for BA, BC-ABA, Asst. BC-ABA or BHT-ABA services to be initiated. If services are to begin prior to completion of an assessment and ITP, a treatment plan is also required.

MEDICAL NECESSITY GUIDELINES FOR INITIATION OF ABA SERVICES

When evaluating whether the order contains clinical information to support the need for an assessment and ITP to be completed or the medical necessity of the BA, BC-ABA, Asst. BC-ABA or BHT-ABA services ordered, the following must be taken into account:

A. 1. The use BA, BC-ABA, Asst. BC-ABA or BHT-ABA services is reasonably expected to reduce or ameliorate the child's, youth's or young adult's identified therapeutic needs and increase the child's, youth's or young adult's coping strategies.

or

The use of BA, BC-ABA, Asst. BC-ABA or BHT-ABA services is necessary to support skill development to promote positive behaviors that will assist the child, youth or young adult with achieving or maintaining maximum functional capacity.

2. The child's, youth's or young adult's behaviors do not pose a risk to the safety of the child, youth or young adult or others that cannot be managed while in the community and the child, youth or young adult does not require a more restrictive

level of care, such as inpatient treatment or a psychiatric residential treatment facility.

3. The number of hours of services prescribed are necessary for an assessment to be conducted and an ITP completed or are reasonably expected to reduce or ameliorate the behavioral or developmental effects of the child's, youth' or young adult's behavioral health disorder diagnosis; enable the child, youth or young adult to achieve or maintain maximum functional capacity; or acquire the skills needed to maximize functioning within the child's, youth's or young adult's home, school or community.

OR

B. If the written order does not support the above, BA, BC-ABA, Asst. BC-ABA or BHT-ABA services must be otherwise medically necessary to meet the behavioral health needs of the child, youth or young adult.

CONTINUED CARE REQUIREMENTS FOR ABA SERVICES

The following documentation is required for BA, BC-ABA, Asst. BC-ABA or BHT-ABA services to continue:

1. A written order that complies with 55 Pa. Code § 1155.33(a)(6).

2. An updated assessment that complies with 55 Pa. Code § 5240.85(b)-(d)

3. An updated ITP that complies with 55 Pa. Code § 5240.86(b)-(e) and (g).

MEDICAL NECESSITY GUIDELINES FOR CONTINUATION OF ABA SERVICES

An evaluation of the medical necessity of continued BA, BC-ABA, Asst. BC-ABA or BHT-ABA services must take into account whether the required documentation indicates the following:

A. 1. The child, youth or young adult shows measured improvement and/or demonstrates alternative/replacement behaviors.

or

There is a reasonable expectation that continuation of BA, BC-ABA, Asst. BC-ABA or BHT-ABA services will reduce or ameliorate the child's, youth's or young adult's identified therapeutic needs and increase the child's, youth's or young adult's coping strategies.

or

There is a reasonable expectation that continuation of BA, BC-ABA, Asst. BC-ABA or BHT-ABA services is necessary to support skill development to promote positive behaviors that will assist the child, youth or young adult with achieving or maintaining maximum functional capacity.

2. The child's, youth's or young adult's behaviors do not pose a risk to the safety of the child, youth or young adult or others that cannot be managed while in the community and the child, youth or young adult does not require a more restrictive level of care, such as inpatient treatment or a psychiatric residential treatment facility.

3. The BA, BC-ABA, Asst. BC-ABA, or BHT-ABA services are needed to maintain the child's, youth's or young adult's maximum functional capacity and the benefit of continuing the BA, BC-ABA, Asst. BC-ABA, or BHT-ABA services is not outweighed by the risk that continuing the services will impede the child's, youth's or young adult's progress toward achieving his or her highest functional level.

4. The number of hours of services prescribed are reasonably expected to reduce or ameliorate the behavioral or developmental effects of the child's, youth' or young adult's behavioral health disorder diagnosis; enable the child, youth or young adult to achieve or maintain maximum functional capacity; or acquire the skills needed to maximize functioning within the child's, youth's or young adult's home, school or community.

OR

B. If the required documentation does not support the above, continued BA, BC-ABA, Asst. BC-ABA or BHT-ABA services must be otherwise medically necessary to meet the behavioral health needs of the child, youth or young adult.

DESCRIPTION OF GROUP SERVICES

Group services are therapeutic interventions provided primarily in a group format through psychotherapy; structured activities, including ABA services; and community integration activities that address a child's, youth's or young adult's identified treatment needs. Group services can be provided in a school, community setting or community like setting. A community like setting is a setting that simulates a natural or normal setting for a child, youth or young adult.

Group services can be delivered by graduate level professionals and individuals who meet the qualifications to provide behavioral health technician (BHT) services of BHT-ABA services.
A graduate level professional may provide individual, group and family psychotherapy; design of psychoeducational group activities; clinical direction of services to a child, youth or young adult; creation and revision of the individual treatment plan (ITP); oversight of the implementation of the ITP and consultation with the child's, youth's or young adult's treatment team regarding the ITP. An individual who is qualified to provide BHT services or BHT-ABA services may assist with conducting group psychotherapy, facilitate psychoeducational group activities and implement the child's, youth's or young adult's ITP.

INITIATION REQUIREMENTS FOR GROUP SERVICES

A written order that complies with 55 Pa. Code § 1155.34(a)(1) is required for group services to be initiated. If services are to begin prior to completion of an assessment and ITP, a treatment plan is also required

MEDICAL NECESSITY GUIDELINES FOR INITIATION OF GROUP SERVICES

When evaluating whether the order contains clinical information to support the need for an assessment and ITP to be completed or the medical necessity of the group services ordered, the following must be taken into account:

A. 1. The use of group services is reasonably expected to reduce or ameliorate the child's, youth's or young adult's identified therapeutic needs and increase the child's, youth's or young adult's coping strategies.

or

The use of group services is necessary to support skill development to promote positive behaviors that will assist the child, youth or young adult with achieving or maintaining maximum functional capacity.

2. The child's, youth's or young adult's behaviors do not pose a risk to the safety of the child, youth or young adult or others that cannot be managed while in the community and the child, youth or young adult does not require a more restrictive level of care, such as inpatient treatment or a psychiatric residential treatment facility.

3. The number of hours of services prescribed are necessary for an assessment to be conducted and an ITP completed or are reasonably expected to reduce or ameliorate the behavioral or developmental effects of the child's, youth' or young adult's behavioral health disorder diagnosis; enable the child, youth or young adult to achieve or maintain maximum functional capacity; or acquire the skills needed to maximize functioning within the child's, youth's or young adult's home, school or community.

OR

B. If the written order does not support the above, group services must be otherwise medically necessary to meet the behavioral health needs of the child, youth or young adult.

CONTINUED CARE REQUIREMENTS FOR INDIVIDUAL SERVICES

The following documentation is required for group services to continue:

1. A written order that complies with 55 Pa. Code § 1155.34(a)(6).

2. An updated assessment that complies with 55 Pa. Code § 5240.95(b)

3. An updated ITP that complies with 55 Pa. Code § 5240.96(b)-(e) and (g).

MEDICAL NECESSITY GUIDELINES FOR CONTINUATION OF GROUP SERVICES

An evaluation of the medical necessity of continued group services must take into account whether the required documentation indicates the following:

A. 1. The child, youth or young adult shows measured improvement and/or demonstrates alternative/replacement behaviors.

or

There is a reasonable expectation that continuation of group services will reduce or ameliorate the child's, youth's or young adult's identified therapeutic needs and increase the child's, youth's or young adult's coping strategies.

or

There is a reasonable expectation that continuation of group services is necessary to support skill development to promote positive behaviors that will assist the child, youth or young adult with achieving or maintaining maximum functional capacity.

2. The child's, youth's or young adult's behaviors do not pose a risk to the safety of the child, youth or young adult or others that cannot be managed while in the community and the child, youth or young adult does not require a more restrictive level of care, such as inpatient treatment or a psychiatric residential treatment facility.

3. The group services are needed to maintain the child's, youth's or young adult's maximum functional capacity and the benefit of continuing the group services is not outweighed by the risk that continuing the services will impede the child's, youth's or young adult's progress toward achieving his or her highest functional level.

4. The number of hours of services prescribed are reasonably expected to reduce or ameliorate the behavioral or developmental effects of the child's, youth' or young adult's behavioral health disorder diagnosis; enable the child, youth or young adult to achieve or maintain maximum functional capacity; or acquire the skills needed to maximize functioning within the child's, youth's or young adult's home, school or community.

OR

B. If the required documentation does not support the above, continued group services must be otherwise medically necessary to meet the behavioral health needs of the child, youth or young adult.

DISCHARGE FROM INDIVIDUAL SERVICES, ABA SERVICES, OR GROUP SERVICES AND SERVICE TRANSITION

A provider may discharge a child, youth or young adult who is receiving individual services, ABA services, or group services for any of the following reasons:

1. The prescriber, with the participation of the treatment team, has determined that the child, youth or young adult has completed the goals and objectives identified in the ITP and no new goals or objectives have been identified and that individual services, ABA services, or group services are no longer necessary.

2. The prescriber, with the participation of the treatment team, has determined that the child, youth or young adult is not progressing towards the goals identified in the ITP within 180 days for the initiation of individual services, ABA services, or group services and other clinical services are being provided.

3. The prescriber, with the participation of the treatment team, has determined that the child, youth or young adult requires a more restrictive setting and other clinical services are being provided.

4. The parent or legal guardian of a child or youth who provided consent for the child or youth to receive individual services, ABA services, or group services agrees that services should be discontinued.

5. The youth or young adult agrees that individual services, ABA services, or group services should be discontinued.

6. The child, youth or young adult failed to attend scheduled individual services, ABA services, or group services for 45 consecutive days without any notification from the youth, young adult or the parent, legal guardian or caregiver of the child or youth. Prior to discharge, the IBHS agency made at least three attempts to contact the youth, young adult or the parent, legal guardian or caregiver to discuss past attendance, ways to facilitate attendance in the future and the potential discharge of the child, youth or young adult for lack of attendance.

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES

GUIDELINES for MENTAL HEALTH MEDICAL NECESSITY CRITERIA

ADULT

PSYCHIATRIC INPATIENT SERVICES

Admission (must meet criteria I, II, and III):

A physician has conducted an evaluation and has determined that:

I. The person has a psychiatric diagnosis or provisional psychiatric diagnosis, excluding mental retardation, substance abuse or senility, unless these conditions coexist with another psychiatric diagnosis or provisional psychiatric diagnosis,

and

II. The person cannot be appropriately treated at a less intense level of care because of the need for:

* 24 hour availability of services for diagnosis, continuous monitoring and assessment of the person's response to treatment,
* availability of a physician 24 hours a day to make timely and necessary changes in the treatment plan,
* the involvement of a psychiatrist in the development and management of the treatment program, and
* 24 hour availability of professional nursing care to implement the treatment plan and monitor/assess the person's condition and response to treatment.
* 24 hour clinical management and supervision,

and

III. The severity of the illness presented by the person meets one or more of the following:

* The person poses a significant risk of harm to self or others, or to the destruction of property.

* The person has a medical condition or illness which cannot be managed in a less intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.
* The person's judgment or functional capacity and capability has decreased to such a degree that self-maintenance, occupational, or social functioning are severely threatened.
* The person requires treatment which may be medically unsafe if administered at a less intense level of care.
* There is an increase in the severity of symptoms such that continuation at a less intense level of care cannot offer an expectation of improvement or the prevention of deterioration, resulting in danger to self, others, or property.

Continued stay **(must meet criteria I and II):**

I. The severity of the illness presented by the person meets one or more of the following:

* persistence of symptoms which meet admission criteria; or
* development of new symptoms during the person's stay which meet admission criteria; or
* there is an adverse reaction to medication, procedures, or therapies requiring continued hospitalization; or
* there is a reasonable expectation based on the person's current condition and past history, that withdrawal of inpatient treatment will impede improvement or result in rapid decompensation or the re-occurrence of symptoms or behaviors which cannot be managed in a treatment setting of lesser intensity.

and

II. The person continues to need the intensity of treatment defined under Admission Criterion II; and

* a physical examination is conducted within 24 hours after admission; and
* a psychiatrist conducts a psychiatric examination within 24 hours after admission; and
* the person participates in treatment and discharge planning; and
* treatment planning and subsequent therapeutic orders reflect appropriate, adequate and timely implementation of all treatment approaches in response to the person's changing needs.

Discharge Indicators (must meet I or II):

I. The person no longer needs the inpatient level of care because:

* The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
* The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and
* The person does not pose a significant risk of harm to self or others, or destruction of property; and
* There is a viable discharge plan which includes living arrangements and follow-up care

or

II. Inpatient psychiatric treatment is discontinued because:

* A diagnostic evaluation and/or a medical treatment has been completed when one of these constitutes the reason for admission; or
* The person withdraws from treatment against advice and does not meet criteria for involuntary commitment; or
* The person is transferred to another facility/unit for continued inpatient care.

Admission **(must meet criteria I, II, and III):**

I. A mental health professional, as defined in Chapter 5210.3 of the Partial Hospitalization regulations, has conducted an evaluation and has determined that the person meets one of the following:

* The person has an established history of a psychiatric disorder, excluding mental retardation, substance abuse or senility, unless these conditions co-exist with other psychiatric symptomatology, and is presenting symptoms which require this level of care; or
* The person does not have an established psychiatric history, but a psychiatrist, or physician, or a licensed clinical psychologist has been consulted and has confirmed the presence of a psychiatric disorder that requires this level of care; or

* The person has had an evaluation by a psychiatrist, a physician, or a licensed clinical psychologist at another mental health treatment facility, (e.g., inpatient, outpatient or crisis intervention) and is being directly referred to this level of care; or
* The person needs a diagnostic evaluation that cannot be performed at a lesser level of care.

and

II. The partial hospital level of care is appropriate because:

* The person has the capacity to participate in the partial hospitalization level of care; and
* The person has a community based network of support that enables him/her to participate in the partial hospitalization level of care; and
* The person exhibits sufficient control over his/her behavior such that he/she is judged not to be an imminent danger to self, others or property.

and

III. The severity of the symptoms presented by the person meets one or more of the following:

* The person's judgment or functional capacity and capability is compromised to such a degree that self-maintenance, occupational, educational or social functioning are significantly impaired, and the severity of the presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
* The person requires treatment which may be unsafe if administered at a less intense level of care; or
* Sufficient clinical gains have not been made within a less intensive level of care, and the severity of presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
* Co-existing, non-psychiatric medical conditions preclude treatment at a less intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.

Continued Stay Criteria **(must meet criteria I and II)**

I. One or more of the symptoms or conditions which necessitated admission persist, or new symptoms develop which meet admission criteria, and the person meets one or more of the following:

* The person has not completed the goals and objectives of the Individualized Treatment Plan that are necessary to warrant transition to a less intensive level of care; or
* The person demonstrates a current or historical inability to sustain/maintain gains without a comprehensive program of treatment services provided by the partial hospital program; or
* Attempts to reduce the intensity and structure of the therapeutic program have resulted in, or are likely to result in, exacerbation of the psychiatric illness as manifested by regression of behavior and/or the worsening of presenting symptomatology; or
* Attempts to increase the person's level of functioning or role performance in the areas of interpersonal, occupational or self-management functioning have resulted in exacerbation of psychiatric illness as manifested by regression of behavior and/or the worsening of presenting symptomatology; or
* An adverse reaction to medication, procedures or therapies requires frequent monitoring which cannot be managed at a less intensive level of care.

and

II. The partial hospital program provides the following service elements:

* The person is receiving active treatment within the framework of a multi-disciplinary individualized treatment plan approach; and
* There is the involvement of a psychiatrist in the development and management of the treatment program and discharge plan; and
* The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to respond to changes in the person's clinical presentation or lack or progress; and
* The person is an active participant in treatment and discharge planning; and
* Where clinically appropriate, and with the person's informed consent, timely attempts are made by the treatment team, and documented in the treatment plan, to involve the family and other components of the person's community support network in treatment planning and discharge planning.

Discharge Indicators **(must meet I or II):**

I. The person no longer needs the partial hospital level of care because:

* The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
* The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and

* There is a viable discharge plan with which service and care providers identified for after-care treatment, if needed, and support have concurred.

or

II. The partial hospital level of care is discontinued because:

* The diagnostic evaluation has been completed when this constitutes the reason for admission; or
* The person withdraws from treatment against advice and does not meet criteria for involuntary commitment; or
* The person is transferred to another facility/unit for continued care.

Admission **(must meet criteria I and II):**

I. A mental health professional determines that the outpatient level of care is appropriate and there is the potential for the person to benefit from outpatient care. The person must meet at least one of the following condition elements:

* The person has a psychiatric illness exhibited by reduced levels of functioning and/or subjective distress in response to an acute precipitating event; or
* The person is exhibiting signs or symptoms of a psychiatric illness, associated with reduced levels of functioning and/or subjective distress; or
* The person has a history of psychiatric illness and presents in remission or with a residual state of a psychiatric illness, and without treatment there is significant potential for serious regression,

and

II. A comprehensive diagnostic evaluation, including an assessment of the psychiatric, medical, psychological, social, vocational and educational factors important to the person, is conducted.

Continued Stay **(must meet criteria I, II and III):**

I. The person has a current psychiatric diagnosis or provisional psychiatric diagnosis.

and

II. The treatment team determines that:

* The person continues to exhibit one or more signs or symptoms that necessitated admission and can be expected to benefit from the outpatient level of care; or
* The person has developed new signs or symptoms that meet admission criteria and could be expected to benefit from the outpatient level of care; or
* There is a reasonable expectation based on the person's clinical history that withdrawal of treatment will result in decompensation or recurrence of signs or symptoms.

III. The services provided to the person meet the following criteria:

* The person is an active participant in treatment and discharge planning; and
* A psychiatrist reviews and approves the treatment plan; and
* The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to address changes in the person's clinical presentation and response to treatment; and
* The person is receiving treatment within the framework of a multidisciplinary individualized treatment plan approach.

Discharge Indicators

* The person no longer meets continued stay criteria; or
* The person withdraws from treatment against advice and does not meet criteria for involuntary treatment.

Appendix T
Part A

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA

ADULT

TARGETED CASE MANAGEMENT SERVICES

Admission Criteria

An individual who meets the minimum staff requirements for an Intensive Case Manager as defined by Chapter 5221, Mental Health Intensive Case Management; a Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; or a Blended Case Manager as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

I. The person meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management; or Blended Case Management as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised;

or

II. The person meets the criteria for serious mental illness (SMI) as described in *Federal Register Volume 58 No. 96, May 20, 1993, pages 29422- 29425*; and cited in OMH-94-04: p. 1;

and

III. The person is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the Targeted Case Management-Adult Environmental Matrix, and in conjunction with clinical information and the professional judgement of the reviewer.

Continued Stay and/or Change of Level of Need

The consumer must be reassessed at the point of concurrent review, but no less frequently than six month intervals, and when there are significant changes in the individual's situation that warrants a change in level of TCM services.

I. The consumer continues to meet either I or II of part A Admission Criteria. and

II. The person is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the Targeted Case Management-Adult Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.

Discharge Indicators

Targeted Case Management may be terminated when one of the following criteria is met:

A. The consumer receiving the service determines that Targeted Case Management is no longer needed or wanted and the consumer no longer meets the continued stay criteria; or

B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the adult receiving the service and the consumer no longer meets the continued stay criteria; or

C. The consumer receiving the service determines that Targeted Case Management is no longer wanted, however, the consumer does meet continued stay criteria; or

D. The consumer has moved outside of the current geographical service area (e.g., county, state, country); or

E. The consumer is undergoing long-term incarceration and/or long-term hospitalization or long-term skilled-nursing care without a discharge or anticipated discharge date.

TCM ENVIRONMENTAL MATRIX — ADULTS INSTRUCTIONS

The Environmental Matrix - Adults is a scale that evaluates the functional level of consumers on the six activities identified by regulation as Targeted Case Management activities. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals must be assessed in the following areas, in a face-to-face interview with the evaluator.
Individuals should be reassessed as needed, but no less than every six months.

1. Assessment and Service Planning
2. Informal Support and Network Building
3. Use of Community Resources
4. Linking and Accessing Services
5. Monitoring of Service Delivery
6. Problem Resolution

The scale has a range from 0 to 5 with the following values for each activity:

0	1	2	3	4	5
No assistance Needed	Minimal assistance needed		Needs Moderate assistance in this area		Needs Significant assistance in this area

All six activities are ranked on the above scale. The evaluator must complete the environmental matrix in a face- to – face, strengths - based assessment interview with the consumer. Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e., extended family, allocation of family resources, the decision making process, values, etc.). The evaluator should consider the individual's strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

. Housing/living situation
. Education/vocation
. Income/benefits/financial management
. Mental Health treatment
. Alcohol and other drug use.
. Socialization/support
. Activities of daily living
. Medical treatment
. Legal situation
. Transportation issues
. Criminal justice system involvement

Each area is defined at the "1", " 3 ", and " 5 " levels (See attached Environmental Matrix) and the subtotal score is divided by 6 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Service Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels on individual assessment areas may be gradated to the 0.5 level only; this allows for minor differentiation of consumer need without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, of the consumer during the last ninety (90) days, rate the consumer's functional level in each of the six areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the six (6) scores should then be taken and divided by 6 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer's need for service. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person's average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value.

The Environmental Matrix score, your *professional judgement* *, and other information (e.g., cultural factors, records of past treatment, psychiatric evaluations, psychosocial summaries) that impacts on the consumer's level of need should then be considered and the Recommended Level of TCM service should be entered on the recommended level of TCM line of the Scoring Sheet. (These levels are consistent with minimum levels of contact as defined in

Chapter 5221, Intensive Case Management regulations and Bulletin *OMH-93-09, Resource Coordination: Implementation*.) If the recommended level of TCM service differs from the Environmental Matrix score, the difference must be justified with professional judgement in "Other Factors/Issues Affecting Score" section of the scoring sheet. **Note: The level of service indicated by the assessment represents the individual's needs at the time of assessment.**
Service intensity could change as an individual's needs and/or desires for service change.

ENVIRONMENTAL MATRIX
TCM SERVICE SCORING GRID

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended).
1.5 – 3.9	RC	At least 1 face to face contact every two months
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

* ***professional judgement:*** *opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.*

ASSESSMENT & SERVICE PLANNING

The consumer is able to provide meaningful and accurate information regarding own mental health status and needs. The consumer, with possible assistance from the targeted case manager, identifies, formulates, and expresses personal goals and objectives and can correlate these into concrete service needs and activities. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to service planning (i.e., language, perceived/actual institutional racism/discrimination, etc.)

0 1 2 3 4 5

Needs minimal assistance in this area	Needs moderate assistance in this area	Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able to provide meaningful/relevant/accurate information regarding own mental health status. Consumer is able to identify and formulate and express personal goals and objectives with minimal assistance from others. Consumer is able to translate/correlate these goals and objectives, with minimal direction, into concrete service needs and activities.

3= Consumer needs and/or requests moderate assistance in identifying and conveying information regarding own mental health status/problems. Consumer needs and/or requests moderate assistance from others in order to identify, formulate, and express personal goals and objectives. Consumer needs and/or requests moderate assistance from others to translate/correlate needs and goals into concrete service needs and activities.

5= Consumer needs and/or requests significant assistance from others to provide any meaningful information regarding own mental health status and/or needs.
Consumer is unable to express personal goals nor objectives without assistance. Consumer needs and/or requests significant assistance from others to design/formulate service plan and activities.

USE OF COMMUNITY RESOURCES

The consumer is able to identify, understand, and articulate daily living needs as well as those community/neighborhood resources that may be needed to meet these needs. The consumer may need additional support from the targeted case manager in utilizing the services that may go beyond the realm of traditional mental health/substance abuse services. TCM must recognize cultural and linguistic needs as an important element in articulating daily living needs and resources. Many services may not be available in the immediate community and be less effective if located outside the community.

---

0 1 2 3 4 5

Needs minimal assistance in this area	Needs moderate assistance in this area	Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able, when encouraged, to identify and articulate daily living needs. Consumer is able to access, navigate, and utilize community/neighborhood resources with minimal assistance. Consumer's needs may be fulfilled through the use of existing community resources such as social/religious groups, libraries, stores, directories, and public transportation and consumer is able to utilize these with minimal assistance.

3= Consumer needs and/or requests moderate assistance in identifying daily living needs as well as those community resources needed to meet these needs. When directed to community resources such as social/religious groups, libraries, stores, directories, and public transportation, the consumer may require and/or request moderate assistance to access and utilize these resources in order to accomplish a planned task.

5= Consumer is unable to identify nor understand daily living needs. Consumer is not familiar with community/neighborhood resources and has had very few, if any, positive experiences while living in the community. Consumer needs and/or requests significant assistance to access, navigate, or utilize existing community resources.

INFORMAL SUPPORT NETWORK BUILDING

The consumer identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the consumer may gain informal support. The TCM should recognize that service system barriers may impede the consumer from interacting with family, friends, significant others and community groups. The consumer may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

---

0 1 2 3 4 5

Needs minimal assistance in this area	Needs moderate assistance in this area	Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom consumer interacts and from whom consumer may gain informal support. Consumer is able, with minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

3= Consumer needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom consumer may gain informal support. Consumer needs and/or requests moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

5= Consumer is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. Consumer has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. Consumer needs and/or requests significant assistance from others to elicit information and support on his/her behalf.

LINKING AND ACCESSING SERVICES

The consumer is able to locate, gain access, and maintain contact and services with the service providers that have been identified as needed in the treatment or service plan. The treatment or service plan must recognize the cultural and linguistic needs of the consumer. At times, the targeted case manager may be needed to provide assistance in nontraditional and/or assertive ways to successfully gain and maintain these resources.

---

0 1 2 3 4 5

Needs minimal assistance in this area	Needs moderate assistance in this area	Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able, with minimal assistance from others, to locate and gain access to services identified in the treatment or service plan. Consumer is able, when encouraged, to establish and maintain appointments/services with appropriate service providers with minimal assistance. Consumer needs and/or requests minimal assistance by others to successfully gain access to and to maintain contact with community resources and services.

3= Consumer needs and/or requests moderate assistance in locating and gaining access to services identified in the treatment or service plan. Consumer may require and/or request moderate assistance, often in nontraditional ways, to access, establish, and maintain contact and services with the identified service providers.

5= Consumer is unable and/or unwilling to locate or gain access to services identified in the treatment or service plan. Consumer's identified needs are so immense or so unusual that assertive and creative efforts outside of the usual and normal practice must be employed in order to help the person gain the resources and services identified. Consumer needs and/or requests significant (frequent and continual) assistance by others to successfully gain access to and to maintain contact with community resources and services.

MONITORING OF SERVICE DELIVERY

The consumer gauges and communicates her/his satisfaction with the progress that has been made and with the services offered/delivered by the service providers identified in the treatment plan. The consumer suggests possible needed revisions and/or additions to the treatment/service plan. The TCM should recognize that language and culture has much to do with expressions of satisfaction/dissatisfaction and be prepared to assist the consumer in suggesting changes in the treatment plan/service plan or actual provider.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able to communicate, when encouraged, his/her opinion of the progress and satisfaction with the service provider and/or the delivered services as well as the need for revisions to the treatment/service plan. Consumer is able and willing to participate in intra- and inter-agency as well as cross-systems reviews of the need for and appropriateness of the specific services delivered. Minimal assistance from others is needed and/or requested to ensure that the consumer is satisfied with the services received.

3= Consumer needs and/or requests moderate assistance in determining and communicating his/her satisfaction with the service provider and with the services delivered. Consumer needs and/or requests moderate assistance in identifying what progress has been made and the possible need for revisions to the treatment/service plan.

5= Consumer is almost totally dependent on others to see that progress is being made and to suggest needed revisions to the treatment/service plan. Consumer needs and/or requests significant assistance to communicate effectively and realistically about her/his progress and satisfaction with the service provider and/or the services delivered.

PROBLEM RESOLUTION

The consumer is able to resolve issues and overcome barriers, including those that are cultural and linguistic in nature, that prevent her/him from receiving needed treatment, rehabilitation, and/or support services as well as entitlements. The consumer is aware of and able to utilize complaint/grievance procedures as well as additional appropriate advocacy supports. The targeted case manager, when requested and or needed, may be called upon to not only help the consumer with these tasks but also to provide information to the County Office of Mental Health and/or the BHMCO in order to overcome barriers and to assist the consumer in obtaining needed services.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer needs and/or requests minimal assistance to resolve issues and overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.

3= Consumer is able, with moderate assistance and encouragement, to identify issues that need to be resolved but is unable, without direct assistance from others, to formulate steps or implement actions that would overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.

5= Consumer needs and/or requests significant assistance, to identify and resolve issues that prevent him/her from receiving treatment, rehabilitation and/or support services. Consumer is totally dependent on others to recognize and to take steps to overcome these barriers. Resolution may require the intervention of the County Office of Mental Health and/or the modification of existing services or the development of new services.

TARGETED CASE MANAGEMENT ENVIRONMENTAL MATRIX - ADULT

Agency **County**

CONSUMER INFORMATION:

Name :

(Last) (First) (MI)

Parent/Guardian Name:

Identifying Number(s):

Date of Birth: / /
(MM)/(DD)/(YYYY)

Social Security Number: - - CIS/BSU/MCO Number:

PHMCO:

BHMCO:

Form Completed by: Date Completed:

The purpose of this form is to assess what environmental and cultural factors help to determine an individual's need for the various levels of case management services. Please complete this form utilizing the individual's behavior during the last ninety days as a basis for scoring each indicator. Please see the *Scoring Sheet* for additional information on determining the Environmental Matrix Score and its meaning for level of care assignments.

ENVIRONMENTAL MATRIX ADULT SCORING SHEET

CONSUMER NAME:

ID#(SOCIAL SECURITY/CIS/BSU):

SCORES:

1. Assessment and Service Planning _____
2. Use of Community Resources _____
3. Informal Support Network Building _____
4. Linking and Assessing Services _____
5. Monitoring of Service Delivery _____
6. Problem Resolution _____

SUBTOTAL

ENVIRONMENTAL MATRIX SCORE = SUBTOTAL □□6= _____

OTHER FACTORS/ISSUES AFFECTING SCORE:

_____

_____

_____

_____

ENVIRONMENTAL MATRIX TCM SERVICE SCORING GRID

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended).
1.5 – 3.9	RC	At least 1 face to face contact every two months
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

[*] ***professional judgement:*** *opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.*

RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:

CONSUMER: **DATE:**

PERSON COMPLETING THE FORM: **DATE:**

APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:

REVIEWER **DATE:**

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

PSYCHIATRIC INPATIENT HOSPITALIZATION RESIDENTIAL TREATMENT PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS PSYCHIATRIC OUTPATIENT TREATMENT

Purpose

The purpose of this document is to provide decision-making criteria for the admission of children and adolescents to four (4) treatment environments under regulation. This document provides a clear interpretive framework, in accordance with Office of Mental Health and Substance Abuse Services (OMHSAS) program, and Office of Medical Assistance Programs (OMAP) payment regulations, for deciding when to treat, continue or discontinue treatment, and refer elsewhere for other services. These criteria will serve the basis for decision-making for Managed Care Organizations (MCOs), county Mental Health/Mental Retardation/Intellectual Disabilities (MH/MR/ID) offices, and prescribers of children's mental health services in general, as well as for providers delivering their respective services to children qualifying for Medical Assistance (MA) coverage. This document provides a common set of criteria for reference by all the decision-makers in a child's care. These four (4) sets of criteria are intended to further consistency between the child's treatment needs and the broader philosophy of individualized service delivery in the most appropriate and least restrictive setting as guided, respectively, by the principles of the Child and Adolescent Service System Program (CASSP) and the Community Service Program (CSP).

Background

The Office of Mental Health and Substance Abuse Services (OMHSAS) produced Title 55 PA Code Chapters 5100, 5300, 4210, 5200, 5310, and 5210 to regulate the general delivery of services in community psychiatric inpatient, outpatient, residential, and partial hospitalization settings, while OMAP produced Title 55 PA Code, Chapters 1151 and 1153 to regulate M.A. payment for these services. Additional clarity for psychiatric residential treatment is provided in OMHSAS's proposed Chapter 5215 regulations. However, as more mental health services are developed for delivery in the home and community, in conjunction with a growing emphasis on providing services in the least restrictive environments necessary, greater clarity is required for mental health providers, case managers, interagency teams, and third party payers, including Managed Care Organizations and their sub-contractors, to make coordinated treatment determinations concerning appropriateness of admissions, continued stay, and discharge planning. It is for this reason that the criteria provided below have been developed.

Presented in the opening section which precede the criteria, is a summary outline of the major aspects of service delivery, including: CASSP principles, the function of each of the four (4) treatment environments, and the importance of prescribing the least restrictive setting necessary. More detail is provided by the addenda in the document. Following the introduction are the individual "Admission Criteria" for each service. Each set of criteria is divided into three (3) sections, the first for determining "Admission", the second for determining the appropriateness of "Continued Stay," and the third for identifying "Discharge Criteria."

For ease of reading in the following text, "child(ren) and adolescent(s)" shall be commonly referred to as "child(ren)," unless otherwise indicated.

Introduction

The mental health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and fostering increasing independence of individuals (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). These changes are further reflected in the development of the Child and Adolescent Service System Program (CASSP) and its philosophy. The OMHSAS summary representation of CASSP, is provided below:

The CASSP philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP involves all child-serving systems including mental health, mental retardation, education, special education, children and youth services, drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also include informal community supports and organizations. This philosophy is essential to making decisions to provide treatment for children. It is also the foundation for the development of these criteria. These principles are represented in the following six summary statements:

(1) Child-centered - Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services should be develop- mentally appropriate and child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

(2) Family-focused - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.

(3) Community-based - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

(4) Multi-system - Services should be planned in collaboration with all thechild- serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.

(5) Culturally competent - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

(6) Least restrictive/least intrusive - Services should take place in settings that are the most appropriate and natural for the child and family and
are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and socio-cultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the four services for which "Admission Criteria" are provided below, can be understood as components within a wider network of service options.

Severity of Symptoms

The child's expression of impairment in any of the following should be considered in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/excitation, physiological functioning and/or cognitive/perceptual abilities. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must also be considered when determining an appropriate treatment design, and the concomitant discharge planning.

Intensity of Treatment

The intensity and range of treatment varies for each of the four services. Psychiatric Inpatient and Residential Treatment are out of home services which provide highly intensive treatment for the purpose of returning children home, or to a homelike setting. Partial Hospitalization and Psychiatric Outpatient provide services of varying intensity depending on the

child's need for therapeutic support to remain home. The therapeutic function and emphasis of each of the four services to return a child home, or to prevent out-of-home placements, depends strongly on the interaction between the therapist, the parents/guardians, and the child, for the effectiveness of the treatment plan developed.

Psychiatric Inpatient hospitalization provides the most restrictive level of care. The setting is locked and highly focused toward the delivery of intensive, short term treatment. It serves as an appropriate placement for children expressing the sudden onset of acute symptoms, and/or requiring treatment which cannot be managed outside of a 24 hour, secure setting.

Residential Treatment facilities provide a stable, open, community living setting for the delivery of comprehensive mental health treatment with 24 hour monitoring and a strong supportive environment from which the child is able to reenter the community. This is a longer term treatment option for children who require the comprehensive treatment and professional support of this setting to prevent a need for inpatient hospitalization.

Partial hospitalization lies between the most restrictive and community-based levels of care. A partial hospitalization treatment program offers a wide range of treatment in a setting segregated from the child's natural setting for part of the day. Effective treatment and stabilization of the child must be possible within the partial hospital program hours prescribed in the treatment plan. Partial hospitalization provides an opportunity to observe a child's behavior and the effects of treatment, for the purpose of developing and confirming a proper course of treatment designed for the effective reintegration of the child into the community.

Outpatient treatment is for children and their families who are seeking help and believe there is a need for mental health services. Services and treatment approaches include, diagnostic testing, crisis intervention services, behavior therapy, individual, group and family psychotherapy, medication, and similar services. The child should be able to maintain sufficient stability in his/her existing support network, to be treated effectively within the hours of outpatient treatment prescribed in the treatment plan. Treatment and services should be directed toward helping the child to remain integrated with his/her natural community and work to prevent the necessity of a more restrictive or intrusive service.

Least Restriction

The four services addressed in this bulletin are presented in descending order of restrictiveness and in increasing order of community integration. The need for greater or lesser restrictiveness must be adjusted to the individual's need for active treatment as reflected in the treatment plan. Increased restrictiveness of setting improves the convenience and opportunity for immediate intervention in the delivery of treatment. However, less restrictive environments should be considered to prevent the removal of children from their families, peers, and normalized settings in the community. Each service provides treatment with the object of helping a child with acute behavioral problems or serious emotional disturbance to increase his or her functional capacity, in order to increase his/her ability to reintegrate into the community.
Therefore, the goals of treatment may be summarized by the following:

- amelioration of symptoms such that less restrictive and/or less intrusive services can be planned and introduced;
- stabilization of medical regimen for children requiring psychotropic medication so they may remain in the least restrictive setting possible;
- prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance;
- coordination of the treatment and discharge plan on an ongoing basis with the family and the appropriate agencies to provide the necessary community based supports, including wraparound services; and
- increase in the age-appropriate interactiveness in a variety of settings [see Community Integration Attachment in Appendix C].

Admission of a child for psychiatric inpatient treatment is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. When a certified psychiatrist is not available, a diagnosis may be provided by a Board eligible psychiatrist or a licensed physician contingent on confirmation by a Board Certified psychiatrist within forty-eight (48) hours of admission, or as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Presenting illness is diagnosed on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a licensed physician[1] contingent on confirmation by a child and adolescent psychiatrist or Board Certified psychiatrist within forty-eight (48) hours of admission.

AND

B. Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating that this is the most appropriate, and least restrictive service to meet the mental health needs of the child;

AND

[1] Diagnosis by a resident physician with training license must receive confirmation within 24 hours.

C. Documentation in the current psychiatric evaluation that the treatment, 24-hour supervision, and observation, provided in the Psychiatric Inpatient setting, are necessary as a result of:

-severe mental illness or emotional disorder, *and/or*
-behavioral disorder indicating a risk for safety to self/others;

AND

D. Based on the patient's current condition and current history, reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, and*/or* careful consideration of treatment within an environment less restrictive than that of a Psychiatric Inpatient Hospitalization, *and* the direct reasons for its rejection, have been documented;

AND

E. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission, or within 120 hours in the event of an emergency admission.

II. SEVERITY OF SYMPTOMS

A. Significant risk of danger is assessed for any of the following,
1. child HARMING HIM/HERSELF
2. child HARMING OTHERS
3. DESTRUCTION TO PROPERTY which is:
    a. life-threatening, *OR*
    b. in combination with "B", "C", or "D" below;

OR

B. There is an acute occurrence or exacerbation of impaired judgement or functional capacity and capability, for the child's developmental level, that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

OR

C. There are endangering complications in *either* of the following:

1. *complications* of the child's psychiatric illness *or* treatment would seriously threaten the child's health safety due to a lack of capacity for self-care; *OR*
2. due to a *coexisting medical condition* where the child has a medical condition or illness which, as a result of a psychiatric condition, cannot be managed in a less intensive level of care without significant risk of medical crisis or instability;

OR

D. The severity of the child's symptoms are such that continuation in a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified in the above three categories of "II."

Requirements for Continued Stay

(Must meet I and II. Complete documentation for each is required, and additional documentation as indicated in Appendix B.)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. The initial evaluation and diagnosis is updated and revised as a result of a face-to-face diagnostic examination by the treating psychiatrist;

AND

B. Continued Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan;

II. SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a psychiatric inpatient setting, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care, necessitating hospitalization;*

AND

B. Although child is making *progress toward goals* in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review must recommend continued stay;

OR

C. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

D. Appearance of *new symptoms* meeting admission criteria.

III. DISCHARGE CRITERIA

A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Admission of a child to a JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child psychiatrist a diagnosis may be appropriately provided by a Board Certified psychiatrist. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained. Admission to a Non-JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis as described above for JCAHO accredited facilities, or by a licensed psychologist specializing in treatment for children and adolescents.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I *and* II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a psychiatrist (as defined in Chapter 5200.3 of the Pennsylvania Code) for JCAHO accredited facilities, or by a psychiatrist or a licensed psychologist for Non JCAHO accredited facilities;

AND

B. Residential Treatment service is prescribed by the diagnosing psychiatrist or psychologist, as appropriate to the accreditation of the facility, indicating that this is the most appropriate, least restrictive service to meet the mental health needs of the child;

AND

C. Documentation in the current psychiatric/psychological evaluation[2] that the treatment, 24-hour supervision, and observation, provided in the Residential Treatment setting, are necessary as a result of:

- severe mental illness or emotional disorder, *and/or*
- behavioral disorder indicating a risk for safety to self/others;

AND

D. Reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, *and/or* careful consideration of treatment within a less restrictive environment than that of a Residential Treatment Facility, *and* the direct reasons for its rejection, have been documented;

AND

E. Placement in a Residential Treatment Facility must be recommended as the least restrictive and most clinically appropriate service for the child, by an interagency service planning team as currently required by the OMHSAS and OMAP. Following PA School Code, Sections 1306-1309 and 2561, when a child is removed from the school setting for the purpose of receiving mental health treatment, it is expected that the appropriate school system will be involved in the child's educational planning and the interagency team. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team;

AND

F. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission.

---

[2] A current psychiatric/psychological evaluation is one which has been conducted within sixty (60) days prior to admission to the program. A psychiatric/psychological evaluation for a child placed on a waiting list during which time the thirty (30) day maximum has passed, shall continue to be "current" for an additional thirty (30) days.
(updated 9/10/09)

II. SEVERITY OF SYMPTOMS

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history *and* psychiatric/psychological examination must include at least one (1) of the following:

A. Suicidal/homicidal ideation

B. Impulsivity and/or aggression

C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)

D. Psychomotor retardation or excitation.

E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)

F. Psychosocial functional impairment

G. Thought Impairment

H. Cognitive Impairment

III. OBSERVATION

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history *and* psychiatric/psychological examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist/psychologist must clarify the criteria for admission under II *AND/OR* recommend development of a discharge plan. Should it be found that the child does not fit the criteria for admission, an appropriate discharge plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,

- they are not observed on a psychiatric inpatient unit, *or*
- they are denied by the child in outpatient or partial hospitalization treatment,

such that the residential treatment milieu provides an ideal opportunity to observe and treat the child;

OR

B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team.

REQUIREMENTS FOR CONTINUED STAY

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION (see also, Appendix A)

A. The initial evaluation and diagnosis is updated and revised as a result of a face-to-face diagnostic examination by the appropriate treating psychiatrist or psychologist;

AND

B. Less restrictive treatment environments have been considered in consultation with the Interagency Service Planning Team;

AND

C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Residential Treatment setting, without which there is great risk of a recurrence of symptoms;

AND

D. Any other clinical reasons supporting the rejection of other alternative services in favor of continuing Residential Treatment;

AND

E. Residential Treatment service is prescribed by the diagnosing psychiatrist/psychologist following a current face-to-face psychiatric evaluation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan.

II. . SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a psychiatric residential treatment setting, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care;*

AND

B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals;

AND

C. Although child is making *progress toward goals* in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review, in conjunction with an interagency team, must recommend continued stay;

OR

D. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

E. Appearance of *new symptoms* meeting admission criteria.

III. DISCHARGE CRITERIA

A. A child admitted under Sections I and III only, of the ADMISSION CRITERIA must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.

B. A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Admission of a child to a Partial Hospitalization Program is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board-Certified psychiatrist. A diagnosis may otherwise be provided as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I *and* II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II as part of a complete multiaxial diagnostic examination (MR or D&A cannot stand alone) by a psychiatrist or psychologist (as defined in Chapter 5200.3 of the Pennsylvania Code);

AND

B. Behaviors which indicate a risk for safety to self/others, and/or decreased functioning for the child's developmental level, such that:
   1. this behavioral disturbance requires regular observation and treatment, but does not require 24-hour supervision, *and*
   2. reasonable treatment within a less restrictive setting has been attempted by a mental health professional, *or* treatment in a less restrictive setting has been considered and documented, but is rejected directly in favor of partial hospital treatment;

AND

C. Partial hospitalization must be recommended as the most clinically appropriate and least restrictive service available for the child, by the *treatment team* [as described in PA 55 §5100.2.] to also include: child, parent/guardian and/or caretaker, and case manager;

AND

D. Removal of a child from his/her regular classroom for all or part of the school day necessitates the incorporation of an interagency planning team (in accordance with Chapter 5210.24,(b), except when partial provides acute hospital diversion. [The interagency planning team must include the appropriate representative from the child's local school in compliance with PA School Code, Sections 1306-1309 and 2561, and establish that the child's mental health needs cannot be otherwise met with appropriate supports in a school setting];

AND

E. A treatment plan [See PA 55 §5210.35], to include a complete strengths-based assessment of the child, including identifying the strengths of child's family, community, and cultural resources, can be completed prior to admission or within five (5) days of service in the partial hospitalization program;

AND

F. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents, and/or reasons explaining their non-involvement, must be fully documented and presented to the interagency team.

II. SEVERITY OF SYMPTOMS

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history *and* psychiatric examination must include at least one (1) of the criterion in A through F with a severity level as indicated in "B" above.

A. Suicidal/homicidal ideation

B. Impulsivity and/or aggression

C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)

E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)

F. Psychosocial functional impairment

G. Thought Impairment

H. Cognitive Impairment

III. OBSERVATION

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history *and* psychiatric examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist must clarify the criteria for admission under II *AND/OR* recommend development of a transition plan. Should it be found that the child does not fit the criteria for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,
   - they are not observed on a psychiatric inpatient unit, *or*
   - they are denied by the child in outpatient treatment,

   such that the day treatment milieu and return to home environment daily, provides an ideal opportunity to observe and treat the child;

OR

B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team in planning, coordinating and providing this treatment, and the interagency team currently recommends this level of treatment.

REQUIREMENTS FOR CONTINUED STAY

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION (see also, Appendix A)

A. The initial evaluation and diagnosis is updated and revised as a result of a current face-to-face diagnostic examination by the treating psychologist or psychiatrist;

AND

B. Less restrictive treatment modalities have been considered;

AND

C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Partial Hospitalization Program, without which there is great risk of a recurrence of symptoms;

AND

D. Any other reasons supporting the rejection of other alternative services in favor of continuing Partial Hospitalization;

II. SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a partial hospitalization program, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care;*

B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals;

AND

C. Child is making *progress toward treatment goals* in the expected treatment process as evidenced by reductions in the problematic signs, symptoms, and/or behaviors the child presented upon admission; and the treatment team or interagency team review recommends continued stay, documenting the need for further improvement and the corresponding modifications in both treatment plan and the discharge goals;

OR

D. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

E. The appearance of *new problems, symptoms, or behaviors* meet the admission criteria.

III. DISCHARGE CRITERIA

A. A child admitted under Sections I and III only, of the ADMISSION CRITERIA must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.

B. A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Admission of a child for Psychiatric Outpatient Treatment (clinic) is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board-Certified psychiatrist. A diagnosis may otherwise be provided by a developmental pediatrician or otherwise as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face assessment (ID or D&A cannot stand alone), by a Mental Health Professional (as defined under 55 Pa. Code § 5200.3) and reviewed and approved as outlined in 55 Pa. Code § 5200.31);

AND

B. Behaviors indicate *minimal* risk for safety to self/others and child must not require inpatient treatment or a psychiatric residential treatment facility.

II. SEVERITY OF SYMPTOMS

A. Service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the *treatment team director* [described in PA 55 §5100.2], as informed by the *treatment team* [described in PA 55 §5210.34]. Parent(s)/guardian(s), and/or caretaker, as appropriate, case

manager (when one is assigned) and the child must be involved in the planning process. Where a parent or the child are not or cannot be involved, the attempts to involve either or both and the reasons for non-involvement must be documented. *The treatment team should otherwise recommend the most appropriate alternatives should treatment at an outpatient clinic not be recommended*;

AND

B. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission;

OR

C. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level;

OR

D. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of outpatient treatment to sustain and reenforce stability;

OR

E. Requires prescription and monitoring of medications to mitigate the effects of the child's symptoms.

REQUIREMENTS FOR CONTINUED STAY

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Revised and updated diagnosis by a Mental Health Professional (as defined under 55 Pa. Code § 5200.3) and reviewed and approved as outlined in 55 Pa. Code § 5200.31;

AND

B. There is significant family (including the child) cooperation and involvement in the treatment process, except where the involvement of family members other than the child would be clinically counter-productive or legally prohibited.

II. SEVERITY OF SYMPTOMS

A. Child is making *progress toward goals*, and the treatment team review recommends continued stay;

OR

B. The *presenting conditions, symptoms or behaviors continue* such that natural community supports alone are insufficient to stabilize the child's condition;

OR

C. The appearance of *new problems*, *symptoms*, or behaviors meet the admission criteria.

III. DISCHARGE CRITERIA

A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

FUNCTION OF THE FOUR SERVICES

Inpatient Hospitalization:

- Inpatient hospitalization provides a locked setting for the delivery of acute care.

- Inpatient hospitalization combines security and restrictiveness with intensive treatment, for the purpose of ameliorating symptoms and reducing the need for such intensity of service by establishing within the child the self-control a n d ***/or*** capacity for constructive expression and more adaptive interpersonal skills necessary to continue treatment in a more natural and less restrictive setting.

- Inpatient hospitalization provides service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a secure setting.

- The inpatient hospitalization process and treatment must meet the conditions set forth in the MH/MR Act of 1966 and the MH Procedures Act of 1976.

- Treatment components include: major diagnostic assessments, medical and psychiatric treatment, and psychosocial rehabilitation (to include educational components, as appropriate to the child's development).

Residential Treatment Facilities:

- Residential Treatment Facilities provide a safe environment within a restrictive setting for the delivery of psychiatric treatment and care. However, it is an unlocked, and otherwise, less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care and for the provision of transitional care from an acute inpatient setting.

- Residential Treatment Facilities offer the comprehensive and intense services needed for the purpose of ameliorating symptoms, by establishing within the child the self-control, the capacity for constructive expression, and the adaptive interpersonal skills necessary to continue in a more natural and less restrictive setting.

- Residential Treatment Facilities provide service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a structured, residential setting.

- Treatment components include: major diagnostic assessments, psychiatric and other medical treatment, and psychosocial rehabilitation. Psychosocial rehabilitation is an important vehicle through which psychiatric residential treatment facilities provide culturally competent service. These services provide the child with community linkages and the real world competency necessary for his/her successful return to the community.

- Residential Treatment Facilities must collaborate with the school district of residency, and, if different, the school district where the child in treatment is enrolled, to ensure the child receives educational instruction in the least restrictive setting appropriate to meet their needs while accommodating their behavioral and psychiatric difficulties (see Commonwealth of Pennsylvania, OMH-95-07; BEC 19-93; OCYF.

- Parents/guardians are actively involved in the treatment planning process and provided the opportunity to address the treatment of the child in the broader context of the family system. They may receive other additional supports necessary to develop the therapeutic environment the child needs to return home or to other community settings, including training and family therapy. Also, parents/guardians are to be informed of the appropriate parent support and advocacy groups available [see addendum], or any other involvement consistent with the applicable regulations.

Partial Hospitalization Programs:

- Partial hospitalization provides a less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care, *by providing* transitional and diversionary care from an acute inpatient setting.

- Partial hospitalization provides a short-term, intensive outpatient treatment as a transition to Outpatient Clinic services. Its purpose is to reduce the child's need for restrictive therapeutic settings for treatment, and help the child develop the necessary self-control *and/or* capacity for constructive expression, including more adaptive interpersonal skills, to make the transition to interacting more fully in family and community environments.

- Partial hospitalization provides service for children with serious mental and/or psychosocial disorders who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a single setting (see **"Settings"** below).

- Partial hospitalization provides day, after school**,** weekend, and evening service for children with mental and/or psychosocial disorders, so that :
  - the child receives the additional support necessary to interact effectively and cooperatively with family members, thereby helping to insure the family bond;
  - parents/guardians can receive family therapy/treatment consistent with the treatment of their child.

- Partial hospitalization uses group approaches to the treatment of children with serious mental and/or psychosocial disorders.

- Treatment components include: major diagnostic assessments, medical and psychiatric treatment, psychosocial rehabilitation (to include educational and prevocational components, as appropriate to the child's development), individual and group therapies and opportunities for family therapy. Recognizing the responsibility of the school districts to provide an educational program for all children, full day or school day partial hospitalization programs must collaborate with the school district of residency and the school district where the child in treatment is enrolled, to incorporate an educational program within the therapeutic milieu.

  Program Range- Partial hospitalization programs vary in the intensity and purpose of the services offered. The range of programs includes, on the one end, those serving a more acute population as a step-down from inpatient treatment, or as a preventive for a more restrictive treatment setting. On the other end are programs serving those with more long standing impairments, where clinical judgement suggests that partial hospitalization is therapeutically necessary to return the child or maintain the child in a stable condition while providing effective treatment.

  Settings- Child partial hospitalization programs serve a range of age groups from pre-school to late teens, and they also occur in a variety of settings. Typical settings may be characterized individually or in combination by place, such as, school settings, clinics, and free-standing units; by specified time of service, such as, morning, afternoon, all day, after-school, and evening, and some have 24 hour emergency phone service; and by established age categories, such as, pre-school, children, and adolescents. In those provided in public and private school settings serving the general population, the school system and the mental health system collaborate closely in meeting the educational and mental health needs of the child. Many facilities described as "free-standing" are designed specifically for those

children who require a secure setting for mental health treatment, and the coordination of education and treatment in the same setting. In other settings, such as a mental health agency, the educational component must be designed and developed to meet the child's needs in collaboration with the mental health agency.

Outpatient Treatment:

- Provision of services which are less restrictive, more flexible yet effective supports for patients discharged from in-patient or partial hospitalization. In this way outpatient services provide for the delivery of transitional care from a more restrictive setting.

- Prevent the need for more intense services, or accompany more enhanced or community based services, to help the child develop the necessary self-control, *and/or* capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.

- Provision of service for children with mental and/or psychosocial disorders who require the periodic support provided by this treatment, to remain stable and ensure the effectiveness of a treatment plan.

- Provision of after school service for children with mental and/or psychosocial disorders, so that :
  - parents/guardians can receive the additional support necessary to maintain a therapeutic environment for the child;
  - parents/guardians can receive family therapy consistent with the treatment of their child.

  Should service require removing the child during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.

- Treatment components include: major diagnostic assessments, medical and psychiatric treatment. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is problematic, the reasons must be clearly documented.

Treatment Range- Outpatient treatment varies in both intensity and purpose. Intensity may be reflected in the number and length of visits as well as the duration and types of service offered. The range of service provides support for a more acute population and for those without long standing impairments, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to or maintain the child in a stable condition. Outpatient treatment may serve as a step-down from inpatient treatment and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the support of short term services to ameliorate the presiding condition or stress.

Outpatient treatment is clearly identified by the setting from which it is offered. In concordance with 55 Pa. Code, Chapter 5200 *Psychiatric Outpatient Clinics*, the domain of this level of treatment for the scope of this document is the clinic, exclusive of partial hospitalization and other day-treatment programs.

Continued Stay Service Documentation

The following list of information should be documented for all four services.

1. Routine assessments and treatment updates chart child's progress.

2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.

3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.

4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.

5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).

6. The initial discharge criteria formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.

7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary supports for the child's successful transition into the community, including mental health and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to a less restrictive setting.

8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and forms linkages with community and family supports.

9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.

10. As the child improves clinically, active treatment facilitates and increases contact of the child with the community (including home and school) to which the child will return.

11. The provision of services supports the child's involvement in age appropriate activities and interests.

12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan *and/or* plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.

13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.

14. Continued inpatient hospitalization **must** be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).

15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more *or* less intense.

Community Integration Questionnaire

1. Are the **child's <u>interest areas</u>?** and **<u>strengths</u>?** documented, with a plan to **<u>explore new interests and strength's</u>** for the child?

2. Have the **child's <u>community and family support network, and cultural resources</u>** been explored for the purpose of involving the child in his/her own community, and recorded?

3. Has there been **<u>recruitment of family members, or other significant individuals,</u>** to participate as designated support persons

4. Do you have a list of the **<u>available services, events and activities</u>** in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].

5. What activities has the child been **<u>involved in</u>** over the past two months? Is there a plan to **<u>continue</u>** this involvement?

6. Does the **<u>treatment plan</u>** include community integrative activities, such as:
   - planned parental supervised activities?
   - age appropriate, child independent participation in planned community activities [such as: Traditional events; school sponsored clubs and gatherings; extra-curricular classes (ie. dance, music, martial arts, etc); church or community center picnic, etc.]?
   - opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities [such as: neighborhood "hoops", stick ball, parties and informal gatherings].
   - [other activities- specify in treatment plan].

   OR, for children who may be more severely impaired:
   - staff oversite of planned parental supervised activities?
   - staff supervised activities for parent/child interaction? for child/community peer interaction?
   - staff supervised activities in the community?
   - planned reentry into the regular classroom (independently, or with a therapeutic staff support)?

7. Do you have a **plan of reenforcement** for a child's successful participation outside of the treatment setting? and a **crisis intervention plan** for the child while outside of the treatment setting?

8. Do the **progress notes** detail the outcome of the home/community integrative activity?

9. Do you have a data gathering form or instrument to **measure the outcome** of a child's participation in a home/community activity?

10. Do you have a **plan to expand** the child's home/community/cultural participation?

References

American Psychiatric Association

1994 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association.
Commonwealth of Pennsylvania

1995 "Educational Portions of 'Non-Educational' Residential Placements." Mental Health Bulletin OMH-95-07, 3 April 1995, Commonwealth of Pennsylvania, Office of Mental Health.

1993 "Interdistrict Placements-New School Code Provisions." Basic Education Circular, BEC 19-93. Harrisburg, Commonwealth of Pennsylvania, Department of Education.

1993 "Mental Health Procedures." Title 55 PA Code, Chapter 5100. Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.

1993 "Psychiatric Outpatient Clinics." Title 55 PA Code, Chapter 5200, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.

1993 "Partial Hospitalization." Title 55 PA Code, Chapter 5210, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.

1992 "Private Psychiatric Hospitals." Title 55 PA Code, Chapter 5300, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.

1992 "Community Residential Rehabilitation Services for the Mentally Ill." Title 55 PA Code, Chapter 5310, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.

1985 "Description of Services and Service Areas." Title 55 PA Code, Chapter 4210, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health. Title 55 PA Code, Chapters 1151 and 1153
Commonwealth of Pennsylvania, Office of Medical Assistance Programs.

1976 Mental Health Procedures Act of 1976. P. L. 817, No. 143. 1966 Mental Health/Mental Retardation Act of 1966. P. L. 96, No.6 .
PA School Code, Sections 1306-1309 and 2561

APPENDIX T
Part B (2)

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

The Family Based Mental Health Services Program (1st Edition)

INTRODUCTION:

The Family Based Mental Health Services Program (FBMHS) represents an important option within the array of services for children and adolescents up to age 21, and their families. Utilization of the FBMHS program occurs following referral for this service and the subsequent determination by the FBMHS treatment team that the service is clinically appropriate. FBMHS is available to children who are at risk for out-of-home placement due to a severe emotional or behavioral disorder, or due to a severe mental illness. FBMHS is also used as a step-down for children returning to their family, which may include natural or substitute care families, following out-of-home placement.

These Family Based Mental Health Services Program guidelines for medical necessity (and its subsequent revisions) provide a basis for the referral of children and their families for this service. [See FBMHS program standards in State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I), available in the HealthChoices Proposers' Library].

PROGRAM PHILOSOPHY & ORGANIZATION:

Consistent with the CASSP principles and philosophy, the guiding tenets of FBMHS are that children grow-up best in their own home, that the family is a resource and partner in the treatment process, that treatment utilizes strengths in addressing areas of need and concern, and that coordination among other human service systems and with the community is essential. In addition, while the child receives treatment, services also work to enhance the family role as a resource and partner in the treatment process.

The Family Based Mental Health Services Program is a discrete service provided by a team composed of either two child mental health professionals or one child mental health professional and a child mental health worker, which is comprehensive in scope, incorporating intensive home therapy, casework services, family support services and 24 hour, 7 day availability for crisis stabilization. Each team maintains a caseload of up to eight (8) families to ensure the intensity of service and team availability to the families they serve. Team members receive supervision together as an integral part of an ongoing program for the families served. In addition, there is an ongoing training curriculum that extends over a three year period designed specifically for Family Based Mental Health Service Team members.

The service is broadly conceived for flexible use in the home and community. The specific frequency and schedule of face-to-face contacts are developed collaboratively with the family, based on needs at that time. This allows the team to provide for individual family needs when they are closely associated with the child's treatment, such as time for family education/training regarding therapeutic components and skill building for the child and family. The team also works with the family to identify resources available to them. Teams are available to provide 24 hour service, and they also work with other systems when they are involved with the child and family, such as Drug and Alcohol Services, Children and Youth, Juvenile Justice, special education, etc. Clinical treatment within FBMHS is guided by the recognition of the normal growth and development of children at different ages, and supports family caretaking and functioning through collaborative, conjoint family meetings, which can include different combinations of family members and community members as indicated. Due to its commitment to support both the development of children and the integrity of the family, FBMHS, while primarily treatment, also serves a preventive function. The needs of all the children within a family, not just the child in response to whom services were initiated, are actively considered and included as part of the treatment process.

Services offered by the FBMHS program include formal individual and family therapy sessions with the child and/or family. In addition, program service requirements include the following:

- Crisis intervention and stabilization;

- Emergency availability;

- Ongoing information-gathering in support of active treatment;

- Collaborative development and modification of the treatment plan;

- Clinical intervention by each team member with the child in attaining identified treatment goals and objectives within the treatment plan, including: remediation of child's symptoms (i.e. behavioral, affective, cognitive, thought impairments, etc.), improvement of family relationships, community integration, and other aspects of psychosocial competence and skill development in the home, school, or community;

- Support for the parents in implementing effective behavior management and parenting approaches specific to the presenting problems of their child;

- School-based consultation and intervention as needed;

- Referral, coordination, and linkage to other agencies, social services, and community services, as appropriate;

- Assistance in obtaining relief services such as babysitters, homemakers, respite care and supportive services such as transportation and recreation, and developing a network in order to receive these services.

The Family Support Service (FSS) is a requirement in the Family Based Mental Health Services Program under Health Choices. Family-Based Family Support Services (FBMHS) are formal and informal services or tangible goods which are needed to enable a family to care for and live with a child who has a serious emotional disturbance. FBMHS/FSS include supportive services and tangible goods, which facilitate achievement of the child's treatment goals. If a child is in temporary out-of-home placement, FBMHS/FSS should be used to facilitate the return of the child to the natural family and in this instance should be available to both the natural family as well as the foster family.

A cost component for FBMH/FSS is built into the HealthChoices capitation rate. As such, it is recommended that the provider and the BH-MCO agree to a method for setting aside an appropriate percentage of the FBMHS provider fee for the purchase of services or goods needed to further the child's treatment goals.

The FBMHS budget identifies administrative and program costs which include family support services.

- The FBMHS unit of service is billed for activities or direct services which are provided by the Family-Based team members using existing procedure codes. Only such FBMHS units are reported as encounter data.

- There is no separate reporting requirement for FBMH Family Support Services.

- The provider must have an accounting system that identifies revenue sources and expenditures.

ADMISSION CRITERIA

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (as defined under 55 Pa. Code § 5200.3). A psychiatrist, physician or licensed psychologist determines that the child is eligible and recommends the FBMHS program (State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I));

AND

B. Other less restrictive, less intrusive services have been provided and continuation in this less intensive level of care cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition;

OR

Child has been discharged from an Inpatient Hospitalization or a Residential Treatment Facility, and other less restrictive, less intrusive services cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition;

AND

C. Behaviors indicate manageable risk for safety to self/others and child must not require treatment in an inpatient setting or a psychiatric residential treatment facility.

II. SEVERITY OF SYMPTOMS

A. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child,

AND

1. the family recognizes the child's risk of out of home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family;

AND/OR

2. the child is returning home and FBMHS is needed as a step down from an out-of-home placement;

AND

B. The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination must include at least one (1) of the following:

1. Suicidal/homicidal ideation
2. Impulsivity and/or aggression
3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4. Psychomotor retardation or excitation.
5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6. Psychosocial functional impairment
7. Thought Impairment
8. Cognitive Impairment

AND

C. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process;

AND

D. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment in the home and family involvement to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or tentative remission;

OR

E. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in the home is severely compromised, and intervention involving the child and family is necessary;

OR

F. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;

OR

G. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.

REQUIREMENTS FOR CONTINUED CARE

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND RECOMMENDATION

A. Recommendation to continue FBMHS must occur:

1. by the treatment team every 30 days through an updated and revised treatment plan, and

2. by a psychiatrist, licensed psychologist, or physician at the end of 32 weeks, with an updated diagnosis;

AND

B. There is significant family (including the child) cooperation and involvement in the treatment process.

AND

C. An updated treatment plan by the treatment team indicates child's progress toward goals, the progress of the child and family as a unit, and revision of goals to reflect documented changes, and the child and family involvement in the treatment planning process.

II. SEVERITY OF SYMPTOMS

A. Child and the family are making progress toward goals, and the treatment team review recommends continued stay;

OR

B. The presenting conditions, symptoms or behaviors continue, such that family and natural community supports alone are insufficient to stabilize the child's condition;

OR

C. The appearance of new conditions, symptoms or behaviors meeting the admission criteria.

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE DOCUMENTATION

A. Child must be reevaluated every 30 days for the purpose of updating the treatment plan and continue to meet Requirements for Continued Care.
   1. The review of the child being served must:
      a. clarify the child's progress within the family context and progress toward developing community linkages; and
         1) clarify the goals in continuing FBMHS; and
         2) the need for continuing FBMHS if continuation beyond 32 weeks is recommended; and
      b. whenever FBMHS service is considered for a term greater than 32 weeks:
         1) a psychiatrist, licensed psychologist, or physician must update the diagnosis; and
         2) review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources; and

B. Child demonstrates:
   1. measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation); *or*
   2. increased *or* continued behavioral disturbance with continued expectation for improvement (indicate rationale in the treatment plan);

and

C. Treatment plan is addressing the behavior within the context of the child's problem and/or contributing psychosocial stressor(s)/event(s);

and

D. Treatment plan is updated to reflect recommendation to continue care.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES

A. The treatment team, determines that FBMHS:

1. up to 32 weeks of FBMHS services has been completed; and/or
2. the service results in an expected level of stability and treatment goal attainment for the intervention such the child meets:
   a. expected behavioral response, and/or
   b. the FBMHS program is no longer necessary in favor of a reduced level of support provided by other services, or
3. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to offering further FBMHS; or
4. creates a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR

B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent (14 years old or older) requests a reduction in service or complete termination of the service.

TABLE OF FAMILY BASED MENTAL HEALTH SERVICES PROGRAM ADMISSION CRITERIA

Family Based Mental Health Services (Must meet I/II and III)
I. & II. [Combined] DIAGNOSTIC INDICATORS [Axis I or Axis II; D&A on Axis I, and MR on Axis II do not stand alone] (Must meet A, B, C & D)
A. Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the treatment team as an alternative to out-of-home placement or as a step down from inpatient hospitalization or Residential Treatment, **or** as a result of little or no progress in a less restrictive/intrusive service,
AND
B. Severe functional impairment is assessed in the child's presenting behavior. The intensity of service is determined on an individualized basis according to the following parameters: severity of functional impairments, risk of out-of-home placement, and risk of endangerment to self, others or property.
1. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission; and
2. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child, and a. the family recognizes the child's risk of out-of-home placement and the problem of maintaining their child at home

Family Based Mental Health Services (Must meet I/II and III)
without intensive therapeutic interventions in the context of the family; and/or b. the child is returning home and FBMHS is needed as a step down from an out-of-home placement; and
3. Presence of at least one (1) of the following: a. Suicidal/homicidal threatening behavior or intensive ideation b. Impulsivity and/or aggression c. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) d. Psychomotor retardation or excitation. e. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) f. Psychosocial functional impairment g. Thought Impairment h. Cognitive Impairment and
4. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school /community is/are severely compromised; and
5. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process; and

Family Based Mental Health Services (Must meet I/II and III)
6. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level; or
7. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.
AND
C. Behavior is assessed to be manageable in the home setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of the treatment plan, as a result of:
1. the delivery of the therapy and casework services in the home, required to serve the child's specific treatment needs; and
2. there is documented commitment by the family to the treatment plan and
3. if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent (age 14+) and family member develop a **safety plan** which, the family member signs.
AND
D. The severity and expression of the child's symptoms are such that:
1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above;

Family Based Mental Health Services

(Must meet I/II and III)

and

2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV.CONTINUED CARE

Child must be reevaluated every 30 days for the purpose of updating the child's progress, progress toward developing community linkages, and the necessity for continuing Family Based Mental Health Services in the treatment plan.

A. The review of the child being served must:

1. clarify the child's progress in treatment, within the family context, and toward developing community linkages; and
   a. clarify the goals in continuing FBMHS; and
   b. the need for continuing FBMHS, if continuation beyond 32 weeks is recommended; *and*
2. whenever FBMHS service is considered for a term greater than 32 weeks:
   a. a psychiatrist, licensed psychologist, or physician must revise and/or update the diagnosis; *and*
   b. review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources;

AND

B. Treatment plan is updated to reflect the recommendation to continue care.

AND

C. Treatment plan is addresses the presenting problem within the context of the family and/or contributing psychosocial stressor(s)/event(s); *and*

AND

D. Child demonstrates:

1. measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation);

or

2. increased *or* continued behavioral or emotional disturbance with continued expectation for improvement (indicate rationale in the treatment plan);

V. DISCHARGE CRITERIA

A. Prescriber, with the participation of the interagency team, determines that:

1. Up to 32 weeks of FBMHS services has been completed;

and/or

2. The service results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
   a. expected positive behavioral response; *and/or*
   b. FBMHS are no longer necessary in favor of a reduced level of support provided by other services;

or

3. FBMHS should be discontinued because it *ceases to be effective*, requiring reassessment of services and alternative planning prior to authorization of any further Family Based Mental Health Services;

or

4. the services provided create a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

or

AND

B. The parent/guardian or adolescent, 14 years old or older, requests reduction in service or termination of the service.

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA

CHILD/ADOLESCENT **TARGETED CASE MANAGEMENT SERVICES**

Admission Criteria

An individual who meets the minimum staff requirements for an Intensive Case Manager as defined by Chapter 5221, Mental Health Intensive Case Management; or a Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; or a Blended Case Manager as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

I. The child/adolescent meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; or Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management; or
Blended Case Management as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised;

or

II. The child/adolescent meets the criteria for serious emotional disturbance (SED) as described in *Federal Register Volume 58 No. 96, May 20, 1993, pages 29422- 29425*;

and

III. The child/adolescent is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the Targeted Case Management — Child/Adolescent Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.

Continued Stay and/or Change of Level of Need

The child/adolescent and his/her family and/or guardian, or caregiver/natural support must be reassessed at the point of concurrent review, but no less frequently than six-month intervals, and when there are significant changes in the individual's situation that warrants a change in level of TCM services.

I. The child/adolescent continues to meet either I or II of Admission Criteria.

and

II. The child/adolescent is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the *Targeted Case Management — Child/Adolescent Environmental Matrix* and in conjunction with clinical information and the professional judgement of the reviewer

Discharge Indicators

Targeted Case Management may be terminated when one of the following criteria is met:

A. The child/adolescent or family receiving the service determines that targeted case management is no longer needed or wanted and the child/adolescent no longer meets the continued stay criteria; or

B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the child/adolescent receiving the service and the child/adolescent no longer meets the continued stay criteria; or

C. The child/adolescent or family receiving the service determines that targeted case management is no longer wanted, even though, the child/adolescent does meet continued stay criteria; or

D. the child/adolescent and family has moved outside of the current geographical service area (e.g., county, state, country).

TCM ENVIRONMENTAL MATRIX —CHILDREN INSTRUCTIONS

The Environmental Matrix — Children is a scale that evaluates the functional and need levels of children and adolescents who are under the age of 18 years old or who are over 18 years of age but who are still attending a school program. *Note: Adolescents age 16 – 22 may be assessed on either the child/adolescent environmental matrix or the adult environmental matrix, depending on the adolescent's current circumstances. The parent/guardian and adolescent, in discussion with the reviewer, should determine which Environmental Matrix will be used.* The child/adolescent and family and/or guardian or care giver/natural support must be assessed in a face to face interview assessment with the evaluator. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals should be reassessed as needed, but no less than every six months. There are ten (10) assessment areas identified in relationship to Targeted Case Management services:

1. Accessing Mental Health Services
2. Informal Support Network Building
3. Education/Vocation
4. Children and Youth System Involvement
5. Juvenile Justice/Criminal Justice System Involvement
6. Parent/Guardian and/or Other Family Members with Significant Family Needs.
7. Drug and Alcohol System Involvement
8. Mental Retardation System Involvement
9. Physical Health System Involvement 10a. At Risk of Out-of-Home Placement

Or

10b. Currently in RTF, Other Out of Home Placements or Inpatient

Please note: Although items 10a. and 10b. both deal with residential placement, scoring is done for ***only one of the items***, ***either*** item 10a. ***or*** item 10b., since only one of these items can be relevant to the child/adolescent's current residential status.

The scale has a range from 0 to 5 with the following values for each activity:

0	1	2	3	4	5
No assistance needed	Minimum of assistance needed		Needs moderate assistance in this area		Needs significant assistance in this area

All ten assessment areas are ranked on the above scale. The evaluator must complete the environmental matrix in a face-to-face, strengths-based assessment interview with the child/adolescent and his/her family and/or guardian, or care giver/natural support.
Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e., extended family, resourcefulness and responsibility). The evaluator should consider the child's/adolescent's and parent's/guardian's (family) strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

. Housing/living situation
. Income/benefits/financial management
. Socialization/support
. Activities of daily living
. Medical treatment

Each assessment area is defined at the " 1", " 3 ", and " 5 " levels (See attached Environmental Matrix) and the subtotal score is divided by 10 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels may be gradated to the 0.5 level only; this allows for minor differentiation of the child's/adolescent's needs without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, and situation of the child/adolescent during the last ninety (90) days, rate the child's/adolescent's need for TCM in each of the ten areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the ten (10) scores should
then be taken and divided by 10 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer's need for service.
Note: If a particular assessment area does not apply to the individual being assessed, a score should not be given for that assessment area and the total score should be
divided by the number of assessment areas scored. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person's average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value. The Environmental Matrix score, your *professional judgement* *, and other information (e.g., cultural factors, records of past treatment, etc.) that impacts on the child's/adolescent's level of need should then be considered and the recommended

level of TCM service should be entered on the recommended level of TCM line of the scoring sheet. (These levels are consistent with minimum levels of contact as defined in *Chapter 5221, Intensive Case Management* regulations and bulletin *OMH-93-09, Resource Coordination: Implementation*.) If the recommended level of TCM services differs from the Environmental Matrix Score, the difference must be justified with professional judgement in the "Other Factors/Issues Affecting Score" section of the scoring sheet. **Note: The level of service indicated by the assessment represents the individuals needs at the time of the assessment. Service intensity could change as an individual's needs and/or desires for service change.**
Please note:

ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT
TCM SERVICE SCORING GRID

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended).
1.5 –3.9	RC	At least 1 contact every 30 days (Face to Face)
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

* ***professional judgement:*** *opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.*

ACCESSING MENTAL HEALTH SERVICES

Child's/adolescent's mental health problems require mental health services and the family requires help to access them. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to assessing services (e.g., language, perceived/actual institutional racism/discrimination, the family may mistrust the behavioral health system, the family may lack the capability to access services, the family may lack information, be overwhelmed, poorly informed about the benefits of such services, or intimidated by the system). The TCM is instrumental in assuring that the child/adolescent receives the necessary services for therapy, medication monitoring, etc.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support to obtain mental health and other essential services to meet the child's/adolescent's multiple needs.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support to obtain mental health and other essential services to meet the child's/adolescent's multiple needs.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support to obtain mental health and other essential services to meet the child's/adolescent's multiple needs.

INFORMAL SUPPORT NETWORK BUILDING

The child/adolescent and parent/guardian identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the child/adolescent may gain informal support. Service system barriers and other factors, however, may impede the child/adolescent and parent/guardian from interacting with family, friends, significant others and community groups. The child/adolescent may need assistance to challenge and remove barriers so as to enhance the informal building of supports. The child/adolescent may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Child/adolescent is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom he/she interacts and from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

3= Child/adolescent needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

5= Child/adolescent is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. The child/adolescent has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. The parent/guardian and child/adolescent requires and/or desires significant assistance from others to elicit information and support on his/her behalf.

EDUCATION/VOCATION

The need for additional or more appropriate educational and/or vocational services, based on the needs of the child/adolescent, including a more appropriate educational and/or vocational placement, may require school meetings, IEP

meetings, meetings with the Office of Vocational Rehabilitation or other vocational planning or service groups (e.g., vocational service providers), advocacy for the child's/adolescent's needs and providing information to the parent/guardian regarding their rights in determining the appropriate education/vocational setting for their child/adolescent. The child/adolescent should have everything that is necessary to be successful in an educational and/or vocational environment, including access to the family's primary language for all meetings. TCM assists the parent/guardian in accessing educational and/or vocational advocacy and obtaining the appropriate education and/or vocational training for the child/adolescent and offers support in conflicts between the school and parent/guardian concerning the child/adolescent's needs and services to be provided.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

CHILDREN AND YOUTH SYSTEM INVOLVEMENT

TCM may assist family in working with CYS and meeting CYS requirements for the parent/guardian or care giver/natural support and their child/adolescent with serious emotional disturbances. TCM assists the family in responding to the CYS family services plan. TCM may be needed to assure collaboration between the Children and Youth and Mental Health systems and a need for collaboration among multiple providers from these two systems. TCM may also participate in court processes for the family and the child/adolescent.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Children and Youth System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child's/adolescent's participation in mental health services.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child's/adolescent's participation in mental health services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child's/adolescent's participation in mental health services.

JUVENILE JUSTICE/CRIMINAL JUSTICE SYSTEM INVOLVEMENT

A child or adolescent with a serious emotional disturbance who demonstrates delinquent behavior and/or is not compliant with probation and mental health service needs may require TCM support in addition to probation services. TCM uses his/her ongoing relationship with the child/adolescent and family to encourage compliance with the probation plan and participation in mental health services. TCM may be needed to assure collaboration between the Juvenile Justice/Criminal Justice and Mental Health systems. The TCM may also participate in court processes with family/juvenile.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= P a r e n t /Guardian and child/adolescent does not need/have involvement with the Juvenile Justice/Criminal Justice System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, support and TCM involvement to assure child's/adolescent's cooperation with the probation plan.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, support and TCM involvement to assure child's/adolescent's cooperation with the probation plan.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, support and TCM involvement to assure child's/adolescent's cooperation with the probation plan.

PARENT/GUARDIAN AND/OR OTHER FAMILY MEMBERS WITH SIGNIFICANT FAMILY NEEDS

Other members of the family may have individual needs that have a serious impact on the child/adolescent's ability to function at home and in the community. Other family members may have chronic mental illness, serious emotional disturbances, substance abuse problems, and/or physical illness that combine to compromise caretaker availability to the child. TCM provides culturally consistent and language appropriate service to the child/adolescent and family, assuring access and participation in services, including mental health services.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a minimal level of TCM services to support the family in meeting the child's/adolescent's basic living needs and emotional well-being.

3= Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a moderate level of TCM services to support the family in meeting the child's/adolescent's basic living needs and emotional well-being.

5= Other family members may have a mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a significant level of TCM services to support the family in meeting the child's/adolescent's basic living needs and emotional well-being.

DRUG AND ALCOHOL SYSTEM INVOLVEMENT

TCM assists family in obtaining drug and alcohol treatment for a child/adolescent with serious emotional disturbances and co-occurring drug and alcohol problems and encouraging child/adolescent to accept and comply with these services. The TCM supports the child's/adolescent's participation in all phases of treatment, including aftercare. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Drug and Alcohol System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in drug and alcohol services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child's/adolescent's participation in drug and alcohol services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in drug and alcohol services.

MENTAL RETARDATION SYSTEM INVOLVEMENT

TCM assists the family in obtaining and maintaining participation in mental retardation services for a child/adolescent with a serious emotional disturbance and a co-occurring diagnosis of mental retardation. The TCM supports the child's/adolescent's and parent's/guardian's participation in all phases of mental retardation services. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Mental Retardation System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in mental retardation services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child's/adolescent's participation in mental retardation services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in mental retardation services.

PHYSICAL HEALTH SYSTEM INVOLVEMENT

TCM assists family and child/adolescent with a serious emotional disturbance in attending to significant physical/medical needs by helping parent/guardian to access medical care, and to develop confidence in working with physical health care providers. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

CHILD/ADOLESCENT AT RISK OF OUT-OF-HOME PLACEMENT

The risk that a child/adolescent with a serious emotional disturbance will require an out-of-home placement may be reduced significantly through TCM services which assist parent/guardian in accessing needed child serving systems. TCM assistance may include information sharing with parent/guardian, advocacy with mental health service providers and other systems and support in working with multiple service providers. Every effort should be made to consider the child's ethnicity, culture and religious background in any out-of-home placement. TCMs may need to provide assistance in the provision of cultural competence supports for children (e.g., grooming, leisure activities, etc.).

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Child's/adolescent's ongoing emotional/behavioral issues place the child/adolescent at low risk of out-of- home placement.

3= Child's/adolescent's ongoing emotional/behavioral issues place the child/adolescent at moderate risk of out-of-home placement.

5= Child's/adolescent's ongoing emotional/behavioral issues place the child/adolescent at high risk of out-of-home placement.

CURRENTLY IN RTF, OTHER OUT-OF-HOME PLACEMENTS OR INPATIENT

Child/adolescent with a serious emotional disturbance is currently or has been receiving services in an RTF, other out-of-home placement or inpatient setting. The child/adolescent has been discharged within the past 30 days or discharge is anticipated within thirty 30 days. The child/adolescent may have been discharged for more than 30 days, however, TCM services are needed to assist with the discharge plan.

The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a minimal level of TCM service.

3= Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a moderate level of TCM service.

5= Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a significant level of TCM service.

.

TARGETED CASE MANAGEMENT
ENVIRONMENTAL MATRIX - CHILD/ADOLESCENT

Agency **County**

CHILD/ADOLESCENT INFORMATION:

Name :

(Last) **(First)** **(MI)**

Parent/Guardian Name:

Identifying Number(s):

Date of Birth:

/

/
(MM)/(
DD)/(Y
YYY)

Social Security Number: - - **CIS/BSU/MCO**

Number:

PHM

CO:

BHM

CO:

Form

Completed

by: Date

Completed:

The purpose of this form is to assess what environmental and cultural factors help to determine an individual's need for the various levels of case management services. Please complete this form utilizing the individual's behavior and situation during the last ninety days as a basis for scoring each indicator. Please note that the decision for level of need in each of the areas must be determined in collaboration with family and/or guardian, or care giver/natural supports and child/adolescent. Please see the *Scoring Sheet* for additional information on determining the Environmental Matrix Score and its meaning for level of care assignments.

ENVIRONMENTAL MATRIX CHILD/ADOLESCENT SCORING SHEET

CHILD/ADOLESCENT NAME:

ID#(SOCIAL SECURITY/CIS/BSU):

SCORES:

1.	Accessing Mental Health Services	_____
2.	Informal Support Network Building	_____
3.	Education	_____
4.	Children and Youth System Involvement	_____
5.	Juvenile Justice System Involvement	_____
6.	Parent/Guardian and/or Other Family Members With Significant Needs	_____
7.	Drug and Alcohol System Involvement	_____

8.	Mental Retardation System Involvement	_____
9.	Physical Health System Involvement	_____
10a.	At Risk of Out-of-Home Placement	_____
	Or	
10b.	Currently in RTF, Other Out-of-Home Placements or Inpatient	_____
	SUBTOTAL	

ENVIRONMENTAL MATRIX SCORE = SUBTOTAL □ □BY ALL

APPLICABLE ASSESSMENT AREAS (*AREAS SCORED "N/A" ARE NOT USED IN DETERMINING OVERALL SCORE)*

OTHER FACTORS/ISSUES AFFECTING SCORE:

ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT TCM SERVICE SCORING GRID

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended)
1.5 –3.9	RC	At least 1 contact every 30 days (Face to Face)
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

* ***professional judgement:*** *opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.*

RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:

CONSUMER (if age appropriate):

DATE:

PARENT/GUARDIAN

DATE:

PERSON COMPLETING THE FORM:

DATE:

APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:

REVIEWER

DATE:

Appendix T
Part B (3)

Placement Guidelines for Drug and Alcohol Services

AMERICAN SOCIETY OF ADDICTION MEDICINE

The ASAM CRITERIA

ASAM Website: https://www.asam.org/resources/the-asam-criteria/about

Can be purchased through The Change Companies, see below:

Phone: **1-888-889-8866**
E-Mail: **contact@changecompanies.net**
Website: **https://www.changecompanies.net/products/?id=ASM0**

The Department requires all substance use disorder placement, continued stay, and discharge be conducted in accordance with the most recent version of the *American Society of Addiction Medicine (ASAM) criteria.* Additional guidance is available at:

https://www.ddap.pa.gov/Documents/ASAM/ASAM%20Application%20Guidance%20Final.pdf

https://www.ddap.pa.gov/Professionals/Pages/ASAM-Transition.aspx

.

VALUE BASED PURCHASING

Value-based Purchasing (VBP) is the Department's initiative to transition Providers from volume to value payment models for the delivery of behavioral health services. VBP Payment Strategies and VBP Models are critical for improving quality of care, efficiency of services and reducing costs.

The Department has developed an aligned VBP framework that consists of both VBP Payment Strategies and VBP Models. VBP Payment Strategies define the mechanism by which the Providers are paid by the BH-MCO. VBP Payment Strategies are tiered by three levels of risk: low, medium, and high.

VBP Models define a way to organize and deliver care and may incorporate one or more VBP Payment Strategies as ways to pay Providers. The Department is categorizing VBP Models into recommended models and required models. PH-MCOs, Primary Contractors and their BH-MCOs, CHC-MCOs, and CHIP-MCOs can form integrated VBP Models. Primary Contractors and BH-MCOs should work towards integrating VBP Models because addressing behavioral health needs can improve physical health outcomes, and vice versa. Additionally, Primary Contractors are required to incorporate Community-Based Organizations within VBP agreements to help address the Social Determinants of Health (SDOH).

Definitions:

VBP Payment Arrangement: An agreement which links Provider payments for services to the value of services provided and to relevant quality measures that are indicative of health outcomes.

VBP Payment Strategy: The mechanism that is used to pay a Provider (such as Performance-based Contracting, Shared Savings, Shared Risk, Bundled Payment and Global Payment).

VBP Model: A way to organize and deliver care that may incorporate one or more VBP Payment Strategies as a ways to pay a Provider.

A. VBP Payment Strategies

The Primary Contractor and its BH-MCO must enter into VBP Payment Arrangements with Providers that incorporate approved VBP Payment Strategies. The Department retains the ability to accept or reject any proposals to count toward the required VBP medical spend percentage. The approved VBP Payment Strategies are tiered as low-risk (Performance-based Contracting), medium risk (Shared Savings, Shared Risk, Bundled

Payments), and high risk (comprehensive Global Payments). VBP Payment Arrangements must include quality benchmarks containing financial incentives or penalties, or both, without which the Department will reject the arrangement as counting towards the required VBP medical spend percentage. Primary Contractors and their BH-MCOs can also layer additional non-financial incentives, such as the elimination of prior authorization requirements for high-performing Providers, as long as financial incentives are also in the arrangement.

Approved VBP Payment Strategies

Performance-based Contracting (low-risk strategy) – FFS contracts in which incentive payments and/or penalties are linked to performance. The Primary Contractor and its BH-MCO must measure performance against quality benchmarks or incremental improvement benchmarks and must include in the contract incentives or penalties, or both, based upon meeting these benchmarks.

Shared Savings (medium-risk strategy) - Supplemental payments if they are able to reduce health care spending relative to an annual cost benchmark, either for a defined Member sub-population or the total Member population served. The cost benchmark should be developed prospectively, based at least in part on historical claims, and be risk adjusted if needed for a defined patient population relative to a benchmark. The supplemental payment is a percentage of the net savings generated.

Shared Risk (medium-risk strategy) – Supplemental payments if health care spending is reduced relative to a cost benchmark, either for a defined Member sub-population or the total Member population. The cost benchmark should be developed prospectively, based at least in part on historical claims, and be risk adjusted if needed. The payment is a percentage of the net savings generated. These arrangements also include shared losses if costs are higher relative to a benchmark.

Bundled Payments (medium-risk strategy) - Bundled payments include all payments for services rendered to treat a Member for an identified condition during a specific time period. The payments may either be made in bulk or be paid over regular predetermined intervals. Bundled Payments should be risk adjusted if appropriate. The Department may specify certain services that must be paid through Bundled Payments.

Global Payments (high-risk strategy) - Population-based payments that cover all services rendered by a Network Provider, hospital, or health system . An annual global budget is developed prospectively. These payments can either be made in bulk, delivered over regular predetermined intervals, or based on fee-for-service payments with retrospective reconciliation to the global budget. If these payments are retrospective, at least a portion of the payment must be prospective to allow for upfront investments in population health infrastructure.

Global Payments should link payments to both improved physical health and behavioral

health quality measures and provide incentives to reduce potentially avoidable utilization and address SDOH. Global Payments must also take into consideration market shift on an annual basis, to ensure that Network Providers are not simply decreasing the amount of care provided.

Network Providers who are paid via Global Payments are excluded from participating in Bundled Payment arrangements, because this would result in a duplication of payment for services rendered. The reduction of prior authorization requirements should be considered for Network Providers who are paid via Global Payments.

B. VBP Required Models

Primary Contractors and their BH-MCOs must participate in required VBP payment models as specified by the Department and work with the Department on the development of new models. VBP Payment Arrangements outside of the required models may also be adopted.

Standardized Transitions to Community (TC) - The TC Model is a structure that standardizes performance measures to better support care transitions from psychiatric inpatient (IP) discharge to community-based services across the entire healthcare system. Requirements include (1) standardized performance measures tied to payment for IP Providers and (2) standardized data collection for outpatient (OP), Behavioral Health Home Programs (BHHP), and Case Management VBP models to link natural pathways of care that can structure standardization of attribution for VBP arrangements. The required standardized measures are:

- Follow up after Hospitalization (FUH) for mental illness — The measure identifies the percentage of members who received follow-up within 7 days and 30 days of discharge.
- PA Specific Readmission — the percentage of acute inpatient stays for psychiatric care with subsequent readmission to inpatient acute psychiatric care within 30 days of the initial inpatient acute psychiatric discharge.

C. Financial Goals

The financial goals for the VBP Payment Strategies for each Contract Year are based on a percentage of the Primary Contractor's VBP expenditures to total medical expenses. The Primary Contractor must achieve the following percentages through VBP payment arrangements:

Contract Year 2022:

- 30% of the medical expenses must be expended through VBP payment strategies.

At least 50% of the 30% of medical expenses must be from a combination of medium or high financial risk categories

- The MCO must incorporate CBOs into VBP arrangements with Network Providers to address SDOH. Eighty-five percent (85%) of strategies that are medium and high risk must incorporate one or more CBOs that together address two or more SDOH domains.

- The Primary Contractor and its BH-MCO must require the CBO to address at least one of the following SDOH domains, which are included in the statewide resource and referral tool:

    - Childcare access and affordability
    - Clothing
    - Employment
    - Financial strain
    - Food insecurity
    - Housing instability/homelessness
    - Transportation
    - Utilities

- Additionally, in determining which CBOs to incorporate into VBP agreements, the Primary Contractor/ and its BH-MCO should also consider the following characteristics of CBOs:

    - Types of services provided
    - Accessibility to community members, including hours of operation, location, staffing capacity, accommodations for individuals with special needs including physical disabilities and language barriers
    - Number of MA participants served
    - Quality of social services provided and experience addressing SDOH
    - Soundness of fiscal, operational and administrative practices and capacity
    - Service area and populations served
    - Capacity for increased referrals from Providers or the BH-MCO
    - Ability to capture and report SDOH data

- The Primary Contractor and its BH-MCO must incorporate CBOs into VBP arrangements by either:

    - Contracting with a CBO directly; or
    - Contracting with a Network Provider that subcontracts with a CBO.

E. Reporting

The Department will measure compliance with the financial goals set forth in this appendix using the following required documents of which the content and/or format will be defined by the Department:

- Proposed VBP plan
- Annual summary

The Department will review the plan and summary and provide feedback to the Primary Contractor.

By October 1 of the preceding Contract Year, the Primary Contractor must submit its proposed VBP plan to the Department. The proposed VBP plan must outline and describe the Primary Contractor's plan for compliance for the next Contract Year.

Primary Contractor should monitor the VBP payment arrangements continuously, but no less than quarterly, and provide updates to OMHSAS as requested.

By June 30 of the subsequent Contract Year, the Primary Contractor must submit an annual summary using the OMHSAS Template that includes the following:

- A review of the accomplishments and outcomes from the prior Contract Year;
- A report on the percentage of medical expenses expended through VBP strategies and the associated levels of financial risk; and
- A VBP detail report by Provider that identifies the following:
  - Level of financial risk (no, low, medium, high) and Dollar amount spent for medical services expended;
  - VBP Payment Strategy/Model(s) used;
  - Program type(s) included (Federally Qualified Healthcare Centers (FQHC), Assertive Community Treatment (ACT) and Behavioral Heath Homes, etc.), if applicable;
  - CBOs and SDOH domains included; and
  - Evidence-based Practices and Programs (EBPP) [must be on the Substance Abuse & Mental Health Services Administration (SAMHSA) list of approved EBPPs and adhere to fidelity requirements]

F. Assessment

This section provides for an assessment against the Primary Contractor's Capitation payment if an annual goal is not met.

Not later than ninety (90) calendar days after receipt of the VBP annual summary from the Primary Contractor the Department will notify the Primary Contractor of its determination about compliance with the goal for the preceding Contract Year. The Primary Contractor may provide a response within thirty (30) calendar days. After considering the response from the Primary Contractor, if any, the Department will notify the Primary Contractor of its final determination of compliance. If the determination results in a finding of non-compliance, the Department may reduce the next monthly Capitation payment by an amount equivalent to one (1) percent of the medical portion of the Capitation payments it paid to the Primary Contractor for the last month of the prior Contract Year.

If the Primary Contractor fails to provide a timely and adequate VBP annual summary, the Department may determine that the Primary Contractor and is not compliant with the goal of the preceding Contract Year.

G. Data Sharing

The Primary Contractor must provide timely and actionable data to its Providers participating in VBP arrangements.

- Provider performance baseline measures, results and progress toward goals must be established and shared with Providers quarterly.

- Provider results must be published in the Provider profile reports.

- Service utilization and claim data across the clinical service spectrum must be analyzed for cost and treatment efficacy.

HEALTHCHOICES BEHAVIORAL HEALTH RECIPIENT COVERAGE DOCUMENT

Background

This document includes descriptions of policies supported by the Department of Human Services (Department) data systems and processes. In cases where the policy expressed in this document conflicts with another provision of the contract (i.e., the Department Agreement) between the Primary Contractor and the Department, the Agreement will take precedence.

The Department will provide sufficient information to the Primary Contractor in order for it to reconcile Behavioral Health Managed Care Organization (BH-MCO) membership data and amounts paid to/ recovered from the Primary Contractor.

Instances of Medical Assistance (MA) coverage for a Recipient do not imply corresponding HealthChoices coverage on the same dates by a BH-MCO. Because not all persons eligible for MA benefits are also eligible for BH-MCO membership on the same date, MA eligibility does not equate to BH-MCO coverage.

Instances of simultaneous MA eligibility and BH-MCO coverage for a Recipient do not imply corresponding HealthChoices coverage on the same dates by a Physical Health Managed Care Organization (PH-MCO) or a Community HealthChoices Managed Care Organization (CHCMCO). Please refer to the *PH-MCO Recipient Coverage Document* (Exhibit BB of the HealthChoices Physical Health Agreement) for physical health coverage guidelines- and CHCMCO Participant Coverage Document (Exhibit K of the CHC Agreement)

Coverage Rules

A BH-MCO is responsible for a member if coverage is determined by applying the general rules found in any of paragraphs A, B, or C below, subject to exceptions and clarifications found in paragraphs D, E, F, G, H and I.

A. Unless otherwise specified, the BH-MCO is responsible to provide MA behavioral health benefits to BH-MCO Members in accordance with eligibility information included on the Monthly Membership File and/or the Daily Membership File, which is provided by the Department to each BH-MCO.

B. Monthly Membership Files containing information on Members are created on the next to the last Saturday of each month and are normally provided to the BH-MCO no later than the following Monday. Information on the file includes retroactive, current or prospective eligibility periods, PH-MCO coverage and BH-MCO coverage, and demographic data. For each BH-MCO member identified on the Monthly Membership File, the BH-MCO is responsible to provide behavioral health benefits from the beginning of the month or from the BH-MCO coverage start date, whichever is later. BH-MCO coverage will continue from the start date through the last day of the calendar month unless the Department subsequently sends the BH-MCO updated information on a Daily Membership File. BH-MCO coverage beyond the last date of the month in which a Monthly Membership File is created is preliminary information that is subject to change.

Daily Membership Files are provided to each BH-MCO with changes that have been applied to their enrolled population. In the example that follows, assume that the only information provided by the Department is on the November Monthly Membership File (created in late October). If an eligibility period of October 11 through November 18 is provided, the BH-MCO is responsible from October 11 through November 30, assuming no subsequent daily file changes occur prior to November 1 to end the coverage in October. If two eligibility periods are provided (e.g., one from October 11 through October 25 and one from October 29 on with no end date), the BH-MCO is responsible from October 11 through at least November 30, subject to a daily file change prior to November 1. Coverage after October 31 is preliminary based on daily file changes.

If a Recipient is shown on the Department's Client Information System (eCIS) as covered by a BH-MCO (coverage by a BH-MCO is indicated by an open MA eligibility record and a corresponding open BH-MCO record), the BH-MCO is responsible for the person from the first day of BH-MCO coverage through the last day of the month of the BH-MCO end date (if any). The Department will pay the Primary Contractor from the first day of coverage in a month through the last calendar day of the month. Because a Recipient may lose MA eligibility (and potentially regain MA eligibility), information on eCIS for any future date should be viewed as preliminary. If a Recipient has eligibility in more than one county during the month, the BH-MCO with the earliest period of responsibility is responsible for providing services for the month.

A Recipient who becomes ineligible for MA will lose BH-MCO coverage. If a Recipient subsequently regains MA eligibility, and the Recipient's category of assistance and geographic location remain valid, the Recipient will be auto-assigned back into BH-MCO coverage. Upon regaining MA eligibility, the Recipient's BH-MCO effective date will be their MA eligibility begin date ***or*** the date eCIS is updated (i.e., the systems date), ***whichever is later***. The change in MA eligibility will normally result in a period of MA Fee-For-Service coverage for the MA Recipient's behavioral health coverage. However, an exception request may be submitted to the Department for OMHSAS to review BH-MCO eligibility for the period that MA was reinstated (Reference D. Exceptions and Clarifications #12.) MA eligibility does not equate to BH-MCO coverage. Periods of time where a person is MA eligible yet where there is no corresponding BH-MCO coverage on the same date is normal, so providers and BH-MCOs must plan accordingly in the authorization, delivery and payment of services. This will include coverage for children placed in a Residential Treatment Facility (RTF), who lose BH-MCO coverage and become covered under the MA Fee-For-Service (FFS) Program. In these and other scenarios, barring those cases identified in Section D below, the BH-MCO is not responsible for MA Recipients for whom the Department has informed the BH-MCO on Monthly and/or Daily Eligibility Files that it has no responsibility.

C. The Department has established benefit packages based on category of assistance, program status code, age, and for some packages, the existence of Medicare coverage or a Deprivation Qualifying Code. In cases where the Recipient benefits are determined by the benefit package, the most comprehensive package is to be honored. For example, if a

Recipient has the most comprehensive package on the first of the month but changes to a lesser level package during the month, they should receive the higher level of benefits for the entire month. If a Recipient has a lesser level benefit package at the beginning of the month but changes to a higher level during the month, they should receive the higher- level benefits effective the first day of coverage under the higher level. The daily and monthly files can be used for determining increased benefits during a month.

D. BH-MCO Coverage Exceptions and Clarifications:

1. The BH-MCO will not be responsible and will not be paid when the Department sends the BH-MCO correspondence specifying member months for which they are not responsible. The Department will recover capitation payments made for a Recipient for whom it had been determined the BH-MCO was not responsible to provide services.

2. In the unlikely case where eCIS shows FFS coverage that coincides with BH-MCO coverage, the Recipient may use either coverage and there will be no monetary adjustment between the Department and the BH-MCO. (This is subordinate to #8 below.)

3. If the BH-MCO receives information about changes in a Recipient's circumstances that may affect the Recipient's eligibility, including changes in a Recipient's residence or death of a Recipient, the BH-MCO shall promptly notify the CAO and the Department. The BH-MCO shall also promptly notify the CAO and the Department if the BH-MCO receives information that a Recipient is deceased and if such Recipient is shown on either the Monthly Membership File or the Daily Membership File as active. The Department will recover capitation payments made for deceased Recipients after the service month in which the date of death occurred.

4. If it is determined that the member was not MA eligible on the begin date of coverage during a month, and the BH-MCO was paid, the Department will recover or adjust capitation payments.

5. If a member is placed in a setting that results in the termination of coverage by the BH-MCO (e.g., State Mental Hospital), the Department will recover capitation payments made for the member after the service month in which the termination of coverage occurred.

6. The BH-MCO retains responsibility for Members when placed outside the county, HealthChoices zone or state by the BH-MCO, juvenile court or county Children and Youth (C&Y) even if PH-MCO coverage information is not found on eCIS, the daily or monthly eligibility files. The BH-MCO will continue to receive capitation payments.

   If a member is placed in a facility by juvenile court or county C&Y authority for service(s) which the BH-MCO determines is not medically necessary, the cost of the service is the responsibility of the placing authority, not the BH-MCO. (See

Section H for additional details).

7. Newborn babies are the responsibility of the BH-MCO that covered the mother on the date of birth. Where e CIS does not reflect this, if the PH-MCO notifies the Department, the Department will coordinate adjustment of coverage. Limitations in Sections E-2 and E-3 applicable to the mother will apply to the newborn.

8. Placement out of a BH-MCO's service area, or lack of MA coverage or eligibility on a date of service for which the policies in this document otherwise hold a BH-MCO responsible for a Recipient do not negate a BH-MCO's responsibility to provide MA benefits. If a BH-MCO is aware that a Recipient is placed outside of its county, it is the BH-MCO's responsibility to notify the CAO, within ten (10) days of the date of learning of the Recipient's status. Gaps in the notification process may result in loss of BH-MCO coverage, and MA FFS coverage may apply.

9. If the rules to determine BH-MCO responsibility to provide benefits to MA Members that are outlined in this document indicate that a BH-MCO is responsible to provide benefits to a MA Recipient on a certain date, a lack of MA eligibility indicated on e CIS for that date does not negate this responsibility.

10. Errors in coverage must be reported to the Department within 45 days of receipt of the monthly eligibility file in order for retroactive changes to be considered. The BH-MCO will be responsible to cover Members, even when coverage assignment resulted from errors, if not reported to the Department within 45 days unless the error results in duplicate payment or coverage.

11. If eCIS shows an exemption or facility/placement code (e.g., facility/placement code 14 – State Mental Hospital) that precludes BH-MCO coverage, the Recipient may not be enrolled in a BH-MCO.

12. If a recipient loses MA coverage and coverage is subsequently reinstated by the Department with no break in coverage, the reinstated segment will typically result in a period of FFS coverage. The BH-MCOs may request an exception review by the Department to align BH-MCO eligibility.

E. When a Recipient has managed care coverage during part of an inpatient/residential stay, financial responsibility* is as follows: For purposes of this document, an inpatient/residential stay shall include those in the following facilities:

General Hospital
Rehabilitation Hospital
Acute Care Hospital (PT 01 – Spec 010)
Private Psychiatric Hospital (PT 01 – Spec 011)
Residential Treatment Facility – Accredited (PT 01 – Spec 013)
Extended Acute Care Psychiatric Hospital (PT 01– Spec 018)
Drug & Alcohol Rehab Hospital (PT 01 – Spec 019)

Private Psychiatric Unit (PT 01 – Spec 022)
Drug & Alcohol Rehab Unit (PT 01 – Spec 441)
Residential Treatment Facility - Non-Accredited (PT 56 – Spec 560)

*The covering plan will only be responsible for inpatient/residential services for continuous stays when the service is included as a covered service under its contract with the Department.

1. Inpatient/residential Facilities Covered Under the Prospective Payment System for Diagnostic Related Groups.

   If a Recipient is in a facility covered by a DRG and is FFS on the admission date (or determined eligible through a retroactive determination by the CAO) and the BH-MCO coverage begins while the Recipient is in the inpatient/residential facility, the FFS program is financially responsible for the entire initial stay. The BH-MCO will become financially responsible for the member upon discharge. Upon becoming aware of a new member currently in one of these facilities, the BH-MCO must coordinate with the Provider in determining an appropriate course of treatment as soon as possible, prior to discharge.

   EXAMPLE: If a Recipient is determined to be covered by FFS on the admission date to an inpatient/residential facility, which is covered under the prospective payment system for Diagnostic Related Groups, on June 21, and the BH-MCO coverage begin date is July 1, and the individual is transferred/discharged on July 15, the FFS program will be financially responsible for the entire stay. The BH-MCO will be financially responsible for all covered services beginning July 15. Upon becoming aware of a new member currently in a facility on July 1, the BH-MCO must become involved in discharge planning for the individual.

2. Recipient Covered by FFS Becomes BH-MCO Covered While in Facility

   If a Recipient is covered by FFS on the admission date and the BH-MCO coverage begins while the Recipient is in an inpatient/residential facility not covered under the DRG Prospective Payment System, the FFS program is financially responsible for the stay until the BH-MCO begin date. Starting with the BH-MCO begin date, the BH-MCO is financially responsible for the remainder of the stay, as well as physician or other covered services not included in the inpatient/residential facility bill that would be the BH-MCO's responsibility as the Recipient's BH-MCO. Upon assuming financial responsibility of a Recipient age 21 and over, the BH-MCO has the ability to conduct a concurrent review of the FFS authorized inpatient/residential facility stay to determine continued medical necessity.

   EXAMPLE: If a Recipient covered by FFS is admitted to an inpatient/residential facility on June 21 and the BH-MCO coverage begin date is July 1, the BH-MCO will assume payment responsibility for the inpatient/residential facility stay in July 1. The FFS program will remain financially responsible for the stay through June 30. Any time after June 30, the BH-MCO may conduct a concurrent review to

determine medical necessity of the inpatient/residential facility stay if the member is an adult age 21and over.

3. Recipient Covered by BH-MCO Becomes FFS While in Facility

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential facility and the Recipient loses BH-MCO coverage and assumes FFS coverage while still in the inpatient/residential facility, the BH-MCO is responsible for the stay except as indicated below.

EXAMPLE #1: If the Recipient is still in the inpatient/residential facility on the FFS coverage begin date, and the Recipient's FFS coverage begin date is the first day of the month, the BH-MCO will be financially responsible for the stay through the last day of that month. The FFS program will be financially responsible for the stay beginning on the first day of the next month. For example, if a Recipient covered by the BH-MCO is admitted to an inpatient/residential facility on June 21 and the FFS program coverage begin date is July 1, the FFS program will assume payment responsibility for the inpatient/residential facility stay on August 1. The BH-MCO will remain financially responsible for the stay through July 31.

EXAMPLE #2: If the Recipient is still in the inpatient/residential facility on the FFS program coverage begin date, and the Recipient's FFS program coverage begin date is any day other than the first day of the month, the BH-MCO will be financially responsible for the stay through the last day of the FOLLOWING month. The FFS program will be financially responsible for the stay beginning on the first day of the NEXT month. For example, if a Recipient covered by a BH-MCO is admitted to an inpatient/residential facility on June 21 and the FFS program coverage begin date is July 15, the FFS program will assume payment responsibility for the inpatient/residential facility stay on September 1. The BH-MCO program will remain financially responsible for the stay through August 31.

4. Recipient Covered by BH-MCO Loses MA eligibility and BH-MCO coverage while in Facility

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential facility and the Recipient loses MA eligibility and BH-MCO coverage while in the inpatient/residential facility, the BH-MCO is responsible for the stay except as indicated below.

EXAMPLE: #1: If the Recipient is still in the inpatient/residential facility on the date the clients loses MA eligibility, the BH-MCO will be financially responsible through the end of the month in which MA eligibility is lost. The CAO subsequently reestablishes MA eligibility retroactively to the last MA eligibility end-date resulting in consecutive MA eligibility spans and the BH-MCO coverage resumes on the system store date. For example, if a Recipient covered by a BH-MCO is admitted to an inpatient/residential facility on August 26 and loses MA eligibility on August 27, the BH–MCO is responsible through August 31. (Reference D. Exceptions

and Clarifications #9). The BH-MCO coverage will then resume on the system store date of October 15. If requested, MA FFS may review the case to determine medical necessity for possible FFS coverage of the stay where the dates of service were September 1 through October 14. Additionally, if requested, an exception may be considered to align BH-MCO coverage for continuity of care (Reference D. Exceptions and Clarifications #12).

5. Recipient Covered by one BH-MCO Becomes Covered by a Different BH-MCO While in a Facility

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential facility and transfers to another BH-MCO while still in the inpatient/residential facility, the first BH-MCO is responsible for that stay except as indicated below.

EXCEPTION #1: If the Recipient is still in the inpatient/residential facility on the gaining BH-MCO coverage begin date, and the Recipient's gaining BH-MCO coverage begin date is the first day of the month, the first BH-MCO will be financially responsible for the stay through the last day of that month. The second BH-MCO will be financially responsible for the stay beginning on the first day of the next month. For example, if a Recipient is admitted to an inpatient/residential facility on June 21 and the second BH-MCO coverage begin date is July 1, the second BH-MCO will assume payment responsibility for the inpatient/residential facility stay on August 1. The first BH-MCO will remain financially responsible for the stay through July 31.

EXCEPTION #2: If the Recipient is still in the inpatient/residential facility on the second BH-MCO coverage begin date, and the Recipient's second BH-MCO coverage begin date is any day other than the first day of the month, the first BH-MCO will be financially responsible for the stay beginning on the first day of the NEXT month. The second BH-MCO will be financially responsible for the stay beginning on the first day of the following month. For example, if a Recipient is admitted to an inpatient/residential facility on June 21 and the second BH-MCO coverage begin date is July 15, the second BH-MCO will assume payment responsibility for the inpatient/residential facility stay on September 01. The first BH-MCO will remain financially responsible for the stay through August 31.

F. When a Recipient has managed care coverage during a stay in an Institution for Mental Diseases (IMD), financial responsibility is as follows. For purposes of this provision, an IMD stay is a stay in a freestanding psychiatric or substance use disorder facility with more than sixteen (16) beds by an individual age 21-64. It does not include a stay in the following:

Acute Care Hospital (PT 01 – Spec 010)
Private Psychiatric Unit within a General Hospital (PT 01- Spec 022)

If a Member between the ages of 21 and 64 is eligible for MA on the first day of the month, the BH-MCO is responsible for all services for the entire month. If a Member between the ages of 21 and 64 stays in a psychiatric IMD for longer than fifteen (15) cumulative days

within a month, a capitation recoupment will be processed for the entire month the Member is an inpatient in the psychiatric IMD and the Primary Contractor and its BH-MCO will receive a separate pro-rated capitation payment for the days of the month in which the Member was not in a psychiatric IMD facility. If a Member between the ages of 21 and 64, stays in a psychiatric IMD for fifteen (15) cumulative days or fewer within a month, the Primary Contractor may retain the capitation payment. A capitation recoupment will not be processed for stays longer than fifteen (15) cumulative days in substance use disorder facilities.

G. Other Causes for Coverage Termination:

1. Nursing Facility – If a Recipient loses Community HealthChoices (CHC) coverage while in a nursing facility, the Recipient is disenrolled from the BH-MCO after 30 consecutive days of placement in a nursing facility. This includes cases where the CAO enters a facility code placement on a Recipient's record with a retroactive begin date and the BH-MCO record remains opened, the Department will take into consideration the 30 days from the begin date of the placement prior to end-dating BH-MCO coverage. Example: A Recipient is determined BH-MCO eligible beginning January 1 and is admitted to a nursing facility on February 17. On February 28 the CAO retrospectively enters a facility placement code of "36" onto the Recipient's eCIS record (eCIS systems date = 02/28) with a placement begin date of February 17. The BH-MCO record will remain open for the period of January 1 through March 18 before end-dating; with the last 30 days of BH-MCO coverage corresponding to the first 30 consecutive days of nursing facility placement.

2. Aging Waiver (also known as the Pennsylvania Department of Aging (PDA) Waiver) If a BH-MCO Member loses CHC coverage and enrolls in the Aging Waiver the BH-MCO Member will be disenrolled thirty (30) days after enrollment in the Aging Waiver.

3. Admission to a State Facility - BH-MCOs are not responsible for BH-MCO Members placed in a state facility. The Recipient will be disenrolled from the BH-MCO effective the day before placement in the facility. Medical Assistance eligibility will be determined by the CAO. The Department will recover MCO capitation payments made for any months after the month of placement.

4. Admission to a Correctional Facility – A member who becomes an inmate of a penal facility or correctional institution (including work release), or a member who is remanded to a Youth Development Center/Youth Forestry Camp will be disenrolled from the BH-MCO effective the day before placement in the facility. The Department will recover MCO capitation payments made for any months after the month of placement.

5. Placement in a Juvenile Detention Center (JDC) – A member who is placed in a juvenile detention center is disenrolled from the BH-MCO after 35 days and covered through MA Fee-For-Service. During the first 35 days of this JDC

placement, the BH-MCO is responsible for all covered services that are provided to the member outside the JDC site; services provided inside the JDC site are the responsibility of the FFS program. This includes cases where the CAO enters a facility code placement on a client's record with a retroactive begin date and the BH-MCO record remains opened, the Department will take into consideration the 35 days from the begin date of the placement prior to end-dating BH-MCO coverage. Example: if a client is BH-MCO eligible beginning July 1 and the CAO retroactively enters a facility code "74" (store date 11/08) with a placement begin date of August 17; the BH-MCO record will remain open from July 1 through September 20.

6. Health Insurance Premium Payment Program (HIPP) - BH-MCO Members determined by the Department to be HIPP eligible (Employer Group Health Plan) will be disenrolled from the BH-MCO as of the date when the BH-MCO Member Record reflects such disenrollment. Additionally, HIPP eligible MA Members are prevented from enrolling in BH-MCOs.

7. A member enrolled in Living Independence for the Elderly (LIFE), also known as LTCCAP (Long-Term Care Capitated Assistance Program), is disenrolled from the BH-MCO effective the day before the begin date of LIFE.

8. Residing in a PA Veterans Home – The BH-MCO will not be responsible for a Member residing in a PA Veterans Home. The Member will be disenrolled from the BH-MCO the day before the admission date and covered by the MA FFS program.

H. **Other Facility Placement Coverage:**

1. Intermediate Care Facility- Intellectual Disability or Other Related Conditions (ICFMR or ICF-ORC) - Members placed in a private ICF-MR or ICF-ORC facility will continue to be covered by their BH-MCO for all medically necessary behavioral health services that are included in the scope of benefits provided by the contract with DHS.

2. Residential Facilities - BH-MCO Members placed by the BH-MCO in mental health and drug and alcohol residential treatment facilities will continue to be covered by their BH-MCO for all behavioral health services. The residential/treatment costs of Members placed by the BH-MCO in residential treatment facilities will be the responsibility of the BH-MCO. (See section I. 2 for exceptions for children in substitute care)

3. Extended Acute Care Psychiatric Hospital - BH-MCO Members admitted to an extended acute care psychiatric hospital will continue to be covered by their selected BH-MCO for all behavioral health services. The residential/treatment costs will be the responsibility of the BH-MCO.

I. **Children and Adolescents In Substitute Care Issues:**

When children have been adjudicated dependent or delinquent and are placed in substitute care, behavioral healthcare coverage is the responsibility of the BH-MCO. For purposes of this Section, terms "child" and "children" shall include "adolescents". For a definition of Child in Substitute Care see "Definitions."

1. Behavioral Health Services (includes MH and D&A)

   If a child is placed in a substitute care setting, either in the same or different zone, the child is enrolled in the BH-MCO county of origin. The child remains enrolled in that BH-MCO which retains authorization and payment responsibility for BH-MCO approved behavioral health services, including both residential and non-residential services**.** For a child placed in a substitute care setting out of zone, the child remains enrolled in the BH-MCO which retains authorization and payment responsibility for BH-MCO approved behavioral health services, including residential and non-residential services.

2. Placement in a Mental Health or Drug and Alcohol Residential Facility

   a. Medically Necessary - Consistent with I.1 above, if a Child in Substitute Care is placed in a mental health or drug and alcohol RTF either in or out of state and the BH-MCO determines the placement is medically necessary, the behavioral health services are the responsibility of the BH-MCO.

   b. Not Medically Necessary - If a Child in Substitute Care is placed in a mental health or drug and alcohol residential facility by a placement authority or juvenile court and the BH-MCO in which the child is enrolled determines the placement is not medically necessary; the BH-MCO is not responsible for payment for the placement. The child remains enrolled in the BH-MCO and the BH-MCO remains responsible for medically necessary Behavioral Health Services other than the mental health or drug and alcohol residential placement.

   c. If a Child in Substitute Care is covered by the HealthChoices Behavioral Health program and is placed in a mental health or drug and alcohol residential facility without review by the BH-MCO, the BH-MCO is not responsible for payment for residential behavioral health services. The BH-MCO will be responsible for medically necessary Behavioral Health Services other than the residential placement. The facility or placing authority can request authorization of services from the BH-MCO which will determine the medical necessity of the placement. The BH-MCO will not be responsible for any services delivered prior to the request for medical necessity determination unless, at the discretion of the placing authority and the BH-MCO, they can agree to begin BH-MCO coverage at the admission date or any mutually agreeable later date. The child is enrolled in a Physical Health Service System (PHSS) serving the zone in which the child is placed. Children placed out of state revert to FFS for physical health and for ancillary behavioral health services other than the placement. Ancillary services could include services such as assessments, psychotherapy, or medication management provided on an outpatient basis.

3. **Placement in a C&Y or JPO non-Mental Health Placement**

   If a Child in Substitute Care is placed in a non-mental health or drug and alcohol placement such as:

   a. Shelter programs
   b. Diagnostic centers
   c. Foster family home, including kinship care homes
   d. Residential facilities

   The child remains enrolled in the BH-MCO from the original placing county.
   The child is enrolled in PHSS serving the zone in which the child is placed. Children placed out of state revert to FFS for physical health.

4. The BH-MCO will be required to pay for Out-of-Network medically necessary behavioral health care services for up to ten days for a child enrolled in its plan who is placed in substitute care if the (County C&Y Agency) CCYA cannot identify the child nor verify MA coverage. However, this Out-of-Network coverage will only be required in certain circumstances, such as emergency placement as determined by county child welfare or juvenile probation, or where the CCYA has had no contact with the child prior to the placement. All efforts must be made by the CCYA to identify the child and to determine MA coverage responsibility in the most expedient manner possible.

5. For youth placed in a Juvenile Detention Center, the BH-MCO is responsible for medically necessary State Plan Services delivered in treatment settings outside (off site) the JDC during the first 35 consecutive days of detention. However, the BH-MCO is not responsible at any time for services delivered within the JDC.

6. Children whose adoptions have been finalized by the court and for whom there is an adoption assistance agreement in place, enrolls in the BH-MCO of the county where the adoptive family resides. If the family has moved to a permanent residence outside the Commonwealth of Pennsylvania and the family retains Pennsylvania Medicaid for the adopted child, the child will revert to Fee-For- Service for behavioral health services.

Definitions:

BH-MCO Coverage Period - A period of time during which a Recipient is eligible for MA coverage ***and*** a BH-MCO coverage period exists on the Department's eCIS. Exceptions and Clarifications are identified in Sections D, E, F, G and H of this document.

BH-MCO Member **-** An MA Recipient who is enrolled with the BH-MCO under the HealthChoices Behavioral Health Program and for whom the BH-MCO is responsible to provide behavioral health services under the provisions of the HealthChoices Behavioral Health Program. Not all persons who are MA eligible are simultaneously BH-MCO members.

BH-MCO Member Record - A record contained on the Daily Membership File or the Monthly Membership File that contains information on MA eligibility, managed care coverage, and the category of assistance, which identifies the Recipient as a BH-MCO member.

Child in Substitute Care – A Child in Substitute Care is one who has been adjudicated dependent or delinquent and residing outside their own home. *Dependent* children and adolescents are living in the legal custody of a public child welfare agency, in any of the following settings:

- Shelter programs
- Foster family homes
- Group homes
- Supervised independent living
- Residential treatment facilities (RTF)
- Drug and alcohol treatment facilities
- Transitional living residence
- Mobile and outdoor programs
- Residential facilities
- Kinship homes

Children in Substitute Care classified as *delinquent* are adjudicated as such by the juvenile court and placed in temporary secure juvenile detention center (JDC), secure care or any of the settings listed above. They are under the supervision of the juvenile court and there is no transfer of legal custody to a public agency.

electronic Client Information System (eCIS) - The Department's automated file of previous, current and future MA Recipients and BH-MCO members.

Community HealthChoices (CHC)– Pennsylvania's managed care program that uses managed care organizations to coordinate physical health care and long-term services and supports (LTSS) for older persons, persons with physical disabilities, and persons who are dually eligible for Medicare and Medicaid (dual eligibles).

Community HealthChoices Managed Care Organizations –. A Commonwealth-licensed risk bearing entity which has entered into an Agreement with the Department to manage the purchase and provisions of physical health and long-term services and supports (LTSS) under Community

HealthChoices.

Daily Membership File – A HIPAA-compliant 834 electronic file generated by the Department's contractor on a daily basis (exclusive of weekends and Department holidays), which is transmitted to the Primary Contractor (or its subcontractor). The Daily Membership File contains information on changes made to MA Recipient records on eCIS, and may include: retroactive, current or prospective MA eligibility, and current or retrospective BH-MCO coverage information.

Drug and Alcohol Residential Facility – Includes inpatient or non-hospital residential drug and alcohol services. Non-hospital residential includes residential detox, rehab and half-way house.

Institution for Mental Disease (IMD) (as defined by CMS in 45 CFR 435.1010) - A hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental disease, whether or not it is licensed as such.

Long-Term Services and Supports – Services and supports provided to a CHC Member who has functional limitations or chronic illnesses that have a primary purpose of supporting the ability of the CHC Member to live or work in the setting of his or her choice, which may include the individual's home or worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

MA Eligibility Period - A period of time during which a Recipient is eligible to receive MA benefits. An eligibility period is indicated by the eligibility start and end dates on eCIS. A blank eligibility end date on eCIS signifies an open-ended eligibility period. MA eligibility on a date does not necessarily equate to BH-MCO membership on the same date.

Monthly Membership File - A HIPAA-compliant 834 electronic file, generated by the Department's contractor on the next to the last Saturday of the month that is transmitted to the Primary Contractor (or its subcontractor). The Monthly Membership File lists retroactive, current and prospective BH-MCO Members, specifying for each BH-MCO Member the corresponding eligibility period, PH-MCO coverage and BH-MCO coverage. Recipients not included on this file with an indication of prospective coverage will not be the responsibility of the BH-MCO unless a subsequent Daily Membership File indicates otherwise. Those with an indication of future month coverage will not be the responsibility of the BH-MCO if a Daily Membership File received by the BH-MCO prior to the beginning of the future month indicates otherwise.

Negation BH-MCO Member Record - A BH-MCO Member Record used by the Department to advise the Primary Contractor that a certain related BH-MCO Member Record previously submitted by the Department to the Primary Contractor should be negated. A Negation BH-MCO Member Record can be recognized by its sequence of BH-MCO membership start and end dates with the end date preceding the start date.

Open-ended - A period of time that has a start date and does not have a definitive end date.

PH-MCO Coverage Period - A period of time during which a Recipient is eligible for MA coverage and a PH-MCO coverage period exists on eCIS. Exceptions and clarifications are identified in the *PH-MCO Recipient Coverage Document* (Exhibit BB of the HealthChoices Physical Health Agreement).

PH-MCO Member - An MA Recipient who is enrolled with a specific PH-MCO and to whom the PH-MCO is responsible to provide physical health MA benefits under the provisions of the HealthChoices Physical Health Program. BH-MCO coverage for a Recipient does not suggest the Recipient also has PH-MCO coverage on the same date.

Physical Health Managed Care Organization (PH-MCO) - A Commonwealth licensed risk-bearing entity, which has contracted with the Department to manage the purchase and provision of physical health services under the HealthChoices Physical Health Program.

Recipient - A person eligible to receive medical and behavioral health services under the MA program of the Commonwealth of Pennsylvania.

System Date – The System Date is the date a change in coverage or eligibility is entered into the e CIS. The effective date of the change may be different than the System Date, as evidenced by the fact that the BH-MCO coverage effective begin date is the MA eligibility begin date or the System Date – whichever is greater.

BEHAVIORAL HEALTH AUDIT CLAUSE

AUDITS

Annual Contract Audits

The Primary Contractor shall cause, and bear the costs of, an annual contract audit to be performed by an independent, licensed Certified Public Accountant. The contract audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The contract audit shall be submitted to the Commonwealth no later than the 15th day of the fifth month after the contract period is ended.

If circumstances arise in which the Commonwealth or the Primary Contractor invoke the contractual termination clause or determine the contract will cease, the contract audit for the period ending with the termination date or the last date the contractor is responsible to provide medical assistance benefits to HealthChoices recipients shall be submitted to the Commonwealth no later than the end of the fifth (5th) month after the contract termination date or the last date the contractor is responsible to provide medical assistance benefits.

The Primary Contractor shall ensure that audit working papers and audit reports are retained by the Primary Contractor's auditor for a minimum of five (5) years from the date of final payment under the contract, unless the Primary Contractor's auditor is notified in writing by the Commonwealth to extend the retention period. Audit working papers shall be made available, upon request, to authorized representatives of the Commonwealth or Federal agencies. Copies of working papers deemed necessary shall be provided by the Primary Contractor's auditor.

Distribution shall be as follows:

Three (3) copies to: Pennsylvania Office of the Budget
Public Health and Human Services Comptroller Office 1010
North 7th Street
Eastgate Building, Suite 316 Harrisburg,
PA 17102-1410

Two (2) copies to:

Regular Mail:

Department of Human Services
Office of Mental Health and Substance Abuse Services
Bureau of Financial Management and Administration
Division of Medicaid and Financial Review
P.O. Box 2675
Harrisburg, PA 17105-2675

Overnight Courier:

Department of Human Services
Office of Mental Health and Substance Abuse Services Bureau of Financial Management and Administration Division of Medicaid and Financial Review Commonwealth Towers, 12th Floor
303 Walnut Street
Harrisburg, PA 17101

Annual Entity-Wide Financial Audits

The Primary Contractor and its Prime Subcontractor shall provide to the Commonwealth a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in accordance with generally accepted auditing standards. If the Primary Contractor is a county government, the report on such audit shall be submitted within nine months after the end of the county's fiscal year. If the Primary Contractor or Prime Subcontractor is not a county government, such audit shall be submitted to the Commonwealth within 180 days after the entity's fiscal year end. If the Primary Contractor or Prime Subcontractor is a Commonwealth-licensed, risk-bearing entity, the annual audit prepared and submitted to the Pennsylvania Insurance Department, is acceptable for submission to the Department of Human Services.
Distribution shall be as follows:

One (1) copy to: Pennsylvania Office of the Budget
Public Health and Human Services Comptroller Office
Assistant Comptroller for Medical Assistance
P.O. Box 2675
Harrisburg, PA 17105-2675

One (1) copy to: Department of Human Services
Office of Mental Health and Substance Abuse Services Bureau of Financial Management and Administration Division of Medicaid and Financial Review
P.O. Box 2675
Harrisburg, PA 17105-2675

Other Financial and Performance Audits

The Commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional financial or performance audits of the Primary Contractor, its Prime Subcontractors or providers. Any such additional audit work will rely on work already performed by the Contractor's auditor to the extent possible. The costs incurred by the federal or state agencies for such additional work will be borne by those agencies.

Audits of the Primary Contractor, its Prime Subcontractors or providers may be performed by the Commonwealth or its designated representatives and include, but are not limited to:

- Financial and compliance audits of operations and activities for the purpose of determining the compliance with financial and programmatic record keeping and reporting requirements of this contract;

- Audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Commonwealth is properly safeguarded, accurate, timely, complete, reliable, and in accordance with contract terms and conditions; and

- Program audits and reviews to measure the economy, efficiency and effectiveness of program operations under this contract.

Audits performed by the Commonwealth shall be in addition to any federally-required audits or any monitoring or review efforts. Commonwealth audits of the Primary Contractor's or its Prime Subcontractor's operations will generally be performed on an annual basis. However, the Commonwealth reserves the right to audit more frequently, to vary the audit period, and to determine the type and duration of these audits. Audits of Prime Subcontractors or providers will be performed at the Commonwealth's discretion.

The following provisions apply to the Primary Contractor, its Prime Subcontractors and providers:

- Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the Primary Contractor, its Prime Subcontractors or providers (Entity) at least three weeks advance written notice of the start date, expected staffing, and estimated duration of the audit. While the audit team is on-site, the Entity shall provide the team with adequate workspace; access to a telephone, photocopier and facsimile machine; electrical outlets; and privacy for conferences. The Primary Contractor shall also provide, at its own expense, necessary systems and staff support to timely extract and/or download information stored in electronic format, gather requested documents or information, complete forms or questionnaires, and respond to auditor inquiries. The Entity shall cooperate fully with the audit team in furnishing, either in advance or during the course of the audit, any policies, procedures, job descriptions, contracts or other documents or information requested by the audit team.

- Upon issuance of the final report to the Entity, the Entity shall prepare and submit, within thirty (30) calendar days after issuance of the report, a Corrective Action Plan for each observation or finding contained therein. The Corrective Action Plan shall include a brief description of the finding, the specific steps to be taken to correct the situation or specific reasons why corrective action is not necessary, a timetable for performance of the corrective action steps, and a description of the monitoring to be performed to ensure that the steps are taken.

Record Availability, Retention and Access

The Primary Contractor shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Records required for this purpose include, but are not limited to: books, contracts, computer or other electronic systems of the Primary Contractor, its BH-MCO, BH-MCO Services Providers and Subcontractors. Access shall be provided either on-site, during normal business hours, or through the mail. During the contract and record retention period, these records shall be available at the Primary Contractor's chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The Primary Contractor shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this agreement as well as to all required programmatic activity and data pursuant to this agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period, and for ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed.

Audits of Subcontractors

The Primary Contractor shall include in Prime subcontract agreements clauses, which reflect the above provisions relative to "Annual Contract Audits", "Annual Entity-Wide Financial Audits", "Other Financial and Performance Audits" and "Record Availability, Retention, and Access".

The Primary Contractor shall include in all contract agreements with other subcontractors or providers clauses, which reflect the above provisions relative to "Other Financial and Performance Audits" and "Record Availability, Retention, and Access".

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Program Standards and Requirements

Appendix X

HealthChoices Category/Program Status Coverage Chart Updated

Facility/Placement and Waiver Coverage Chart: Appendix X.1 PROMISe Managed

Care Payment System Table for HealthChoices: Appendix X.2

The Department is moving the HealthChoices website from an intranet to an extranet platform sometime in March 2019. Access to the extranet will require business partners to register for the access and log in using a b- account user id. The Department will soon have available the ability for business partners to register for the access. Once the registration process is available, information will be distributed on how to register. The extranet will not be available until several weeks after the registration process has been in place to give users time to register.

ACA Health Insurance Providers Fee

This Appendix provides for potential payments by the Department to the impacted Behavioral Health (BH) Primary Contractors related to the Health Insurance Providers Fee (HIPF).

Fee Year – The year in which a HIPF payment is due from the BH-MCO to the Internal Revenue Service (IRS) is referred to as the Fee Year.

Data Year – The IRS calculates HIPF due in the Fee Year using submitted information on net premiums written for the previous calendar year, which is referred to as the Data Year.

A. If a BH-MCO is a covered entity or a member of a controlled group under Section 9010 of the Affordable Care Act (ACA) that is required to file IRS Form 8963, Report of Health Insurance Provider Information (Report 8963), the BH-MCO must perform the following steps. If a BH-MCO is a Primary Contractor of the Department, the BH-MCO must provide the required materials directly to the Office of Mental Health and Substance Abuse Services (OMHSAS). If a BH-MCO is a subcontractor to a Primary Contractor, the BH-MCO must provide the Primary Contractor with the required materials and upon receipt the Primary Contractor must provide the materials to the Department. Submission is not required if the BH-MCO is exempt from the HIPF.

    1. By April 30th of each calendar year, the BH-MCO shall provide the Department (directly or via the Primary Contractor) with a copy of the Form 8963 the BH-MCO submitted to the IRS. The BH-MCO shall also provide, for each line on Form 8963 that reports premiums written, the amount of HealthChoices (HC) premium included on that line. For BH-MCOs with multiple HC BH agreements, the BH-MCO shall provide the breakdown of HealthChoices premiums reported on Form 8963 separately for each agreement.

    2. The BH-MCO shall provide to the Department (directly or via the Primary Contractor) a copy of the IRS HIPF preliminary fee calculation notice within ten (10) business days of its receipt from the IRS.

    3. If a corrected Form 8963 is submitted to the IRS during the error correction period, the BH-MCO shall provide the Department (directly or via the Primary Contractor) with a copy of the corrected Form 8963within ten (10) business days of submission to the IRS. The BH-MCO shall also provide, for each line on a corrected Form 8963 that reports premiums

written, the amount of HC BH premiums that are included on that line.

4. The BH-MCO shall provide the Department (directly or via the Primary Contractor) with a copy of the IRS Annual Fee on Health Insurance Providers for 20xx notice for that Fee Year within five (5) business days of receipt from the IRS.

5. If the BH-MCO's net income is subject to federal income tax and the BH- MCO desires the Department to consider this in its calculation of the payment amount, the BH-MCO shall provide to the Department the average federal income tax rate that applies to its income for the Data Year. The BH- MCO shall also provide the amount of taxable income subject to federal income tax and the amount of federal income tax paid for the most recent income tax year for which a tax filing has been made. The BH- MCO shall specify the tax year and shall provide the information by June 30 or by August 30 pursuant to a permitted IRS extension as to such tax filing.

6. If the BH-MCO's net income is subject to Pennsylvania (PA) corporate net income tax and the BH-MCO desires the Department to consider this in its calculation of the payment amount, the BH-MCO shall provide the average state income tax rate that applies to its PA corporate net income for the Data Year. The BH-MCO shall also provide the amount of taxable income subject to PA corporate net income tax and the amount of PA corporate net income tax paid for the most recent income tax year for which a tax filing has been made. The BH-MCO shall specify the tax year and provide the information by June 30 or by August 30 pursuant to a permitted IRS extension as to such tax filing for the Fee Year.

B. The Department will:

1. Review each submitted document and notify the Primary Contractor and/or the BH-MCO of any questions. The BH-MCO must respond to questions from the Department within five (5) business days.

2. By September 30 of each Fee Year, the Department will calculate the portion of the Data Year HIPF allowance amounts that covers the HealthChoices portion (specific to this Agreement) of the BH-MCO's HIPF obligation per the IRS HIPF preliminary fee calculation notice (as noted in A.2 above). This calculation will be called the Initial HIPF Payment. To calculate the amount, the Department will:

    a. Calculate the HIPF obligation rate (the "HIPF%") from information on the IRS document "Annual Fee on Health Insurance Providers for 20xx", where 20xx is the Fee Year. For a BH-MCO that is a single- person covered entity, the IRS will send this document to the BH- MCO. For a BH-MCO that is a member of controlled group, the IRS will

send this document to the designated entity of the controlled group on behalf of all members of the controlled group.

$$\text{Single-person covered entity or controlled group HIPF\%} = \frac{\text{Amount labeled "Your share of fee"}}{\text{Amount labeled "Sum of total net premiums written as reported"}}$$

The amount "Sum of total net premiums written as reported" is before the reduction of 100% of the first $25 million of premium and 50% of the next $25 million of premium. The single-person covered entity or controlled group HIPF% is unique to each entity that is subject to the HIPF. The above formula produces the HIPF% to be used in subsequent steps of the calculation in the following circumstances:

i. The BH-MCO is a single-person covered entity.
ii. The BH-MCO is a member of a controlled group and none of the controlled group's premiums are reported as "Premiums eligible for partial exclusion for certain exempt activities" (listed on Form 8963 as attributable to 501(c)3, (c)4, (c)26, or (c)29 entities).
iii. The BH-MCO is a member of a controlled group and all of the controlled group's premiums are reported as "Premiums eligible for partial exclusion for certain exempt activities" (listed on Form 8963 as attributable to 501(c)3, (c)4, (c)26, or (c)29 entities).

If the document "Annual Fee on Health Insurance Providers for 20xx" has an amount for the "Premiums eligible for partial exclusion for certain exempt activities" that is not zero and not equal to the amount "Sum of total net premiums written as reported", then information from Form 8963 on the premiums attributable to 501(c)3, (c)4, (c)26, or (c)29 entities will be used to develop a non-profit HIPF% for the 501(c)3, (c)4, (c)26, or (c)29 entities that is 50% of the HIPF% for the other (for-profit) entities, where the application of the two rates to the respective premiums produces the amount "Your share of fee". The HIPF% to be used in subsequent steps of the calculations is either the non-profit or for-profit HIPF%, as determined by the status of the BH-MCO.

b. Calculate Figure A. Figure A is the total revenue for coverage in the Data Year that the Department or the Primary Contractor has provided the BH-MCO for this Agreement, as known through payments made by August 1 of the Fee Year. The Figure A amount has no provision for the HIPF obligation.

c. Calculate Figure B. Figure B is the portion of Figure A that is for services subject to the HIPF. Capitation revenue for services that are

excludable under Section 9010, such as long-term care services, will not be included in Figure B. The Figure B amount has no provision for the HIPF obligation.

d. Calculate Figure C. Figure C is the calculation of total revenue that incorporates provision for the HIPF and other taxes. The Department will use the following formula to calculate Figure C. If the BH-MCO has not provided satisfactory documentation of federal income tax obligations under section A.5, then the federal income tax rate (FIT%) in the formula will be zero. If the BH-MCO has not provided satisfactory documentation of Pennsylvania corporate net income tax obligations under section A.6, then the state income tax rate (SIT%) in the formula will be zero. However, the BH-MCO and the Primary Contractor shall be notified by the Department in writing of any determination that the submitted documentation is not satisfactory, and the basis for that determination, and the BH- MCO shall have thirty (30) days from receipt of such notification to provide additional documentation to support its federal or state tax obligations under section A.5 and for the calculation under this section B.2.d.

$$\frac{\text{Figure B}}{1 - (\text{HIPF\%} / (1 - \text{SIT\%} - \text{FIT\%} \times (1 - \text{SIT\%})))}$$

e. Calculate Figure D. the Department will calculate Figure D by subtracting Figure B from Figure C. This is the final HIPF adjustment amount that will serve as the basis for the Department payment to the impacted Primary Contractors. For BH-MCOs with multiple agreements, the HIPF will be allocated across the agreements based on revenue and separate payments will be made.

f. The Department will compare Figure D with the sum of the HIPF allowance amounts it has withheld for the Agreement for the Data Year. The lesser of these two figures will be the Initial HIPF calculation. For BH-MCOs with multiple agreements, the HIPF will be allocated across the agreements based on revenue. The Data Year may encompass multiple rating periods. The Primary Contractor and its BH-MCO, if applicable, will review this calculation and notify the Department of any identified discrepancies within ten (10) business days.

3. The Department will utilize the steps provided in B.2. above to calculate a final HIPF payment amount, with these exceptions:

a. The Department will utilize the IRS HIPF final fee calculation notice for that Fee Year instead of the preliminary fee calculation.

b. Figure A is the total revenue for coverage in the Data Year, as known through payments made by November 1 of the Fee Year.

c. The Final HIPF payment amount may not exceed the sum of the HIPF allowance amounts for the Data Year.

C. The Department will perform the steps provided by this Appendix for any year that a BH-MCO pays a HIPF, even if the BH-MCO is no longer providing HealthChoices BH services during that Fee Year.

D. The BH-MCO shall notify the Department (directly or via the Primary Contractor) if the HIPF actually paid is less than the amount in the IRS final fee calculation notice or if the IRS refunds any portion of the HIPF. If such changes affect the calculations provided in this Appendix, the Department will recalculate its obligation and the BH- MCO will refund the difference.

E. The Department will not make a payment per this Appendix if the BH-MCO is not subject to the HIPF.

F. The Department will have no obligation to the BH-MCO per this Appendix unless CMS has approved the Agreement that includes this Appendix.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Enrollment Process for "In Lieu Of " and "In Addition To" Service Providers

1. The HealthChoices enrollment process for in lieu of and in addition to service providers begins when a Primary Contractor or Behavioral Health Managed Care Organization (BH-MCO) identifies a service need and credentials and contracts with a provider. The following steps are included in this process:

   A. The Primary Contractor or BH-MCO identifies the need for in lieu of or in addition to service(s) and an appropriate provider (or providers) to deliver the service(s).

   B. The Primary Contractor or BH-MCO works directly with the Provider(s) to make application to enroll as an "in lieu of" and/or "in addition to" service provider.

   C. The Provider(s), with assistance from the Primary Contractor or BH-MCO, completes an enrollment application. The enrollment application includes:

      - HealthChoices In Lieu Of and In Addition To Services Provider Enrollment Application;
      - Provider Agreement for Outpatient Providers;
      - Ownership or Control Interest Form;
      - Document Generated by the Federal IRS listing name and FEIN or SSN;
      - In Lieu Of and In Addition To Service Description (where applicable);
      - BH-MCO Attestation Form;
      - OMHSAS Field Office Attestation Form (where applicable);

   D. There are two categories of services which require an In Lieu Of and In Addition To Service Description tailored to describe the provider-specific information. They are "standard" and "newly proposed."

      The "standard" services which require the submission of an In Lieu Of and In Addition To Service Description with the provider enrollment application include:

      - BSU Diagnostic Assessment
      - Drug and Alcohol Intervention
      - Drug and Alcohol Intensive Case Management
      - Drug and Alcohol Resource Coordination
      - Drug and Alcohol Level of Care Assessment

   A "newly proposed" service should fall into one of the 3 categories listed below:

   - Community Treatment Team

- Community Mental Health Services, Other
- Drug and Alcohol Services, Other

The Office of Mental Health and Substance Abuse Services (OMHSAS) will review the service description to determine if it is consistent with the requirements for the service and describes how the provider is proposing to deliver the service. Service descriptions that are incomplete or do not reflect provider-specific information will be returned to the Primary Contractor or BH-MCO.

A service description must be completed for each requested in lieu of and in addition to service a Provider is seeking to provide. The Enrollment Form identifies standard (i.e. existing in lieu of and in addition to services). Whether the Primary Contractor or BH-MCO is requesting one of these standard services or a brand new service not included on the form, a Service Description Form must be completed. The Primary Contractor or BH-MCO needs to review the OMHSAS' list of in lieu of and in addition to service descriptions, which have standard descriptions, staff qualifications, expected outcomes, and other information to determine if the particular service being considered is included.

If the in lieu of or in addition to service is not on the standard services list, the Primary Contractor or BH-MCO must assist the provider with developing a new in lieu of or in addition to service description.

- **Date of Submission** - list the date the Primary Contractor or BH-MCO submitted the service description to OMHSAS for review and approval;
- **Provider's Name** - Enter the name of the provider who will be providing this service;
- **Service Name** – Enter the name of the proposed service;
- **Primary Contractor or BH-MCO Name** – enter the name of the Primary Contractor or BH-MCO who is requesting this new service;
- **Description of Service** - complete this section;
- **Coding for Billing and/or Reporting of Services Rendered** – complete this section;
- **Anticipated Units of Services per Person** - complete this section;
- **Targeted Length of Service** - complete this section;
- **Information About Populations to be Served** - complete the table indicating the population, age ranges, projected numbers, and characteristics of the population to be served;
- **Program Philosophy, Goals, and Objectives** - complete this section;
- **Expected Outcomes** - complete this section;
- **Clinical Staffing Patterns** – complete this section;

- **Cost-Benefit Analysis** - complete this section.

E. The Primary Contractor or BH-MCO reviews the enrollment application for accuracy and completeness and completes the credentialing of the Provider.

F. If the original or modified enrollment application is accepted and is complete, the Appropriate entity signs the Attestation Form and forwards the enrollment application to the OMHSAS Field Office – when applicable.

G. OMHSAS Field Office (when applicable) - will review the enrollment application for completeness and for determination of the desire to include the In Lieu Of and In Addition To service provider and submit the new service description for review and approval through the Service System Review Committee (SSRC). After approval is received, the Field Office representative signs the OMHSAS Field Office Attestation Form and secures it to the front of the enrolment application.

H. OMHSAS has delegated the approval of Out-of-Network Providers to the Primary Contractor or BH-MCO. It is the BH-MCO's responsibility to enter into a written agreement with an Out-of-Network Provider, and to report person level encounters for the usage of Out-of-Network Providers. Out-of-Network Providers are not required to enroll as Medicaid providers. The Primary Contractor or BH-MCO should consider bringing frequently-used Out-of-Network Providers into the BH-MCO's network to ensure their inclusion in the BH-MCO's quality management review.

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
DEPARTMENT OF HUMAN SERVICES
PRIOR AUTHORIZATION REQUIREMENTS
FOR PARTICIPATING BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS IN THE
BEHAVIORAL HEALTH HEALTHCHOICES PROGRAM

A. GENERAL REQUIREMENT

The HealthChoices Behavioral Health Managed Care Organizations (BH-MCO) must submit to the Department of Human Services (Department) a written description of their policies and procedures for the prior authorization of services. The BH-MCO may require prior authorization for any services which require prior authorization in the Medical Assistance Fee-for-Service (FFS) Program. The BH-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for their determinations of medical necessity. The BH-MCO must request the Department's approval to require the prior authorization of any services not currently required to be prior authorized under the FFS Program. The BH-MCO cannot require prior authorization for emergency services or emergency inpatient admissions. Authorization of emergency inpatient services must be consistent with Attachment 1. For each service to be prior authorized, the BH-MCO must submit for the Department's review and approval the written policies and procedures in accordance with the guidelines described below.
The policies and procedures must:

- be approved by the Department in writing prior to implementation;
- adhere to specifications of the HealthChoices Behavioral Health (HC BH) Agreement, including the Program Standards and Requirements (PSR), applicable policy in Medical Assistance General Regulations, Chapter 1101, and DHS regulations;
- ensure that behavioral health care is medically necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- adhere to the applicable requirements of The Centers for Medicaid and Medicare Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- include an expedited review process to address those situations when an item or service must be provided on an urgent basis.

Future changes in state and federal law, state and federal regulations, and court actions may require review of any previously approved prior authorization proposal. Any deviation from the Department's approved policies and procedures, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure of the BH-MCO to comply may result in the Department taking a corrective action.

The Department defines prior authorization as any review of a service or request for a service, which must be conducted as a condition of the service being delivered. The term prior authorization is understood to include but is not limited to:

- pre-certification;
- concurrent;
- predetermination;
- any other review for the purpose of authorizing services.

B. GUIDELINES FOR REVIEW

1. Basic Requirements:
a. If the prior authorization is limited to specific populations, the BH-MCO must identify all populations who will be affected by the proposal for prior authorization.

2. Medical Necessity Requirements:

a. The BH-MCO must describe the process to validate medical necessity for:
- covered care and services
- procedures and level of care
- medical or therapeutic items

b. The BH-MCO must identify the source of the guidelines used to review the request for prior authorization of services. The guidelines must be consistent with the HC BH PSR definition of medical necessity.

c. Medical necessity guidelines used by BH-MCOs must be approved by the Department and conform to Appendix S or T (as applicable) of the HC BH PSR.

For BH-MCOs, if the guidelines being used are:
- purchased and licensed, the BH-MCO must identify the vendor;
- developed/recommended/endorsed by a national or state health care provider association or society, the BH-MCO must identify the association or society;
- based on national best practice guidelines, the BH-MCO must identify the source of those guidelines;
- based on the medical training, qualifications, and experience of the BH-MCO's Medical Director or other qualified and trained practitioners, the BH-MCO must identify the individuals who will make the medical necessity determinations.

d. The BH-MCO must identify the qualifications of staff who will determine medical necessity. Medical necessity determinations must be made by qualified and trained practitioners with appropriate clinical experience or expertise in treating the Member's condition or disease in accordance with CMS Guidelines, the HC BH PSR, and applicable legal settlements.

Requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical experience or expertise in treating the Member's condition or disease determines:

- that the prescriber did not make a good faith effort to submit a complete request, or

- that the service or item is not medically necessary, after making a reasonable effort to consult the prescriber.

Additionally, if the Member is under 21 years of age, the reasonable efforts to consult with the prescriber must include a request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the prescriber to request that the prescriber contact the BH-MCO. The BH-MCO may request either in writing or by telephone that the prescriber be contacted by the Member, parent, or authorized representative of the Member at the same time the BH-MCO is attempting to consult the prescriber. The BH-MCO's decision on whether to approve or deny the requested service cannot take into account whether the Member, parent, or the authorized representative chose to contact the prescriber. The BH-MCO must document its attempts to reach the prescriber, including its request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the prescriber to request that the prescriber contact the BH-MCO.

3. Administrative Requirements

A. The BH-MCO's written policies and procedure must demonstrate how the MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

B. The BH-MCO's written policies and procedures must explain how prior authorization data will be incorporated into the BH-MCO's overall Quality Management Plan.

4. Notification, Complaint, Grievance, and Fair Hearing Requirements

The BH-MCO must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with the Member notification requirements and the Complaint, Grievance, and Fair Hearing requirements of the HC BH PSR.

5. Requirements for Care Management/Care Coordination of Service(s)/Items(s) that do not require Prior Authorization

For purposes of tracking/care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the BH-MCO may choose to establish a process or protocol requiring notification prior to service delivery. If this process does not involve any approvals/denials or delays in receiving the service, the BH-MCO must notify Providers of this notification requirement. This process may not be administratively cumbersome to Providers and Members. These situations need not comply with the other prior authorization requirements contained in this Appendix.

C. Prior Authorization Review and Decision Process:

1. Time frames for Notice of Decisions

a. The BH-MCO is required to process each request for Prior Authorization (prospective utilization review) of a service and ensure that the Member is notified of the decision as expeditiously as the Member's health condition requires, at least verbally within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the BH-MCO must mail written notice of the decision to the Member and the prescribing Provider within two (2) business days after the decision is made.

b. If additional information is needed to make the decision, the BH-MCO must request the additional information from the Provider within forty-eight (48) hours of receipt of the request and allow up to fourteen (14) Days for the Provider to submit the additional information.

c. The BH-MCO must provide written notice to the Member that additional information has been requested on the date the additional information was requested using the Notice of Request for Additional Information template. The BH-MCO must also include the Non-Discrimination Notice and Language Assistance Services templates when it sends the request for additional information. The BH-MCO must use the templates supplied by the Department, which are available in DocuShare. The BH-MCO may not modify the templates. The BH-MCO must also follow the instruction in the templates for including detailed, specific information related to the Denial.

d. If the requested information is provided within fourteen (14) Days, the BH-MCO must make the determination to approve or deny the service and notify the Member orally, within two (2) business days of receipt of the additional information. The BH-MCO must mail written notice of the decision to the Member and the prescribing Provider within two (2) business days after the decision is made. If the additional information is not received within fourteen (14) Days, the decision to approve or deny the service must be made based upon the available information and the Member notified orally within two (2) business days after the additional information was to have been received. The BH-MCO must mail written notice of the decision to the Member and the prescribing Provider within (2) two business days after the decision is made.

In all cases, if the Member does not receive written notification of the decision to approve or deny a covered service within twenty-one (21) Days from the date the BH-MCO received the request, the service is automatically approved. To satisfy the twenty-one (21) Day time period, the BH-MCO may mail written notice to the Member and the prescribing Provider on or before the eighteenth (18th) Day from the date the request is received. If the notice is not mailed by the eighteenth (18th) Day after the request is received, then the BH-MCO must hand deliver the notice to the Member, or the request is automatically authorized (i.e., deemed approved).

e. If the Member is currently receiving a requested service, the written notice of denial must be mailed to the Member at least ten (10) Days prior to the effective date of the denial of authorization for continued services. If probable Member fraud has been verified, the period of advance notice is shortened to five (5) Days. For acute inpatient services, the

effective date on a denial of a continuation of services must be at least one (1) Day after the date of the notice. If the Member wishes to have services continued as previously approved, the Member must file a Grievance before the effective date of the denial as indicated on the denial notice.

f. Advance notice is not required when the BH-MCO has factual information confirming the death of a Member; the BH-MCO receives a clear written statement signed by a Member that s/he no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that s/he understands that termination or reduction must be the result of supplying that information; the Member has been admitted to an institution where s/he is ineligible under the HC BH PSR for further services; the Member's whereabouts are unknown and the post office returns BH-MCO mail directed to the Member indicating no forwarding address; the Member has been accepted for Medicaid services by another State; or a change in the level of medical care is prescribed by the Member's physician.

2. Denial of Service:

A determination made by a BH-MCO in response to a Provider's or Member's request for approval to provide a service of a specific amount, duration and scope which:

A. disapproves the request completely, or
B. approves provision of the requested service(s), but for a lesser amount, scope or duration than requested, or
C. approves provision of the requested service(s), but by a Network Provider, or
D. disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
E. reduces, suspends, or terminates a previously authorized service.

NOTE: A denial of a request for service must be based upon one of the following five reasons, along with an explanation for the reason**,** which must be explicitly stated on the notice of action:

- The service requested is not a covered service.
- The service requested is a covered service but not for this particular Member (due to age, etc.)
- The provider is not a Network Provider
- The information provided is insufficient to determine that the service is medically necessary.
- The service requested is not medically necessary.

3. Authorization Decisions:

A behavioral health denial decision based on medical necessity may be made only by a licensed physician or by a licensed psychologist if the requested service is within the psychologist's scope of practice. A licensed psychologist may not determine the medical necessity of requested inpatient services or prescribed medication. For substance abuse

services, a decision based on medical necessity must be made by a licensed physician. Any representative of the BH-MCO who determines the medical necessity of a requested service must, in addition to being appropriately licensed, be appropriately experienced to render such a decision.

4. Denial Notice:

When a BH-MCO denies a request for services as defined in Section C.2. of this Appendix a written denial notice must be issued to the Member using the appropriate denial notice template. The BH-MCO must also include the Non-Discrimination Notice and Language Assistance Services templates when it sends the denial notice. The BH-MCO must use the templates supplied by the Department, which are available in DocuShare.

5. Denial Notice Reporting:

The BH-MCO must report denial of services to the Department via the denial log, as detailed in Appendix M.

6. Quality Review of Denial Notices

A. The Primary Contractor is responsible for ensuring the content and quality of the denial notices are consistent with the Department's requirements by implementing a formal monitoring process with documented procedures that include (but may not be limited to):
   - criteria used to review denial notices,
   - frequency of reviews,
   - percentage of denial notices to be reviewed,
   - selection process for the denial notices to be reviewed,
   - plan to ensure denial notices for various levels of care are reviewed,
   - plan to communicate review results to the BH-MCO,
   - individuals responsible for the review and dissemination of results of the review, and
   - process to ensure the BH-MCO incorporates recommendations from the review.

B. The Primary Contractor and BH-MCO are expected to comply with the Department's quality review of denial notices and the Department's efforts to ensure Primary Contractor oversight is adequate. The Department will specify a specific sample of denial notices that will be reviewed as part of the Department's quality review. The Department will review the denial notices to determine if the denial notices are compliant with federal and state regulations, policies, standards, and best practices.

ATTACHMENT 1

Emergency Inpatient Admission: Prior Authorization, Admission and Documentation

1. Prior authorization of psychiatric emergency inpatient admissions is not permitted. While prior authorization is not allowed for psychiatric emergency inpatient admissions, the BH-MCO may conduct a retrospective review, including review of the documentation by the physician at the emergency department verifying the medical necessity for emergency admission. Continued stay after stabilization of the emergency may be subject to concurrent review and prior authorization. The review procedures used by the BH-MCO shall not be inconsistent with the involuntary commitment processes set forth in the Mental Health Procedures Act, 50 P.S. §§ 7101 et seq.
2. If a request for continued stay after stabilization cannot be reviewed because it is uncertain if the individual is eligible for Medical Assistance, the BH-MCO must review the request within seven (7) days of the eligibility issue being resolved and no later than 180 days of the date of service.
3. The Primary Contractor and its BH-MCO may not refuse to cover emergency services based on the emergency department provider, hospital or fiscal agent not notifying the Member's BH-MCO of the Member's screening and treatment within 10 days of presentation for emergency services.
4. The BH-MCO must use the same time frame to review authorizations for continued stay for Network Providers and Out-of-Network Providers.
5. The Primary Contractor and its BH-MCO shall ensure that after stabilization of the emergency, the Provider completes an assessment and continues to document the Member's need for inpatient services to facilitate authorization for continued stay of the Member.

DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

REGULATIONS AND POLICIES NOT APPLICABLE TO HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Appendix BB(1) is an index of regulations. policies and bulletins which the Department reviewed and identified as either not applicable to the operation of the HealthChoices managed care program or contain MA Program Fee Schedule limits.

NOTE: As a reminder, services that would be subject to MA Program Fee Schedule limits must be approved if medically necessary.

REGULATIONS

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
BH-MCOs are required to adhere to the provisions of all applicable Chapters of Title 55 of the Pennsylvania Code with the following exceptions:	
Chapter 1101 - General Provisions	
1101.21 Definition of "Shared Health Facility" (iv) and (v)	(iv) At least one practitioner receives payment on a fee-for-service basis. (v) A provider receiving more than $30,000 in payment from the MA program during the 12-month period prior to the date of the initial or renewal application of the shared health facility for registration in the MA program.
1101.83 Restitution and Payment	This regulation is waived to the extent it provides for the Department to seek restitution and repayment
Chapter 1151 - Inpatient Psychiatric Services	
1151.34	
1151.41 (b),(c)(1-2),(d),(i) and (j)	
1151.42 (a),(c),(d)	
1151.43 (b)	
1151.45 (2),(3)	
1151.46	
1151.48 (a)(1-6),(9-16),(18-20)	
1151.50 (b)(1-4)	
1151.52	
1151.53	
1151.54	
Chapter 1153 - Outpatient Psychiatric Services	
1153.2 Definitions – "Psychiatric Partial Hospitalization"	"for a minimum of 3 hours"
1153.14 (9)	
1153.52 (a)(2)	"separate billings for these additional services are not compensable"

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
1153.52(b)(1)(iii)	"at least 3 hours"
1153.53(1)	"at least 3 hours"
1153.53(2-4)	
Chapter 1155 – Intensive Behavioral Health Services	
1155.1(b)	"… and the MA Program fee schedule."
1155.31(a)	"… and the MA Program fee schedule."
1155.41	
Chapter 1163 – Inpatient Hospital Services (Provisions applicable to Inpatient Drug and Alcohol Services)	
1163.59a.	"the Pennsylvania Client Placement Criteria". Note: The Department requires the use of The American Society of Addiction Medicine Patient Placement Criteria (ASAM) in place of the *Pennsylvania Client Placement Criteria*.
1163.455a.	"the Pennsylvania Client Placement Criteria". Note: The Department requires the use of The American Society of Addiction Medicine Patient Placement Criteria (ASAM) in place of the *Pennsylvania Client Placement Criteria*.
Chapter 1223 - Outpatient Drug and Alcohol Clinic Services	
1223.2 – Definitions – Level of care assessment	"the Pennsylvania Client Placement Criteria". Note: The Department requires the use of The American Society of Addiction Medicine Patient Placement Criteria (ASAM) in place of the *Pennsylvania Client Placement Criteria*.
1223.14 (8),(9)	
1223.52 (a)(2),(a)(3),(c)	"Separate billing for these interviews are not compensable"
1223.52(d)(1)(i)	Note: This waiver is only for the provision of methadone maintenance services at an inpatient nonhospital facility or partial hospitalization facility, not for any other clinic services.
1223.52(d)(1)(ii)	"A home visit is not compensable when made to an inpatient nonhospital facility…. partial hospitalization facility." Note: This waiver is only for the provision of methadone maintenance services and not for other clinic services provided at an inpatient nonhospital facility or partial hospitalization facility.
Chapter 4300 - County Mental Health and Intellectual Disability Fiscal Manual	
4300.11	
4300.22	
4300.23	
4300.25 through 4300.28	

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
4300.41 through 4300.69	
4300.81 through 4300.108	
4300.111 through 4300.118	
4300.131 through 4300.160	
Chapter 5210 - Partial Hospitalization	
5210.3 Definitions – "Partial Hospitalization"	"for a minimum of 3 hours"
Chapter 5221- Mental Health Intensive Case Management	
5221.42 (b), (c), (f) unit g of services only,()	
5221.42 (h)	….100% of the approved expenditure for

POLICIES

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
BH-MCOs are required to adhere to the provisions set forth in the proposed rulemaking Chapter 5260, Family Based Mental Health Services for Children and Adolescents, published in Pennsylvania Bulletin, Vol. 23, NO. 18, May 1, 1993 with the following exceptions:	
5260.12 (b), (c), (d)	
5260.21 (2)	….full-time director
5260.21 (b)	….members of the treatment team and the program director may not be employed in another MH program…
5260.22 (b) (1-7)	
5260.45 (e), (f), (g),(i), (j), (k)	
5260.46	
Note: These exceptions also apply to the Family-Based Mental Health Services Contract Addendum	

BULLETINS

MEDICAL ASSISTANCE BULLETINS

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
BH-MCOs are required to adhere to the provisions of all Medical Assistance Bulletins addressing the delivery of mental health services or applicable to the delivery of mental health services with the following exceptions:	
<u>Medical Assistance Bulletin 01-93-04,11-93-02, 13-93-02, 41-93-02, 53-93-02, 1165-93-01,</u>	
Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age (applies at accredited RTFs only)	
"Purpose", 1st paragraph	
"Policies & Procedures:", A. 4.	
"Policies & Procedures:", C.	
"Policies & Procedures:", D.	
"Policies & Procedures:", E.	

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
Attachment F, 1150 Administrative Waiver Request Form	
Attachment G, Welfare CASSP Services Plan of Care Summary	
Attachment H, Community-Based Mental Health Services – Alternatives to Residential Treatment Services form	
Attachment I, Area Offices	
Medical Assistance Bulletin 01-94-01, 41-94-01, 48-94-01, 49-94-01, 50-94-01 **Outpatient Psychiatric Services for Children Under 21 Years of Age**	
"Background"	
"Exception"	
"Note"	
"Reminder"	"and must be requested from the Office of Medical Assistance through the 1150 Waiver Process."
"Requirements and Procedures": first two paragraphs and Bullet 1	
"Requirements and Procedures": Bullet 6	
Pages 3 - 9	Content under "MA Fee" and "Procedure Code" Headings, "Limit of three per year of any combination of the procedure codes listed above."
Medical Assistance Bulletin 1153-95-01 **Accessing Outpatient Wraparound Mental Health Services Not Currently Included in the Medical Assistance Program Fee Schedule for Eligible Children Under 21 Years of Age**	
"Requirements for Outpatient … not included on the Fee Schedule": C. 2., third paragraph	"A Provider Type 50 may provide…"
"Requirements for Outpatient … not included on the Fee Schedule": D. 1. & D. 2.	
"Procedures for Outpatient Wraparound MH Services": A. 1. a.	
"Procedures for Outpatient Wraparound MH Services": A. 3. – A. 9. (Including any "Note" paragraphs)	
"Procedures for Outpatient Wraparound MH Services": B	
Attachment D, Subcontract Agreement Form	
Attachment E, Outpatient Service Authorization Request	
Attachment H, Request for Expedited Outpatient Behavioral Health Services	
Medical Assistance Bulletin 1157-95-01, 01-95-12, 12-95-08, 12-95-04, 13-95-01, 14-95-01, 17-95-05, 41-95-03, 50-95-03, 53-95-01 **Mental Health Services Provided in a Non-JCAHO Accredited Residential Treatment Facility for Children Under 21 Years of Age**	
"Requirements for Non-JCAHO…": A. 2. c.	
"Requirements for Non-JCAHO…": A. 4.	

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
"Requirements for Non-JCAHO…": B.	
"Requirements for Non-JCAHO…": C.	"To receive MA reimbursement"
"Requirements for Non-JCAHO…": D. 1.	
"Requirements for Non-JCAHO…": D. 2.	"Payment will be made only for services prior approved by OMAP"
"Requirements for Non-JCAHO…": A. & B.	
Attachment B, Interagency Service Planning Team Procedures and Responsibilities, 3. e., 4. b., & 4. e.	
Attachment F, MA-97 Outpatient Service Authorization Request	
Attachment G, CASSP Services Plan of Care Summary	
Attachment H, Community Based MH Services Form	
Attachment I, OMHSAS, Children's Specialists	
Attachment K, Request for Expedited Services	
Medical Assistance Bulletin 01-95-13, 11-95-09, 12-95-05, 13-95-02, 14-95-02, 17-95-06, 41-95-04, 50-95-04, 53-95-02, 1165-95-01 **Updated – JCAHO Accredited RTF Services**	
"Procedures": final 2 paragraphs	
"Procedures": 3. HIO and HMO	
"Procedures": 4. Invoicing for RTF Services	
"Procedures": 6. Hospital Admissions, b. & c.	
Medical Assistance Bulletin 50-96-03 Summer Therapeutic Activities Program	
Page 2, Services section	"provided for a minimum of three hours and a maximum of six hours per day, at a maximum of five days per week"; "service period is a minimum of two weeks with a maximum of five weeks per calendar year".
"Services": 5th paragraph beginning, "Summer therapeutic activities programs are considered to be…"	Final sentence, "…with full supporting documentation as set forth in MA Bulletin 1153-95-01, through the 1150 Administrative Waiver process." NOTE: The required supporting documentation for the provision of this service does not apply except as required by the MCO for their provider network.
"Provider Requirements": Section 1.	
"Payment for Services"	
Attachment - Service Description Format	
Medical Assistance Bulletin 01-97-08, 17-97-03, 41-97-01, 48-97-01, 49-97-03, 50-97-02	
Diagnostic and Psychological Evaluations	
Page 2, 1st Paragraph	"The Department limits these procedure codes to three per child per year regardless of the combination of procedure codes…..(to end of paragraph)"
Medical Assistance Bulletin 01-98-10, 41-98-02, 48-98-02, 49-98-04, 50-98-03 **Change in Billing Procedure for Behavioral Health Rehabilitation Services**	

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
"Discussion"	
Medical Assistance Bulletin 01-98-19 Clozapine Support Services	
"Non-covered services": 1, 3, 4 and 5	
"Eligible Recipients", 2nd paragraph	The maximum time-period for each order shall not exceed six consecutive calendar months.
"Payment": Second paragraph	
Medical Assistance Bulletin 17-99-02, 50-99-03 **Procedures for Licensed, Enrolled Mental Retardation Providers to Access and Submit Claims for Outpatient Behavioral Health Services for Individuals Under 21 Years of Age**	
"Procedures" 2, 3, 4 and 5	
"Procedures for Handling TSS, MT, and BSC Services Already Approved Through the 1150 Administrative Waiver Process": 1, 2 and 3	
Medical Assistance Bulletin – 28-99-02, 29-99-01	
Medication Management Visit	
Page 1, under **Discussion:** Sub-Heading: "For outpatient psychiatric clinics:" sub-heading: "Medication Management Visit"	"This visit is limited to a maximum of four visits per month"
Page 2, Sub-Heading: "For outpatient drug and alcohol clinics:" sub-heading: "Medication Management Visit"	"This visit is limited to a maximum of four visits per month"
Medical Assistance Bulletin –08-06-18	
Mobile Mental Health Treatment:	
Attachment 1	

BH-MCOs are not required to adhere to the provisions of the following Medical Assistance Bulletins:
Medical Assistance Bulletin 01-97-16 Changes in Procedure for Requesting and Billing Therapeutic Staff Support (TSS) Services
Medical Assistance Bulletin 28-97-06 Change in Billing Procedures for Psychotherapy
Medical Assistance Bulletin 50-97-03 Training for EPSDT Expanded Services Providers (Provider Type 50) on Completing Medical Assistance Invoices
Medical Assistance Bulletin 99-98-12 Accurate Billing for Units of Service Based on Periods of Time
Medical Assistance Bulletin 19-99-04 Prescriptions Not Received by the Medical Assistance Recipients
Medical Assistance Bulletin 28-99-03 Increased Fees for Outpatient Psychiatric Clinics, Psychiatric Partial Hospitalization Programs and Outpatient Drug and Alcohol Clinics

OMHSAS BULLETINS

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
BH-MCOs are to adhere to the provisions of the following Office of Mental Health and Substance Abuse Services Bulletins listed below with the following exceptions:	
OMH-91-19 Transmittal of General Family Based Mental Health Services Program Issues	
"Operational Issues": 7	
Fiscal Issues": 40, 46, 47, 56, 57 and 62	
"Rates": 67, 70, 72-75	
"Miscellaneous Q&A": 1	
OMH-92-16 Mental Health Crisis Intervention Services: Implementation	
Attachment A, Payment Process	
Attachment B, Enrollment	
Attachment C, Guidelines – Payment Section	
Subsections A - E	Payment Conditions
OMH-93-09 Resource Coordination: Implementation	
Attachment A, Fiscal Issues	
Attachment B, Enrollment	
Attachment C, Guidelines – Payment	
OMH-93-10 Mental Health Crisis Intervention Services Guidelines	
"Issues and Guidelines": 1, 2, 3, 4, 8	
OMHSAS 10-03 Blended Case Management (BCM) Revised	
Attachment D, Section 1: General Provisions, Provider Participation	Requirement to be "bound by the General Provisions (Chapter 1101); MA Program Payment Policies (Chapter 1150), and the specific criteria outlined in this bulletin"

BH-MCOs are not required to adhere to the provisions of the following Office of Mental Health and Substance Abuse Services Bulletins:
OMH-94-09 180 Day Exception Requests of MA Invoices
OMH-94-07 180 Day Exception Requests and Invoices Submission Time Frames
OMH- 95-02 Maximum Allowable Rates of Reimbursement for Psychiatric Physicians
OMH-96-04 Procedures for Claiming Federal Reimbursement on Administrative Costs for

BH-MCOs are not required to adhere to the provisions of the following Office of Mental Health and Substance Abuse Services Bulletins:
Medicaid Funded Mental Health Services
OMHSAS-03-01 Mental Health Crisis Intervention (MHCI) Fee Schedule
OMHSAS-99-02 Maximum Allowable Rates of Reimbursement for Psychiatric Physicians
OMHSAS-05-01 Cost Settlement Policy and Procedures for Community-Based Medicaid Initiatives
00-88-03 Appropriate Billing for Psychiatric Partial Hospitalization Services and Psychiatric Outpatient Clinic Providers
00-88-14 Fee Schedule Revisions and Transportation Requirements
4000-95-01 Room and Board Payments for Mental Health Only Children in Residential Facilities Which Are Not JCAHO Accredited
Administrative Bulletin 2015-01 Maximum Rate- of State Participation for Mileage – County Children and Youth Agencies and Mental Health/Intellectual Disabilities/Early Intervention Programs

DEPARTMENT OF HUMAN SERVICES, OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

REGULATIONS AND POLICIES THAT MUST NOT BE IMPLEMENTED WITHIN HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Appendix BB(2) is an index of regulations which the Department determined contain quantitative treatment limitations which must not be applied as limitations on coverage, consistent with the requirements of the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPAEA) of 2008 (P.L. 110-343, 122 Stat. 388) and the final rule *Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans,* issued by CMS on March 30, 2016. See also Medical Assistance Bulletin 99-15-05, *Implementation of HealthChoices Medicaid Expansion*, issued April 28, 2015.

NOTE: Services that would have been subject to these limits must be approved if medically necessary.

CITATION/EXCLUSION	Relevant Portion if Citation Does Not Apply in its Entirety
BH-MCOs must not implement treatment limitations described in the following:	
Chapter 1151 – Inpatient Psychiatric Services	
1151.43(a) – 30 days of inpatient psych hospital services per fiscal year	
Chapter 1153 – Outpatient Psychiatric Services	
1153.2 Definitions – "Psychiatric partial hospitalization"	"a maximum of 6 hours".
1153.53(a)(1)	
1153.53(a)(2)	"a maximum of 6 hours".
1153.53(a)(3)-(6),(11),(12)	
Chapter 1223 – Outpatient Drug and Alcohol Clinic Services	
1223.53	

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of Cultural Competence Principles

Cultural Competence has long been an expectation of Pennsylvania's public mental health system. Included in the CASSP and CSP Principles from their inception, cultural competence has historically focused on the four traditionally under served populations of African Americans, Latinos, Asian Americans and Native Americans. More recently, the Office of Mental Health and Substance Abuse Services (OMHSAS) in collaboration with the OMHSAS Cultural Competence Advisory Committee, has taken a broader view of culture.
Recognizing the diversity that makes up Pennsylvania's population, Cultural Competence is viewed as inclusive of rural and urban populations, deaf persons, the Amish, groups of recent refugees and clusters of various ethnic populations that are scattered across the Commonwealth, as well as the traditionally identified populations.

The Department of Human Services (Department) in its issuance of the Request for Proposals for the HealthChoices Behavioral Health Program recommends the implementation of Cultural Competence Principles by the Primary Contractor, managed care organization (MCO), its subcontractors and any associated provider networks.

It is the expectation that the implementation of Cultural Competence Principles will result in a system that understands the implications of racial genetics for medication prescription, the differences in help seeking behaviors among various groups and populations and the basis of internal and external stigma related to mental illness, as well as many other barriers to a successful and effective system of care.

PRINCIPLES OF CULTURAL COMPETENCE

1. Principle of the Universality of Ethnicity and Culture. Each person is aging therefore has an age and an age cohort. Each person has: a gender, therefore a gender orientation; abilities, therefore limitations; resources deriving from social constructs, therefore a socioeconomic status; a family history and a legacy that precedes by many generations, therefore an ethnicity and a culture. Identification with others by all these means helps provide a sense of security, belonging and identity. It is this power that drives "Honk if you own a Volkswagen", or "the wave" at ball parks to work so effectively. Each human encounter in so far as it crosses some boundary of age, belief or practice is, in a sense, a cross-cultural encounter, but we have many bridges to facilitate the crossing.

Culture is more than just membership in one's racial/ethnic group. Culture is a dominant force arising within us from our parental and community upbringing, serving to shape behavior, values, cognition and social institutions.

In the treatment setting, every consumer must be valued within his/her cultural context. Observed differences are to be appreciated as sources of strength and enrichment and resources of reconnection and reintegration. Within each individual's thinking, personal history and family culture lay the defining attributes of his or her problems and the solutions. The wholeness of the individual is important for a complete evaluation and effective intervention.

2. Principle of Cultural Competence. Treatment, recovery and rehabilitation are more effective when consumers and families fully engage in services that are compatible with their cultural values and world-views. Services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people (Child and Adolescents Services Systems Program Principles). These skills are used to determine consumer wellness/illness, establish individualized and consumer-driven plans and goals, and to create unique services that are community-based and that integrate natural supports. Cultural competence entails knowledge of consumers' literacy level, native languages, levels of acculturation and assimilation, and cultural health care beliefs, customs and practices. This body of knowledge guides the service system to increase consumer access to services, and to better design, implement and evaluate services tailored to particular cultural groups. The principle entails vigorous integration of cultural competency principles and standards of practice throughout all levels of behavioral health and substance abuse planning, policy-making, research, evaluation, training and service delivery.

3. Principle of Social and Environmental Influences. Social conditions of poverty, unemployment, discrimination, class rank, immigration status, and isolation greatly impact all aspects of behavioral health care and contribute deleterious effects and exacerbate symptomatology. Effective service outcomes and quality of life are achieved when the consequences of these social experiences are identified and incorporated into health care planning and service delivery. Services are designed and funded to assure these conditions are not barriers to health care. The service system assures that services do not
merely reach the most motivated, educated and socially mobile consumer and family. Service evaluations entail assessing the prevalence of these social conditions in communities, and engaging consumers at the highest risk of illness. Planning processes recognize social conditions and their impact on health and interventions. Professionals avoid assigning fixed diagnoses and characteristics to consumers who are merely responding to stressful social conditions. Service systems adopt *no-reject/no-eject* standards of practice so that no consumer is rejected or ejected from services because of behavior that is necessary to survive and cope in their social conditions.

4. Principle of Consumer-Driven Services. Consumer-driven services include activities that individualize plans, assessments and services that focus on the priorities, values and goals of consumers and families. Whenever possible, self-help services are created and utilized. Consumer-driven services foster self-determination and choice. Cultural groups are fully engaged when they are actively involved in the design, implementation and evaluation of services that fit their unique worldview. For many cultural groups this entails services that heal the wounds of bias and discrimination. It entails the establishment of linguistically appropriate services, assuring the availability of culturally competent advocates, and educating consumers on the workings of the service system. Consumers, and their families and communities, fully participate in determining the kind of services that best achieve goals for achieving high quality and meaningful lives. Systems of care must have a goal of empowering consumers, during the course of treatment, to be self- determining in all domains of their lives.

5. Principle of a System of Care. Systems of care are consumer-driven, highly coordinated service responses to multiple needs of consumers and families. They require professional willingness to engage, interact and communicate in effective partnerships with culturally diverse populations, and to encourage and value consumers' active role in the service planning process. In a system of care services focus on all domains of consumers' lives (mental health, education, medical, housing, social rehabilitation, employment) and integrate health care needs into a single coordinated plan of services that is individualized and culturally relevant. Services are community-based, involve natural supports, strength-based, and are least restrictive. Cultural and non-traditional ways of healing are integrated in case management and treatment/rehabilitation plans. All planning processes are consumer- driven and family-focused. Family and community members are engaged and invited into the planning and service delivery processes. This entails planning meetings that are community-based and are convenient to consumer availability. These strength-based, comprehensive plans are designed to enhance consumers achieving high quality and meaningful lives.

6. Principle of Access. Access occurs when cultural groups perceive that services are relevant to their life experience and world-view, and use them. Linguistic, geographic and cultural barriers to services are identified and removed. Service systems use culturally relevant media to inform and educate cultural groups, and the general public, about services and supports. Full access to services is determined by evaluating both the use of services by cultural groups as compared to the general population, and by evaluating the prevalence of concerns and problems in specific cultural communities. Increasing access results in less use of crisis and emergency services. Problems and concerns are identified early, and prevention and support services reduce the severity and prevalence of chronic illnesses. This principle entails identifying and overcoming transportation, poverty and community safety barriers to services. Whenever possible, services are community-based.

7. Principle of Quality of Life Outcomes. Consumers and families evaluate outcomes of services, and the service system, by their ability to enhance and improve quality of life. Quality of life is achieved when consumers reach and accomplish self-defined meaningful life goals. It involves having meaningful social roles within family and community. It involves consumer empowerment and self-determination to make decisions in all domains of their life. Case management and treatment/rehabilitation plans encompass all domains of consumers' lives to foster growth and development of necessary personal, social, employment and interpersonal skills to achieve fulfillment and wellbeing. Holistic approaches to health care are essential to assure consumers have a high quality of life.

8. Principle of Managed and Integrated Health Care. Costs of public health care are best managed and contained by providing high quality, effective mental health and substance abuse services tailored to consumers and family culture that integrate and coordinate medical, mental health and substance abuse. In this way, consumer engagement may be maximized, and use of more costly emergency services reduced. Primary health care that engages consumers in preventative health care throughout life development reduces costs and improves the overall health of our communities. Integrating physical and emotional health in assessments, plans and services is essential. The service system emphasizes managing care, and not dollars, by assuring consumers are in least-restrictive treatment settings, and gain access to services early.

Prevention is a key goal for managed and integrated systems of care. Prevention includes community education about mental illness, substance abuse, family support services, early identification programs and services, and social marketing campaigns to de-stigmatize mental illness. Prevention and early intervention necessitate behavioral health providers to link with physical health care providers and other community-based services. Assuring a high quality of life for consumers is considered an important aspect of prevention.
Subsequently, increasing community employment and job skill training are examples of prevention activities.

9. Principle of Data/Evaluated Driven Systems of Care. Traditional ways of collecting information, and planning and evaluating services, do not reach isolated and high-risk populations. Many existing information systems and planning processes do not attain information about communities, and only focus on those currently and traditionally served. Assuring services are culturally competent requires engaging communities to gather information about the prevalence of problems, stressful social conditions, substance abuse and mental illness. Data and findings are always interpreted in the context of each cultural community, and not merely compared to the general population as a normative standard. Individual, family and community outcomes are projected as an aspect of county planning processes. Storytelling, testimonials, and oral accounts of needs and satisfaction are considered data sources. In consumer-driven systems of care, feedback by consumers regarding service satisfaction and outcome are most important data for future planning and system re-design.

Outcomes and effectiveness of services are evaluated based on the prevalence of illness and problems in the cultural community, and not merely by comparing rates to the general population. This principle assures professionals and community members avoid using the dominant culture as a normative standard of health. Rates of illness are impacted by cultural, social and historic differences among social groups. Behavior that seems aberrant to the general population may be healthy responses to social conditions. Services target the unique patterns of illness and problems in cultural communities, and develop unique community-based health standards by which to evaluate services.

10. Principle of Least Restrictive/Least Intrusive Services. Services occur in settings that are the most appropriate and natural for the consumer and family, and are the least restrictive and intrusive in impacting the right of self-determination by consumers, families and communities. (CASSP) This means community-based, in-home and natural support services being first utilized, unless there are assessed indications that other services are necessary to assure outcomes and quality of life. Justification for more restrictive and intrusive services occurs at all levels of planning: initial assessment through discharge. Consumer, family and community members are included in determining the least restrictive/intrusive setting and service. As minorities are over-represented in restrictive settings, and as recipients of behavioral controlling treatments, service systems regularly collect data and monitor these services. Plans of action are created and implemented when evaluation finds cultural groups are over-represented in restrictive treatments.

GUIDELINES FOR THE APPLICATION OF CULTURAL COMPETENCE PRINCIPLES

ACCESS AND SERVICES AUTHORIZATION

Families and natural supports persons (self-defined family) have access to services in a respectful and welcoming manner. Services are provided in timely, convenient and easily accessible ways. Protocols exist to assure services are available to persons who are disinclined to accept treatment. Bilingual and bicultural providers, and trained interpreters, are available throughout the entire service system. Service availability and determination encompass a holistic rehabilitative approach that includes psychiatric, medical, social, vocational, behavioral, cultural, spiritual, familial and community supports.

Indicators of Guideline Application

1. Persons of diverse cultures and linguistic differences are served based on their preference and actual need.

2. Service systems utilize a variety of formats to disseminate culturally relevant information regarding mental health and addiction services, as well as non-traditional and self-help resources.

3. A written plan guides action that engages and encourages individuals in need of services but who are disinclined to accept treatment.

4. Service systems demonstrate timeliness in member access and authorization of services.

5. Service systems adopt flexible service hours to maximize the availability of services.

6. Service systems authorize cultural-based alternative and complementary treatment approaches that assure consumer engagement, retention and follow-up.

7. Service systems staff and Managed Care Organizations have culturally and linguistically competent staff available 24 hours a day, and 7 days a week.

8. Service agencies have a milieu and physical environment that reflects diversity and the surface cultures of consumers being served.

MEASURES OF GUIDELINE APPLICATION

1. Service utilization rates of traditionally under-served and over-represented persons are comparable to the prevalence of illness and problems that occur in the ethnic/cultural group. Cultural/ethnic community residents use behavioral healthcare providers as a community resource for all health concerns. In highly

2. restrictive services, utilization rates are comparable to all other groups in the general population.

3. Service providers have a list available in each facility of culturally and linguistically accessible services.

4. Descriptions of culturally sensitive services and programs are available for consumers in their community and other natural gathering places. Providers develop ethnically/culturally relevant ways of disseminating information that make services widely known in ethnic/cultural communities.

5. Educational and information materials reflect the languages and cultures of persons served.

6. Service systems track the utilization rates of persons who are traditionally disinclined to accept treatment. These systems develop studies on the prevalence of illness and problems in ethnic/cultural communities, and identify the barriers they experience to seeking help. Service systems create correction plans, implements actions, and measure improvements in help-seeking behavior. Indicators of positive impact include: decrease use of emergency rooms, decrease use of crisis services, increase number and use of advocacy groups, decrease arrest rates of persistently ill consumers, increase referral follow-through rates, and increase voluntary use of self- help and prevention services.

7. Service systems track the increase in availability of services. Availability is indicated by services occurring in settings that various ethnic/cultural groups define as comfortable, appropriate, consistent with their values and worldview, and complementary to their natural healing practices.

8. Service systems track the number and type of alternative and complimentary treatment approaches for various cultural groups. High performance is indicated by an integration of traditional healing practices and treatment approaches with professional models that capture the best of each.

9. Service systems determine consumer satisfaction and increase access because of flexible hours, and alternative and complimentary treatment.

10. Waiting area and offices display magazines, art, music, etc., reflective of the cultures and ethnic groups of consumers being served.

CASE MANAGEMENT

Case management shall be central to the operation of the multidisciplinary team. It reflects an understanding and appreciation of the values, norms and beliefs of consumers' cultures, and knowledge of resources in their communities. Case management recognizes the unique mental health/substance abuse issues associated with the consumer's economic conditions, social class, and experience of bias, discrimination and racism. Case management recognizes the impact of these issues on behavioral health and takes these into account in considering the cultural appropriateness of all services that are coordinated and managed. Case management advocates for the consumer, assures consumers are knowledgeable of service options, and assists consumers in making best choices. These activities are individualized to the diverse culture, race, ethnicity and language differences. Case management services participate in ongoing assessments of their service system to determine and assure that they are responsive to diverse consumer needs and experiences.

INDICATORS OF GUIDELINE APPLICATION

1. Consumers have access to a comprehensive array of services that are compatible with their culture.

2. Consumers receive culturally competent services that are coordinated within multiple domains, i.e., vocational, social, educational and residential settings.

3. Culturally competent services are continually created and adapted to meet the needs of consumers.

MEASURES OF GUIDELINE APPLICATION

1. Service utilization data and information are utilized to increase enrollment of under-served populations. Ethnic cultural group enrollment in less restrictive services (outpatient, self-help, social rehabilitation) increases to levels comparable to the general population. Enrollment in restrictive services (inpatient, involuntary commitments, jail treatment settings, court-ordered outpatient) decreases to levels comparable to the general population.

2. Service systems document culturally competent services and resources received by consumers. Individual and family definitions of culture, ethnicity and need guide the development of indicators for high levels of performance. Merely providing culturally competent services to person of color, or persons who are perceived different than

mainstream culture, is not an indicator of compliance.

3. Service systems document family and community contacts/visits, and visit locations. High levels of compliance are system-wide supports for family and community member advocacy and full participation in all aspects of case planning. Parent led support/advocacy groups naturally develop and influence decision-making throughout the delivery system. Merely having record of family member attendance at meetings is not an indicator of compliance.

4. Service systems document that consumers have improved relationships within family, and within social networks of their cultural group. High levels of compliance are indicated by fewer consumers estranged from their natural family, and high levels of family involvement in planning processes and support services.

5. Service systems document that consumers achieve the greatest degree of independence and self-determination. The use of restrictive services by ethnic/cultural groups is reviewed annually for use in comparison to the general population. Each provider implements a plan of correction until usage levels are comparable. Restrictive care includes the use of psychotropic treatment without complementary clinical/rehabilitative services.

6. Revised care plans and services demonstrate inclusion of ethnic, social and cultural factors.

7. Cultural competence training for all case managers is incorporated in reviews for regulation compliance. Training is designed for the ethnic/cultural groups that exist in the service community. Levels of training and competence are established.

8. Community resources and natural supports are included in all care plans.

TREATMENT/REHABILITATION PLAN

All persons served receive a treatment/rehabilitation plan that is holistic, and incorporates the consumer's choice of attainable goals, culturally compatible treatment modalities, and consumer driven alternative strategies of health care. These strategies include the use of family, community supports, spiritual leaders and folk healers. Plans are consumer driven, based on their individual strengths, and developed within the context of family and social networks so as to create a consumer-professional partnership. Plans are formulated and reviewed by culturally competent professionals and culturally competent consultants in full collaboration with consumers and families.

INDICATORS OF GUIDELINE APPLICATION

1. Identification and creation of culturally relevant goals.

2. Use of culturally compatible modalities and alternative strategies.

3. Consumers and families fully participate and share in the development of goals and wishes, and express satisfaction with their role and participation.

MEASURES OF GUIDELINE APPLICATION

1. Plans document consumer wishes and goals. These may be related to employment, education, training, personal appearance, health, family relationships, social activities and social relationships. Plans specify ethnically/culturally relevant wishes and goals.

2. Service systems document consumer and family satisfaction with their participation in the treatment/rehabilitation planning process. Low levels of satisfaction trigger plans of correction, implementation of these plans, and re-evaluation.

3. Plans outline cultural relevant treatment and rehabilitation modalities and strategies.

4. Service systems document that professionals are trained in the development of culturally competent treatment and rehabilitation plans. Training, staff skills, and cultural competence will be greatly impacted by the kinds of ethnic/cultural groups in the service area. A high level of performance is indicated by professional standards for competence for each ethnic/cultural group, and not a generalized declaration of professional competence due to completion of a generalized cultural competence training program.

5. Service systems create all written planning materials and documents in plain and simple text that is readily comprehended by consumers and families.

RECOVERY AND SELF-HELP

Recovery and self-help groups are readily available, and function as an integral part of a seamless continuum of care. Recovery and self-help groups are culturally diverse and culturally compatible, incorporating consumer-driven goals and objectives that are oriented toward rehabilitation and recovery outcomes. Culturally competent providers and consumers in recovery are enlisted as consultants and educators to assist in the creative development of alternative treatment services, models and supports that are compatible with the lifestyles, values and beliefs of various cultures.

INDICATORS OF GUIDELINE APPLICATION

1. Services are accessible and available in a variety of settings, including churches, neighborhood facilities, and consumer residences.

2. Service system creates more integrated, culturally and linguistically specific, recovery groups.

3. Services are readily accessible and available in a variety of settings.

4. Community groups, consumers in recovery and other natural supports groups are recruited in the development and design of recovery and self-help service models.

MEASURES OF GUIDELINE APPLICATION

1. Service systems document the increase use of recovery and self-help programs by consumers of various cultural groups. As families and communities are engaged in services, the number of ethnic/cultural self-help, advocacy and recovery groups increase. A high-level of self-determination which is emphasized while maintaining inclusion in the service system is a strong performance indicator.

2. Service systems document an increase in the variety of ethnically/culturally relevant recovery and self-help programs. The array of ethnic/cultural services increases as the service system better engages and empowers families and communities.

3. Providers make available to consumers a list of recovery and self-help services in locations that are readily accessible to consumers and their communities.

CULTURAL ASSESSMENT

A cultural assessment is conducted by competent staff for each consumer, and within the context of the consumer's culture, family and community. The assessment is individualized, multidimensional and strength-focused. The components of the assessment include functional, psychiatric, social status, cultural milieu, social and economic stresses, discrimination, and family supports.

INDICATORS OF GUIDELINE APPLICATION

1. A cultural assessment is the basis for a culturally relevant diagnosis, goals and rehabilitation/treatment plans.

2. A cultural assessment tool and guide exists to determine cultural factors that impact treatment/rehabilitation services.

3. On-going cultural assessment occurs at each phase of treatment and rehabilitation.

4. Cultural assessment includes consumer preferences, and differentiates pathology from cultural factors.

MEASURES OF GUIDELINE APPLICATION

1. Bilingual staff is available to assess consumers in their language of preference.

2. Qualified cultural interpreters are utilized when bilingual staff is not available.

3. Psychological assessment and measurement tools are culturally valid and reliable, and administered, scored and interpreted by culturally competent providers.

4. All consumers receive an ethnic/cultural assessment. The rates of chronic, anti- social and other serious diagnoses for all ethnic/cultural groups are comparable to the general population. The use of restrictive treatments for all ethnic/cultural groups is comparable to the general population.

5. Providers document the inclusion of family members and significant community support persons in the initial and on-going assessment process. An indicator of high level performance is community-based, including community/family/consumer driven assessments and service planning.

6. The assessment includes cultural factors that are important to the treatment process. These factors include, but are not limited to, the following:

   a) Preferred language.
   b) History of indigenous/immigration/migration/generation behavior patterns.
   c) Degree of acculturation and adaptation.
   d) Cultural, social, economic and discrimination stresses and traumas.
   e) Learning and cognitive styles.
   f) Family organization and relational roles.
   g) Extent of family support.
   h) Social network composition.
   i) Ethnic identity
   j) consumer's perception/belief of presenting problems and explanations for symptoms.
   k) Consumer's belief systems regarding mental illness/substance abuse.
   l) Sexual identity and sex role orientation in cultural group.
   m) Coping strategies utilized within the cultural group.
   n) Help-seeking behavior.
   o) Previous attempts at relieving, managing and treating symptoms. (Including healers, traditional medicine, etc.)

To protect the rights and confidentiality of consumers, family and friends are not to be used as language/communication interpreters. These persons are welcomed to participate in the treatment planning process.

COMMUNICATION STYLE AND LINGUISTIC SUPPORT

Consumers, families and other support persons receive cross-cultural and communication-support, such as assistive devices and qualified language interpreters and professionals' interpreters. These supports are available at each entry point to services and continue throughout the consumer's treatment and rehabilitation services. Staff is knowledgeable in the use of professional interpreters, and telephone interpreters are only utilized in emergencies. Orally presented information, and written materials and documents, are translated in the consumer's preferred language. Examples include consumer rights information, orientation packets, consent forms and treatment plans.

INDICATORS OF GUIDELINE APPLICATION

1. Consumers and family members receive cross-cultural communication supports at each point of entry in the service system.

2. Consumers and family members report their level of satisfaction with communication supports.

3. Staff is knowledgeable in the use of communication supports.

4. Interpreters are qualified, competent, and demonstrate knowledge of consumers' cultural experience; including deaf, hard of hearing, and deaf blind

5. Communication supports demonstrate culturally accurate assessments, treatment/rehabilitation plans and service delivery.

6. Cross-cultural communication supports are available and comparable across all consumer cultural groups.

MEASURES OF GUIDELINE APPLICATION

1. Service systems increase the number of bicultural and bilingual staff, competent in the communication styles of the diverse cultures of consumers, as to minimize the use of interpreters.

2. A resource list of trained and qualified interpreters, updated annually, is maintained by facilities. Consumers and families are aware of the availability of interpreters through service advertisement efforts.

3. Certified qualified interpreters are available within 24-hour notice for routine situations, and within one hour for emergencies.

4. Service systems document consumer satisfaction of communication supports. A plan of correction and implemented action occur when consumer are not satisfied with communication supports.

5. Service systems document that staff receives training in the use of interpreters.

6. Service systems document that interpreters are certified (sign language interpreters), qualified and competent.

7. Service systems document that communication supports are comparable across consumer cultural groups.

CONTINUUM OF SERVICE/DISCHARGE PLANNING

Service and discharge planning begin at all points of entry along the continuum of services. It is provided by culturally competent providers in cooperation and collaboration with consumer, family, community support persons, and persons in consumer social networks. Service and discharge planning are done consistent with the values, norms and beliefs of consumers. These plans incorporate pertinent information from the cultural assessment and include service/discharge factors that are culturally relevant and important to the consumer's recovery.

Plans identify personal, family, social environment, social network and cultural resources necessary for treatment and rehabilitation services that assure consumer recovery.

INDICATORS OF GUIDELINE APPLICATION

1. A culturally compatible continuum of service/discharge plan is developed for each consumer.

2. Plans include clear goals and recommendations for necessary services in the post-discharge continuum of care.

3. Plans use the resources of family and social networks.

4. Plans assure consumers remain connected to treatment/rehabilitation recovery services as needed.

Measures of Guideline Application

1. Service systems document service/discharge plans involve consumers, family members, community resources, and social supports. High levels of performance occur when family and community members are partnered with consumers and driving the planning process. Family and community members merely attending meetings is not an indicator of adequate performance.

2. Plan lists the resources and services utilized, and consumer accomplishments.

3. Consumer values, norms and beliefs are documented in the plan and drive the planning process.

4. Service systems document future treatment and rehabilitation goals.

5. Service systems document recommendations for the use of consumer, family, social networks and cultural resources in any subsequent treatment/rehabilitation setting.

QUALITY OF LIFE

Quality of life is achieved through a holistic integration of symptom reduction, family and community support, and spirituality, which maximizes the consumer's sense of personal meaning, fulfillment and well-being. Assuring consumers have a high quality of life enhances recovery. Quality of life is determined by an individual's freedom to make choices and enjoy the benefits of those choices.

INDICATORS OF GUIDELINE APPLICATION

1. Service system develops ways of assessing the quality of life for all consumers.

2. Consumers report improved quality of life through services.

3. Consumers direct the recovery planning and treatment process.

MEASURES OF GUIDELINE APPLICATION

1. Assessments, treatment/rehabilitation plans and services incorporate the goals, preferences, hopes and wishes of consumers.

2. Service systems compile, collect and interpret quality of life measures.

3. Service systems utilize quality of life information and data to evaluate and improve service delivery, and to develop new services.

SERVICES ACCOMMODATIONS

Programs respond to the needs of individuals and families from different cultures by ensuring the best *cultural fit* between persons' beliefs, their cultural/behavioral styles and the services provided. Based on information derived from cultural assessments (re: family styles, gender roles, sexual orientation, spirituality/religion, worldview, traditions, work ethic, communication styles, leadership and organizational styles cognitive and learning styles) services, interventions, modalities, and strategies are adapted or developed in order to better promote program engagement, treatment/rehabilitation, and retention. Particular consideration is given to the visible presence of different cultures throughout the program's physical environment. Culturally competent strategies are utilized to attract and recruit consumers and families. Varied induction methods that orient persons to types of services offered as well as how to utilize and participate in these services are available. Service outcome expectations as well as clarification of both staff and consumer roles and responsibilities are reviewed.

INDICATORS OF GUIDELINE APPLICATION

1. Program services interventions and modalities are modified and developed in order to enhance consumer engagement, treatment/rehabilitation, or retention.

2. Varied program induction methods are available.

3. Varied outreach and recruitment strategies are utilized.

Measures of Guideline Application

1. Information derived from cultural assessments is collated and summarized.

2. Programmatic needs to ensure responsiveness to persons from different cultures have been identified and prioritized.

3. Selected, prioritized services, interventions and modalities that have been modified are documented.

4. Examples of varied culturally compatible, program outreach and recruitment strategies are documented.

5. Examples of varied program induction methods utilized to engage consumers and families from different cultures are documented.

APPENDIX DD

DEFINITIONS FOR COMMUNICATION WITH POTENTIAL MEMBERS AND MEMBERS

Appeal To file a Complaint, Grievance, or request a Fair Hearing.
Complaint When a member tells an BH-MCO that he or she is unhappy with the BH-MCO or his or her provider or does not agree with a decision by the BH-MCO.
Co-Payment A co-payment is the amount a member pays for some covered services. It is usually only a small amount.
Durable Medical Equipment A medical item or device that can be used in a member's home or in any setting where normal life activities occur and is generally not used unless a person has an illness or injury.
Emergency Medical Condition An injury or illness that is so severe that a reasonable person with no medical training would believe that there is an immediate risk to a person's life or long-term health.
Emergency Medical Transportation Transportation by an ambulance for an emergency medical condition.
Emergency Room Care Services needed to treat or evaluate an emergency medical condition in an emergency room.
Emergency Services Services needed to treat or evaluate an emergency medical condition.
Excluded Services Term should not be used. BH-MCO should use "Services That Are Not Covered" instead.
Grievance When a member tells an BH-MCO that he or she disagrees with an BH-MCO's decision to deny, decrease, or approve a service or item different than the service or item the member requested because it is not medically necessary.
Habilitation Services and Devices Term should not be used by BH-MCO. BH-MCO should define specific service.
Health Insurance A type of insurance coverage that pays for certain health care services. (If used by BH-MCO, should be used to refer only to private insurance.)
Home Health Care Home health care is care provided in a member's home and includes skilled nursing services; help with activities of daily living such as bathing, dressing, and eating; and physical, speech, and occupational therapy.
Hospice Services Home and inpatient care that provides treatment for terminally ill members to manage pain and physical symptoms and provide supportive care to members and their families.
Hospitalization Care in a hospital that requires admission as an inpatient.
Hospital Outpatient Care Care provided by a hospital or hospital based clinic that does not require admission to the hospital.
Medically Necessary A service, item, or medicine that does one of the following:
• Will, or is reasonably expected to, prevent an illness, condition, or disability;
• Will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;
• Will help a member get or keep the ability to perform daily tasks, taking into consideration both the member's abilities and the abilities of someone of the same age.
Network Contracted providers, facilities, and suppliers that provide covered services to

BH-MCO members.

Non-Participating Provider When referring to a provider that is not in the network, BH-MCOs should use the term "Out-of-Network Provider."

Physician Services Health care services provided or directed by a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

Plan A health care organization that provides or pays for the cost of services or supplies.

Preauthorization or Prior Authorization Approval of a service or item before a member receives the service or item.

Participating Provider When referring to a provider that is in the network, BH-MCOs should use "Network Provider."

Premium The amount a member pays for health care coverage.

Prescription Drug Coverage A benefit that pays for prescribed drugs or medications.

Prescription Drugs Drugs or medications that require a prescription for coverage.

Primary Care Physician A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider A doctor, doctors' group, or certified registered nurse practitioner who provides and works with a member's other health care providers to make sure the member gets the health care services the member needs.

Provider An individual or entity that delivers health care services or supplies.

Rehabilitative Services and Devices Term should not be used by BH-MCO. BH-MCO should define specific service.

Skilled Nursing Care Services provided by a licensed nurse.

Specialist A doctor, a doctor's group, or a certified register nurse practitioner who focuses his or her practice on treating one disease or medical condition or a specific part of the body.

Urgent Care Care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition.

Network Provider A provider, facility, or supplier that has a contract with an BH-MCO to provide services to members.

Out-of-Network Provider A provider that does not have a contract with an BH-MCO to provide services to members.

Appendix EE

COMMUNITY BASED CARE MANAGEMENT PROGRAM

The Community Based Care Management (CBCM) Program requirements described in this Appendix EE are for care rendered during a Calendar Year (CY) and defined in the Primary Contractor's and its BH-MCO's specific CBCM Program approved by the Department. The Primary Contractor and its BH-MCO shall submit CBCM proposals that improve behavioral health outcomes, and solely utilize partnerships with Community-Based Organizations (CBOs) and providers that encourage the use of preventative services, mitigate Social Determinants of Health barriers, and reduce healthcare disparities. The Primary Contractor and its BH-MCO may submit proposals that include collaborations with PH-MCOs.

I. CBCM Program Requirements

A. The Primary Contractor and its BH-MCO must propose CBCM activities and funding focused on partnerships with CBOs and providers, integrating a holistic approach to patient care and education to:

1. Assess, refer and mitigate fundamental Social Determinants of Health as exemplified but not limited to the key areas below.
    - Childcare access and affordability
    - Clothing
    - Employment
    - Financial Strain
    - Food insecurity
    - Housing instability/ homelessness
    - Transportation
    - Utilities

2. Enhance coordination of services for behavioral and physical health

3. Promote diversion from
    - Inpatient facilities
    - Residential treatment facilities
    - Emergency departments

4. Enhance crisis services

5. Enhance treatment for substance use disorders
    - Addressing emerging issues with opioids, stimulants, etc.
    - Addressing trauma-informed care

6. Address behavioral health training needs of the following:
    - First responders
    - Individuals who provide trauma-informed care

7. Reduce healthcare disparities

The Primary Contractor and its BH-MCO shall only use funding for CBCM services that have been approved by the Department in writing.

B. CBCM initiatives must:

1. Include clearly defined goals, objectives and outcome measures that include benchmarks for success.
2. Engage CBOs/providers as part of an integrated holistic approach to patient care and education.
3. Be designed in a manner that increases face to face interactions with recipients for the purposes of assessment, education, and/or referral**.**
4. Summarize stakeholder involvement in the planning and decision-making process to ensure the design addresses potential racial bias and inequities within the initiative and as an outcome of the initiative.
5. Ensure stakeholders are regularly provided information about the outcomes achieved by the HealthChoices program. This might include the current strengths and opportunities for improvement as seen by the Primary Contractor and its BH-MCO. Such information will allow stakeholders to provide informed feedback about priorities for CBCM initiatives.

C. The Primary Contractor and its BH-MCO must include in its CBCM agreements the requirements that:

1. Interventions conducted are carried out by appropriately trained/qualified personnel.
2. Participation in collaborative learning sessions.
3. Systems are capable to document services and interventions provided to Members and communities. Where feasible, systems include the use of electronic health records.
4. Exchange program and outcome data with the BH-MCO.
5. CBCM funds cannot be used for commodities.

D. The Primary Contractor and its BH-MCO can utilize CBCM Program funds in conjunction with other Primary Contractors.

E. The Primary Contractor and its BH-MCO shall develop and submit a proposal to the Department prior to implementing its 2022 CBCM Program, which may include multiple programs for use of the CBCM funds. If multiple programs are identified, each one must follow the requirements below. Proposals are due no later than **October 1, 2021** and must be submitted to the appropriate folder in Docushare using the CBCM Proposal template. The Primary Contractor and its BH-MCO must include in each CBCM proposal:

1. A program description that lists targeted CBOs and providers, a twelve- month budget, and operations timeline that outlines the startup of the program from January 1, 2022 through December 31, 2022.
2. The targeted providers/CBOs, or co-location of services being involved with CBCM. The Primary Contractor and its BH-MCO will be responsible for reporting the targeted providers/CBOs, targeted recipients, and the program budget, which should include the payment terms. .
3. Clearly defined goals, objectives and outcome measures that include benchmarks for success.
4. An outline of interventions performed. for each of the targeted CBOs and providers that increases face to face interactions with recipients in clinical and non-clinical settings for the purposes of assessment, education, and/or referral.
5. Outline of payment mechanisms and time frames to CBOs and providers for CBCM.

F. A Primary Contractor's and its BH-MCO's approved CBCM program will remain in effect until December 31 of each calendar year. The Primary Contractor and its BH-MCO may only submit one quarterly revision for the Department's review and approval. The Primary Contractor and its BH-MCO must complete and submit the CBCM Proposal template with the changes identified. The Department will not accept changes for the fourth calendar quarter.

G. Upon determining or being informed by PH-MCO that a member is experiencing maternal depression, the Primary Contractor and its BH-MCO must provide interventions, which include coordination of care or linkage to care which is coordinated with physical health special needs unit and ICP as appropriate.

II. Payments to the Primary Contractor and its BH-MCO

A. The Department will make payments for CBCM based on a per member per month (PMPM) rate. The Department will not include in the CBCM PMPM those Members that have been determined by the Department to have coverage in an IMD as referenced in Section II-.7.C.1.a. of the Program Standards and Requirements.

1. As determined by the Department, if the Primary Contractor and its BH-MCO have unspent CBCM funds as of June 30 of the subsequent calendar year, the Department may reduce a future payment to the Primary Contractor and its BH-MCO by the unspent amount or may direct CBCM funds are to be used for the current or a prior program year. The Primary Contractor and its BH-MCO must use CBCM funds

only to support a program to expand and improve access to care or quality outcomes for Members.

2. If the Department determines CBCM funds were not expended in accordance with the approved Primary Contractor's and its BH-MCO's CBCM plan, upon advanced written notice to the Primary Contractor, the Department may elect to reduce a future payment to the Primary Contractor by the amount identified.
3. The Department will not reimburse the Primary Contractor for CBCM related expenses in excess of payments made by the Department. Any excess related expenses would be the Primary Contractor's responsibility.

III. Payments to Providers

The Primary Contractor and its BH-MCO should make payment to CBOs and providers within the approved time period for the approved CBCM program, as identified above.

IV. Reporting

A. Program Reporting

1. The Primary Contractor and its BH-MCO must submit an annual analysis of its CBCM program. The annual analysis is due by June 30 of the subsequent calendar year.
2. The Primary Contractor and its BH-MCO shall report the clinical and financial outcomes of the program, including return on investment (ROI).

B. Financial Reporting

The Primary Contractor and its BH-MCO must submit the financial report in a format approved by the Department. The final annual financial report is due by June 30 of the subsequent calendar year. If requested by the Department, the Primary Contractor and its BH-MCO must submit additional financial reports in the format and by the date requested.

Regional Accountable Health Council

I. The Primary Contractor must form, with all other MA and CHIP MCOs and Behavioral Health Primary Contractors that operate within the region defined by each Physical Health HealthChoices Zone, a Regional Accountable Health Council (RAHC), subject to the following:

A. The purpose of the RAHC shall be to serve as a forum for regional strategic health planning and coordination of community-wide efforts to improve health outcomes across each region in the state. This planning shall be focused on areas of high burden of disease and on demographic groups impacted by health disparities within the HealthChoices Zone, in order to identify the root causes of those disparities and to establish strategies and interventions to address those root causes of these disparities. The RAHC will use state and community-based health assessments, regional Social Determinants of Health (SDOH) needs assessments, as well as any other specific health indicators, as the basis to advance population health planning.

1. In serving as a forum for regional strategic health planning and coordination of community-wide efforts, with a special focus on addressing the root causes of disparities, the RAHC's goals shall be to:

a. Promote health equity and eliminate health disparities;
b. Address regional SDOH needs;
c. Bend the cost curve by aligning VBP initiatives and achieving better care, better health, at lower costs;
d. Support and steer population health improvement processes, including regional efforts to integrate physical and behavioral health care; and
e. Center health improvement efforts in the communities where people live.

B. Each RAHC's region of operation shall be the Physical Health HealthChoices Zone in which the Primary Contractor operates under agreement with the Department. There shall be five RAHCs: Southeast, Southwest, Northeast, Northwest and Lehigh Capital.

C. The RAHC's governing document, such as Bylaws, are subject to the following:

1. The governing document shall address, at a minimum, the following: the name of the RAHC; the purpose of the RAHC; the constituent parts of the RAHC, such as members or partners; the governing body of the RAHC as set forth below, including appointment, removal, resignation and filling vacancies of positions on the governing body; the standing and ad hoc committees; the procedures of conduct of meetings; the procedures for

exercise of the RAHC's powers; and the enunciation of the RAHC's fiscal year.

2. The governing document shall include a conflict of interest policy for organizations and individuals in the RAHC.

3 The governing document shall allow other health care payers to join the strategic direction outlined by the RAHC, such as regional business groups on health, commercial health insurance plans, special needs plans, health foundations, and other lines of business.

4. All changes to the governing document must be approved by the Department prior to implementation.

D. The governing body of the RAHC shall be a council, the chair of the council and the vice chair of the council.

1. The chair of the council shall be voted on by the Council.

2. The vice chair of the council shall be voted on by the council.

3. The council shall consist of, at the minimum:

a. One representative from the executive leadership team of the Primary Contractor;
b. One representative from each of the executive leadership teams of the MA and CHIP MCOs operating under agreement with the Department in the Physical Health HealthChoices Zone;
c. One representative from each of the high MA utilization health systems (as defined by the Department);
d. One representative from three Community-Based Organizations (CBOs) that focus on Social Determinants of Health (as identified by the Department); and
e. At least one representative from each of the following sectors:

i. Mental health administrators not otherwise represented by a Behavioral Health Primary Contractor:
ii. Single County Authorities;
iii. FQHCs;
iv. Mental health treatment providers;
v. Institutional long-term care service providers;
vi. Home and community-based service providers;
vii. Substance use disorder treatment providers;
viii. Other community institutions outside of clinical settings, such as faith-based organizations, schools, or libraries.

ix. MA Consumers and CHIP consumers.

3. The membership of the council should reflect the racial and ethnic diversity of the HealthChoices Zone.

E. The RAHC shall be a part of a statewide RAHC learning network developed by the Department, so each RAHC can learn best practices from one another in improving population health, reducing costs, improving health equity, and addressing SDOH needs.

F. The RAHC shall be responsible for providing CBOs technical assistance that is available on consultation. The Primary Contractor shall also support a regional or statewide learning network that is informed by frequently asked questions or topics. The goals of the technical assistance will be to help support administrative functions of CBOs that are important in their ability to improve population health, improve equity, and address the SDOH needs of the region. The technical assistance must include the ability to assist with data analytics and measurement, contract management and negotiations, sharing best practices and outcomes, measuring return on investment, and incorporation of CBOs into VBP agreements.

G. The RAHC shall develop an [annual] Regional Health Transformation Plan (RHTP) for its HealthChoices Zone, subject to the following:

1. The RHTP is subject to approval of the Department. The RAHC shall submit its updated annual RHTP for the period of July 1, 2022- June 30, 2023 to the Department no later than June 30, 2022.

2. Each RHTP shall originate from a template published by the Department and fulfill the requirements in the template. The template will include at a minimum the following requirements:

a. Identify demographic groups impacted by health disparities, and geographic areas with significant health disparities ("health equity zones") and strategies for eliminating disparities in these groups and areas;
b. Identify SDOH needs in the area and strategies for addressing them;
c. Identify population health priority measures across physical, behavioral, and integrated health measures of the HealthChoices Zone that should be improved and population health strategies for improvement;
d. Identify strategies and interventions for bending the cost curve and limiting regional cost growth, including aligning VBP arrangements across payers, which must in no way be construed to indicate that payers will coordinate to set prices;

e. Identify CBOs and other trusted community partners and how they are incorporated into the overall plan;
f. Identify strategies and interventions to continuously monitor for improvement in health equity, SDOH, and population health priority measures established by the regional transformation plan, including a rapid-cycle quality improvement strategy to rapidly scale interventions that are successful.
j. Identify best practices and challenges from the prior year's RHTP.

H. The Primary Contractor shall coordinate with other MA and CHIP MCOs and other Behavioral Health Primary Contractors in the Physical Health HealthChoices Zone that the Primary Contractor operates in to begin implementing the strategies outlined in the RHTP, after the RHTP is approved by the Department.

PAY FOR PERFORMANCE PROGRAM: Pay for Performance (P4P) Program

A. OVERVIEW

The Department is implementing a Pay for Performance (P4P) program for all Primary Contractors per HEDIS and select Pennsylvania Performance Measures (PAPMs) as defined in this Appendix. This P4P program is aligned with the Department's goal to improve the quality of health care and to reduce MA expenditures through enhanced mental health care for HealthChoices members.

The Department will provide a funding pool from which the Primary Contractors will be paid on a weighted basis based on the performance measures outlined in this Appendix.

Incentives will be developed and administered in accordance with 42 CFR § 438.6. Financial incentives available through the P4P program will be paid in addition to the Actuarially Sound Capitation Rates paid by the Department to each Primary Contractor and its BH-MCO.

B. PERFORMANCE MEASURES

The following performance measures for the Measurement Year (MY) 2021 /Report Year (RY) 2022 P4P program include:

1. Follow-up after hospitalization for mental illness at 7-Days (FUH-7)*
2. Follow-up after hospitalization for mental illness at 30-Days (FUH-30)*
3. Readmission within 30 Days of inpatient psychiatric discharge (MH-REA)**

Note: The P4P measures are subject to change if the entity responsible for the measurement makes a change.

**CMS Core measure/ NCQA measure*

*** Pennsylvania Performance measure defined by EQRO*

C. PERFORMANCE INCENTIVES

Ten million dollars ($10M) will be allocated statewide to a funding pool for the P4P program in calendar year (CY) 2021. The funding will be allocated to each Primary Contractor according to its overall percent of HealthChoices Members for CY 2021.

The P4P program measures Benchmark Performance and Improvement Performance. Payments will be based on meeting a Benchmark/Goal and an incremental improvement calculated from the previous HEDIS/PAPM 2021/MY of 2020 to the HEDIS/PAPM 2022/MY 2021.

The Performance incentive payments made during CY 2022 will be based on the incremental performance improvement requirements found in Contract Year 2022, calculated from MY 2020 to MY 2021 and will be for measurements B.1-B.3 above.

1. Benchmark Performance: The Department will award a Benchmark Performance payout amount for each measure that will range from 0% up to and including 125% of the measure's value, defined as half of the Primary Contractor's Maximum Program Payout amount divided by 8 quality measures. Distribution will occur as defined below.
    a. The Department will apply a Benchmark Performance payout for performance relative to the HEDIS® Report Year (RY) 2022 (MY 2021) benchmarks.
        i. HEDIS® 2022 rate at or above the 90th percentile benchmark: 125 percent of the measure value
        ii. HEDIS® 2022 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
        iii. HEDIS® 2022 rate at or above the 50th percentile and below the 75th percentile benchmark: 75 percent of the measure value.
        iv. HEDIS® 2022 below the 50th percentile, no benchmark performance payout applies.
    b. The Benchmark Performance Payout applies to the following measures:
        i. Follow-up after hospitalization for mental illness at 7-Days (FUH-7)
        ii. Follow-up after hospitalization for mental illness at 30-Days (FUH-30)

2. The specific goals, methodology and Benchmarked Performance payment distribution will apply to the benchmarked measures below:
    a. Readmission within 30 Days of inpatient psychiatric discharge (MH-REA) (Goal =11.75%)
        i. Performance goal at or below 11.75%, paid at 100% of the measure value
        ii. Performance above goal, no payout.

The Incremental Improvement scales. Incremental performance improvements are measured comparing rates HEDIS® (RY) 2021 (MY 2020) to HEDIS® (RY) 2022 (MY 2021).

3. The Department will distribute the payouts according to the following criteria:
    a. Scale 1:
        i. ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
        ii. ≥ 4 and < 5 Percentage Point Improvement: 80 percent of the measure value.
        iii. ≥ 3 and < 4 Percentage Point Improvement: 60 percent of the measure value.
        iv. ≥ 2 and < 3 Percentage Point Improvement: 40 percent of the measure value.
        v. ≥ 1 and < 2 Percentage Point Improvement: 20 percent of the measure value.
        vi. < 1 Percentage Point Improvement: No payout.
    b. Scale 2:

i. ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
ii. ≥ 4 and < 5 Percentage Point Improvement: 100 percent of the measure value.
iii. ≥ 3 and < 4 Percentage Point Improvement: 100 percent of the measure value.
iv. ≥ 2 and < 3 Percentage Point Improvement: 85 percent of the measure value.
v. ≥ 1 and < 2 Percentage Point Improvement: 75 percent of the measure value.
vi. ≥ 0.5 and < 1 Percentage Point Improvement: 50 percent of the measure value.
vii. < 0.5 Percentage Point Improvement: No payout.

c. The Incremental Improvement scales will be applied contingent on benchmark percentile performance for each HEDIS 2022 measure as follows:
   i. . Scale 1 applies to performance results
      1. If improvement is achieved and the HEDIS® benchmark performance for that measure is <50th percentile.
      2. If improvement is achieved and the HEDIS® benchmark performance for that measure is ≥50th percentile and <75th percentile.
      3. In the above instances of c.i.1 and c.1.2, Scale 1 would apply to the FUH-7 Day and FUH-30 Day measures
   ii. Scale 2 applies to performance results
      1. If improvement is achieved and the HEDIS® benchmark performance for measures are ≥75th percentile
      2. If in the above instance of C.ii.1, Scale 2 would apply to the FUH-7 Day and FUH-30 Day measures
      3. If the MH-REA showed an improvement (decrease in rate)

NOTE: The payout structure is subject to change if there is a delay in encounter reporting due to a natural disaster, pandemic and other unforeseen events. OMHSAS will share those changes with the Primary Contractor and its BH-MCO prior to making the changes.

D. Payment for Performance Incentives

If the Department has a payment obligation to the Primary Contractor pursuant to this Appendix for 2022 , the Department will issue the payment by August 31, 2023.

The Primary Contractor and its BH-MCO will be notified 120 days prior to the start of each measurement period if the P4P program is renewed and if there are modifications to the P4P program.

APPENDIX 3

Rates will be determined through a negotiation or adjustment process as stated in Sections 7.1 and 7.2 of this agreement and will become part of this Agreement once agreed upon by the parties.

APPENDIX 4

RATE SETTING METHODOLOGY OVERVIEW

I. Rate Setting Methodology – Use of Managed Care Data.

To develop Capitation rates on an actuarially sound basis for the HealthChoices program using actual managed care data, the following general steps are performed:

- Summarize, Analyze, and Adjust the Managed Care Data,
- Project the Managed Care Base Data Forward,
- Include the Effect of Program/Policy Changes,
- Adjust the Base Data to Reflect Enhanced Managed Care Practices, and
- Add an Appropriate Non-benefit Load.

Summarize, Analyze, and Adjust the Managed Care Data — The Commonwealth collects data from each of the managed care organizations (MCOs) participating in the HealthChoices program. This data is summarized, analyzed, and adjustments (positive and negative) are applied as needed to account for underlying differences between each MCO's management of the HealthChoices program. These adjustments can account for items such as Alternative Payment Arrangements, reinsurance premiums and reinsurance recoveries, recoveries of overpayments due to fraud, waste or abuse, impact of reinvestment expenditures on State Plan Services, reallocation of services reported in the "other" category of service, collection of Third Party Liability/Coordination of Benefits, over- or under-reserving of unpaid claims, management efficiency, and provider contracting relations. After adjusting each MCO's data, each plan's specific medical claim costs are aggregated together to arrive at a set of base data for each population group by service year and category of service.

Project the Managed Care Base Data Forward — The aggregate base of managed care data is projected forward to the time period for which the Capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the managed care program. These trend factors normally vary by county and category of service. Trend factors include consideration for expected unit cost and utilization changes between the base data and the time period for which the Capitation rates are to be paid.

Include the Effect of Program and Policy Changes — The Commonwealth occasionally changes the services or populations covered under the HealthChoices program (e.g., HealthChoices Expansion, Affordable Care Act, eligibility and rate cell changes). Any new program or policy eligibility changes that occurred during or after the base data years and are not reflected or not fully reflected in the managed care data, are included in the Capitation rates by either increasing or decreasing the managed care data by a certain percentage amount. Adjustments may vary by county, rate cell and category of service.

Adjust the Base Data to Reflect Enhanced Managed Care Practices – The historical managed care encounter data will be reviewed and adjusted, if necessary, to identify opportunities to more efficiently provide care. Adjustments will be determined based on data analyses, cost and utilization statistic comparisons across counties and/or population types, comparisons to clinically established benchmarks and Commonwealth program expectations.

Add an Appropriate Non-benefit Load — After the base data has been trended to the appropriate time period, adjusted for program and policy changes, and adjusted for enhanced managed care practices along with trend and program changes, a non-benefit load will be added to the medical claim cost component to determine the overall Capitation rates applicable to each population group. The non-benefit load includes consideration for administrative and care management expenses and risk margin. The non-benefit load is applied as a percentage of the total Capitation rate and does not vary by population group.

II. Services Covered by Agreement Savings

The reimbursement provided under this Agreement is intended for the coverage of medically necessary services under the Commonwealth's State Plan, as well as those classified as 43 CFR §438.3(e) in lieu of services. The Primary Contractor may utilize this reimbursement to provide medically necessary services in place of, or in addition to, the services covered under the State Plan, to meet the needs of the individual Members in the most efficient manner. Since the Capitation rates cannot include these additional services, an adjustment may be required in the rate development process to incorporate the costs of State Plan Services which would have been provided in the absence of alternative or additional service.

APPENDIX 6

MEDICAL LOSS RATIO REPORTING REQUIREMENTS

This appendix establishes requirements for the Primary Contractor's responsibility to calculate and report their medical loss ratio (MLR) to the Department consistent with the requirements at 42 CFR §438.8.

The Primary Contractor must not include any revenue or costs that are not specific to the HealthChoices BH program in the MLR report.

I. **Timing.** The Primary Contractor must submit the annual MLR report to the Department no later than 11 months following each rating period. For example, Calendar Year 2018 report is due no later than November 30, 2019.

II. **MLR Reporting Year.** Consistent with 42 CFR §438.8, the MLR reporting year is a 12-month period that aligns with the Department's HealthChoices BH rating period. The Department's current, standard rating period is a 12-month calendar year.

III. **Contents of Annual MLR Report.** The Primary Contractor shall submit in their MLR report, at a minimum, the following information for the current MLR reporting year, consistent with the requirements in 42 CFR §438.8(k) or as subsequently modified by CMS. The Department may request additional information and/or require the use of an MLR report template.

- **A.** Total incurred claims
- **B.** Expenditures on quality improving activities
- **C.** Recoveries through fraud reduction
- **D.** Expenditures on fraud reduction
- **E.** Non-claim costs
- **F.** Premium revenue
- **G.** Premium related taxes, licensing, and regulatory fees
- **H.** Methodologies for allocation of expenditures
- **I.** Any credibility adjustment applied
- **J.** The calculated MLR (including numerator and denominator)
- **K.** A comparison of the MLR report information to the Primary Contractor's audited financial report(s).
- **L.** The number of member months
- **M.** A description of the aggregation method used to aggregate data for all Medicaid eligibility groups covered under this Agreement

In accordance with 42 CFR §438.8 (k)(3), the Primary Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Primary Contractor within 180 days of the end of the MLR reporting year, or within 30 days of being requested by the Primary Contractor,

whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

IV. **MLR Numerator and Denominator.** Detail of what is included and how the MLR numerator and denominator are computed can be found in 42 CFR §438.8(e) and (f) respectively. If an expenditure related to Social Determinant of Health is an "activity that improves health care quality" as specified in 42 C.F.R. § 438.8(e)(3), the Primary Contractor may include the costs in the numerator of the MLR. The Primary Contractor shall comply with these requirements and any additional requirements, guidance or instructions released by CMS that relate to the computation of the MLR as required in 42 CFR §438.8.

V. **Aggregation of Data.** The Primary Contractor must aggregate data for all Medicaid eligibility groups covered under the HealthChoices BH Agreement in its MLR report as required under 42 CFR §438.8(i). The Department may modify this requirement and obtain MLR information on a rate cell basis or some other basis.

VI. **Credibility Adjustment.** Per 42 CFR §438.8(h), the Primary Contractor has the option of adding a credibility adjustment to its reported MLR if the Primary Contractor has sufficient Member months to be partially credible, but not enough Member months to be fully credible. The credibility adjustment is required for any remittance calculations. CMS will publish the table of credibility adjustments to be used. Fully credible plans may not use a credibility adjustment.

VII. **MLR Threshold.** Per 42 CFR §438.8(c) the Department has chosen a minimum MLR of 85.00 %. The Department will not require a remittance based on the MLR calculation at this time. For subsequent MLR reporting years, the Department may modify this requirement.

VIII. **Attestation.** The Primary Contractor must provide an attestation of the accuracy of the information provided in its submitted MLR report as required in 42 CFR §438.8(n) and consistent with 42 CFR §§438.604(a)(3) and 438.606. The attestation is due on the report due date. These requirements are subject to change as CMS releases sub-regulatory guidance. If there are retroactive capitation adjustments these MLR reports may need to be updated.

APPENDIX 8

MANAGED CARE ORGANIZATION ASSESSMENT

A. The Primary Contractor shall comply with the requirements of Act 92 of 2015 (the Act), in regards to the Managed Care Organization (MCO) Assessment and its applicability to a Medicaid MCO, as defined in the Act. The Department will provide instructions and reporting forms to the Primary Contractor for purposes of reporting and submitting the electronic payment of the MCO Assessment to the Department.

B. The Department will comply with the Rate Setting Methodology outlined in Appendix 4 and in accordance with Section 4.4 of the Agreement and take into consideration the costs of the MCO Assessment as long as the MCO Assessment remains in effect.

C. The Primary Contractor shall remit the fee electronically in quarterly submissions as specified in the HealthChoices Behavioral Health Financial Reporting Requirements.

D. The Department will include in the capitation rates consideration for the MCO Assessment fee amount as provided for in the Act, or as adjusted pursuant to the Act. The Primary Contractor will be assessed a fixed fee for each unduplicated Member for each month the Member is enrolled for any period of time. The Capitation rates will include consideration of a factor which will account for Members who were enrolled for a partial month.

E. The Primary Contractor shall report and provide an electronic payment for the MCO Assessment fee on a quarterly basis. A reconciliation process will occur annually, after all material adjustments to the capitation are completed. Any payments or recoupments will be processed via a gross adjustment.

F. In April of each year, the Department will process a gross adjustment, equal to three times the number of Members at the beginning of January times the fee, to accommodate the expedited due date of the fourth quarter (April through June) MCO Assessment. Once the delayed capitation payments have been paid, the Department will process a gross adjustment to recoup the MCO Assessment fee amount that is included in the gross adjustment in August of each year.

G. If either the Department or the Primary Contractor notifies the other party that it is terminating this Agreement, the Primary Contractor shall pay to the Department the amount that was paid but not yet recouped, after determining the MCO Assessment fee owed. The Primary Contractor must make payment within 30 business days.

H. If the Department has notified the Primary Contractor of the future termination of the MCO Assessment, the Department will proportionately reduce the payment/recoupment, after determining any MCO Assessment liability.

APPENDIX 9

COMMONWEALTH OF PENNSYLVANIA
BUSINESS ASSOCIATE ADDENDUM

WHEREAS, the Pennsylvania Department of Human Services (Covered Entity) and Primary Contractor (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 services to or on behalf of Covered Entity, in accordance with the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 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 C.F.R. §§ 431.301-431.302, 42 C.F.R. Part 2, 45 C.F.R. § 205.50, 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, 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 Addendum 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 Addendum 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, Pub. L. No. 104-191.
d. "HITECH Act" shall mean the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009).

e. "Privacy Rule" shall mean the standards for privacy of individually identifiable health information in 45 C.F.R. Parts 160 and 164, as amended, and related agency guidance.
f. "Protected Health Information" or "PHI" shall mean 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 which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA, the HITECH Act and related regulations and agency guidance. PHI also includes any and all information that can be used to identify a current or former applicant or recipient of benefits or services of Covered Entity (or Covered Entity's contractors/business associates).
g. "Security Rule" shall mean the security standards in 45 C.F.R. Parts 160, 162 and 164, as amended, and related agency guidance.
h. "Unsecured PHI" shall mean PHI that is not secured through the use of a technology or methodology as specified in HITECH regulations and agency guidance or as otherwise defined in the HITECH Act.

2. Stated Purposes For Which Business Associate May Use Or Disclose PHI. The Business Associate shall be permitted to use and/or disclose PHI provided by or obtained on behalf of Covered Entity for the purposes of providing services under its HealthChoices Agreement with Covered Entity, except as otherwise stated in this Addendum.

NO OTHER DISCLOSURES OF PHI OR OTHER INFORMATION ARE PERMITTED.

3. BUSINESS ASSOCIATE OBLIGATIONS:

a) Limits On Use And Further Disclosure. Business Associate shall not further use or disclose PHI provided by, or created, or obtained on behalf of Covered Entity other than as permitted or required by this Addendum 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 Addendum. 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 DHS Chief Information Security Officer at (717) 772-6469**,** within

two (2) business days of discovery any use or disclosure of PHI not provided for or allowed by this Agreement.

d) Reports Of Security Incidents. In addition to the breach notification requirements in section 13402 of the HITECH Act and related regulations, agency guidance and other applicable federal and state laws, Business Associate shall report to DHS Chief Information Security Officer at (717) 772-6469**,** within two (2) business days of discovery any security incident of which it becomes aware. At the sole expense of Business Associate, Business Associate shall comply with all federal and state breach notification requirements, including those applicable to Business Associate and those applicable to Covered Entity. 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. At any time PHI is provided or made available to Business Associate 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 Addendum.

(f) Right Of Access To PHI. Business Associate shall 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 in the format requested, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by Business Associate and the individual. If the request is for information maintained in one or more designated record sets electronically and if the individual requests an electronic copy of such information, Business Associate must provide the individual with access to the PHI in the electronic form and format requested by the individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by the Business Associate and the individual. If any individual requests from Business Associate or its agents or subcontractors access to PHI, Business Associate shall notify Covered Entity within five (5) business days. Business associate shall further conform with 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 an 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 shall 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 Rules, as amended, and other applicable statutory and regulatory requirements, and agency guidance.

(j) Access To Books And Records. Business Associate shall 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 or expiration of the contract, Business Associate shall return or destroy all PHI provided by or obtained on behalf of Covered Entity. Business Associate may not retain any copies of the PHI after termination or expiration of its contract. If return or destruction of the PHI is not feasible, Business Associate shall extend the protections of this Addendum 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 its contract and this Addendum and shall continue to maintain the information required under the various documentation requirements of its contract and this Addendum (such as those in §3(h)) for a period of six (6) years after termination or expiration of its contract, unless Covered Entity and Business Associate agree otherwise.

(m) Mitigation Procedures. Business Associate shall establish and 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 Addendum or the Privacy Rules, as amended. Business Associate shall mitigate any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of this Addendum or applicable laws and agency guidance.

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

(o) Grounds For Breach. Non-compliance by Business Associate with this Addendum or the Privacy or Security Rules, as amended, is a breach of the contract, for which the Commonwealth may elect to terminate Business Associate's contract.

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

(q) Failure to Perform Obligations. In the event Business Associate fails to perform its obligations under this Addendum, 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 Addendum and applicable laws and agency guidance.

(r) Privacy Practices. Covered Entity 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 Covered Entity. Covered Entity may change applicable privacy practices, documents and forms. The Business Associate shall implement changes as soon as practicable, but not later than 45 days from the date of notice of the change. Business Associate shall otherwise comply with all applicable laws and agency guidance pertaining to notices of privacy practices, including the requirements set forth in 45 C.F.R. § 164.520.

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. Covered Entity will post on its website any material changes to its notice of privacy practices by the effective date of the material change

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.