# EXHIBIT A

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## MANAGED CARE REGULATORY COMPLIANCE GUIDELINES

The following apply to all managed care organizations under contract with the Office of Medical Assistance Programs:

- All federal and state laws, including but not limited to 55 Pa. Code Chapters 1101-1249
- Non-compensable or non-covered services (managed care organizations may provide additional services beyond MA Fee for Service (FFS), but must cover, at a minimum, those services on the fee schedule in the same amount, duration and scope as the Fee for Service Program.)
- Scope of Benefits based on Recipient's eligibility (as determined by the County Assistance Office)
- Staff/Provider Licensing/Scope of Practice Requirements
- Frequency of service
- Program standards/quality of care standards
- Provider participation (enrolled as an MA Participating Provider)
- Utilization review
- Administrative sanctions
- Definitions

The following, which may appear in any of the above sections or Medical Assistance Bulletins, will not apply to managed care organizations:

- Maximum frequency of service limits (managed care organizations may provide more than the maximum).
- Maximum service reimbursement rates.
- Payment methodology.

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| **Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1101, General Provisions, with the following exceptions:** | |
| 1101.21 Definition of "Prior Authorization" | Definitions |
| 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. |
| 1101.21 Definition of "Medically Necessary" | A service, item, procedure or level of care that is: (i) Compensable under the MA Program. (ii) Necessary to the proper treatment or management of an illness, injury or disability. (iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice. |
| 1101.31(b) (13) "…Dental Services as specified in Chapter 1149 (relating to Dentists' Services)." | Benefits, Scope for categorically needy |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1101.31(f)<br><br>Note: The managed care organizations are not required to impose limits that apply in the Fee-for-Service delivery system, although they are permitted to do so. The managed care organizations may not impose limits that are more restrictive than the limits established in the Fee-for-Service system. If the managed care organizations impose limits, their exception process cannot be more restrictive than the process established in §1101.31(f). | Benefits, Exceptions (for limits specified in subsections (b) and (e) - FFS Program Exception Process |
| 1101.32(a) (1) "…Medically needy children referred from EPSDT are not eligible for pharmaceuticals, medical supplies, equipment or prostheses and orthoses."<br><br>1101.32(a)(2) | Coverage Variations, Expanded coverage EPSDT<br><br>Coverage Variations, Expanded Coverage School Medical Program for Medically Needy school children |
| 1101.33(a) "…If the applicant is determined to be eligible, the Department issues Medical Services Eligibility (MSE) cards that are effective from the first of the month through the last day of the month..." | Recipient Eligibility, Verification of Eligibility (issuance of card) |
| 1101.33(b) | Recipient Eligibility, Services restricted to a single provider |
| 1101.51(a) | Responsibilities, Ongoing responsibilities of providers, Recipient freedom of choice of providers |
| 1101.61 | Fees and Payments, Reimbursement policies. |
| 1101.62 | Maximum fees |
| 1101.63(b)(1) through (10) | Payment in full, Copayments for MA services |
| 1101.63(c) | Payment in full, MA deductible |
| 1101.64(b) "…Payment will be made in accordance with established MA rates and fees." | Third-party medical resources, Persons covered by Medicare and MA |
| 1101.65 | Method of payment |
| 1101.67 | Prior Authorization (including timeframes for notice) |
| 1101.68 | Invoicing for services |
| 1101.69 | Overpayment – underpayment (related to providers) |
| 1101.69(a) | Establishment of a uniform period for the recoupment of overpayments from providers (COBRA) |
| 1101.72 | Invoice adjustment |
| 1101.83 | Restitution and repayment (related to providers for payments that should not have been made) |
| **Managed care organizations are not required to adhere to the provisions of 55 Pa. Code Chapter 1102, Shared Health Facilities. Managed care organizations are responsible for establishing their own provider networks.** | |
| **Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1121, Pharmaceutical Services, with the following exceptions:** | |
| 1121.2 | Definitions of AWP, Compounded Prescription, Pricing Service, Federal Upper Limit, CMS Multi-source Drug, State MAC, and Usual and Customary Charge |
| 1121.52(a)(6) | Payment conditions for various services (indication for "brand medically necessary") |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1121.52(b) | Payment conditions for various services (prenatal vitamins) |
| 1121.53(a) | Limitations on payment (not exceeding UCC to general public) |
| 1121.53(b)(1) | Limitations on payment (conditions when limits on the State MAC will not apply) |
| 1121.53(b)(2) | Limitations on payment (conditions when limits on the State MAC will not apply) |
| 1121.53(c) | Limitations on payment (34 day supply or 100 units, total authorization not exceeding 6 months' or five refill supply) |
| 1121.53(f) | Limitations on payment (Payment to pharmacy for prescriptions dispensed to a recipient in either a skilled nursing facility, an intermediate care facility or an intermediate care facility for the mentally retarded and specific scripts not included in the limitation) |
| 1121.54(10) | Drugs prescribed in conjunction with sex reassignment procedures or other noncompensable procedures. As directed in MAB 99-16-11, this is inconsistent with the Federal Final Rule, "Nondiscrimination in Health Programs and Activities", and will no longer be applied. |
| 1121.55 | Method of payment. (relating to the Department's payment to pharmacies) |
| 1121.56 | Drug cost determination. |
| **Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1123, Medical Supplies, with the following exceptions:** | |
| 1123.1 "and the MA Program fee schedule" | Policy. (Payment for medical supplies is subject to this chapter, Chapter 1101 (relating to general provisions) and the limitations established in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule. |
| 1123.13(a) and (b). | Inpatient services. |
| 1123.22(1). | Scope of benefits for the medically needy. ("Medical supplies which have been prescribed through the School Medical Program...") |
| 1123.22(2) "who are enrolled in EPSDT, or which have been prior authorized by the Department as specified in 1123.56 (a) (2) (relating to vision aids)" | Scope of benefits for the medically needy. ("Eyeglasses which have been prescribed as treatment for individuals under 21 years of age who are enrolled in EPSDT...") |
| 1123.51 "and the MA Program fee schedule" | Payment for Medical Supplies. General payment policy. |
| 1123.53 | Hemophilia products. |
| 1123.54 "in accordance with the limitations described in this section and the maximum fees listed in Chapter 1150 (relating to Medical Assistance program payment policies) and the Medical Assistance Program fee schedule" | Orthopedic shoes, molded shoes and shoe inserts (Relating to payment when prescribed for eligible persons to approved MA providers) |
| 1123.54(1) through (5). | Orthopedic shoes, molded shoes and shoe inserts (Relating to prior approval, conditions for payment, payment for modifications necessary for the application of a brace or splint, payment for repairs w/o a prescription or prior authorization, and payment for orthopedic shoes only if the recipient is 20 years of age or younger." |
| 1123.55(a) "The prescription shall contain the cardiopulmonary diagnosis" | Oxygen and related equipment. (Relating to payment conditions) |
| 1123.55(b) and (c). | Oxygen and related equipment. (Relating to prior authorization and prescription inclusion requirements) |
| 1123.55(d) "and recertification shall be kept by the provider" | Oxygen and related equipment. ("A physician shall recertify orders for oxygen at least every 6 months and recertification shall be kept by the provider.") |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1123.56(a)(1) through (3) | Vision aids. (“Payment for eyeglasses is made only if the recipient is 20 years of age or younger and the eyeglasses have been one of the following...”) |
| 1123.56(b)(1) through(3) | Vision aids. (“Payment for low vision aids is made only if the recipient is categorically needy or if the recipient is medically needy and the low vision aid has been one of the following...”) |
| 1123.56(c) | Vision aids. (“Payment for eye prostheses will be made only if the recipient is categorically needy.”) |
| 1123.57(a) and (b) | Hearing aids. (Relating to payment for hearing aids only if recipient is 20 years of age or younger and have been prescribed through the EPSDT program, and for repairs to hearing aids owned by the recipient when the invoice is accompanied by an itemized statement.) |
| 1123.58(1) and (2) | Prostheses and orthoses. |
| 1123.60(a) through (i) | Limitations on payments. |
| 1123.61 (1) through (8) and (10) | Noncompensable services and items. (Relating to when payment will not be made. (9) is not excluded, as it relates to items prescribed or ordered by a practitioner who has been barred or suspended during an administrative action from participation in the MA Program.) |
| 1123.62 | Method of payment. |
| **Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-86-02, Durable Medical Equipment Warranties.** | |
| **Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 05-87-02, Coverage of Motorized Wheelchairs, with the following exceptions:**<br>**- requiring Prior Authorization at the State level.**<br>**- Page 2, number 7.** | |
| **Managed care organizations are to adhere to the provisions of Medical Assistance Bulletin 1123-91-01, EPSDT – OBRA ’89 with the following exceptions:**<br>**- Page 3 – Vision Services – the “age of 21” and the MA fee schedule do not apply.**<br>**- Page 3 – Dental Services – the “age of 21” and the MA fee schedule do not apply.**<br>**- Page 3 – Hearing Services – the “age of 21” and the MA fee schedule do not apply.**<br>**- Page 3 – “and use of existing Medical Assistance Program Fee Schedule”** | |
| **Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-85-02, Policy Clarification for Services Provided to Hospitalized Recipients Under the DRG Payment System.** | |
| **Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1126, Ambulatory Surgical Center and Hospital Short Procedure Unit Services, with the following exceptions:** | |
| 1126.51(f) through (h) and (k) through (m) | Payment for Same Day Surgical Services. General payment policy. ((f-h)Relating to submission of invoices to the Department, consideration if ASC or SPU has fee schedule based on patient's ability to pay that the Department will consider it as the usual and customary charge, and the Department's payment being the lesser of the facility's charge to general public to be the most frequent charge to the self-paying public for the same service.) and (k-m relating to payment when patient in conjunction with same day service are transferred to a hospital due to complications and when patients due to complications must be transferred to inpatient hospital care) |
| 1126.52(a) and (b) | Payment criteria. (Relating to the Department's maximum reimbursement and developed fees.) |
| 1126.53(b) | Limitations on covered procedures. (Relating to limits for appropriate same day surgical procedures for same day surgery but are not yet included in the established list of covered ASC/SPU services.) |
| 1126.54(a)(7) | Procedures and medical care performed in connection with sex reassignment. As directed in MAB 99-16-11, this is inconsistent with the Federal Final Rule, “Nondiscrimination in Health Programs and Activities”, and will no longer be applied. |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1126.54(a)(11) through (13) and (b) | Noncompensable services and items. ("...The Department does not pay ASCs and SPUs for services directly or indirectly related to, or in conjunction with...diagnostic tests and procedures that can be performed in a clinic or practitioner's office and diagnostic tests and procedures not related to the diagnosis"; "Services and items for which full payment equal to or in excess of the MA fee is available through Medicare or other financial resources or other health insurance programs"; "Services and items not ordinarily provided to the general public"; and "...if the admission to the ASC or SPU is not certified under the Department's utilization review process applicable to the type of provider furnishing the service".) |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1127, Birth Center Services, with the following exceptions:** | |
| 1127.51(d) | Payment for Birth Center Services. General payment policy. ("Claims shall be submitted to the Department under the provider handbook.") |
| 1127.52(a) through (c) | Payment criteria. (Relating to the Department's establishment of maximum reimbursement fees and payment methodology) |
| 1127.52(d) "The birth center visit fee shall be the amount equal to that of the midwives' or physicians' visit fee under the MA Program fee schedule." | Payment criteria. (Relating to termination of birth center services during prenatal care) |
| 1127.52(e) "The amount of the payment is 50% of the third trimester rate of payment." | Payment criteria (to payment if complications develop during labor and patient is transferred to a hospital) |
| 1127.53(c) | Limitations on payment. |
| **Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1128, Renal Dialysis Facilities, with the following exceptions:** | |
| 1128.51(a) "and the MA Program fee schedule" | Payment for Renal Dialysis Services. General payment policy. |
| 1128.51(b) | General payment policy. ("A fee determined by the Department is paid for support services provided to an eligible recipient during the course of a dialysis procedure." |
| 1128.51(c) "and for billings" | General payment policy. ("The dialysis facility is considered the provider regardless of whether the facility is operated directly by the enrolled provider or through contract between the provider and other organizations or individuals. The enrolled provider is responsible for the delivery of the service and for billings.") |
| 1128.51(d) "up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee" | General payment policy. ("The Department will pay for the unsatisfied portion of the Medicare deductible and remaining 20% coinsurance up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee.") |
| 1128.51(f) through (i), (k) and (l) | General payment policy. (Relating to what is included in the fee paid to the facility, procedures fees are applicable to, Department's consideration of provider's usual and customary charge if facility has a fee schedule based on patient's ability to pay, and the Department's payment for dialysis services shall be considered payment in full.) |
| 1128.51(m) "Payment shall be made in accordance with §1128.52 (relating to payment criteria)." | General payment policy. ("If a dialysis facility voluntarily terminates the provider agreement, payment is made for services provided prior to the effective date of the termination of the provider agreement. Payment shall be made in accordance with §1128.52 (relating to payment criteria).") |
| 1128.51(n) | General payment policy. (Relating to payment to out-of-State dialysis facility.) |
| 1128.52 | Payment criteria. |
| 1128.53(a) through (e) | Limitations on payment. |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1128.53(f) "Payment for backup visits to the facility is limited to no more than 15 in one calendar year" | Limitations on payment. |
| 1128.53(g) | Limitations on payment. (Relating to payment for nonexpendable equipment or installation of equipment necessary for home dialysis) |
| 1128.54(1) | Noncompensable services and items. ("The Department does not pay dialysis facilities for: (1) Services that do not conform to this chapter.") |
| 1128.54(4) through (7) | Noncompensable services and items. (Relating to Diagnostic or therapeutic procedures solely for experimental, research or educational purposes; procedures not listed in the MA Program fee schedule; services that are not medically necessary; and services provided to recipients who are hospital inpatients.) |
| **Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1129, Rural Health Clinic Services, with the following exceptions:** | |
| 1129.51(b) and (c) | Payment for Rural Health Clinic Services. General payment policy. (Relating to payment for rural health clinic services made on the basis of an all-inclusive visit fee established by the Medicare carrier. When the cost for a service provided by the clinic is included in the established visit fee, the practitioner rendering the service shall not bill the MA Program for it separately; and adjustment to the all-inclusive visit fee when Medicare determines the difference between the total payment due and the total payment made. The Department will make a lump sum payment for the amount due.) |
| 1129.52 | Payment policy for provider rural health clinics. |
| 1129.53 | Payment policy for independent rural health clinics. |
| **Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1130, Hospice Services, with the following exceptions:** | |
| 1130.22(4) "…Department's…specified in Appendix A." ***Note: The provider must have a Certification of Terminal Illness form containing the information found in Appendix A. The provider is not required to use the Department's Certification of Terminal Illness form.*** | Duration of coverage. Certification form. (Relating to certification of terminal illness carried out using the Department's certification of terminal illness form.) |
| 1130.41(a) "…specified in Appendix B." ***NOTE: The provider must have an Election statement containing the information found in Appendix B. The provider is not required to use the Department's Election statement.*** | Election of hospice care. Election statement. (Relating to filing of the Election statement by the recipient or recipient's representative.) |
| 1130.41(c) "specified in Appendix C." ***Note: The provider must have a Change of Hospice statement containing the information found in Appendix C. The provider is not required to use the Department's Change of Hospice statement.*** | Election of hospice care. Change of designated hospice. (Relating to the ability to the ability to change hospices once in each certification period.) |
| 1130.42(a) "specified in Appendix D." ***Note: The provider must have a Revocation statement containing the information found in Appendix D. The provider is not required to use the Department's Revocation statement.*** | Revocation of hospice care. Right to revoke. (Relating to the ability of the recipient or recipient's representative to revoke the election of hospice care at any time utilizing the revocation statement.) |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1130.63(b) | Limitations on coverage. (Relating to Respite care not exceeding a total of 5 days in a 60 day certification period.) |
| 1130.63(c) "…but it is not reimbursable." | Limitations on coverage. (Relating to Bereavement counseling being a required hospice service but it is not reimbursable.) |
| 1130.63(d) "…participating in the MA Program." | Limitations on coverage. (Relating to general inpatient care being provided in a general hospital, skilled nursing facility or a freestanding hospice participating in the MA Program.) |
| 1130.63(e) | Limitations on coverage. (Relating to intermediate care facilities may only provide respite services to the hospice. Eligible MA recipients residing in an intermediate care facility may elect to receive care from a participating hospice.) |
| 1130.71(c) through (h) | Payment for Hospice Care. General payment policy. (Relating to days not covered by valid certification, limitations on inpatient respite care to 5 days in a 60 day certification period; payment limitation for general inpatient care, if lesser care was provided; no MA payments will be made directly to nursing facility for services provided to a recipient under the care of a hospice; ambulance transportation inclusion in daily rates; and the Department's reduction in payment for hospice care by the amount of income available from the recipient towards the hospice care rate established by the Department.) |
| 1130.72. | Payment for physicians' services. (Relating to the services performed by hospice physicians that are included in the level of care rates paid for a day of hospice care." |
| 1130.73. | Additional payment for nursing facility residents. (Relating to additional payments made to a hospice for hospice care furnished to an MA recipient who is a resident of a skilled or intermediate care facility – taking into account the cost of room and board and how room and board rates will be calculated.) |
| **Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1140, Healthy Beginnings Plus Program, with the following exceptions:** | |
| 1140.52(2) "…billed to the Department…" | Payment for HBP Services. Payment Conditions. |
| 1140.53 | Limitations on Payment. (Relating to payment for the trimester component including all prenatal visits during the trimester; qualified providers may bill for either high risk maternity care package OR the basic maternity care package for each trimester; and the fee for the applicable trimester maternity care package includes payment to the practitioner performing the delivery and postpartum care.) |
| 1140.54(1) | Noncompensable services and items. |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1141, Physicians' Services, with the following exceptions:** | |
| 1141.53(a) through (c) | Payment conditions for outpatient services. (Relating to payment made in an approved SPU only if the service could not appropriately and safely be performed in the physician's office, clinic or ER of a hospital; prior authorization requirements for specialists' examinations and consultations; and services provided to recipients in skilled and intermediate care facilities by the physician administrator or medical director.) |
| 1141.53(f) and (g) | Payment conditions for outpatient services. (Relating to all covered outpatient physicians' services billed to the Department shall be performed by such physician personally or by a registered nurse, physician's assistant, or a midwife under the physician's direct supervision; and payment by the Department of a $10 per month fee to physicians who are approved by the Department to participate in the restricted recipient program.) |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1141.54(a)(1) through (3) | Payment conditions for inpatient services. (Relating to when a physician is eligible to bill the Department for services provided to a hospitalized recipient.) |
| 1141.54(f) | Payment conditions for inpatient services. (Relating to inpatient physicians' services billed to the Department shall be performed by the physician, an RN, PA or midwife under the physician's direct supervision.) |
| 1141.55(b)(1) "MA 31"; "in accordance with all instructions in the Provider Handbook"; and "See Appendix A for a facsimile of the Consent Form and the Provider Handbook for detailed instructions on its completion." ***NOTE: A consent form is required and must contain all the information found in Appendix A.*** | Payment conditions for sterilizations. (Relating to consent requirements and use of the MA31 Consent Form.) |
| 1141.55(c) "MA 31"<br><br>1141.55(c)(2) "in accordance with instructions in the Provider Handbook"<br><br>1141.55(c)(3) "in accordance with instructions in the Provider Handbook" | Payment conditions for sterilizations. ("A Consent Form, MA 31, is considered to be completed correctly only if all of the following requirements are met:")<br><br>Payment conditions for sterilizations. ("The person obtaining informed consent has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given."<br><br>Payment conditions for sterilizations. ("Any other witness or interpreter has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given.") |
| 1141.56(a)(3) "See the Provider Handbook for a facsimile of the Patient Acknowledgement Form for Hysterectomy, MA 30, and for instructions on its completion." | Payment conditions for hysterectomies. (Relating to Patient Acknowledgement Form for Hysterectomy MA 30) |
| 1141.57(a)(1) "Where a physician has certified in writing and documented in the patient's record that the life of the woman would be endangered if the pregnancy were allowed to progress to term. The decision as to whether the woman's life is endangered is a medical judgment to be made by the woman's physician. | Payment conditions for a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed. |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1141.57(a)(2) "and the incident was reported to a law enforcement agency or to a public health service within 72 hours of its occurrence in the case of rape and within 72 hours of the time the physician notified the patient that she was pregnant in the case of incest. A law enforcement agency means an agency or part of an agency that is responsible for the enforcement of the criminal laws, such as a local police department or sheriff's office. A public health service means an agency of the Federal, State, or local government or a facility certified by the Federal government as a Rural Health Clinic that provides health or medical services except for those agencies whose principal function is the performance of abortions." | Payment conditions for necessary abortions (Where the recipient was the victim of rape or incest) |
| 1141.57(a)(2)(i) "with the Medical Services Invoice along with documentation signed by an official of the law enforcement agency or public health service to which the rape or incest was reported. The documentation shall include the following":<br><br>1141.57(a)(2)(i)(A) and (B) | Payment conditions for necessary abortions (Payment will be made only if a licensed physician submits a signed ''Physician Certification for an Abortion'' form, as set forth in Appendix B,)<br><br>(A) All of the information specified in subparagraph (ii).<br><br>(B) A statement that the report was signed by the person making the report. |
| 1141.57(a)(2)(ii)(A) through (D) | Payment conditions for necessary abortions (report of rape or incest) |
| 1141.57(c) | Abortions after the first 12 weeks |
| 1141.59(1) through (5) | Payment for Physician Services, Noncompensable services, Procedures not listed in the Medical Assistance program fee schedule. Medical services or surgical procedures performed on an inpatient basis that could have been performed in the physician's office, the clinic, the emergency room, or a short procedure unit without endangering the life or health of the patient, Medical or surgical procedures designated in the Medical Assistance program fee schedule as outpatient procedures, Dental rehabilitation and restorative services, Diagnostic tests, for which a patient was admitted, that may be performed on an outpatient basis; tests not related to the diagnosis and treatment of the illness for which the patient was admitted; tests for which there is no medical justification. |
| 1141.59(7) and (8) | Payment for Physician Services, Noncompensable services, Hysterectomy performed solely for the purpose of rendering an individual incapable of reproducing, Acupuncture, medically unnecessary surgery, insertion of penile prosthesis, gastroplasty for morbid obesity, gastric stapling or ileo-jejunal shunt—except when all other types of treatment of morbid obesity have failed— |
| 1141.59(10) and (11) | Services to inpatients who no longer require acute inpatient care and surgical procedures and medical care provided in connection with sex reassignment. |
| 1141.59 (14) through (16) | Diagnostic pathological examinations of body fluids or tissues, Services and procedures related to the delivery within the antepartum period and postpartum period, Medical services or surgical procedures performed in a short procedure unit that could have been appropriately and safely performed in the physician's office, the clinic, or the emergency room without endangering the life or health of the patient. |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1141.60 | Payment for medications dispensed or ordered in the course of an office visit. |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1142, Midwives' Services, with the following exceptions:** | |
| 1142.51 "and the MA payment fee schedule" | General payment policy for Midwife services |
| 1142.52(2) "billed to the Department" | General payment policy for Midwife services |
| 1142.55(1) through (4) | Noncompensable Midwife services. Procedures not listed in the fee schedule in the MA Program fee schedule, More than 12 midwife visits per recipient per 365 days. Services and procedures furnished by the midwife for which payment is made to an enrolled physician, rural health clinic, hospital or independent medical clinic. Services and procedures for which payment is available through other public agencies or private insurance plans as described in § 1101.64 (relating to third party medical resources (TPR)). |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1143, Podiatrists' Services, with the following exceptions:** | |
| 1143.2 Definition of "Medically-necessary" | A term used to describe those medical conditions for which treatment is necessary, as determined by the Department, and which are compensable under the MA Program. |
| 1143.2 Definition of "Non-emergency medical services." | A compensable podiatrists' service provided for conditions not requiring immediate medical intervention in order to sustain the life of the person or to prevent damage to health. |
| 1143.51 "and the MA Program fee schedule" and "as specified in §1101.62(relating to maximum fees)." | General Payment Policy |
| 1143.53 | Payment conditions for outpatient services. |
| 1143.54 | Payment conditions for inpatient hospital services. |
| 1143.55(1),(2) and (4) | Payment conditions for diagnostic X-ray services performed in the podiatrist's office. |
| 1143.56 | Payment conditions for orthopedic shoes, molded shoes and shoe inserts (enrolled medical suppliers). Refers to 1123.54 |
| 1143.57 | Limitations on payment for podiatrist visits and x-rays. |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
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| 1143.58(a)(1) through (12) | Noncompensable services and items for podiatry services. (1) Services and items not listed in the MA Program fee schedule. (2) Fabricating or dispensing orthopedic shoes, shoe inserts and other supportive devices for the feet. (3) Casting for shoe inserts. (4) Medical services or surgical procedures performed on an inpatient basis that could have been performed in the podiatrist's office, the emergency room, or a short procedure unit without endangering the life or health of the patient. (5) Medical or surgical procedures designated in the fee schedule in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule as outpatient procedures. (6) Medical services or surgical procedures performed on an inpatient basis if the Department denies payment to the hospital for the days during which the podiatrist's care is rendered. (7) Services rendered in the emergency room of a hospital if the recipient is admitted to the hospital as an inpatient on the same day or the service is a nonemergency medical service. (8) Treatment of flat foot. (9) Treatment of subluxations of the foot. (10) Routine foot care, including the cutting or removal of corns, callouses, the trimming of nails and other routine hygienic care. (11) Physical therapy. (12) Diagnostic or therapeutic procedures for experimental, research or educational purposes. |
| 1143.58(a)(13) "as specified in § 1101.62 (relating to maximum fees)" | Compensable podiatrist services if full payment is available from another agency, insurance or health program. |
| 1143.58(b) | Noncompensable services and items. Payment is not made for sneakers, sandals etc., even if prescribed by a podiatrist. |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1144, Certified Registered Nurse Practitioner Services, with the following exceptions:** | |
| 1144.42(b) "to the Department" | Ongoing responsibilities of providers |
| 1144.52(1)<br><br>1144.52(2) "billed to the Department"<br><br>1144.52(3) | Payment conditions for CRNP services. CRNP employee<br><br>Payment conditions for CRNP services. CRNP employee<br><br>Payment conditions for CRNP services. CRNP employee |
| 1144.53(1), (2), and (4) | Noncompensable services. Procedures not listed in the MA Program fee schedule. Services and procedures furnished by the CRNP for which payment is made to an enrolled medical service provider or practitioner. The same service and procedure furnished to the same recipient by a CRNP and physician. |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1145, Chiropractor's Services, with the following exceptions:** | |
| 1145.11 | Types of services covered. Evaluation by means of examination. Treatment by means of manual manipulation of the spine. |
| 1145.12 | Services are covered when rendered in the chiropractors' office, the home of the patient or in a skilled nursing or intermediate care facility. |
| 1145.13 | Chiropractors' services are not covered when rendered in a location in a hospital. |
| 1145.14 | Payment will not be made for treatment other than manipulation of the spine, physical therapy, traction, physical examinations, and consultations. |
| 1145.51 "and the MA Program fee schedule" and "Chiropractors' services shall be billed in the name of the chiropractor providing the services." | Payment policy for chiropractor services. |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
|---|---|
| 1145.54 | Noncompensable services. Payment will not be made to a chiropractor for 1) Orthotics, 2) Prosthetics, 3) Medical supplies, 4) X-rays, 5) Services not included in Chapter 1150 |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1147, Optometrists' Services, with the following exceptions:** | |
| 1147.2 Delete the following portion included in the definition of eyeglasses: "untinted." | Definitions - *Eyeglasses*—A pair of untinted prescription lenses and a frame. |
| 1147.12 "Outpatient optometric services are compensable when provided in the optometrist's office, the office of another optometrist during the other optometrist's temporary absence from practice, a hospital, a nursing home or in the patient's home when the patient is physically incapable of coming to the optometrist's office." "and the MA Program Fee Schedule" | Outpatient services |
| 1147.13 "and the MA Program Fee Schedule" | Inpatient services |
| 1147.14(1) | Non-covered services: Orthoptic training. |
| 1147.21 "They are not eligible for eyeglasses unless they are 20 years of age or younger and the eyeglasses have been: "<br><br>1147.21(1) through (3) | Scope of benefits for the categorically needy: eyeglasses.<br><br>Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program. |
| 1147.22 "They are not eligible for eyeglasses, low vision aids or prostheses unless they are 20 years of age or younger and the eyeglasses, low vision aids or prostheses have been:"<br><br>1147.22 (1) through (3) | Scope of benefits for the medically needy: eyeglasses.<br><br>Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program. |
| 1147.23 "only" and "They are not eligible for eyeglasses, low vision aids or eye prostheses. However, State Blind Pension recipients are eligible for eye prostheses if they are also categorically needy." | Scope of benefits for State Blind pension recipients. |
| 1147.51 "and §§ 1147.53 and 1147.54 (relating to limitations on payment; and noncompensable services and items)" and "and the MA Program fee schedule" and "Optometric services shall be billed in the name of the optometrist providing the service." | General payment policy for optometric services |
| 1147.53 | Limitations on payments for optometric services |
| 1147.54 | Noncompensable optometric services and items |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1149, Dentists' Services, with the following exceptions:** | |
| 1149.1 "and the MA Program Fee Schedule" | Dental services general policy |
| 1149.43(6) | Radiographs are requested by the Department for prior authorization purposes |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
|---|---|
| 1149.43(9) through (11) | Pathology reports are required for surgical excision services. Pre-operative X-rays are required for surgical services. Postoperative X-rays are required for endodontic procedures. |
| 1149.51 "and the MA Program Fee Schedule" and “The following payment policies are applicable for dental services:” | General payment policy for dental services |
| 1149.51(1) and (2) | General payment policy for dental services |
| 1149.52 | Payment conditions for various dental services |
| 1149.54 "and the MA Program Fee Schedule"<br>1149.54 (1) through (7)<br>1149.54(10) | Payment policies for orthodontic services |
| 1149.55(1)<br>1149.55(5) through (8) | Payment conditions for orthodontic services |
| 1149.56 | Payment limitations for orthodontic services |
| 1149.57 | Noncompensable dental services and items |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1150, MA Program Payment Policies, with the following exceptions:** | |
| 1150.2 Definitions of PSR and Second Opinion program | Definitions |
| 1150.51(a) "Payment will be made to providers. Payment may be made to practitioners' professional corporations or partnerships if the professional corporation or partnership is composed of like practitioners. Payment will be made directly to practitioners if they are members of professional corporations or partnerships composed of unlike practitioners. Practitioners who render services at eligible provider hospitals, either through direct employment or through contract, may direct that payment be made to the eligible provider hospital." **and** "Payment will not be made for services that are not medically necessary."<br><br>1150.51(b)<br><br>1150.51(c) “facilities and practitioners rendering services which require a PSR or second opinion, or both” and “funeral directors”<br><br>1150.51(d) “which is contained in the Provider’s Handbook” and the following”<br><br>1150.51(d)(1) “all-inclusive”<br><br>1150.51(d) (2) through (8)<br><br>1150.51(e) through (h) | General MA Program Payment policies |
| 1150.52 | Payment for Anesthesia services |
| 1150.54 | Payment for Surgical Services |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
|---|---|
| 1150.55 | Payment for Obstetrical Services |
| 1150.56 | Payment for Medical Services |
| 1150.56a | Payment Policy for Consultations |
| 1150.56b | Payment Policy for Observation Services |
| 1150.57 | Payment for Diagnostic Services and Radiation Therapy |
| 1150.58 | Prior authorization for services in the MA Program Fee Schedule |
| 1150.59 | PSR Program |
| 1150.60 | Second Opinion Program |
| 1150.61 | Guidelines for Fee Schedule changes |
| 1150.62 | Payment levels and notice of rate setting changes |
| 1150.63<br><br>1150.63(a) Delete the word “Department”<br><br>1150.63(b) Delete the word “Department”. Also delete in second sentence “the practitioner may either …by mail.”<br><br>1150.63(c) Delete the first two sentences: The CAO shall …consultants. The office of MA…decision.”<br><br>1150.63(d)Delete the word “Department” | Waiver of General Payment Policies. The plan must adhere to the following section, except: |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1151, Inpatient Psychiatric Services, with the following exceptions:** | |
| 1151.34 | Inpatient Psychiatric Services, Provider Participation, Changes of ownership or control |
| 1151.41(b) | Payment for inpatient psychiatric services, Readmission within 24 hours after discharge |
| 1151.41(c) (1) and (2) | Payment for Inpatient Psychiatric Services, Admitted and discharged the same calendar day |
| 1151.41(d), (i) and (j) | Payment for Preadmission diagnostics, transfer to another facility due to strike, payment for studies related to the patient’s condition not preprinted regimen. |
| 1151.42 (a), (c) and (d) | Payment methods and rates |
| 1151.43(a) and (b) | Limitations on payments |
| 1151.45(2) and (3) | Nonallowable costs, costs related to a noncompensable item, costs related to preadmission diagnostics |
| 1151.46 | Payment rate calculations for FY 1993-94 and 1994 - 95 |
| 1151.48(a)(2)through (6), (9) through (16) and (18) through (20) | Noncompensable services and items, experimental procedures and services, inpatient treatment for diagnostic testing that could be done as outpatient, inpatient care if payment is available from another source, services not normally provided to the public, methadone maintenance, days of inpatient care that the patient was absent due to training, meetings or conferences, unnecessary inpatient care, and days of care that are not certified or failure to apply for a court-ordered commitment. |
| 1151.52 | Payment for capital costs not included in the base year |
| 1151.53 | Billing requirements for inpatient psychiatric services |
| 1151.54 | Disproportionate share payments |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1153, Outpatient Psychiatric Services, with the following exceptions:** | |
| 1153.1 “and the MA Program fee schedule” | Outpatient psychiatric services, general policy |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
|---|---|
| 1153.2 Psychiatric outpatient clinic services -- "listed in the MA Program Fee Schedule" | Definitions |
| 1153.2 Psychiatric partial hospitalization -- "listed in the MA Program Fee Schedule" and "and a maximum of six hours in a 24 hour period" | Definitions |
| 1153.11 "as specified in the MA Program Fee Schedule" | Types of Outpatient Psychiatric Services |
| 1153.12 "specified in the MA Program Fee Schedule" | Coverage of outpatient Psychiatric services |
| 1153.14(2), (3), (9) and(13) | Noncovered services: cancelled appointments, covered services not rendered, Psychiatric outpatient clinic services and psychiatric partial hospitalization provided on the same day to the same patient, and Services not specifically included in the MA Program Fee Schedule |
| 1153.21 "in the MA Program Fee Schedule" | Scope of benefits for the categorically needy |
| 1153.22 "in the MA Program Fee Schedule" | Scope of benefits for the medically needy |
| 1153.23 "in the MA Program Fee Schedule" | Scope of benefits for State Blind Pension recipients |
| 1153.51 "and the MA Program Fee Schedule" | Payment for Outpatient Psychiatric clinic and partial hospitalization |
| 1153.52(a)(2) "Separate billings for these additional services are not compensable." | Additional interviews with other staff may be included as part of the examination but shall be included in the psychiatric evaluation fee. |
| 1153.52(d) "listed in the MA Program Fee Schedule" | Psychiatric clinic services provided in the home. |
| 1153.53 | Limitations on payments |
| 1153.53a | Request for waiver of hourly limits |
| 1153.54 | Noncompensable services and items |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
|---|---|
| **Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 1157-95-01 Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children Under 21 Years of Age with the following exceptions:**<br>• Page 2, A. 2. c.<br>• Page 3, A. 4.<br>• Page 3, Section B.<br>• Page 3, C. "To receive MA reimbursement,"<br>• Page 3, D. 1.<br>• Page 3, D. 2. "Payment will be made only for services prior approved by OMAP."<br>• Pages 5-7 Sections A and B.<br>• Attachment 2, 3.e.; 4.b.; and 4.e.<br>• Attachment 5<br>• Attachment 6<br>• Attachment 7<br>• Attachment 8<br>• Attachment 9<br>• Attachment 11 | |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1163, Inpatient Hospital Services, Subchapter A, Acute Care General Hospitals Under the Prospective Payment System, with the following exceptions:** | |
| 1163.32 | Hospital Units excluded from the DRG prospective payment system |
| 1163.41 | General participation requirements for general hospitals and out of state hospitals for Commonwealth recipients |
| 1163.51 (a) through (s) | General payment policy for hospital services |
| 1163.52 through 1163.59 | Prospective payment methodology, assignment of DRG, prospective capital reimbursement system, payments for direct medical education, outliers, payment policy for readmissions and transfers, and noncompensable services and items and outlier days. |
| 1163.60(b)(1) “in accordance with the instructions in the Provider Handbook”. | Informed consent for voluntary sterilization |
| 1163.60(c)(2) “in accordance with the instructions in the Provider Handbook”. | The person obtaining informed consent signs and dates the form on same day informed consent was obtained. |
| 1163.60(c)(3) “in accordance with the instructions in the Provider Handbook”. | Another witness or interpreter must sign the consent form. |
| 1163.62 (a) (2) through 1163.65 | Payment conditions for abortions if the recipient was a victim of rape or incest, billing, cost reports and payment for out of state services. |
| 1163.67 | Disproportionate share payments |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
|---|---|
| 1163.70 through 1163.71 | Changes of ownership or control and scope of utilization review process |
| 1163.72 (a), (c) through (g) | General utilization review, admissions, day and cost outliers. |
| 1163.73 through 1163.75 (6) and (8) through (12) | Hospital utilization review plan, requirements for hospital utilization review committees, and responsibilities for hospital utilization review committees. |
| 1163.76 through 1163.77 | Written plan of care within 2 days of admission and Admission review requirements within 24 hours of admission |
| 1163.78a and 1163.78b | Review requirements for day outliers and cost outliers |
| 1163.92 (a) through (f) | Administrative sanctions |
| 1163.122 | Determination of DRG relative values |
| 1163.126 | Computation of hospital specific computation rates |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1163, Inpatient Hospital Services, Subchapter B, Hospitals and Hospital Units Under Cost Reimbursement Principles, with the following exceptions:** | |
| 1163.402 Definition of “certified day” | Definitions |
| 1163.451 (a) through (g), (i), (k) through (o) | General payment policy |
| 1163.452 | Payment methods and rates |
| 1163.453 (a) and (c) | Allowable and nonallowable costs, allowable costs for inpatient services, payment not higher than hospital’s customary charge |
| 1163.453 (d) (2) through (9) | Costs not allowable under the MA Program |
| 1163.453 (e) and (f) | Allowable costs |
| 1163.454 | Limitations on payment |
| 1163.455 (a)(1) through (5) and (7) through (16) | Noncompensable inpatient services |
| 1163.455 (b) and (c) | Noncompensable inpatient services |
| 1163.457 | Payment policies relating to out of state hospitals |
| 1163.458 | Payment policies relating to same calendar day admissions and discharges |
| 1163.459 | Disproportionate share payments |
| 1163.481(b) and (c) | Utilization review sanctions |
| 1163.511 | Change of ownership or control |
| **Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 1165-93-07 Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age with the following exceptions:**<br>• Page 1 - Beginning with the second sentence "The procedures described in this Bulletin apply to every child." up to “A separate bulletin will describe the procedures necessary to seek reimbursement for other mental health services not on the Medical Assistance Fee Schedule.”<br>• Page 2, Section A.4.<br>• Pages 3 - 4, Sections C through E<br>• Attachment 6<br>• Attachment 7<br>• Attachment 8<br>• Attachment 9 | |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
|---|---|
| **Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 1165-95-01 Update JCAHO-Accredited RTF Services with the following exceptions:**<br>• Page 2 - The two paragraphs following item c. "If a child is admitted . . . alternative to RTF."<br>• Page 2 - The third complete paragraph, "All admissions are subject," through the end of 3.<br>• Page 3, number 4. | |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions:** | |
| 1221.43 through 1221.45 | Participation requirements for hospital clinics and emergency rooms for higher reimbursement rate, additional participation requirements for independent clinics, and additional participation requirements for medical school clinics. |
| 1221.51 and 1221.52 | General payment policy for clinic and emergency room services and payment conditions for various services. |
| 1221.55 (b) (1). NOTE: A consent form is required and must contain all of the information found in Appendix A to 55 PA Code Chapter 1141 | Voluntary informed consent for sterilizations |
| 1221.57(a) (2) and 1221.57(c). NOTE: PH-MCO must comply with MA Bulletin 99-95-09 | Payment conditions for necessary abortions for victims of rape or incest |
| 1221.58 and 1221.59 | Limitations on payments and noncompensable services and items |
| **Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletins related to 55 PA Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions:**<br>• 11-95-04<br>• 11-95-10<br>• 11-95-12 | |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1223, Outpatient Drug and Alcohol Clinic Services, with the following exceptions:** | |
| 1223.1 “and the MA fee schedule” | Payment for specific medically necessary outpatient drug and alcohol clinic services rendered to eligible recipients by drug/alcohol outpatient clinics. |
| 1223.11 “as specified in the fee schedule in the Medical Assistance program fee schedule” | Medical Assistance Program coverage for outpatient drug/alcohol clinics is limited to professional medical and psychiatric services. |
| 1223.12 "specified in the Medical Assistance program fee schedule"; "and the Medical Assistance program fee schedule"; and "fee for service" | Outpatient drug and alcohol clinic services |
| 1223.14 (3) and (4) | Noncovered services: Cancelled appointments and Covered services that have not been rendered. |
| 1223.14(6) “and the Medical Assistance program fee schedule” | Noncovered services: Vocational rehabilitation; day care; drug/alcohol or mental health partial hospitalization; reentry programs, occupational or recreational therapy; Driving While Intoxicated (DWI) or Driving Under the Influence Programs or Schools; referral, information or education services; experimental services; training; administration; follow-up or aftercare; program evaluation; case management; central intake or records; shelter services; research; drop-in, hot-line or social services; inpatient nonhospital or occupational program services, or any other service or program not specifically identified as a covered service in Chapter 1150. |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
|---|---|
| 1223.14 (8) and (9) | Drug/alcohol outpatient clinic services provided to residents of treatment institutions. outpatient clinic services provided to residents of inpatient nonhospital and shelter facilities. outpatient clinic services provided to patients receiving psychiatric partial hospitalization services or drug/alcohol partial hospitalization services |
| 1223.14(14) | Methadone maintenance clinic services provided before the date of the physician's comprehensive medical examination, diagnosis and treatment plan. |
| 1223.21 "in the MA Program fee schedule" | Scope of services for the categorically needy |
| 1223.22 "in the MA Program fee schedule" | Scope of services for the medically needy |
| 1223.23 "in the MA Program fee schedule" | Scope of services for State Blind Pension recipients |
| 1223.51 "and the Medical Assistance program fee schedule" | General payment policy for outpatient drug/alcohol clinic services |
| 1223.52(a)(2) and (a)(3) "Separate billings for these interviews are not compensable." | Additional interviews with other staff |
| 1223.52(a)(5) "listed in the Medical Assistance Program Fee Schedule" | Diagnostic psychological services |
| 1223.52(c) "Separate billings for these interviews are not compensable." | Interviews or consultations with family members alone, without the presence of the family member with a drug/alcohol abuse or dependence problem, are considered to be part of the family psychotherapy fee. |
| 1223.53 | Limitations on Payment for outpatient drug and alcohol clinic services |
| 1223.54(2) "and the Medical Assistance program fee schedule" | Items and services not listed as compensable in Chapter 1150 |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1225, Family Planning Clinic Services, with the following exceptions:** | |
| 1225.1 "and the MA Program fee schedule" | General provisions |
| 1225.51"and the MA Program fee schedule" | General payment policy |
| 1225.54(2) | Noncompensable family planning services |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1229, Health Maintenance Organizations Services, with the following exceptions:** | |
| NONE | |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1230, Portable X-Ray Services, with the following exceptions:** | |
| 1230.1 "and the MA Program fee schedule" | General provisions |
| 1230.51 "and the MA fee schedule" | General payment policy for portable x-ray services |
| 1230.52(b) "and the MA Program fee schedule" | Payment for transporting portable X-ray equipment from the provider's office to the place of service |
| 1230.53 (a) through (c) | Portable x-ray services, provider maximum payment, payment for transportation of portable x-ray equipment and electrocardiogram services |
| 1230.54 (1) | Noncompensable services, procedures not listed in the MA Program fee schedule |
| **Managed care organizations are to adhere to the requirements of Medical Assistance Bulletin 99-94-08 (relating to 55 Pa. Code Chapter 1239, Medical Case Management), Medical Assistance Case Management Services for Recipients Under the Age of 21, with the following exceptions:**<br>• Discussion<br>• Page 2, paragraph 3 "The OMAP reserves the right to limit the number of recipients in a case manager's caseload."<br>• Page 3, Payment for case management services covered by this bulletin, 1 through 3 and 4 c through f. | |

| CITATION/SPECIFIC EXCLUSION | REGULATORY LANGUAGE DESCRIPTION |
|---|---|
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1241, Early and Periodic Screening, Diagnosis and Treatment Program, with the following exceptions:** | |
| 1241.2 Definition of "Administrative contractors" | Definitions |
| 1241.42(1) "or to the CAO for supportive help in locating an appropriate provider" | If not licensed or equipped to render the necessary treatment or further diagnosis, the screening provider shall refer the individual to an appropriate enrolled practitioner or facility. |
| 1241.51 | Payment to the provider |
| 1241.53 | Limitations on payments |
| 1241.54 (a) (1) through (5) | Noncompensable services and items |
| 1241.54 (b) (1) through (5) | Noncompensable services and items |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1243, Outpatient Laboratory Services, with the following exceptions:** | |
| 1243.51 "and the MA Program fee schedule" | General payment policy for outpatient laboratory services |
| 1243.52(b) "billed to the Department" | Laboratory services billed to the Department will be based on the written request of the practitioner |
| 1243.53 (a) | The fees listed in the MA Program fee schedule are the maximum allowed |
| 1243.54 (1) and (2) | Noncompensable services |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1245, Ambulance Transportation, with the following exceptions:** | |
| 1245.1 "and the MA Program fee schedule" | General provisions for payment of ambulance transportation to eligible beneficiaries |
| 1245.21 "and the MA Program fee schedule" | Scope of services for the categorically needy |
| 1245.22 "and the MA Program fee schedule" | Scope of services for the medically needy |
| 1245.23 "and the MA Program fee schedule" | Scope of services for State Blind Pension recipients |
| 1245.51 (b) | Ambulance services which obtain Voluntary Ambulance Service Certification (VASC) from the Department of Health will be reimbursed at a higher rate than non-VASC certified services |
| 1245.52(1) | Payment conditions for ambulance transportation, medically necessary |
| 1245.52(3) through (5) | Transportation to the nearest appropriate medical facility and medical services/supplies invoice. |
| 1245.53 | Limitations on payment for ambulance service when more than one patient is transported. Payment is made for transportation of the patient whose destination is the greatest distance. No additional payment is allowed for the additional person. |
| 1245.54(1) through (7) | Noncompensable services and items relating to ambulance transportation. |
| **Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1249, Home Health Agency Services, with the following exceptions:** | |
| 1249.51 "and the MA Program fee schedule" | General payment policy for Home Health Services |
| 1249.55(b) | Payment conditions for medical supplies. Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care services. Payment for these supplies is included in the comprehensive fee. |
| 1249.57 | Payment conditions for maternal/child services |
| 1249.58 | Payment conditions for travel costs |
| 1249.59 | Limitations on payments for home health agency services |

EXHIBIT B(1)

# EXHIBIT B(1)

## MCO PAY FOR PERFORMANCE

This Exhibit B(1) defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® as defined below. This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022. If the PH-MCO 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 Exhibit.

This Exhibit supplements but does not supplant Exhibits that provide for Pay for Performance (P4P) and incorporate different dates in Section II. below.

### I. Quality Performance Measures

For 2022, the Department selected ten (10) HEDIS® and two (2) Pennsylvania Performance Measure (PAPM) as quality indicators (representing MY 2021 data) for the MCO P4P program. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices Program as well as the potential to improve health care for a broad base of the HealthChoices population. The twelve (12) quality indicators are:

HEDIS®

1. Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
2. Controlling High Blood Pressure
3. Prenatal Care in the First Trimester
4. Postpartum Care
5. Well-Child Visits in the First 15 Months
6. Child and Adolescent Well-Care Visits (Total)
7. Annual Dental Visit (Ages 2 – 20 years)
8. Asthma Medication Ratio
9. Lead Screening in Children
10. Plan All Cause Readmissions – Count of Observed 30-Day Readmissions

PAPM

1. Developmental Screening First Three Years of Life
2. Maternal Home Visiting

The MCO P4P Program measures Benchmark Performance and Improvement Performance. The PAPM measure, Developmental Screening First Three Years of Life, will be eligible for a performance goal and an Improvement Performance component. While this measure does not have a national benchmark, the measure value will be calculated the same as HEDIS measures in the benchmark performance, Section I. A., below.

NOTE: The MCO P4P measures are subject to change due to NCQA specifications.

**A. Benchmark Performance***:* The Department will award a Benchmark Performance payout amount for each measure in Section I. that will range from 0% up to and including 125% of the measure's value. The PH-MCO's Maximum Program Payout amount is equivalent to 43% of the sum of the amounts defined in Section II. below divided by twelve (12) (consisting of eleven (11) quality indicators with Annual Dental Visit counted twice). The Department will make Benchmark Performance payouts for performance relative to the HEDIS® MY 2021 benchmarks, for all measures excluding Developmental Screening First Three Years of Life. A goal has been set for Developmental Screening First Three Years of Life (see Section I.A.3.) If the PH-MCO's HEDIS MY 2021 performance rate is below the 50th Percentile Benchmark, the Department will implement a 75% off-set. The Department will distribute the payouts according to the following criteria:

1. 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: No payout.
   - HEDIS® MY 2021 rate below the 50th percentile benchmark: -75 percent offset

2. Annual Dental Visit Performance Only

   - The Benchmark Performance measure value applicable to Annual Dental Visit Performance is equal to double the Benchmark Performance measure value (as identified in Section I.A.).
   - The -50% off-set will be applied to double the Benchmark Performance measure value (as identified in Section I. A.).

3. Developmental Screening First Three Years of Life

   - Performance goal at or above 57.00 percent (57.00%): 100 percent of the measure value.
   - Performance goal below 57.00 percent (57.00%): No payout

4. Benchmark Bonus Bundles: The Department will award a Benchmark Bonus Bundle payment for two groups of measures in the current MCO P4P model. If a bundle payment is earned this payment method will apply in addition to I.A.

The first bundle is the Perinatal and Infant Bundle. The measures in this bundle are:

- Prenatal Care in the First Trimester
- Postpartum Care, and
- Well-Child Visits in the First 15 Months

The second bundle is the Child and Adolescent Well Care Bundle. The measures in this bundle are:

- Child and Adolescent Well Care Visits (Total) and
- Lead Screening in Children

a. Perinatal and Infant Bundle:

- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months is ≥90$^{th}$ percentile benchmark: 130% of the measure value payout for each measure.

- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months is ≥75$^{th}$ percentile benchmark: 115% of the measure value payout for each measure.

- If a rate achieved is ≥50$^{th}$ percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a ≥ 75$^{th}$ percentile benchmark and another measure(s) achieves a ≥90$^{th}$ percentile benchmark, the measure(s) that achieved the ≥75$^{th}$ percentile benchmark will receive 115% of the measure value payout, while the measure(s) that achieved a ≥90$^{th}$ percentile benchmark will receive 130% of the measure value payout.

b. Child and Adolescent Well Care Bundle:

- If the rate for Child and Adolescent Well Care Visits (Total) and Lead Screening in Children are ≥90$^{th}$ percentile benchmark: 130% of the measure value payout will be issued for each measure.

  If the rate for Child and Adolescent Well Care Visits (Total) and Lead Screening in Children are ≥75$^{th}$ percentile benchmark: 115% of the measure value payout will be issued for each measure.

- If the rate achieved for any of the measures is ≥50th percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a ≥ 75th percentile benchmark and another measure(s) achieves a ≥90th percentile benchmark, the measure (s) that achieved the ≥75th percentile benchmark will receive 115% of the measure value payout, while the other measure(s) that achieved a ≥90th percentile benchmark will receive 130% of the measure value payout.

**B. Improvement Performance***:* The Department will award an Improvement Performance payout amount for each measure in Section I. that will range from 0% up to and including 100% of the measure's value. The PH-MCO's Maximum Program Payout amount is equivalent to 43% of the sum of the amounts defined in Section II. below divided by twelve (12) (consisting of eleven (11) unique quality indicators with Annual Dental Visit counted twice).

The improvement performance payout scales will be applied contingent on benchmark percentile performance for each HEDIS MY 2021 measure (see Section I.C.1. and I.C.2.).

- 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 (see Section I.C.2.), Scale 2 will be applied.

Scale 2 applies to improvement performance for the PAPM Developmental Screening the First Three Years of Life. Receiving the Improvement Performance payout is not contingent on meeting the goal of 57.00 percent (57.00%) for Developmental Screening First Three Years of Life.

1. Scale 1:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® MY 2020 (RY 2021) to HEDIS® MY 2021 (RY 2022).

- ≥ 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: 70 percent of the measure value.

- < 3 Percentage Point Improvement: No payout

2. Scale 2:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® MY 2020 (RY 2021) to HEDIS® MY 2021 (RY 2022) and PAPM MY 2020 (RY 2021) to PAPM MY 2021 (RY 2022).

- ≥ 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.

3. Annual Dental Visit Performance Only

The Improvement Performance measure value available for Annual Dental Visit Performance is equal to double the Improvement Performance measure value (identified in Section I.C.).

**C. Health Equity:** The PH-MCO is eligible for a Health Equity Improvement Performance payout for Controlling High Blood Pressure, Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months for their African American population. The PH-MCO's Maximum Program Payout amount is equivalent to 10% of the sum of the amounts defined in Section II. below divided by five (5) unique quality indicators.

Scale 2 (See Section I. B. 2.) applies to improvement performance for the Health Equity quality measures Controlling High Blood Pressure, Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months.

**D. Maternal Home Visiting:** The PH-MCO is eligible for a Home Visiting Performance payout for meeting a set of performance goals. The PH-MCO's

Maximum Program Payout amount is equivalent to 4.0% of the sum of the amounts defined in Section II. below.

- **Tier 1** – Greater than 6 home visits and 8-10 EPSDT visits: 100 percent of the relevant incentive pool
- **Tier 2** – Between 4-6 home visits and 6-7 EPSDT visits: 20 percent of the relevant incentive pool
- **Tier 3** - Less than 4 home visits: No payout

## II. Payment for MCO Pay for Performance

The Department will inform the PH-MCO of the Maximum Program Payout amount by November 30, 2022.
The Maximum Program Payout amount will be equivalent to two (2.0) percent of the sum of the amounts defined below:

Limitation on Payout Amounts

The total awarded payout amount to a PH-MCO, which includes Benchmark Performance (I.A.) and Improvement Performance (I.C.), cannot exceed the Maximum Program Payout amount, as identified in Section II. below.
Capitation Revenue - For the purpose of this Exhibit, Capitation Revenue is defined as all Capitation revenues paid or payable by the Department to the PH-MCO in accordance with this Agreement or another HealthChoices Agreement, Appendix 3b and Appendix 3f, for the program period July 2021 through June 2022 inclusive of allowance amounts for the risk sharing and risk pool arrangements. Any settlements for the risk sharing and risk pool arrangements will not be considered in the Capitation Revenue.

Maternity Care Revenue - For the purpose of this Exhibit, Maternity Care Revenue is defined as all Maternity Care payments, paid or payable by the Department to the PH-MCO in accordance with this Agreement, for the program period July 2021 through June 2022.

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously contracted with the Department to operate a HealthChoices program in the same zone (“Previous PH-MCO”); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will allow the PH-MCO to include Capitation Revenue and Maternity Care Revenue paid to the Previous PH-MCO for the program period July 2021 through June 2022, provided the Previous PH-MCO relinquishes any claims to payment under the terms of this Exhibit B(1 ).

Capitation Revenues or Maternity Care Revenue paid or payable by the Department can be included in only one Maximum Program Payout amount provided by the Department. Transition in HealthChoices Agreements or in PH-MCOs will not lead to double counting of any set of revenue when the Department calculates Maximum Program Payout amounts.

Per 42 C.F.R. 438.6(b)(2)(ii) –(iii), this incentive arrangement does not automatically renew and is made available to both public and private PH-MCOs under the same terms of performance.

NOTE: The Department may change the payout methodology based on reporting restrictions due to a natural disaster, pandemic or other unforeseen events. The payout methodology will be shared with the PH-MCOs prior to finalizing.

If the Department has a payment obligation to the PH-MCO pursuant to this Exhibit B(1), the Department will issue the payment by August 31, 2023. If the PH-MCO has a payment obligation to the Department pursuant to this Exhibit B(1), the Department will reduce a subsequent payment to the PH-MCO by this amount.

EXHIBIT B(2)

**Exhibit B(2)**

## PH-MCO and BH-MCO INTEGRATED CARE PLAN (ICP) PROGRAM PAY FOR PERFORMANCE PROGRAM

This Exhibit B(2) defines a potential payment obligation by the Department to the PH-MCOs for Quality Performance Measures achieved per HEDIS® and select Pennsylvania Performance Measures (PAPMs), as defined below.

This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2022. If the PH-MCO 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 Exhibit.

The Department will provide financial incentives to the PH-MCOs and the Behavioral Health Managed Care Organizations (BH-MCOs) for the Integrated Care Plan (ICP) Program. The Department will provide a funding pool from which dollars will be paid to the PH-MCO based on shared PH/BH-MCO performance measures outlined in this Exhibit. 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 PH-MCOs, BH-MCOs and providers.

**A.** **In order to be eligible for payments under the ICP**, the PH-MCO must submit Operations Report 17 for Calendar Year (CY) 2022 following the time frames outlined within the Report Description and that contains the following specific data requirements for individuals with serious persistent mental illness (SPMI).

1. **Member stratification** - Re-stratification shall be conducted on all members in the targeted SPMI population from the previous calendar year in January. New members shall have an initial stratification level established within sixty (60) days of the date of identification that a member has SPMI. The PH-MCO will report on the member ID, initial stratification level, and six (6) month re-stratification level. 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** - At least **1200 members** must receive an ICP that has been used in care management activity by both the PH and BH MCO. For purposes of this requirement, the Department considers an ICP or member profile, 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 ICP must be reviewed and updated at least annually. An ICP will not count towards the required amount if the member has disenrolled from the PH-MCO prior to the calendar year. An ICP will count towards the required amount if a member has an ICP and disenrolls from the PH-MCO during the calendar year.

3. **Hospitalization Notification and Coordination** - Each PH-MCO and BH-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 individual's member 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 PH-MCO knows of an admission, it will notify the BH-MCO within one (1) business day and vice versa). Each PH-MCO will attest on the Operations 17 report that 90% of the admission notifications occurred within one (1) business day of the PH-MCO learning of the admission. The PH-MCO must maintain documentation to support the attestation of 90% admissions notifications.

   For CY 2022, the PH-MCO must create a process to share and discuss the ICP with the Member and the member's Primary Care Provider (PCP). Beginning in CY 2023 sharing and discussing the ICP with both the Member and member's PCP will become an eligibility requirement for an incentive payout.

   The Operations Report 17 will be reviewed to verify the accuracy of the stratification, number of integrated care plans, hospital notification information and sharing and discussing the ICP with the Member and Member's PCP.

## 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*
   b. Engagement rate*

2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia*

3. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI)**

4. Emergency Department Utilization for Individuals with Serious Persistent Mental Illness (SPMI)**

5. Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI)**

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 NCQA specifications.

**NCQA HEDIS® measure ** Pennsylvania Performance measure defined by EQRO*

## C. Payment for MCO 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 MY 2020 (RY2021) to the current HEDIS®/PAPM MY 2021 (RY 2022).

- **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 SPMI,
    - Combined BH-PH Inpatient Admission Utilization for Individuals with SPMI.

  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 PH-MCO's Maximum Program Payout amount divided by seven (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 SPMI
   - 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 SPMI
   - 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 PH-MCO'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 <50$^{th}$ percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance for that measure is ≥50$^{th}$ percentile and <75$^{th}$ percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance ≥75$^{th}$ percentile Scale 2 will be applied.

a. Scale 1:

   The Department will make Improvement Performance payouts for incremental performance improvement from the previous year 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 the measure value.

- ≥ 3 and < 4 Percentage Point Improvement: 60 percent the measure value.
- ≥ 2 and < 3 Percentage Point Improvement: 40 percent the measure value.
- ≥ 1 and < 2 Percentage Point Improvement: 20 percent 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 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/Rate Improvement: 100 percent of the measure value.
- ≥ 4 and < 5 Percentage Point/Rate Improvement: 100 percent the measure value.
- ≥ 3 and < 4 Percentage Point/Rate Improvement: 100 percent the measure value.
- ≥ 2 and < 3 Percentage Point/Rate Improvement: 85 percent the measure value.
- ≥ 1 and < 2 Percentage Point/Rate Improvement: 75 percent the measure value.
- ≥ 0.5 and < 1 Percentage Point/Rate Improvement: 50 percent the measure value.
- < 0.5 Percentage Point Improvement: No payout.

NOTE: The payout structure is subject to change based on reporting restriction due to a natural disaster, pandemic and other unforeseen events. The Department will share those changes with the PH-MCO prior to making the changes.

**D.** Payment to the PH-MCO

Ten million dollars ($10M) will be allocated for the ICP Program in RY 2022 for the PH-MCOs. The funding will be allocated to each PH-MCO according to its overall percent of HealthChoices member months from the previous calendar year.

If the Department has a payment obligation to the PH-MCO under Section C above, pursuant to this Exhibit B(2), the Department will issue the payment by August 31, 2023.

EXHIBIT B(3)

## Exhibit B(3)

## PROVIDER PAY FOR PERFORMANCE PROGRAM

The Provider Pay-for-Performance (Provider P4P) program described in this Exhibit B(3) is for services rendered by providers during a Calendar Year (CY) and defined in Section I below.

### I. Provider P4P Program Requirements

All Provider P4P programs must target improvements in the quality of or access to health care services for HealthChoices members and must not limit the appropriate use of services by members.

A. The PH-MCO is required to develop a Provider P4P program using the following **mandatory** ten(10) HEDIS® Quality Measures (per HEDIS® MY 2021 Technical Specifications, Vol. 2), one (1) PA Performance Measures (PAPM) and three (3) Electronic Quality Measure:

**HEDIS®**

1. Annual Dental Visit (Age 2 – 20 Years)
   a. Part of the incentive for the Annual Dental Visit measure must include payments to dental providers that must be based on preventive dental services. The incentives must be structured to pay defined minimal amounts to dentists for performing episodes of preventive care for new and established recipients in at least two age bands (0-5 years and 6-20 years). The specific incentive model will be relatively uniform across the HealthChoices program. The incentive model will be determined by the Department in cooperation with all HealthChoices PH-MCOs.
2. Controlling High Blood Pressure
3. Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
4. Prenatal Care in the First Trimester
5. Postpartum Care
6. Child and Adolescent Well-Care Visits (Total)
7. Well-Child Visits in the First 15 Months of Life
8. Asthma Medication Ratio
9. Lead Screening for Children
10. Plan All Cause Readmissions

**PAPM**

1. Developmental Screening in the First Three (3) Years of Life

**Electronic Quality Measure**

Payment for electronic submission of any mandatory measure, the Obstetrical Needs Assessment Form (ONAF), or any Electronic Clinical Quality Measure (eCQM) approved by the current CMS Promoting Interoperability electronic

health record program rules. Information on these eCQMs may be found at the following link: http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

In addition, the PH-MCO must work with their Providers and Health Information Exchanges to obtain actual data values, not just CPT-II codes. For 2022, the Department added the following mandatory measures:

1. Comprehensive Diabetes Care: Hemoglobin A1c Poor Control – (>9.0%)
2. Controlling High Blood Pressure

**NOTE: The Provider P4P program measures are subject to change due to NCQA specifications.**

B. The PH-MCO is required to develop and submit a proposal to the Department using the Provider P4P Submission Template on DocuShare. The proposal must be reviewed by the Department prior to implementing.

C. A PH-MCO's approved Provider P4P program will remain in effect until December 31 of each calendar year. The PH-MCO may submit one (1) revision per quarter only to the provider payout amounts for the Department's review and approval. The PH-MCO must complete and submit the Provider P4P Submission Change Form. Payout revisions must be submitted no later than close of business on the last day of each calendar quarter. No Provider P4P Change Forms will be accepted in the fourth quarter. No other revisions to the Provider P4P program will be accepted.

D. The PH-MCO must provide a quarterly analysis of its approved Provider P4P program through updates at the Quarterly Quality Review Meetings (QQRM).

E. The PH-MCO must annually evaluate and provide an analysis to the Department of the effectiveness of its Provider P4P.

F. The Department may request that PH-MCOs share Provider P4P program findings with other HealthChoices PH-MCOs to identify best practices and improve the overall HealthChoices Program.

G. The PH-MCO must implement an incentive program for the following Health Equity Measures:

- Prenatal Care in the First Trimester

- Postpartum Care
- Well-Child Visits in the First 15 Months of Life
- Controlling High Blood Pressure
- Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)

## II. Payments to the PH-MCO

A. The Department will make payments for Provider P4P based on a per member per month (PMPM) rate, noted in Appendix 3f. The Provider P4P payments are part of the monthly capitation process, as identified in Appendix 3b. Coverage for Members in a freestanding IMD is specified in Section VII. E. 13.

1. If the PH-MCO has unspent Provider P4P funds, as determined by the Department, upon receipt and review of Report #40, the Department may reduce a future payment to the PH-MCO by the unspent amount or the Department may direct unspent Provider P4P funds provided to the PH-MCO per this Exhibit for the current or a prior program year. Any directed P4P funds are to be used in support of an initiative to improve access to care or improved quality outcomes for Members.

2. If at any time the Department determines Provider P4P funds were not disbursed in accordance with the approved Provider P4P plan, upon advanced written notice to the PH-MCO, the Department may elect to reduce a future payment to the PH-MCO by the amount identified.

B. Payments made to the PH-MCO under the Provider P4P program are intended to fund all mandatory measures

## III. Payments to Providers

A. All Provider P4P funds received from the Department for this HealthChoices Agreement should be paid to network providers in accordance with the approved Provider P4P program above.

B. The PH-MCO is required to develop and maintain a separate accounting process of the receipts and disbursements of all Provider P4P funds. The PH-MCO must be able to separately identify and track each payment to a provider for each specific mandatory HEDIS® Quality Measure identified in the Provider P4P program.

C. Each PH-MCO may determine the frequency of issuing payments to its providers. However, the Department recommends, at a minimum, quarterly

payouts. The PH-MCO must issue Provider P4P payments to its providers for services rendered under approved terms of this Exhibit B(3) to be paid out in full no later than June 30 of the subsequent calendar year.

## IV. Reporting

A. Clinical Reporting
The PH-MCO is required to meet the Department's reporting requirements for the submissions of quarterly analyses of its approved Provider P4P Program through updates at the QQRMs and an annual analysis of the effectiveness of its approved Provider P4P program.

B. Financial Reporting
Expenditures for this program are reported on annual Report #40 as required by the annual Financial Reporting Requirements. Reported disbursements should only reflect disbursements for the specified program year.

## V. Clinical Review

The Department may choose to perform a clinical review of the Provider Pay-for-Performance program. The PH-MCO must reasonably cooperate with Department staff during the clinical review process.

EXHIBIT B(4)

## Exhibit B(4)

## HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)

The Department is administering a HQIP. This program is designed to incentivize acute care general hospitals, and potentially other hospitals, enrolled in HealthChoices to improve the quality of healthcare services. The Department developed this initiative as part of its commitment to promote cost-effective, quality healthcare through an outcome and value-based payment structure. The Department makes an annual determination of Hospital Quality measures.

The Department will measure performance by hospital statewide across HealthChoices. The performance measurements will not be PH-MCO specific. The Department will make two HQIP payment(s) to the PH-MCO with one made on or before July 31, 2022 and the second on or before October 31, 2022 per this Agreement if the PH-MCO is responsible to operate a HealthChoices program per this Agreement on July 1, 2022 and October 1, 2022, respectively.

The Department's obligation for this program across all PH-MCOs that are responsible to operate a HealthChoices program in any or all zones on July 1, 2022 is $30 million for the 2022 performance year and October 1, 2022, is $80 million for the 2021 performance year for a total obligation paid during calendar year 2022 of $110 million. The Department will divide the $30 million and $80 million, respectively, across all PH-MCOs participating in HealthChoices in any or all zones based on each PH-MCO's monthly enrollment, as determined by the Department. If a PH-MCO operates in more than one HealthChoices zone, the Department will make each HQIP payment, as determined above, to the PH-MCO's zone having the largest enrollment.

The Department will calculate the HQIP payments by hospital and will provide a schedule of HQIP payment(s) and instructions to each PH-MCO. The PH-MCO will make HQIP payments to hospitals per the instructions within ten business days of the later of the receipt of this payment or the PH-MCO's receipt of payment instructions from the Department. The PH-MCO will not be required to make HQIP payments that exceed, in total, the amount paid by the Department for this purpose.

The Department will continue this HQIP for subsequent calendar years' performance. The Department will share hospital quality data prepared per this program with all PH-MCOs.

EXHIBIT B(5)

**Exhibit B(5)**

## COMMUNITY BASED CARE MANAGEMENT PROGRAM

The Community Based Care Management (CBCM) Program requirements described in this Exhibit B(5) are for care rendered during a CY and defined in the PH-MCO specific CBCM Program approved by the Department. The PH-MCO shall submit CBCM proposals solely utilizing partnerships with Community-Based Organizations (CBOs), Hospital/Health systems, and Providers that encourage the use of preventive services, mitigate Social Determinates of Health barriers, reduce healthcare disparities and improve maternal and child health.

### I. CBCM Program Requirements

A. The PH-MCO must propose CBCM activities and funding focused on partnerships with CBOs, Hospital/Health systems, and Providers integrating a holistic approach to patient care and education to:

1. Assess, refer and mitigate Social Determinants of Health;
2. Promote maternal, infant and early childhood assessment, education and referral including expansion and capacity building of existing home visiting programs;
3. Localize efforts to promote health education and wellness and encourage the use of preventive health services;
4. Promote education on the appropriate management of chronic health conditions;
5. Enhance behavioral and physical health coordination of services; and
6. Reduce healthcare disparities.

The PH-MCO cannot propose any new CBCM initiatives using CBCM funds for hiring PH-MCO staff. For existing CBCM initiatives using CBCM funds for PH-MCO staff, the PH-MCO will not be able to use CBCM funds for these initiatives beyond 12/31/2022. The PH-MCO must submit a transition plan how they are going to transition existing CBCM initiatives using CBCM funds to hire staff to meet the requirement of not using CBCM funds to hire PH-MCO staff by the end of Q1 2022. The PH-MCO must provide quarterly updates on the CBCM transition plan by the end of each quarter.

**The PH-MCO shall only use funding for CBCM services that have been approved by the Department in writing.**

B. The PH-MCO must implement a minimum of one rapid cycle quality improvement pilot program per year. To qualify as a rapid cycle quality improvement program, the PH-MCO must make and test changes over a period of three months or less. The PH-MCO must implement at least one rapid cycle quality improvement pilot program by the end of the second calendar quarter. If a rapid cycle quality improvement pilot program is demonstrating success, the PH-MCO must progressively expand the program.

C. The PH-MCO must include in it 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 PH-MCO.
5. CBCM funds cannot be used for commodities.

D. If the PH-MCO does business in multiple HealthChoices Zones, the PH-MCO may allocate CBCM Program funds across any Zone in which it provides Physical Health HealthChoices services.

E. The PH-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 PH-MCO must include in each CBCM proposal:

1. A program description, a twelve- month budget and operations timeline that outlines the startup of the program from January 1, 2022 through December 31, 2022.
2. For rapid cycle quality improvement pilot programs, the budget for the pilot phase of the program. If the program is expanded, a revised budget for the expanded program must be submitted.
3. Clearly defined goals, objectives and outcome measures that include benchmarks for success.
4. An outline of interventions performed.
5. Outline of payment mechanisms and time frames.

F. A PH-MCO's approved CBCM program will remain in effect until December 31 of each calendar year. The PH-MCO may only submit one revision per quarter no later than the last business day of each calendar quarter for the Department's review and approval. The PH-MCO must complete and submit the CBCM Proposal Change Form, that is available on DocuShare. The Department will not accept changes for the fourth calendar quarter.

G. The PH-MCO must implement an evidenced informed, outcomes-based home visit program as per Exhibit B(5)A.

## II. Payments to the PH-MCO

A. The Department will make payments for the CBCM program as part of each per member per month (PMPM) Base Capitation Rate in Appendix 3f. The PH-MCO must spend at least $0.75 PMPM from each Base Capitation Rate after risk adjustment for their approved CBCM program.

If the PH-MCO has not spent at least $0.75 PMPM from each Base Capitation Rate after risk adjustment on their approved CBCM program as determined by the Department as of June 30 of the subsequent calendar year, the Department will apply a sanction to the PH-MCO in an amount equivalent to the difference between the $0.75 PMPM multiplied by the PH-MCO's Member Months for the applicable CBCM program year minus the actual amount spent by the PH-MCO on their approved CBCM program. If applicable, the Department will recover this sanction amount by reducing a future payment to the PH-MCO. The Department may agree to waive this sanction based on additional information provided by the PH-MCO to the Department detailing the reasons why the expenditures for the CBCM program were less than the required $0.75 PMPM.

If the Department determines the PH-MCO made CBCM expenditures that were not in accordance with the PH-MCO's approved CBCM plan, upon advanced written notice to the PH-MCO, the Department may require that the PH-MCO resubmit any required CBCM reporting to remove these expenditures. Please refer to the paragraph above if the resubmitted report(s) result in expenditures that are less than the required $0.75 PMPM.

Maternity Care, as shown on Appendix 3f, is excluded from this requirement.

## III. Payments to Providers

The PH-MCO must make payment within the approved time period for the approved CBCM program, as identified above.

## IV. Reporting

A. **Clinical Reporting**

1. The PH-MCO must submit an annual analysis of their Comprehensive Care Management in addition to submitting a sub-analysis of the CBCM program.
2. The PH-MCO shall report on the clinical and financial outcomes of the program, including return on investment (ROI).

B. **Financial Reporting**

The PH-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 PH-MCO must submit additional financial reports in the format and by the date requested.

EXHIBIT B(5a)

## Exhibit B(5a)

## HOME VISITING PROGRAM

The Home Visiting Program requirements described in this Exhibit B(5a) are for maternal and infant care coordination activities rendered during a CY and defined in the PH-MCO specific Home Visiting Program approved by the Department per Section II below. Proposals submitted for the Home Visiting Program must encourage the use of preventive services, identify and resolve barriers to care, and mitigate social determinants of health barriers.

### I. Home Visiting Program Requirements and Goals

A. The PH-MCO must implement a Home Visiting Program that is available to all first-time parents and parents/caregivers of children who have been identified as having additional risk factors which may include social, clinical, racial, economic or environmental factors. The Home Visiting Program must also be available to any infant and the infant's parent/caregiver who requests Home Visiting services. Services must be available from the prenatal period through the child's first 18 months of life.

B. The Home Visiting Program must be designed to provide support to parents/caregivers, children, and families. The program must be individualized, strengths-based and family-focused to ensure that all needs are addressed, and families are active partners in their care. The Home Visiting Program must be innovative, expansive, and inclusive.

C. Home Visiting activities must be primarily be focused on:

1. Maternal and Infant Health promotion and prevention
2. Parent/caregiver education and support
3. Healthy child development
4. Child safety (Infant sleep safety, car seat safety, crib and changing table safety, environmental lead, accident prevention, environmental safety, etc.)
5. Identification and mitigation of social determinants of health (SDOH)
6. Increasing screenings and referrals to community resources for SDOH (food insecurity, health care access/affordability, housing, education transportation, childcare, employment, utilities, clothing, financial strain)
7. Prevention of intimate partner violence
8. Reducing disparities in perinatal health
9. Strengthening family economic self-sufficiency
10. Family planning, which includes access to counseling for available contraceptive options, childbirth-spacing education, and support to attain contraceptives if requested by mother
11. Increasing postpartum health care visits
12. Increasing screenings for Maternal/Caregiver depression and anxiety
13. Increasing screenings for substance use disorder (SUD)

14. Increasing follow up care on positive postpartum depression screenings and/or other behavioral healthcare needs
15. Increasing rates of well-child visits and follow up on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) appointments
16. Increasing plans of safe care for all infants born affected by substance abuse, NAS and FASD.

D. The objective of the Home Visiting Program is to improve maternal and infant health outcomes and reduce maternal and infant morbidity and mortality, especially in individuals identified to be at risk.

E. Home Visiting Programs will include licensed and/or non-licensed staff, that are not hired by the PH-MCO, with an emphasis on expanding the use of non-licensed providers.

1. Home visitors must meet the requirements of nationally recognized Home Visiting Programs. Home visitors must be provided initial and ongoing training, supervision and professional development. High-quality supervision, including reflective supervision, must be implemented for all home visitors.
2. The home visitor must have knowledge about resources in the family's community and be able to link the family to needed services and local health care organizations.

F. The PH-MCO maternity case manager must offer to initiate a warm handoff to a Home Visiting vendor.

G. Families who decline Home Visiting services at initial outreach must receive follow up outreaches by the PH-MCO to the parent/caregiver every 90 days until the child has reached age 18 months to ensure the family does not need home visiting support. The PH-MCO must reach out to parents/caregivers who did not participate in the PH-MCO's Maternity Care Management program to inform and offer the Home Visiting Program.

H. If the family has risks identified that are already being met by an evidence-based or evidence-informed Home Visiting Program, the PH-MCO case manager will follow up with the evidence-based or evidence-informed program, with caregiver/parental consent, to avoid duplication of services and to ensure that there are no unmet needs.

I. The PH-MCO should focus on expanding existing Home Visiting Programs to new geographic areas and new populations. PH-MCOs that are currently working with evidence-based Home Visiting Programs are encouraged to expand and build their capacity and also partner with evidence-informed Home Visiting Programs.

J. The PH-MCO must educate their network providers on their Home Visiting Program and services offered.

K. The PH-MCO maternity case manager must discuss and offer Home Visiting services to the parent/caregiver during the first postpartum contact. Home Visiting services must be initiated by a Home Visiting vendor as soon as the parent/caregiver agrees to the first visit, but no more than fourteen (14) calendar days after first contact. If services cannot be provided during this time frame, the member must be contacted by the PH-MCO case manager to assess and address any immediate needs and refer to needed resources or services.

L. Home Visiting services must be delivered appropriate to the family's level of knowledge and must be culturally and linguistically competent. Bilingual services must be provided or arranged for when necessary and any health care records must be accessible in the beneficiary's primary language. There must be no barriers to services for families with limited English proficiency, partial/full vision and/or auditory loss. Necessary supportive aids and services, such as sign language, interpretation, translation, and alternative formats must be available to beneficiaries.

M. All first-time parents, parents/caregivers of children who have been identified as having additional risk factors, any infant and the infant's parent/caregiver who requests Home Visiting services are to be offered home visits. The time and location of the visit must be scheduled to accommodate the parent/caregiver. Visits should be at the home unless the parent/caregiver requests services at another location frequented by the parent/caregiver or if the parent/caregiver requests a telemedicine visit as per O below.

N. All postpartum visits must include the parent/caregiver and child as appropriate. Health promotion must begin at the first visit. Services will be individualized and will focus on the parent/caregiver-child dyad and family supports. The needs and risks identified in the family's plan of care must be addressed at every visit. Subsequent home visits must be tailored to the family and must follow the objectives, interventions and goals outlined in the plan of care.

O. In-person home visits are preferred but the use of telemedicine visits are allowed in situations where in-person visits are not possible, such as during a public health emergency. Telemedicine visits must provide the same level of care and achieve the same outcomes as an in-person home visit. Telephone calls are acceptable in situations where the family does not possess or have access to video technology. Text messages may be used to provide supplemental communication between visits but are not considered a telemedicine visit. The PH-MCO or contracted Home Visiting agency must obtain and document informed consent for the use of telemedicine technology for the initial telemedicine visit.

P. The PH-MCO or the contracted Home Visiting agency must work to identify the family's risks and needs and provide referrals to needed resources and services. Parental/caregiver, infant and family risk levels must be assigned

based on the needs and risk assessments. The duration and frequency of Home Visiting services and referrals will be managed according to risk level. The number of visits received must be based on need and cannot be limited to a certain number. Home visits must be continuous without limitations of prior authorizations or approvals.

Q. The PH-MCO or contracted Home Visiting agency must follow-up with all provided referrals to ensure risks and needs are addressed. All families must receive information on child development, well child visits/EPSDT screenings and their importance, lead exposure during pregnancy through infancy and during childhood, infant safety, safe sleep practices, family planning, positive parenting techniques, health promotion, preventative health care and decision making around accessing safe child care, if needed. Families must also be offered a referral to Women Infants and Children (WIC) services if they are not already involved. Referrals must be made to Early Intervention Services as appropriate.

R. The home visitor must complete maternal, infant and family needs and risk assessments starting at the first visit. The home visitor must evaluate the home and environment during the first visit to ensure there are no safety concerns that need addressed. The PH-MCO maternity case manager must coordinate with the home visitor to develop a parent/caregiver, infant, and family focused plan of care based on the home visitor's assessment. The plan of care addresses the family's needs, applies the family's strengths and is outcome focused. The plan of care includes family-specific objectives, interventions and goals based on identified needs and risks. If any safety concerns are identified for the parent/caregiver or child, a safety plan must be included.

S. The PH-MCO maternity case manager must monitor the plan of care implementation throughout the Home Visiting Program duration and ensure all needs are met and referrals are followed up and completed.

T. The Maternal Needs and Risk Assessment must include at a minimum the following: demographic information, pregnancy health history, chronic disease health history, other health history (sexually transmitted infections, prescription drugs, oral health), family planning, prenatal care, nutrition, breastfeeding, tobacco, alcohol and drug use, stressors, social support, mental health (depression, anxiety), intimate partner violence and social determinants of health (food insecurity, health care access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain), and parenting.

U. Infant Needs and Risk Assessment must include at a minimum the following: infant and caregiver demographics, parental family planning, parental/caregiver tobacco, alcohol and drug use, parental/caregiver stress, parental/caregiver mental health (depression, anxiety), intimate partner violence, social determinants of health (food insecurity, health care/medical access/affordability, housing, education, transportation, childcare,

employment, utilities, clothing, financial strain), infant family support, parenting and childcare, infant birth health status, infant health care, infant safety, safe sleep practices, infant feeding and nutrition, infant development and infant needs (clothing, car seat, crib, diapers, formula, etc.).

For families of multiples (for example: twins, triplets), an Infant Needs and Risk Assessment must be completed for each infant.

V. The following domains must be addressed in assessments for all families:

Socio-Economic Status: Examples of factors that indicate risks under this domain include family living below the poverty level, parent/caregiver employment status, highest education level attained by parent/caregiver, age of parent/caregiver, family participation in assistance benefits (SSI, Cash assistance, SNAP, WIC, etc.) and current or past food insecurity.

Substance Use: Examples of factors that indicate risks under this domain include parent/caregiver/household member current opioid prescription, current or past substance abuse treatment, history of impaired driving, history of opioid overdose hospitalization, substance use disorder, binge alcohol use, marijuana use, illicit drug use, pain medication use, maternal smoking during pregnancy and child born with neonatal abstinence syndrome.

Perinatal and Child Health Outcomes: Examples of factors that indicate risks under this domain include mother's utilization of adequate and timely prenatal care, was the mother counseled about family planning options, is the mother breastfeeding, current or past maternal postpartum depression, infant preterm birth, low birth weight, NICU admission and status of well child visit utilization.

Child Maltreatment: Examples of factors that indicate risks under this domain include reported child abuse and neglect, substantiated child abuse and neglect, current or past child maltreatment and current or past intimate partner violence for parent/caregiver/household member.

Environment and Community: Examples of factors that indicate risks under this domain include family access to SNAP and WIC authorized stores, adequate access to affordable health care, does the family feel safe in their neighborhood, lead, air and/or water pollution concerns in the home environment, family access to transportation, adequate housing, family sharing the home with others, and current or recent homelessness.

Child Care: Examples of factors that indicate risks under this domain include family access to affordable and quality childcare.

**Note:** The Office of Child Development and Early Learning (OCDEL) funded Evidence-based home vising programs use Maternal Infant Early Childhood Home Visiting (MIECHV) approved screening tools for Intimate Partner Violence, Parent-Child Interaction, Depression and

Child Development. A list of the screening tools will be made available to the PH-MCOs via DocuShare.

W. The Home Visiting Program must minimally address the following:

1. Maternal Physical Assessment
2. Infant Physical Assessment
3. Maternal Depression and Anxiety Screening
4. Childbirth Preparation including obtaining prenatal care if needed
5. Substance Use Assessment and Referral (Drug, Opioid and Alcohol)
6. Tobacco Use Assessment
7. Lactation Care
8. Parent/Caregiver-Infant Care and interaction
9. Well Child Screening and Visits Assessment
10. Family Planning
11. Home Assessment
12. Intimate Partner/Interpersonal Violence Risk Assessment
13. Parent/Caregiver Skills Education
14. Positive Parenting Practices
15. Nutrition Counseling
16. Physical recovery from birth
17. Chronic disease management
18. Health promotion
19. Postpartum health
20. Safe Sleep practices
21. Assessment and Development of Home Visiting Plan
22. Social Determinants of Health (food insecurity, health care access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain)
23. Referral to support programs (Home Visiting Programs, Health coverage, SNAP, housing, employment, transportation, WIC)
24. Child Safety Education
25. Child Development Screening
26. Age Appropriate Immunizations
27. EPSDT scheduling and education
28. Early language and literacy activities
29. Maternal and Infant Lead Screening and education

## II. Reporting

A. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its Home Visiting Program. The Home Visiting Program may include multiple programs. 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 Home Visiting Program proposal template. Each Home Visiting Program proposal must include:

1. An initial Home Visiting Program description that lists targeted providers/organizations, a twelve (12) month budget, and operations timeline that outlines the startup of the program from January 1, 2022 through December 31, 2022.

2. The targeted providers/organizations involved with the Home Visiting Program. The PH-MCO will be responsible for reporting the targeted providers/organizations, targeted recipients, and define the financial spending for each arrangement.

3. Clearly defined goals, objectives and outcome measures that include benchmarks for success.

4. An outline of interventions that the Home Visiting worker will be performing for each of the targeted providers.

5. Outline payment mechanisms and time frames to providers for Home Visiting.

6. Program Budget, which should include the payment terms.

B. The PH-MCO must submit an analysis of their Home Visiting Program. This analysis must be submitted as part of Operations Report #15 to the Department on the scheduled reporting due date(s).

## III. Clinical Review

A. The Department may choose to perform a review of the Home Visiting Program. The PH-MCO must reasonably cooperate with Department staff during the review process.

EXHIBIT B(6)

## Exhibit B(6)

## MEDICATION ADHERENCE PAY FOR PERFORMANCE

This Exhibit B(6) defines a potential payment obligation by the Department to the PH-MCO for managing Members with a diagnosis of Hepatitis C to cure through adherence to their medication regimen as verified through point of sale claims for Hepatitis C medication dispensed and by the Member's subsequent laboratory test post medication regimen for viral load.

The Department will make a one-time payment in the amount of $1,000 to the PH-MCO for each Member with a diagnosis of Hepatitis C that has received Hepatitis C medication(s), as identified on the Department's Specialty Drug List, within the given calendar year and received a subsequent laboratory test that confirms the Member has achieved cure. Example: A Member's last Hepatitis C medication was dispensed on October 1, 2021 and a Sustained Viral Response (SVR) was administered on February 15, 2022 with cure. The Member will be considered for the second semi-annual period.

The Department will verify eligible Members for this incentive payment through encounter data for pharmacy services that have dates of service during the given calendar year and for which the PH-MCO submits an SVR that confirms the Member achieved cure. The PH-MCO will notify the Department of SVRs it has obtained that document undetectable Hepatitis C Ribonucleic Acid (RNA) twelve to twenty-four weeks following completion of the medication therapy. The Department will not utilize an SVR if it utilized an SVR for the same Member that is dated less than 24 months prior, or if the MCO has not followed procedures specified by the Department.

The Department will accept a SVR from the PH-MCO if at least one of the following criteria is met, along with other requirements:

A. The PH-MCO has paid for a Hepatitis C drug for the Member during the given calendar year; OR
B. The Member was enrolled with the PH-MCO on the date the SVR was completed and confirmed cure.

If the Member switches PH-MCOs prior to the date of the SVR confirming cure, the Department will make a proportional payment to the PH-MCO in which a Member was enrolled on the date of the SVR. If the PH-MCO did not make a payment for any days of the medication regimen received by the switching Member, the one-time payment will be multiplied by 10 percent (10.0%); If the PH-MCO paid for 1 to 28 days of the medication regimen received by the switching Member, the one-time payment will be multiplied by 50 percent (50.0%); If the PH-MCO paid for 29 days or more of medication regimen received by the switching Member, the PH-MCO will receive the one-time payment in full. The difference between the one-time payment less the proportional payment, will be paid to the PH-MCO from which the Member switched.

The Department will process one payment to the PH-MCO for each semi-annual period for the given calendar year. Each payment will total the sum of the one-time payments earned plus

any proportional payments earned by the PH-MCO during that period. The Department will determine the inclusion of Members in each semi-annual period based on the date of service for that Member's last Hepatitis C drug claim as identified through encounter data. The Department will not process each semi-annual payment until, at the earliest, nine months after the end of the semi-annual period. Members that have been determined cured will be included in only one of the two semi-annual periods during the given calendar year.

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously had an Agreement with the Department to operate a HealthChoices program ("Previous PH-MCO"); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will include claims paid by the Previous PH-MCO.

EXHIBIT B(7)

## EXHIBIT B(7)

## MATERNITY CARE BUNDELED PAYMENT

1. Maternity Care Bundle: As part of VBP, the PH-MCO must utilize a Maternity Care Bundled Payment for Network Providers that elect to take part in the model, use a maternity care team, and have at least twenty (20) births annually attributed to the maternity care team. A PH-MCO utilizing a Maternity Care Bundled Payment must require that the Network Provider use a maternity care team that:

    a. Includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to provide prenatal care to pregnant women.
    b. Includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to assist in vaginal delivery of babies.
    c. Includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to provide newborn services.
    d. Provides access to at least one (1) physician who is qualified to treat women with high-risk pregnancies, to treat complications experienced during pregnancy or childbirth, and to perform cesarean sections.
    e. Provides access to at least one (1) hospital that has the capability to perform cesarean sections and treat common complications of labor and delivery.
    f. Provides access to at least one (1) physician practice, hospital, clinical laboratory, or other entity that has the ability to perform laboratory tests or imaging studies needed as part of prenatal care, labor and delivery, and postpartum care.
    g. Includes at least one (1) individual, such as a doula, community health worker, social worker, or peer recovery specialist, to coordinate the care of the pregnant woman to address other needs, including behavioral health, substance use disorder, and Social Determinants of Health.

2. Payment to the Maternity Care Team: The target price of the bundle shall be prospectively developed with the maternity care team. The PH-MCO shall pay the maternity care team the applicable fee-for-service payments and perform a retrospective review to compare the fee-for-service payments to the target price. If the fee-for-service payments made for the services included in the bundle are less than the target price, the PH-MCO shall include the difference in a pool of shared savings. On an annual basis, the PH-MCO shall determine the amount of shared savings to be paid to a Network Provider using a maternity care team as specified in section 9.

    The PH-MCO must base the prospectively developed target price on:

    a. The trimester in which the pregnant woman engaged in care;
    b. Historical spending, with factors taken into consideration that reflect patient acuity.

In addition, the PH-MCO may base the prospectively developed target price on:

Blended regional prices of vaginal births, cesarean section rates, including prenatal, postpartum, and newborn services for up to sixty (60) days postpartum, with a proportion of cesarean sections set for 2021 at:

i. 27.25% cesarean sections in the Southeast Zone
ii. 27.25% cesarean section in the Southwest Zone
iii. 29.25% cesarean sections in the Lehigh/Capital Zone
iv. 30.75% cesarean sections in the Northeast Zone
v. 31.50% cesarean sections in the Northwest zone

3. Services included in the bundle: The PH-MCO must develop a target payment that includes all services provided during pregnancy episode: prenatal care, labor and delivery, care coordination services, and up to sixty (60) days postpartum for the mother and newborn, other than contraceptive care.

4. Services excluded from the bundle: Contraceptive care, including placement of long-acting reversible contraception.

5. Pregnancies excluded from the bundle: Non-singleton pregnancies.

6. Stop loss mechanism: If the cost of the maternity care episode (including services provided during pregnancy, labor and delivery, and postpartum) for a member exceeds 300% of the target price of the maternity care bundle, then no costs over 300% of the target price of the bundle will be attributed to the Maternity Care Team.

7. Quality Measures: The PH-MCO shall use the following quality measures to determine its incentive payments:

    a. Social Determinants of Health Screening: Complete at least one (1) Social Determinants of Health screening using a Nationally recognized tool, during the episode duration with submission of G9919 (positive screening result) or G9920 (negative screening result) Procedure Codes. Claims must include appropriate ICD-10 Z-codes when relevant those determinant areas as defined by Social Determinants of Health.
    b. Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS®)
    c. Timeliness of Prenatal Care (HEDIS®)
    d. Postpartum Care (HEDIS®)
    e. Prenatal Depression Screening and Follow Up (HEDIS® - ECDS)
    f. Postpartum Depression Screening and Follow Up (HEDIS® - ECDS)
    g. Prenatal Immunization Status (HEDIS® - ECDS)
    h. Well-Child Visits: Children who receive two (2) or more well-child visits with a primary care physician within the first sixty (60) days after birth.

8. Scoring of Quality Measures: Point totals for each quality measures are listed below. Virtual or telehealth visits should count for calculation of quality scores.

    a. Social Determinants of Health:
        i. 0.5 points for screening 50% of Members
        ii. 1 point for screening 75% of Members
        iii. 1.5 points for screening 90% of Members

    b. Initiation of Alcohol and Other Drug Abuse or Dependence Treatment: (HEDIS®)
        i. 0.5 points for reaching NCQA 50th percentile
        ii. 1 point for reaching NCQA 75th percentile
        iii. 1.5 points for reaching NCQA 90th percentile

    c. Timeliness of Prenatal Care (HEDIS®):
        i. 0.5 points for reaching NCQA 50th percentile
        ii. 1 point for reaching NCQA 75th percentile
        iii. 1.5 points for reaching NCQA 90th percentile

    d. Postpartum Care (HEDIS®):
        i. 0.5 points for reaching NCQA 50th percentile
        ii. 1 point for reaching NCQA 75th percentile
        iii. 1.5 points for reaching NCQA 90th percentile

    e. Prenatal Depression Screening and Follow Up (HEDIS® - ECDS):
        i. 1 point for reaching or exceeding the goal of 73.66%

    f. Postpartum Depression Screening and Follow Up (HEDIS® - ECDS):
        i. 1 point for reaching or exceeding the goal of 87.29%

    g. Prenatal Immunization Status (HEDIS® - ECDS):
        i. 0.5 points for reaching NCQA 50th percentile
        ii. 1 point for reaching NCQA 75th percentile
        iii. 1.5 points for reaching NCQA 90th percentile

    h. Well-Child Visits: Benchmarks are based on the HEDIS® Well-Child Visits in the First 30 Months of Life, Well-Child in the First 15 Months age band, two (2) visits in the first fifteen (15) months of life:
        i. 0.5 points for reaching NCQA 50th percentile
        ii. 1 point for reaching NCQA 75th percentile
        iii. 1.5 points for reaching NCQA 90th percentile

    i. Health Equity score: Points should be awarded for the following quality measures: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment, Timeliness of Prenatal Care, Postpartum Care, Prenatal Immunization Status and Well-Child Visits as follows:

i. 0.5 points for reaching NCQA 75th percentile for two (2) out of the five (5) HEDIS® measures within the Black/ African American community
ii. 1 point for reaching NCQA 75th percentile for three (3) out of the five (5) HEDIS® measures within the Black/ African American community
iii. 1.5 points for reaching NCQA 75th percentile for four (4) out of the five (5) HEDIS® measures within the Black/ African American community

9. Shared Savings Incentive Payment: The PH-MCO will pay eligible Network Providers the following percentage of shared savings based on the Network Provider's performance:

    a. (0-2 points): 0% of shared savings
    b. (2.5-3.0 points): 25% of shared savings
    c. (3.5-5.5 points): 50% of shared savings
    d. (6-8 points): 75% of shared savings
    e. (8.5-12.5 points): 100% of savings

10. Incentive Payment Attestation: The PH-MCO shall make a shared savings incentive payment to Network Providers using a maternity care team contingent upon submission by July 31, 2023 of an attestation of the maternity care team receiving the payment. No less than 80% of the reward payment will be dispersed to the maternity care team or distributed to the maternity care staff who cared for the Member, and that no more than 20% of those funds will be used for general administrative purposes.

11. Attestation for The Joint Commission Standards: The PH-MCO must attest by July 31, 2023 that each Maternity Care Bundle practice meets The Joint Commission Standard PC.06.01.01 (Reduce the likelihood of harm related to maternal hemorrhage Requirement EP 2) and Standard PC.06.01.03 (Reduce the likelihood of harm related to maternal severe hypertension/preeclampsia Requirement EP 2). The link to The Joint Commission is:
    https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_24_maternal_safety_hap_9_6_19_final1.pdf.

    The Department may waive this requirement upon receipt of information from the PH-MCO.

12. Quality measures that will be reported to DHS by PH-MCOs: This is the list of quality measures that PH-MCOs will report to the Department at the aggregate level for their Maternity Care Bundle population and non-Maternity Care Bundle population. The PH-MCO must track these quality measures for the Maternity Care Bundle population at the Practice level and report to the Department, as requested.

a. Severe Maternal Morbidity (SMM) rate by race and ethnicity (+Alliance for Innovation on Maternal Health (AIM®)): The PH-MCO must provide an aggregate SMM rate by race and ethnicity for their Maternity Care Bundle population and non-Maternity Care Bundle population. The link to the AIM SMM code set is:
https://safehealthcareforeverywoman.org/aim/resources/aim-data-resources/ - SMM Codes List
b. Obstetrical Needs Assessment Form (ONAF) screening: The PH-MCO is to report the total number of completed ONAF forms submitted to the PH-MCO for the Maternity Care Bundle population and non-Maternity Care Bundle population.
c. Postpartum visit follow-up: The PH-MCO needs to provide the total number of postpartum visits completed between 7 and 84 days after delivery for their Maternity Care Bundle population and non-Maternity Care Bundle population. In addition, the PH-MCO must also include a breakout rate for the medical home visit and telehealth visits in the numerator.
d. Prenatal Care Screening Rate (AHRQ): The PH-MCO will provide the AHRQ Prenatal Care Screening rate for their Maternity Care Bundle population and non-Maternity Care Bundle population. The link to the AHRQ Prenatal Care Screening specification is:
https://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/fullreports/chipra-170-prenatal-screening-specifications.pdf
e. C-section Rate: The PH-MCO must report the percent of nulliparous women with a term, singleton baby in vertex position delivered by C-section for their Maternity Care Bundle population and non-Maternity Care Bundle population.
f. Birth Weight outcomes: The PH-MCO must report the percent of low birth weight and very low birth weight for their Maternity Care Bundle population and non-Maternity Care Bundle population.
g. Average Length of Stay: The PH-MCO will report the average inpatient length of stay of all neonates for their Maternity Care Bundle population and non-Maternity Care Bundle population.

NOTE: The Quality Measures and Quality Measure Reporting may be revised based upon NCQA technical specifications, PA Perinatal Quality Collaborative feedback and data reporting from the PH-MCOs. The Department may waive this requirement upon receipt of information from the PH-MCO.

13. The PH-MCO will attest by July 31, 2023 to the completion of maternity care bundled payment arrangements described in this Exhibit with providers that account for 25% of the PH-MCO's live births in calendar year 2022.

# EXHIBIT C

# EXHIBIT C

## PH-MCO REQUIREMENTS FOR PROVIDER TERMINATIONS

The PH-MCO must comply with the requirements outlined in this Exhibit when they experience a termination with a provider. The requirements have been delineated to identify the requirements for terminations that are initiated by the PH-MCO and terminations that are initiated by the provider. Also provided in this Exhibit are the requirements for submission of workplans and supporting documentation that is to be submitted to the Department for hospital terminations, terminations of a specialty unit within a facility and terminations with large provider groups, which would negatively impact the ability of members to access services.

## I. Termination by the PH-MCO

### A. Notification to Department

The PH-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes a hospital, specialty unit within a facility, and/or a large provider group) ninety (90) days prior to the effective date of the termination.

The PH-MCO must submit a Provider termination work plan and supporting documentation within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates to this information. The requirements for the workplan and supporting documentation are found in this Exhibit, under 3. Workplans and Supporting Documentation.

### B. Continuity of Care

The PH-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 Pa. Code § 9.684.

Unless the Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), the PH-MCO must allow a Member to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Member is notified by the PH-MCO of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater. A Member is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve (12) months the Member was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been Prior Authorized**.** Any adult member with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the provider, unless the appointment is for a well adult check-up. Any child (under age 21) with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing

course of treatment from the provider. Per Department of Health regulation Title 28, §9.684(d), the transitional period may be extended by the PH-MCO if the extension is determined to be clinically appropriate. The PH-MCO shall consult with the Member and the health care provider in making the determination. The PH-MCO must also allow a Member who is pregnant to continue to receive care from the Provider that is being terminated through the completion of the Member's postpartum care.

The PH-MCO must review each request to continue an ongoing course of treatment and notify the Member of the decision as expeditiously as the Member's health condition requires, but no later than 2 business days. If the PH-MCO determines what the Member is requesting is not an ongoing course of treatment, the PH-MCO must issue the Member a denial notice using the template notice titled C(4) Continuity of Care Denial Notice found in Docushare.

The PH-MCO must also inform the Provider that to be eligible for payment for services provided to a Member after the Provider is terminated from the Network, the Provider must agree to meet the same terms and conditions as participating Providers.

## C. Notification to Members

If the Provider that is being terminated from the Network is a PCP, the PH-MCO, using the template notice titled C(1) Provider Termination Template For PCPs found in Docushare, must notify all Members who receive primary care services from the Provider thirty (30) days prior to the effective date of the Provider's termination. Members who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Member is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is not a PCP or a hospital, the PH-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found in Docushare, must notify all Members who have received services from the Provider during the previous twelve (12) months, as identified through referral and claims data; all Members who are scheduled to receive services from the Provider; and all Members who have a pending or approved prior authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination. Members who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Member is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is a hospital (including a specialty unit within a facility or hospital), the PH-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination found in Docushare, must notify all Members assigned to a PCP with admitting privileges at the hospital, all Members assigned to a PCP that is owned by the hospital, and all Members who have utilized the hospital's services within the past twelve (12) months thirty (30) days prior to the effective date of the hospital's termination. The MCO must utilize claims data to identify these Members.

If the PH-MCO is terminating a specialty unit within a facility or hospital**,** the Department may require the PH-MCO to provide thirty (30) day advance written notice to a specific Member population or to all of its Members, based on the impact of the termination.

The Department, at its sole discretion, may allow exceptions to the thirty (30) day advance written notice depending upon verified status of contract negotiations between the PH-MCO and Provider.

The Department, in coordination with DOH, may require the PH-MCO to include additional information in the notice of a termination to Members.

The thirty (30) day advance written notice requirement does not apply to terminations by the PH-MCO for cause in accordance with 40 P.S. Section 991.2117(b). The PH-MCO must notify Members within five (5) Business Days using the template notice titled C(1) Provider Termination Template For PCPs, found in Docushare.

The PH-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

## II. Termination by the Provider

### A. Notification to Department

If the PH-MCO is informed by a Provider that the Provider intends to no longer participate in the PH-MCO's Network, the PH-MCO must notify the Department in writing sixty (60) days prior to the date the Provider will no longer participate in the PH-MCO's Network. If the PH-MCO receives less than sixty (60) days notice that a Provider will no longer participate in the PH-MCO's Network, the PH-MCO must notify the Department by the next Business Day after receiving notice from the Provider.

The PH-MCO must submit a Provider termination work plan within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly status updates to the workplan. The requirements for the

workplan are found in this Exhibit, under 3. Workplans and Supporting Documentation.

The PH-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 Pa. Code § 9.684.

**B. Notification to Members**

If the Provider that is terminating its participation in the Network is a PCP, the PH-MCO, using the template notice titled C(1) Provider Termination Template For PCPs, in Docushare, must notify all Members who receive primary care services from the Provider.

If the Provider that is terminating its participation in the Network is not a PCP or a hospital, the PH-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found in Docushare, must notify all Members, who have received services from the Provider during the previous twelve (12) months; all Members who were scheduled to receive services from the terminating Provider; and all Members who have a pending or approved Prior Authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination. The PH-MCO must use referral and claims data to identify these Members.

If the Provider that is terminating its participation in the Network is a hospital or specialty unit within a facility, the PH-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination, found in Docushare, must notify all Members assigned to a PCP with admitting privileges at the hospital, all Members assigned to a PCP that is owned by the hospital, and all members who have utilized the terminating hospital's services within the past twelve (12) months thirty (30) days prior to the effective date of the Hospital's termination. The MCO must use referral and claims data to identify these Members.

If the Provider that is terminating its participation in the Network is a specialty unit within a facility or hospital**,** the Department may require the PH-MCO to provide thirty (30) days advance written notice to a specific Member population or to <u>all</u> of its Members ,based on the impact of the termination.

The Department, in coordination with DOH, may require additional information be included in the notice of a termination to Members.

The PH-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

## III. Workplans and Supporting Documentation

### A. Workplan Submission

The PH-MCO must submit a Provider termination work plan within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates to the workplan. The workplan must provide detailed information on the tasks that will take place to ensure the termination is tracked from the time it is first identified until the termination effective date. The workplan should be organized by Task, Responsible Person(s), Target Dates, Completed Date and Status. The workplan should define the steps within each of the Tasks. The Tasks may include, but not be limited to:

- Commonwealth Notifications (DHS and DOH)
- Provider Impact and Analysis
- Provider Notification of the Termination
- Member Impact and Analysis
- Member Notification of the Termination
- Member Transition
- Member Continuity of Care
- Systems Changes
- Provider Directory Updates for Enrollment Contractor (include date when all updates will appear on Provider files sent to enrollment broker)
- PH-MCO Online Directory Updates
- Member Service and Provider Service Script Updates
- Submission of Required Documents to the Department (member notices and scripts for prior approval)
- Submission of Final Member Notices to the Department (also include date that DOH received the final notices)
- Communication with the Public Related to the Termination
- Termination Retraction Plan, if necessary

### B. Supporting Documentation

The Department is also requesting the PH-MCO submit the following supporting documentation, in addition to the workplan, within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates as appropriate. The Department is not prescribing the format for the supporting documentation. However, it is required to be submitted through electronic means, if possible.

1. Background Information

    a. Submit a summary of issues/reasons for termination.

b. Submit information on negotiations or outreach that has occurred between the PH-MCO and the Provider including dates, parties present and outcomes.

1. Member Access to Provider Services

a. Submit information that identifies Providers remaining in the Network by Provider type and location that would be available within the appropriate travel times for those members once the termination is effective. Provide the travel times for the remaining providers based upon the travel standards outlined in Exhibit AAA of the contract. For PCPs also list current panel sizes and the number of additional members that are able to be assigned to those PCPs.
b. Submit geographic access reports and maps documenting that all Members currently accessing terminating providers can access services being provided by the terminating Provider from remaining Network Providers who are accepting new Members. This documentation must be broken out by Provider type.
c. Submit a comprehensive list of all Providers, broken out by Provider type, who are affected by the termination and that also Indicates the current number of members either assigned (for PCPs) or utilizing these providers.
d. Submit information that includes the admitting privileges at other hospitals or facilities for each affected Provider and whether each affected Provider can serve the PH-MCO's Members at another hospital or facility.
e. Submit a copy of the final provider notices to the Department.

2. Member Identification and Notification Process

a. Submit information that identifies the total number of Members affected by the termination, i.e., assigned to an owned/affiliated PCP or utilizing the hospital or owned/affiliated provider within the twelve (12) months preceding the termination date, broken down by Provider.
b. Submit information on the number of members with prior authorizations in place that will extend beyond the provider termination date.
c. Submit draft and final Member notices, utilizing the templates included as C(1) – C(4), Provider and Hospital Termination Templates and Continuity of Care Denial Notice, found in Docushare, as appropriate, for Department review and prior approval.

3. Member Services

a. Submit for Department prior approval, the call center script to be used for the termination.
b. Identify the plan for handling increased call volume in the call center while maintaining call center standards.

c. Submit to the Department a call center report for the reporting of summary call center statistics, if requested as part of the termination. This call center report should include, at a minimum, the following elements:

- Total Number of Inbound Member Services Calls (broken out by PCP, Specialist, and Hospital)
- Termination Call Reasons (broken out by Inquiries, PCP Change, Opt Out/Plan Change)

4. Affected Members in Care Management

a. Submit the total number of members in Care Management affected by the termination with sub-breakdowns by members who are pregnant (broken out by total number of pregnant members in care management, those who will deliver before the termination and those members whose due date is past the termination); members with HIV/AIDS; Children in Substitute Care; and members identified as high risk.
b. Submit the criteria to the Department that the PH-MCO will utilize for continuity of care for members affected by the termination.
c. Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform members in care management about the termination.

5. Enrollment Services

a. Submit final, approved member notices to the Department, the member notices should be on PH-MCO letterhead.

6. News Releases

Any news releases related to the termination must be submitted to the Department for prior approval.

7. Website Update

Indicate when the PH-MCO's web-based Provider directories will be updated, and what if any additional information will be posted to the PH-MCO website.

# EXHIBIT D

# EXHIBIT D
# STANDARD 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 PH-MCO 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 PH-MCO, 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 PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO shall be compensated only for work performed to the satisfaction of the Commonwealth. The PH-MCO 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 PH-MCO agrees that the Commonwealth may set off the amount of any state tax liability or other obligation of the PH-MCO or its subsidiaries to the Commonwealth against any payments due the PH-MCO 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 PH-MCO warrants that all services performed by the PH-MCO, 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 PH-MCO and acceptance by the Commonwealth. The PH-MCO shall correct any problem with the service without any additional cost to the Commonwealth.

**9. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY**

The PH-MCO 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 PH-MCO 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 PH-MCO's written request, it shall be at the PH-MCO's expense, but the responsibility for such expense shall be only that within the PH-MCO's written authorization. The PH-MCO shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the PH-MCO 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 PH-MCO in such suit or proceeding are held to constitute infringement and the use is enjoined, the PH-MCO 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 PH-MCO is unable to do any of the preceding, the PH-MCO 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 PH-MCO under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the PH-MCO 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 PH-MCO and the Commonwealth recognize that in actual economic practice, overcharges by the PH-MCO'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 PH-MCO assigns to the Commonwealth all right, title and interest in and to any claims the PH-MCO 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 PH-MCO 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 PH-MCO and its employees and agents under this Agreement provided the Commonwealth gives the PH-MCO 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 PH-MCO 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 PH-MCO to the extent that the books, documents and records relate to costs or pricing data for the Agreement. The PH-MCO shall maintain records that support the prices charged and costs incurred for the Agreement. The PH-MCO 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 PH-MCO 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 PH-MCO in default by written notice to the PH-MCO, 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 PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO and the Department. The Commonwealth may withhold from amounts otherwise due the PH-MCO 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 PH-MCO shall notify the Commonwealth orally within five (5) days and in writing within ten (10) days of the date on which the PH-MCO 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 PH-MCO 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 PH-MCO, 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 PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO. The Commonwealth shall also have the right, upon written notice to the PH-MCO, 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 PH-MCO 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 PH-MCO remove a subcontractor from the Project. The Commonwealth will not be responsible for any costs incurred by the PH-MCO in replacing the subcontractor if good cause exists

c. The PH-MCO 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 PH-MCO may, without the consent of the Department, assign its rights to payment to be received under the Agreement, provided that the PH-MCO 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 PH-MCO; 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 PH-MCO 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 PH-MCO, following which the PH-MCO's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. The PH-MCO 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 PH-MCO 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 PH-MCO, subgrantee, contractor, subcontractor, and any person acting on behalf of the PH-MCO 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 PH-MCO, 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 PH-MCO 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 PH-MCO 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 PH-MCO, 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 PH-MCO, 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 PH-MCO 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 PH-MCO 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 PH-MCO, 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 PH-MCO, 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 PH-MCO'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 PH-MCO 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 PH-MCO, 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. PH-MCO RESPONSIBILITY PROVISIONS**

a. The PH-MCO 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 PH-MCO cannot so certify, then it shall submit, along with its application, a written explanation of why such certification cannot be made.

b. The PH-MCO also certifies, that as of the date of its execution of the Agreement, it has no tax liabilities or other Commonwealth obligations.

c. The PH-MCO's obligations pursuant to these provisions are ongoing from and after the effective date of the Agreement through its termination date. The PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO and the Commonwealth, which results in the suspension or debarment of the PH-MCO. 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 PH-MCO shall not be responsible for investigative costs for investigations that do not result in the PH-MCO's suspension or debarment.

f. The PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO's failure to comply with the provisions of subparagraph a above.

**22. COVENANT AGAINST CONTINGENT FEES**

The PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO agrees that any such court shall have in personam 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 PH-MCO 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 PH-MCO 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 PH-MCO agrees to provide the service in accordance with the change order.

## 26. RIGHT TO KNOW LAW 8-K-1580

a. The PH-MCO 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 PH-MCO, subgrantee or subcontractor's assistance in any matter arising out of the RTKL request related to this Agreement, it shall notify the PH-MCO, subgrantee, or subcontractor using the legal contact information provided in the Agreement. The PH-MCO, 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 PH-MCO, a subgrantee or subcontractor's possession, constituting, or alleged to constitute, a public record in accordance with the RTKL ("Requested Information"), PH-MCO 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 PH-MCO, 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 PH-MCO, 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 PH-MCO, subgrantee or subcontractor considers exempt from production under the RTKL, the PH-MCO, 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 PH-MCO, 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 PH-MCO, 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 PH-MCO, subgrantee or subcontractor fails to provide the Requested Information within the time period required by these provisions, the PH-MCO 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 PH-MCO, 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 PH-MCO, 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 PH-MCO, 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 PH-MCO, 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 PH-MCO, 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 PH-MCO, 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 PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO 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 PH-MCO shall include the provisions of these Enhanced Minimum Wage Provisions in every Subcontract so that these provisions will be binding upon Subcontractors.

# EXHIBIT E

# EXHIBIT E

## DEPARTMENT OF HUMAN SERVICES ADDENDUM TO STANDARD GRANT 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 inpatient 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 theCommonwealth 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 not interest and will not acquired 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 Public Welfare's 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 approval, 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 Intellectual Disability 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/ID facility. If the contract service provider has written proof of a PPD by Mantoux method within the last six months, the MH/ID 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/ID 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.

EXHIBIT F

## EXHIBIT F

## FAMILY PLANNING SERVICES PROCEDURES

Procedures Which May Be Included with a Family Planning Clinic Comprehensive Visit, a Family Planning Clinic Problem Visit or a Family Planning Clinic Routine Revisit:

- Insertion, implantable contraceptive capsules
- Implantation of contraceptives, including device (e.g. Norplant) (once every five years) (females only)
- Removal, Implantable contraceptive capsules
- Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only)
- Destruction of vaginal lesion(s); simple, any method (females only)
- Biopsy of vaginal mucosa; simple (separate procedure) (females only)
- Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only)
- Colposcopy (vaginoscopy); separate procedure (females only)[A]
- Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage[A]
- Colposcopy (vaginoscopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only)[B]
- Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only)[B]
- Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure) (females only)
- Cauterization of cervix; electro or thermal (females only)
- Cauterization of cervix; cryocaury, initial or repeat (females only)
- Cauterization of cervix; laser ablation (females only)

- Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only)
- Alpha-fetoprotein; serum (females only)
- Nuclear molecular diagnostics; nucleic acid probe, each
- Nuclear molecular diagnosis; nucleic acid probe, each
- Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each
- Fluorescent antibody; screen, each antibody
- Immunoassay for infectious agent antibody; quantitative, not elsewhere specified
- Antibody; HIV-1
- Antibody; HIV-2
- Treponema Pallidum, confirmatory test (e.g., FTA-abs)
- Culture, chlamydia
- Cytopathology, any other source; preparation, screening and interpretation
- Progestasert I.U.D. (females only)
- Depo-Provera injection (once per 60 days) (females only)
- ParaGuard I.U.D. (females only)
- Hemoglobin electrophoresis (e.g., A2, S, C)
- Microbial Identification, Nucleic Acid Probes, each probe used
- Microbial Identification, Nucleic Acid probes, each probe used; with amplification (PCR)

[A] Medical record must show a Class II or higher pathology.

[B] Medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure.

Procedures Which May Be Included with a Family Planning Clinic Problem Visit:

- Gonadotropin, chorionic, (hCG); quantitative
- Gonadotropin, chorionic, (hCG); qualitative
- Syphilis test; qualitative (e.g., VDRL, RPR, ART)
- Culture, bacterial, definitive; any other source
- Culture, bacterial, any source; anaerobic (isolation)
- Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography
- Culture, bacterial, urine; quantitative, colony count
- Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection
- Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
- Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
- Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites
- Smear, primary source, with interpretation; wet and dry mount, for ova and parasites
- Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision
- Level IV - Surgical pathology, gross and microscopic examination
- Antibiotics for Sexually Transmitted Diseases (course of treatment for 10 days) (two units may be dispensed per visit)
- Medication for Vaginal Infection (course of treatment for 10 days) (two units may be dispensed per visit)
- Breast cancer screen (females only)
- Mammography, bilateral (females only)
- Genetic Risk Assessment

# EXHIBIT G

## Exhibit G

## OPIOID USE DISORDER CENTERS OF EXCELLENCE

A. The PH-MCO must contract with all physical 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 zones in which the PH-MCO operates, unless the PH-MCO demonstrates to OMAP's satisfaction that the PH-MCO is not able to reach a contractual agreement with the OUD-COE, or that the OUD-COE is not compliant with the terms of this Exhibit.

B. The PH-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). This PMPM will be made in payment 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. The PH-MCO must require that an OUD-COE provides care management services in accordance with the OUD-COE's service description approved by DHS and in accordance with the terms of this Exhibit in order to receive payment for procedure code G9012. DHS will provide the PH-MCO with approved services descriptions for OUD-COEs within the PH-MCO's zone(s) upon approval.

   For members with OUD who are receiving services from OUD-COEs that are dually enrolled in the MA Program as Federally Qualified Health Centers (FQHCs), the MCOs will pay the $277.22 per-member-per-month 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. The MCO will make payment to the service location enrolled as Provider Specialty 080, FQHC, in accordance with Section VII.E.5 of this Agreement.

   The PH-MCO must coordinate with a member's BH-MCO and any OUD-COE providing services to the member in accordance with Section V.D.2 of this Agreement to ensure that the member's care is coordinated and not duplicated.

C. The following services, when provided as clinically appropriate and included or reflected in the individual member's care plan, constitute community-based care management services covered by procedure code G9012.

   1. Screening and Assessment

a. Assessments to identify a member's needs related to Social Determinants of Health, administered in home and community-based settings whenever practicable

b. 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.

c. Screenings for clinical needs that require referrals or treatment

2. Care Planning

a. Development of integrated, individualized care plans that include, at a minimum:

1. A member's treatment and non-treatment needs

2. The member's preferred method of care management, such as in-person meetings, phone calls, or through a secure messaging application

3. The identities of the members of the member's community-based care management team, as well as the members of the member's individual support system

b. Care coordination with a member's primary care provider, mental health service provider, drug & alcohol treatment provider, pain management provider, obstetrician or gynecologist, and PH-MCO, as applicable

3. Referrals

a. Facilitating referrals to necessary and appropriate clinical services according to the member's care plan, including:

1. Primary Care, including screening for and treatment of positive screens for: HIV, Hepatitis A (screening only); Hepatitis B; Hepatitis C; and Tuberculosis.

2. Perinatal Care and Family Planning Services

3. Mental Health Services

4. Forms of Forms of medication approved for use in MAT not provided at the OUD-COE Provider's enrolled service location(s)

5. MAT for pregnant women, if the OUD-COE Provider does not provide MAT to pregnant women

6. Drug and Alcohol Outpatient Services

7. Pain Management

b. Facilitating referrals to any ASAM Level of Care that is clinically appropriate according to a Level of Care Assessment

c. 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

4. Monitoring

a. Individualized follow-up with members and monitoring of members' progress per the member's care plan, including referrals for clinical and non-clinical services

b. Continued and periodic re-assessment of a member's Social Determinants of Health needs

c. Performing Urine Drug Screenings at least monthly

5. 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.

D. 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 PH-MCO may not require an OUD-COE to document provision of each of these services every month for every patient 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.

E. The PH-MCO must pay a claim for procedure code G9012 when it determines that the OUD-COE has met the following requirements:

1. During the first calendar month a Member is engaged with the OUD-COE, the OUD-COE has provided and documented one community-based care management service, as defined in Section C of this Exhibit, and one service for the treatment of a condition associated with an ICD-10 diagnosis code related to OUD.

2. During subsequent months a Member is engaged with the OUD-COE, the OUD-COE has provided and documented one community-based care management service, as defined in Section C of this Exhibit. If a Member does not receive a care management service for two or more consecutive months, the OUD-COE

must also provide a treatment service in addition to a care management service to receive the PMPM for a subsequent month.

3. The OUD-COE has documented the care management service encounter within the Member's electronic health record, including the following information:

    a. Date of encounter

    b. Location of encounter

    c. Identity of the individual employed by the OUD-COE with whom the Member met

    d. Duration of encounter

    e. Description of service provided during the encounter

    f. Next planned activities that the OUD-COE and the Member will undertake

4. 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 PH-MCO has already paid on a Member's behalf.

5. The OUD-COE has obtained written Member consent to share OUD related information with the Member's Physical HealthChoices MCO (PH-MCO), Behavioral HealthChoices MCO (BH-MCO) or Community HealthChoices MCO (CHC-MCO) consistent with state and federal laws and regulations for the purpose of coordinating comprehensive services that address the Member's physical and behavioral needs and any needs related to social determinants of health.

F. The PH-MCO may not pay multiple claims using procedure code G9012 to an OUD-COE for the same Member in the same calendar month. The PH-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 PH-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.

G. The PH-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 DHS monthly.

H. The PH-MCO will perform a claims analysis on an annual basis, due to the Department no later than July 31 of the calendar year following the year for which claims are being analyzed. The PH-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 PH-MCO's members.

I. The PH-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 PH-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 care 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 care 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. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or care 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. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or care 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 and their pregnancy that 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 buprenorphine. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or care management service from a COE during the reporting period) who received Buprenorphine during the COE service window.

10. 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 care management service from a COE during the reporting period) who received naltrexone during the COE service window.

11. 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 care 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.

12. Percentage of Members screened for Hepatitis B, Hepatitis C, HIV, and Tuberculosis. The four separate measures are calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or care management service from a COE during the reporting period) who were screened for (1) Hepatitis B, (2) Hepatitis C, (3) HIV, and (4) Tuberculosis during the COE service window.

13. 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 care management service from a COE during the reporting period) who received any type of contraception during the COE service window.

14. Percentage of female Members who received long-acting reversible contraception. The measure is calculated by determining the number of female enrollee-COE pairs (unique combinations of female enrollees receiving a treatment or care management service from a COE during the reporting period) who received any long-acting reversible contraception (LARC) during a COE service window.

15. Percentage of Members with emergency department visits. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or care management service from a COE during the reporting period) who had an ED visit during a COE service window.

16. Percentage of Members with inpatient acute stays, excluding drug and alcohol stays. The measure is calculated by determining the number of enrollee-COE pairs (unique combinations of enrollees receiving a treatment or care 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.

# EXHIBIT H

# EXHIBIT H

## PRIOR AUTHORIZATION GUIDELINES FOR PARTICIPATING MANAGED CARE ORGANIZATIONS IN THE HEALTHCHOICES PROGRAM

### A. General Requirement

The HealthChoices Physical Health Managed Care Organizations (PH-MCOs) must submit to the Department all written policies and procedures for the Prior Authorization of services. The PH-MCO may require Prior Authorization for any services that require Prior Authorization in the Medical Assistance Fee-for-Service (FFS) Program. The PH-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for determining if the service is Medically Necessary. The PH-MCO must receive advance written approval from the Department to require the Prior Authorization of any services not currently required to be Prior Authorized under the FFS Program. For each service to be Prior Authorized, the PH-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 submitted in writing, for all new and revised criteria, prior to implementation;
- Be approved by the Department in writing prior to implementation;
- Adhere to specifications of the HealthChoices RFP, HealthChoices Agreement, federal regulations, and applicable policy in Medical Assistance General Regulations, Chapter 1101 and DHS regulations;
- Ensure that physical health care is Medically Necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- Adhere to the applicable requirements of Centers for Medicare and Medicaid 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; and
- Be submitted on an annual basis for review and approval.

Future changes in state and federal law, state and federal regulations, and court cases may require re-evaluation of any previously approved Prior Authorization proposal. Any deviation from the policies and procedures approved by the Department, including time frames for decisions, is considered to be a change and

requires a new request for approval. Failure of the PH-MCO to comply may result in sanctions and/or penalties by the Department The Department defines prior authorization as a determination made by a PH-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.

The DHS Prior Authorization Review Panel has the sole responsibility to review and approve all prior authorization proposals from the PH-MCOs.

## B. Guidelines for Review

1. Basic Requirements:

   a. The PH-MCO must identify individual service(s), medical item(s), and/or therapeutic categories of drugs to be Prior Authorized.

   b. If the Prior Authorization is limited to specific populations, the PH-MCO must identify all populations who will be affected by the proposal for Prior Authorization.

2. Medically Necessary Requirements:

   a. The PH-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 PH-MCO must identify the source of the criteria used to review the request for Prior Authorization of services. The criteria must be consistent with the HealthChoices contract definition for a service or benefit that is Medically Necessary. All criteria must be submitted to the Department for evaluation and approval prior to implementation.

   c. For PH-MCOs, if the criteria being used are:

      - Purchased and licensed, the PH-MCO must identify the vendor;
      - Developed/recommended/endorsed by a national or state health care provider association or society, the PH-MCO must identify the association or society;

- Based on national best practice guidelines, the PH-MCO must identify the source of those guidelines;

- Based on the medical training, qualifications, and experience of the PH-MCO's Medical Director or other qualified and trained practitioners, the PH-MCO must identify the individuals who will determine if the service or benefit is Medically Necessary.

d. PH-MCO guidelines to determine medical necessity of all drugs that require prior authorization must be posted for public view on the PH-MCO's website. This includes, but is not limited to, guidelines to determine medical necessity of both specific drugs and entire classes of drugs that require prior authorization for health and safety reasons, non-formulary designations, appropriate utilization, quantity limits, or mandatory generic substitution. The guidelines must specify all of the conditions that the PH-MCO reviewers will consider when determining medical necessity including requirements for step therapy.

e. The PH-MCO must identify the qualification of staff that will determine if the service is Medically Necessary. Health Care Providers, qualified and trained in accordance with the CMS Guidelines, the RFP, the HealthChoices Agreement, and applicable legal settlements must make the determination of Medically Necessary services.

For children under the age of twenty-one (21), requests for service will not be denied for lack of Medical Necessity unless a physician, dentist or other health care professional with appropriate clinical 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 at a minimum three reasonable efforts to contact the prescriber prior to issuing a denial for the requested service. For Drug denials, refer to Exhibit BBB. The reasonable efforts to contact the prescriber must be documented in writing.

3. Administrative Requirements

a. The PH-MCO's written policies and procedures must identify the time frames for review and decisions and the PH-MCO must demonstrate that the time frames are consistent with the following required

maximum time frames:

- Immediate: Inpatient Place of Service Review for emergency and urgent admissions.

- 24 hours: All drugs; and items or services which must be provided on an urgent basis.

- 48 hours: (following receipt of required documentation) Home Health Services.

- 21 days: All other services.

b. The PH-MCO's written policies and procedures must demonstrate how the PH-MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

c. The PH-MCO's written policies and procedures must explain how Prior Authorization data will be incorporated into the PH-MCO's overall Quality Management plan.

4. Notification, Grievance, and DHS Fair Hearing Requirements

The PH-MCO must demonstrate how written policies and procedures for requests for Prior Authorization comply and are integrated with the Member and Provider notification requirements and Member Grievance and DHS Fair Hearing requirements of the RFP and Agreement.

5. Requirements for Care Management/Care Coordination of Non-Prior Authorized Service(s)/Items(s)

For purposes of tracking care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the PH-MCO may choose to establish a process or protocol requiring notification prior to service delivery. This process must not involve any approvals/denials or delays in receiving the service. The PH-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 Exhibit.

# EXHIBIT I

EXHIBIT J

# EXHIBIT J

## EPSDT GUIDELINES

The PH-MCO must adhere to specific Department regulations at 55 PA Code Chapters 3700 and 3800 as they relate to EPSDT examinations for individuals under the age of twenty-one (21) and entering substitute care or a child residential facility placement. These examinations must be performed within the timeframes established by the regulations. The scope of PH-MCO EPSDT requirements that address screening, diagnosis and treatment, tracking, follow-up and outreach, and interagency teams for children are provided below.

The PH-MCO must have written policies and procedures for providing all Medically Necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included on the Medicaid State Plan. The PH-MCO must assist individuals in gaining access to necessary medical, social, education, and other services in accordance with the HealthChoices agreement.

1. Screening

The PH-MCO must ensure that periodic EPSDT screens are conducted by a process, including data collection format, approved by the Department, on all Members under age twenty-one (21) to identify health and developmental problems. These screens must be in accordance with the most current periodicity schedule developed by the Department and recommended pediatric immunization schedules, both of which are based on guidelines issued by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC).

2. Diagnoses and Treatment

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, s/he is required to refer the child (not over five (5) years of age) through CONNECT, 1-800-692-7288, for referral for local Early Intervention Program services. The PH-MCO is also responsible to ensure that a child is referred to the county Intellectual Disabilities (ID) office for a determination of eligibility for home and community-based services. The Intellectual Developmental Disabilities County contacts are found at http://pafamiliesinc.org/understanding-systems/intellectual-disabilities/intellectual-developmental-disabilities-county-contact-information-for-pennsylvania.The PH-MCO is responsible for developing a system that tracks treatment needs as they are identified and ensures that appropriate follow-up is pursued and reflected in the medical record (see Section 3, Tracking, for all requirements).

OBRA ‘89 entitles individuals under the age of twenty-one (21) to receive all Medically Necessary health care services that are contained in Section 1905(a) of the Social Security Act and required to treat a condition diagnosed during any encounter with a Health Care

Provider practicing within the scope of state law. Any Medically Necessary health care, eligible under the federal Medicaid program, required to treat conditions detected during a visit must be covered by the PH-MCO, except Behavioral Health Services which will be covered through the BH-MCO. Even though the PH-MCO is not responsible for behavioral health treatment, it is still responsible for identifying Members who are in need of behavioral health treatment services, and for linking the Member with the appropriate BH-MCO.

The PH-MCO must have a system in place to address the need for and furnish expanded services. Such policies will be clearly communicated to Providers and Recipient through the Provider Manual and the Member Handbook. If a Health Care Provider prescribes services or equipment for an individual under the age of twenty-one (21), which is not normally covered by the MA Program, or for which the PH-MCO requires Prior Authorization, the PH-MCO must follow the Prior Authorization requirements outlined in Section V.B. and Exhibit H of the contract.

3. Tracking

The PH-MCO must establish a tracking system that provides information on compliance with EPSDT service provision requirements in the following areas:

- Initial visit for newborns. The initial EPSDT screen shall be the newborn physical exam in the hospital.

- EPSDT screen and reporting of all screening results.

- Diagnosis and/or treatment, or other referrals for children.

- Other tracking activities include: Number of comprehensive screens (reported by age); hearing and vision examinations; dental screens; age appropriate screens; complete age appropriate immunizations; blood lead screens; prenatal care for teen mothers; provision of eyeglasses to those in need of them; dental sealants; newborn home visits; referral of very low birth weight babies to early intervention; referral of Members under the age of five (5) with elevated blood lead levels to early intervention; routine evaluation for iron deficiencies; maternal depression screening; screenings for developmental delays and autism spectrum disorders; depression screenings; and timely identification and treatment of asthma.

4. Follow-ups and Outreach

The PH-MCO must have an established process for reminders, follow-ups and outreach to Members that includes:

- Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Members.

- Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period.

- If requested, any necessary assistance with transportation to ensure that recipients obtain necessary EPSDT screening services. This assistance must be offered prior to each due date of a child's periodic examination.

- Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate.

- A process for outreach and follow-up to Members under the age of twenty-one (21) with Special Needs, such as homeless children.

- A process for outreach and follow-up with County Children and Youth Agencies and Juvenile Probation Offices to assure that they are notified of all Members under the age of twenty-one (21) who are under their supervision and who are due to receive EPSDT screens and follow-up treatment.

- The PH-MCO may develop alternate processes for follow up and outreach subject to prior written approval from the Department.

The PH-MCO shall submit to the Department reports, as requested, that identify its performance in the above four required services (Screening, Diagnosis and Treatment, Tracking, and Follow-up and Outreach).

Arranging for Medically Necessary follow-up care for health care services is an integral part of the Provider's continuing care responsibility after a screen or any other health care contact. In cases involving a Member under the age of twenty-one (21) with complex medical needs or serious or multiple disabilities or illnesses, case management services must be offered, consistent with the HealthChoices agreement and exhibits.

To assist the PH-MCO in provision of the above four (4) required services (Screening, Diagnosis and Treatment, Tracking and Follow-up and Outreach) to children in substitute care, the PH-MCO will be required to develop master lists of all enrolled children who are coded as such on the monthly membership files. The PH-MCO must assign specific staff to monitor the services provided to these children and to ensure that they receive comprehensive EPSDT screens and follow-up services. The assigned staff must contact the relevant agencies with custody of these Members or with jurisdiction over them (e.g., County Children and Youth Agency, Juvenile Probation Office) when a particular child has yet to receive an EPSDT screen or is not current with their EPSDT screen and/or immunizations and to ensure that an appointment for such service is scheduled.

Further, in addition to the EPSDT related Pennsylvania Performance Measures, the PH-MCO must submit to the Department reports, as requested, providing all data regarding children in substitute care (e.g., the number of children enrolled in substitute care who have received comprehensive EPSDT screens, the number who have received blood level assessments, etc.).

5. Interagency Teams for EPSDT Services for Children

For the ongoing coordination of EPSDT services for Members under the age of twenty-one (21) identified with Special Needs, the PH-MCO must appoint a PH-MCO representative who will ensure coordination with other health, education and human services systems in the development of a comprehensive individual/family services plan.

The goal is to develop and implement a comprehensive service plan through a collaborative interagency team approach, which ensures that children have access to appropriate, coordinated, comprehensive health care. To achieve this goal, The PH-MCO must ensure the following:

- Children have access to adequate pediatric care.
- The service plan is developed in coordination with the interagency team, including the child (when appropriate), the adolescent and family members and a PH-MCO representative.
- Development of adequate specialty Provider Networks.
- Integration of covered services with ineligible services.
- Prevention against duplication of services.
- Adherence to state and federal laws, regulations and court requirements relating to individuals with Special Needs.
- Cooperation of PH-MCO Provider Networks.
- Applicable training for PCPs and Providers including the identification of PH-MCO contact persons.

# EXHIBIT K

EXHIBIT L

# EXHIBIT L

## MEDICAL ASSISTANCE TRANSPORTATION PROGRAM

The Medical Assistance Transportation Program (MATP) is responsible for the following:

- Providing non-emergency medical transportation to and/or from a MA compensable service received at a medical facility, doctor's or dentist's offices, hospital, clinic, pharmacy or supplier of medical equipment.

- Providing the least costly and most appropriate transportation to meet the needs of its consumers, including paying for mass transit trips on buses or trains or providing rides in paratransit vehicles. .

- Reimbursing the consumer for mileage at a rate determined by the Department, parking, and tolls with valid receipts, when the consumer uses their own car or someone else's to get to the medical care provider.

- Providing transportation services when the consumer has no other available means of transportation for urgent care. Urgent care, for the purpose of this agreement, is defined as 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. A hospital discharge shall be considered urgent care.

- Referring any requests for medically necessary non-emergency ambulance transportation and any requests that MATP cannot accommodate due to the requests being outside the scope of the MATP services.

The county MATP agency, Program Monitor, and/or MATP Standards and Guidelines, found on the MATP website, should be contacted or referenced for the detailed policies and procedures in carrying out the above responsibilities.

EXHIBIT M

# EXHIBIT M(1)

# EXHIBIT M(1)

## QUALITY MANAGEMENT, UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT PROGRAM REQUIREMENTS

The Department will monitor the Quality Management (QM),Utilization Management (UM) and Quality Improvement (QI) programs of all PH-MCOs and retains the right of advance written approval of all QM, UM and QI activities. The PH-MCO's QM, UM and QI programs must be designed to assure and improve the accessibility, availability, and quality of care being provided to its members. The PH-MCO's QM, UM and QI programs must, at a minimum:

A. Contain a written program description, work plan, evaluation and policies/procedures that meet requirements outlined in the agreement;

B. Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the PH-MCO in collaboration with the Department;

C. Be based on statistically valid clinical and financial analysis of Encounter Data, Member demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and other data that allows for the identification of prevalent medical conditions, barriers to care and health inequities to be targeted for quality improvement and disease management initiatives;

D. Allow for the continuous evaluation of its activities and adjustments to the program based on these evaluations;

E. Demonstrate sustained improvement for clinical performance over time; and

F. Allow for the timely, complete, and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including HEDIS and CAHPS as outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).

G. Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the PH-MCO or the Department that:

1. Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;

2. Allow for submission of improvement plans, as determined by and within time frames established by the Department. Failure by the PH-MCO to comply with the requirements and improvement actions requested by the Department may result in the application of penalties and/or sanctions as outlined in Section VIII.H, Sanctions, of the Agreement.

H. Obtain accreditation by a nationally recognized organization, such as National Committee of Quality Assurance (NCQA).

1. The PH-MCO must demonstrate evidence by submitting to the Department accreditation survey type and level, results of survey including recommendations actions and/or improvements, corrective action plans, and summaries of findings conducted by the accrediting national recognized organization.

2. The PH-MCO must submit to the Department an expiration of the accreditation and future accreditation surveys.

I. Attain NCQA Multicultural Health Care Distinction by meeting the requirement guidelines set forth by NCQA for multicultural health care. The PH-MCO must submit a workplan and timeline to the Department depicting their progress in achieving NCQA Multicultural Distinction at least annually.

J. Determine whether algorithms used for case management, disease management, quality management, or decisions about which enrollees receive additional services from the PH-MCO, contain inadvertent racial bias. If any racial bias is identified, the PH-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 PH-MCO will work with entities designated by the Department to identify bias and the actions that can be taken to eliminate or mitigate bias.

**Standard I:** The scope of the QM, UM and QI programs must be comprehensive in nature; allow for improvement and be consistent with the Department's goals related to access, availability and quality of care. At a minimum, the PH-MCO's QM, UM and QI programs, must:

A. Adhere to current Medicaid CMS guidelines.

B. Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and QI techniques of peer review.

C. Ensure that all QM, UM and QI activities and initiatives undertaken by the PH-MCO are—based upon clinical and financial analysis of Encounter Data, Member demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and/or other identified areas.

D. Contain policies and procedures which provide for the ongoing review of the entire scope of care provided by the PH-MCO assuring that all demographic groups, races, ethnicities, care settings and types of services are addressed.

E. Contain a written program description that addresses all standards, requirements and objectives established by the Department and that describes the goals, objectives, and structure of the PH-MCO's QM, UM and QI programs. The written program description must, at a minimum:

1. Include standards and mechanisms for ensuring the accessibility of primary care services, specialty care services, urgent care services, hospitals and Member services in accordance with timeframes outlined in Exhibit AAA, Provider Network Composition/Service Access of the Agreement.

2. Include mechanisms for planned assessment and analysis of the quality of care provided and the utilization of services against formalized standards, including but not limited to:

    a. Primary, secondary, and tertiary care;

    b. Preventive care and wellness programs;

    c. Acute and/or chronic conditions;

    d. Dental care;

    e. Care coordination; and

    f. Continuity of care.

3. Allow for the timely, accurate, complete collection and clinical and financial analysis of Encounter Data and other data including, but not limited to, HEDIS, CAHPS, and Pennsylvania Performance Measures.

4. Allow for systematic analysis and re-measurement of barriers to care, the quality of care provided to Members, and utilization of services over time.

F. Provide a comprehensive written evaluation, completed on at least an annual basis, that details all QM, UM and QI program activities including, but not limited to:

    a. Studies and activities undertaken; including the rationale, methodology and results;

    b. Subsequent improvement actions; and

    c. Aggregate clinical and financial analysis of Encounter, HEDIS, CAHPS, Pennsylvania Performance Measures, Community Based Care Management, Maternity Home Visiting program, Diabetic Prevention

Program and other utilization of services data and quality of care rendered to Members.

G. Include a work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM and QI activities, including, but not limited to:

   a. Data collection and analysis;

   b. Evaluation and reporting of findings;

   c. Implementation of improvement actions where applicable; and

   d. Individual accountability for each activity.

H. Provide for aggregate and individual analysis and feedback of Provider performance and PH-MCO performance in improving access to care, the quality of care provided to Members and utilization of services.

I. Include mechanisms and processes which ensure related and relevant operational components, activities, and initiatives from the QM, UM and QI programs are integrated into activities and initiatives undertaken by other departments within the PH-MCO including, but not limited to, the following:

   a. Special Needs;

   b. Provider Relations;

   c. Member Services; and

   d. Management Information Systems

J. Include procedures for informing both physician and non-physician Providers about the written QM, UM and QI programs, and for securing cooperation with the QM, UM and QI programs in all physician and non-physician Provider agreements.

K. Include procedures for feedback and interpretation of findings from analysis of quality and utilization data to Providers, health professionals, PH-MCO staff, and MA Consumers/family members.

L. Include mechanisms and processes which allow for the development and implementation of PH-MCO wide and Provider specific improvement actions in response to identified barriers to care, quality of care concerns, and over-utilization, under-utilization and/or mis-utilization of services.

**Standard II:** The organizational structures of the PH-MCO must ensure that:

A. The Governing Body:

1. Has formally designated an accountable entity or entities, within the PH-MCO to provide oversight of QM, UM and QI program activities or has formally decided to provide such oversight as a committee, e.g. Quality Management Committee.

2. Regularly receives written reports on the QM, UM and QI program activities that describe actions taken, progress in meeting objectives and improvements made. The governing body formally reviews, on at least an annual basis, a written evaluation of the QM, UM and QI program activities that includes studies undertaken, results of studies, and subsequent improvement actions taken. The written evaluation must include aggregate clinical and financial analysis of quality and utilization data, including HEDIS, CAHPS, and Pennsylvania Performance Measures.

3. Documents actions taken by the governing body in response to findings from QM, UM and QI program activities.

B. The Quality Management Committee (QMC):

1. Must contain policies and procedures which describe the role, structure and function of the QMC that:

   a. Demonstrate that the QMC has oversight responsibility and input, including review and approval, on all QM, UM and QI program activities;

   b. Ensure membership on the QMC and active participation by individuals representative of the composition of the PH-MCO's Providers; and

   c. Provide for documentation of the QMC's activities, findings, recommendations, and actions.

2. Meets at least monthly, and otherwise as needed.

C. The Senior Medical Director must be directly accountable to and act as liaison to the Chief Medical Officer for DHS.

D. The Medical Director:

1. Serves as liaison and is accountable to the governing body and Quality Management Committee for all QM, UM and QI activities and initiatives;

2. Is available to the PH-MCO's medical staff for consultation on referrals, denials, Complaints and problems;

3. Is directly involved in the PH-MCO's recruiting and credentialing activities;

4. Is familiar with local standards of medical practice and nationally accepted standards of practice;

5. Has knowledge of due process procedures for resolving issues between participating Providers and the PH-MCO administration, including those related to medical decision making and utilization review;

6. Is available to review, advise and take action on questionable hospital admissions, Medically Necessary days and all other medical care and medical cost issues;

7. Is directly involved in the PH-MCO's process for prior authorizing or denying services and is available to interact with Providers on denied authorizations;

8. Has knowledge of current peer review standards and techniques;

9. Has knowledge of risk management standards;

10. Is directly accountable for all Quality Management, Utilization Management and Quality Improvement activities and

11. Oversees and is accountable for:

    a. Referrals to the Department and appropriate agencies for cases involving quality of care that have adverse effects or outcomes; and

    b. The processes for potential Fraud and Abuse investigation, review, sanctioning and referral to the appropriate oversight agencies.

E. The PH-MCO must have sufficient material resources, and staff with the appropriate education, experience and training, to effectively implement the written QM, UM and QI programs and related activities.

**Standard III:** The PH-MCO QM, UM and QI programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services provided to Members through quality of care studies and related activities with a focus on identifying and pursuing opportunities for continuous and sustained improvement.

A. The QM, UM and QI programs must adopt, in consultation with network providers, and include professionally developed practice guidelines/standards of care that are:

1. Written in measurable and accepted professional formats,

2. Based on valid and reliable clinical and scientific evidence or a consensus of providers in the particular field; and

3. Applicable to Providers for the delivery of certain types or aspects of health care.

B. The QM, UM and QI programs must include clinical/quality Indicators in the form of written, professionally developed and adopted in consultation with contracting health professionals, with objective and measurable variables of a specified clinical or health services delivery area, which are updated periodically as appropriate and reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.

C. Practice guidelines and clinical indicators must consider the needs of the PH-MCO Enrollees and must address the full range of health care needs of the populations served by the PH-MCO. (per 42 C.F.R. 438.236 (b)(2)).

D. The clinical areas addressed must include, but are not limited to:

1. Adult preventive care;

2. Pediatric and adolescent preventive care with a focus on EPSDT services;

3. Obstetrical care including a requirement that Members be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;

4. Selected diagnoses and procedures relevant to the enrolled population;

5. Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the PH-MCO's membership; and

6. Preventive dental care.

E. The PH-MCO QM, UM and QI programs must disseminate practice guidelines, clinical indicators and medical record keeping standards to all affected Providers and appropriate subcontractors. This information must also be provided to Members or potential Enrollees upon request. (per 42 C.F.R 438.236 (c)).

F. The PH-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, and Providers of ancillary services not less than every two years (e.g., medical record audits). These methodologies must, at a minimum:

1. Demonstrate the degree to which PCPs, specialists, and dental Providers are complying with clinical and preventive care guidelines adopted by the plan;

2. Allow for the tracking and trending of individual and PH-MCO wide Provider performance over time;

3. Include active mechanisms and processes that allow for the identification, investigation and resolution of quality of care concerns, including events such as Health Care-Associated Infections and medical errors; and

4. Include mechanisms for detecting instances of over-utilization, under-utilization, and mis-utilization.

G. The QM, UM and QI program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:

1. Processes that allow for the identification, investigation and resolution of quality of care concerns including Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care patterns;

2. Processes for tracking and trending problematic patterns of care;

3. Use of progressive sanctions as indicated;

4. Person(s) or body responsible for making the final determinations regarding quality problems; and

5. Types of actions to be taken, such as:

    a. Education;

    b. Follow-up monitoring and re-evaluation;

    c. Changes in processes, structures, forms;

    d. Informal counseling;

    e. Procedures for terminating the affiliation with the physician or other health professional or Provider;

    f. Assessment of the effectiveness of the actions taken; and

g. Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care).

H. The QM, UM and QI programs must include methodologies that allow for the identification, verification, and timely resolution of inpatient and outpatient quality of care concerns, Member quality of care complaints, over-utilization, under-utilization, and/or mis-utilization, access/availability issues, and quality of care referrals from other sources;

I. The QM, UM and QI programs must contain procedures for Member satisfaction surveys that are conducted on at least an annual basis including the collection of annual Member satisfaction data through application of the CAHPS instrument as outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).

J. The QM, UM and QI programs must contain procedures for Provider satisfaction surveys to be conducted on at least an annual basis. Surveys are to include PCPs, and specialists, dental Providers, hospitals, and Providers of ancillary services.

K. Each PH-MCO will be required to comply with requirements for Performance Improvement Projects (PIPs) as outlined in Exhibit M(2) External Quality Review.

**Standard IV:** The QM, UM and QI programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to Members through utilization review activities with a focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization.

A. Semi-annually, or more frequently as appropriate, the QM, UM and QI programs must provide for production and distribution to Providers, (in either hard copy or web-based electronic formats) profiles comparing the average medical care utilization rates of the Members of each PCP to the average utilization rates of all PH-MCO Members. The PH-MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to:

1. Utilization information on Member Encounters with PCPs;

2. Specialty Claims;

3. Prescriptions;

4. Inpatient stays;

5. Emergency room use;

6. Clinical indicators for preventive care services (e.g., mammograms, immunizations, pap smear, etc.); and

7. Clinical indicators for EPSDT requirements.

B. PH-MCO must submit to the department on an annual basis network provider profiles.

C. The PH-MCO must have mechanisms and processes for profiling physicians using risk adjusted diagnostic data for profiles.

D. The QM, UM and QI programs must implement statistically valid methodologies for analysis and follow-up of semi-annual practitioner utilization profiles for patterns and instances of over-utilization, under-utilization, and mis-utilization across the continuum of care, as well as, trending of Provider utilization patterns over time. Follow up includes but is not limited to Provider education, Provider improvement plans, and Provider sanctions as necessary.

E. The QM, UM and QI programs must at least annually, provide for verification of Encounter reporting rates and accuracy and completeness of Encounter information submitted by PCPs.

**Standard V:** The PH-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for Members identified. Case/Disease and health management programs must:

A. Include mechanisms and processes that ensure the active collaboration and coordination of care and services for identified members.

B. Include mechanisms and processes that allow for the identification of conditions to be targeted for case/disease and health management programs and that allow for the assessment and evaluation of the effectiveness of these programs in improving outcomes for and meeting the needs of individuals with targeted conditions.

C. Include care guidelines and/or protocols for appropriate and effective management of individuals with specified conditions. These guidelines must be written in measurable and accepted professional formats and be based on scientific evidence.

D. Include performance indicators that allow for the objective measurement and analysis of individual and PH-MCO wide performance in order to demonstrate progress made in improving access and quality of care.

E. Include mechanisms and processes that lead to healthy lifestyles such as weight loss program memberships, gym memberships and asthma camps.

F. Include and refer members who are identified as pre-diabetic to programs that addresses prevention of diabetes mellitus. The programs must be recognized by the Centers for Disease Control (CDC) or be enrolled in the Medicare program as a Medicare Diabetes Prevention Program. Requirements for program recognition by the CDC are available at: https://www.cdc.gov/diabetes/prevention/requirements-recognition.htm

G. Include participation and membership in the Perinatal Collaborative being developed with the DHS and DOH.

H. Include collaboration with the Department to develop, adopt and disseminate a resource and referral tool.

**Standard VI**: The QM, UM and QI programs must have mechanisms to ensure that Members receive seamless, continuous, and appropriate care throughout the continuum of care, by means of coordination of care, benefits, and quality improvement activities between:

A. PCPs and specialty care practitioners and other Providers**;**

B. Other HealthChoices PH-MCOs;

D. The PH-MCO and HealthChoices BH-MCOs;

E. The PH-MCOs and the Department's Fee For Service Program; and

F. The PH-MCO and other third party insurers

**Standard VII:** The PH-MCO must demonstrate that it retains accountability for all QM,UM and QI program functions, including those that are delegated to other entities. The PH-MCO must:

A. Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the PH-MCO.

B. Have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. Document evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

D. Make available to the Department, and its authorized representatives, any and all records, documents, and data detailing its oversight of delegated QM,UM and QI program functions.

E. Must ensure that delegated entities make available to the Department, and its authorized representatives, any and all records, documents and data detailing the delegated QM,UM and QI program functions undertaken by the entity of behalf of the PH-MCO.

F. Compensation and payments to individuals or entities that conduct Utilization Management activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member

**Standard VIII**: The QM/UM/QI program must have standards for credentialing/ recredentialing Providers to determine whether physicians and other Health Care Providers, who are licensed by the Commonwealth and are under contract to the PH-MCO, are qualified to perform their services.

A. The PH-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types. Recredentialing activities must be conducted by the PH-MCO at least every three (3) years. Criteria must include, but not be limited to, the following:

1. Appropriate license or certification as required by Pennsylvania state law;

2. Verification that Providers have not been suspended, terminated or entered into a settlement for voluntary withdrawal from the Medicaid or Medicare Programs;

3. Verification that Providers and/or subcontractors have a current Provider Agreement and an active PROMIS*e*™ Provider ID issued by the Department;

4. Evidence of malpractice/liability insurance;

5. A valid Drug Enforcement Agency (DEA) certification;

6. Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach;

7. Consideration of quality issues such as Member Complaint and/or Member satisfaction information, sentinel events and quality of care concerns.

B. For purposes of credentialing and recredentialing, the PH-MCO must perform a check on all PCPs and other physicians by contacting the National Practitioner Data Bank (NPDB). If the PH-MCO does not meet the statutory requirements for accessing the NPDB, then the PH-MCO must obtain information from the Federation of State Medical Boards.

C. Appropriate PCP qualifications:

1. Seventy-five to 100% of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics;

2. No more than 25% of the Network consists of PCPs without appropriate residencies but who have, within the past seven years, five years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described; and

3. No more than 10% of the Network consists of PCPs who were previously trained as specialist physicians and changed their areas of practice to primary care, and who have completed Department-approved primary care retraining programs.

4. A PCP must have the ability to perform or directly supervise the ambulatory primary care services of Members;

5. Membership of the medical staff with admitting privileges of at least one general hospital or an acceptable arrangement with a PCP with admitting privileges;

6. Demonstrate evidence of continuing professional medical education;

7. Attend at least one PH-MCO sponsored Provider education training session as outlined in Section V.R.2, Provider Education, of the Agreement.

D. Assurance that any CRNP, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team, is performing under the scope of their respective licensure; and

E. As part of the Provider release form, the potential Provider must agree to release all MA records pertaining to sanctions and/or settlement to the PH-MCO and the Department.

F. The Department will recoup from the PH-MCO any and all payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by the PH-MCO in a manner that is not consistent with the Provider's licensure. In addition, the PH-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.

G. The PH-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to

have input on the PH-MCO's credentialing practices.

H. Any economic profiles used by the PH-MCOs to credential Providers should be adjusted to adequately account for factors that influence utilization independent of the Provider's clinical management, including Member age, Member sex, Provider case-mix and Member severity. The PH-MCO must report any utilization profile that it utilizes in its credentialing process and the methodology that it uses to adjust the profile to account for non-clinical management factors at the time and in the manner requested by the Department.

I. In the event that a PH-MCO renders an adverse credentialing decision, the PH-MCO must provide the affected Provider with a written notice of the decision. The notice should include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors. All credentialing decisions made by the PH-MCO are final and may not be appealed to the Department.

J. The PH-MCO must meet the following standards related to timeliness of processing new provider applications for credentialing.

1. The PH-MCO must begin its credentialing process upon receipt of a provider’s credentialing application if the application contains all required information.

2. The PH-MCO may not delay processing the application if the provider does not have an MAID number that is issued by the DHS. However, the PH-MCO cannot complete its process until the provider has received its MAID number from DHS.

3. Provider applications submitted to the PH-MCO for credentialing must be completed within sixty (60) calendar days of the PH-MCO, Dental Benefit Manager (DBM) or Vision Benefit Manager (VBM) receipt of a complete application packet.

4. The PH-MCO, DBM or VBM must notify the provider of the status of their credentialing application as follows:

    a. First Correspondence: The PH-MCO, DBM or VBM must provide an Acknowledge of Application notification to the provider within ten (10) calendar days of receipt.

    b. Second Correspondence: The PH-MCO, DBM or VBM will send an Application Status to the provider within thirty (30) calendar days stating:

i. Their application is clean and is being submitted through the credentialing process or;

ii. Their application is not clean with a list of items needing to be addressed. If a provider's Medicaid ID (PROMISe) number is not in place at the time of this notification, it may be noted as an outstanding item.

c. Third Correspondence: A Credentialing Approval/Denial notice will be sent within a maximum of sixty (60) calendar days. If the provider application is denied, the correspondence should include all of the requirements that were not met.

d. The PH-MCO, DBM and VBM must also include language in the First and Second Correspondence reminding providers that credentialing cannot be completed until their Medicaid Number (PROMISe ID) is in place.

e. The PH-MCO, DBM and VBM are encouraged to provide communications electronically to the provider.

5. Failure to comply will result in sanctions as per Section VIII. H. to include retrospective payments to the provider as directed by the Department.

**Standard IX:** The PH-MCO's written UM program must contain policies and procedures that describe the scope of the program, mechanisms, information sources used to make determinations of medical necessity and in conjunction with the requirements in Exhibit H Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program.

A. The UM program must contain policies and procedures for Prospective, Concurrent, and Retrospective review determinations of medical necessity.

B. The UM program must allow for determinations of medical necessity that are consistent with the HealthChoices Program definition of Medically Necessary:

Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review or Retrospective Review basis, shall be documented in writing. The PH-MCO shall base its determination on medical information provided by the Member, the Member's family/care taker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Member. Medical necessity determinations must be made by qualified and trained

Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement. Satisfaction of any one of the following standards will result in authorization of the service:

1. The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability;

2. The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability;

3. The service or benefit will, assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

C. If the PH-MCO wishes to require Prior Authorization of any services, they must establish and maintain written policies and procedures for the Prior Authorization review process. Prior Authorization policies and procedures must:

1. Meet the HealthChoices Program's definition of Medically Necessary;

2. Contain timeframes for decision making or cross reference policies on time frames for decision making that meet requirements outlined in Section V.B, Prior Authorization of Services, of the Agreement.

3. Contain language or cross reference policies and procedures of notifying Members of adverse decisions and how to file a Complaint/Grievance/DHS Fair Hearing;

4. Comply with state/federal regulations;

5. Comply with HealthChoices RFP and other contractual requirements;

6. Specify populations covered by the policy;

7. Contain an effective date; and

8. Be received under signature of individuals authorized by the plan.

D. The PH-MCO must provide all Licensed Proprietary Products which include, but are not limited to: Interqual and Milliman to the Department annually. All Utilization Review Criteria and/or policies and procedures that contain Utilization Review Criteria used to determine medical necessity must:

1. Not contain any definition of medical necessity that differs from the HealthChoices definition of Medically Necessary;

2. Allow for determinations of medical necessity that are consistent with the HealthChoices Program definition of Medically Necessary;

3. Allow for the assessment of the individual's current condition and response to treatment and/or co-morbidities, psychosocial, environmental and/or other needs that influences care;

4. Provide direction to clinical reviewers on how to use clinical information gathered in making a determination to approve, deny, continue, reduce or terminate a service;

5. Be developed using a scientific based process;

6. Be reviewed at least annually and updated as necessary; and

7. Provide for evaluation of the consistency with which reviewers implement the criteria on at least an annual basis.

E. The PH-MCO must ensure that Prior Authorization and Concurrent review decisions:

1. Are supervised by a physician, dentist or Health Care practitioner with appropriate clinical expertise in treating the Member's condition or disease;

2. That result in a denial may only be made by a licensed physician or licensed dentist;

3. Are made in accordance with established time-frames outlined in the Agreement for routine, urgent, or emergency care; and

4. Are made by clinical reviewers using the HealthChoices definition of medical necessity.

F. The PH-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, and medical supplies. The PH-MCO must have written policies and procedures that address how Members and Providers can make contact with the PH-MCO to receive instruction or Prior Authorization, as necessary

G. Additional Prior Authorization requirements can be found in Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program.

H. The PH-MCO must ensure that utilization records document efforts made to obtain all pertinent clinical information and efforts to consult with the prescribing Provider before issuing a denial based upon medical necessity.

I. The PH-MCO must ensure that sources of utilization criteria are provided to Members and Providers upon request.

J. The UM program must contain procedures for providing written notification to Members of denials of medical necessity and terminations, reductions and changes in level of care or placement, which clearly document and communicate the reasons for each denial. These procedures and process must:

1. Meet requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.

2. Provide for written notification to Members of denials, terminations, reductions and changes in medical services at least ten (10) days before the effective date.

3. Include notification to Members of their right to file a Complaint, Grievance or DHS Fair Hearing as outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.

4. Not allow for UM staff rendering an adverse determination of a denial to use Prior Authorization policy, Medical literature, PA codes and Federal regulations as a means of informing a member of a service or item denial.

K. The PH-MCO must agree to comply with the Department's utilization review monitoring processes, including, but not limited to:

1. Submission of a log of all denials issued using formats to be specified by the Department.

2. Submission of denial notices for review as requested by the Department.

3. Submission of utilization review records and documentation as requested by the Department.

4. Identifying the source of the criteria used to review the request for Prior Authorization of services.

5. Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.

6. Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet

Department requirements. This process must be approved by the Department prior to implementation.

L. The PH-MCO must follow the Department's Technology Assessment Group (TAG) process and determinations when new and existing services or items are reviewed and added to the MA Program.

**Standard X:** The PH-MCO must have a mechanism in place for Provider Appeals/Provider Disputes related to the following:

A. Administrative denials including denials of Claims/payment issues, and payment of Claims at an alternate level of care than what was provided, e.g., acute versus skilled days. This includes the appeal by Health Care Providers of a PH-MCO's decision to deny payment for services already rendered by the Provider to a Member.

B. QM/UM/QI sanctions

C. Adverse credentialing/recredentialing decisions

D. Provider Terminations

**Standard XI:** The PH-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM, UM and QI program activities are documented and reported to appropriate individuals within the PH-MCO for use in other management activities.

A. The QM, UM and QI program must have procedures which describe how findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to individuals within the PH-MCO for use in conjunction with other related activities such as:

1. PH-MCO Provider Network changes;

2. Benefit changes;

3. Medical management systems (e.g., pre-certification); and

4. Practices feedback to Providers.

**Standard XII:** The PH-MCO must have written policies and procedures for conducting prospective and retrospective Drug Utilization Guidelines (DUR) that meet requirements outlined in Exhibit BBB.

**Standard XIII:** The PH-MCO must have written standards for medical record keeping. The PH-MCO must ensure that the medical records contain written documentation of the medical necessity of a rendered, ordered or prescribed service.

A. The PH-MCO must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for medical records that promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

B. Medical record standards must meet or exceed medical record keeping requirements contained in 55 Pa. Code Section 1101.51(d)(e) of the MA Manual and medical record keeping standards adopted by DOH.

C. Additional standards for patient visit data must, at a minimum, include the following:

1. History and physical that is appropriate to the patient's current condition;

2. Treatment plan, progress and changes in treatment plan;

3. Diagnostic tests and results;

4. Therapies and other prescribed regimens;

5. Disposition and follow-up;

6. Referrals and results thereof;

7. Hospitalizations;

8. Reports of operative procedures and excised tissues; and

9. <u>All other aspects of patient care.</u>

D. The PH-MCO must have written policies and procedures to assess the content of medical records for legibility, organization, completion and conformance to its standards.

E. The PH-MCO must ensure access of the Member to his/her medical record at no charge and upon request. The Member's medical records are the property of the Provider who generates the record.

F. The Department and/or its authorized agents (i.e., any individual or corporation or entity employed, contracted or subcontracted with by the Department) shall be afforded prompt access to all Members' medical records whether electronic or paper. All medical record copies are to be forwarded to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. The Department is not required to obtain written approval from a Member before requesting the Member's medical record from the PCP or any other agency.

G. Medical records must be preserved and maintained for a minimum of five years from expiration of the PH-MCO's contract. Medical records must be made available in paper form upon request.

H. When a Member changes PCPs, the PH-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PCP within seven business days from receipt of the request. In emergency situations, the PH-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

I. When a Member changes PH-MCOs, the PH-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PH-MCO within seven business days from the effective date of enrollment in the gaining PH-MCO. In emergency situations, the PH-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

**Standard XIV:** The QM,UM and QI programs must demonstrate a commitment to ensuring that Members are treated in a manner that acknowledges their defined rights and responsibilities.

A. The PH-MCO must have a written policy that recognizes the following rights of Members:

1. To be treated with respect, and recognition of their dignity and need for privacy;

2. To be provided with information about the PH-MCO, its services, the practitioners providing care, and Members rights and responsibilities;

3. To be able to choose Providers, within the limits of the PH-MCO Network, including the right to refuse treatment from specific practitioners;

4. To participate in decision making regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions;

5. To have a Health Care Provider, acting within the lawful scope of practice, discuss Medically Necessary care and advise or advocate appropriate care with or on behalf of the Member including; information regarding the nature of

treatment options; risks of treatment; alternative therapies; and consultation or tests that may be self-administered; without any restriction or prohibition from the PH-MCO;

6. To file a Grievance about the PH-MCO or care provided;

7. To file a DHS Fair Hearing appeal with the Department;

8. To formulate advance directives including:

   a. Written policies and procedures that meet advance directive requirements in accordance with 42 C.F.R. 489, Subpart I

   b. Written policies and procedures concerning advance directives with respect to all adult Members receiving medical care by or through the PH-MCO

9. To have access to his/her medical records in accordance with applicable Federal and State laws and the right to request that they be amended or corrected as specified as in 45 C.F.R. Section 164.526.

B. The PH-MCO must have a written policy that addresses Member's responsibility for cooperating with those providing health care services. This written policy must address Member's responsibility for:

1. Providing, to the extent possible, information needed by professional staff in caring for the Member; and

2. Following instructions and guidelines given by those providing health care services.

   Members shall provide consent to managed care plans, Health Care Providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For these purposes, Members will remain anonymous to the greatest extent possible.

C. The PH-MCO's policies on Member rights and responsibilities must be provided to all participating Providers.

D. Upon enrollment, Members must be provided with a written statement that includes information on the following:

1. Rights and responsibilities of Members;

2. Benefits and services included as a condition of membership, and how to obtain them, including a description of:

a. Any special benefit provisions (for example, co-payment, higher deductibles, rejection of Claim) that may apply to services obtained outside the system; and

b. The procedures for obtaining Out-of-Area Services;

c. Charges to Members if applicable;

d. Benefits and services excluded.

e. Provisions for after-hours, urgent and emergency coverage;

f. The PH-MCO's policy on referrals for specialty care;

g. PH-MCO Procedures for notifying, in writing, those Members affected by denial, termination or change in any benefit or service including denials, terminations or changes in level of care or placement;

h. Procedures for appealing decisions adversely affecting the Member's coverage, benefits or relationship to the PH-MCO;

i. Information about OMAP's Hotline functions;

j. Procedures for changing practitioners;

k. Procedures for disenrolling from the PH-MCO;

l. Procedures for filing Complaints and/or Grievances; DHS Fair Hearings; and

m. Procedures for recommending changes in policies and services.

E. The PH-MCO must have policies and procedures for resolving Member Complaints and Grievances that meet all requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Processes. These procedures must include mechanisms that allow for the review of all Complaints and Grievances to determine if quality of care issues exists and for appropriate referral of identified issues.

F. Opportunity must be provided for Members to offer suggestions for changes in policies and procedures.

G. The PH-MCO must take steps to promote accessibility of services offered to Members. These steps must include identification of the points of access to primary care, specialty care and hospital services. At a minimum, Members are given information about:

1. How to obtain services during regular hours of operation;

2. How to obtain after-hours, urgent and emergency care; and

3. How to obtain the names, qualifications, and titles of the Health Care Provider providing and/or responsible for their care.

H. Member information (for example, Member brochures, Member denials, announcements, and handbooks) must be written in language that is readable and easily understood.

I. The PH-MCO must make vital documents disseminated to English speaking members available in alternate languages, upon request of the member. Documents may be deemed vital if related to the access of LEP persons to programs and services.

**Standard XV:** The PH-MCO must maintain systems, which document implementation of the written QM, UM and QI program descriptions.

A. The PH-MCO must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM, UM and QI programs.

B. The PH-MCO must adhere to all systems requirements as outlined in Section V.O.5., Management Information Systems, and Section VIII.B, Systems Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the HealthChoices Extranet.

C. The PH-MCO must adhere to all Encounter Data requirements as outlined in Section VIII.B.1, Encounter Data Reporting, of the Agreement.

# EXHIBIT M(1a)

## EXHIBIT M(1a)

## QUALITY MANAGEMENT REQUIREMENT FOR REGIONAL ACCOUNTABLE HEALTH COUNCILS

The PH-MCO 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 MCO operates under agreement with the Department. There shall be five RAHCs: Southeast, Southwest, New East, New West 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 (1) representative from the executive leadership team of the MA MCO;
b. One (1) representative from each of the executive leadership teams of the MA and CHIP MCOs and Behavioral Health Primary Contractors operating under agreement with the Department in the Physical Health HealthChoices Zone;
c. One (1) representative from each of the high MA utilization health systems (as defined by the Department);
d. One (1) representative from three Community-Based Organizations (CBOs) that focus on SDOH (as identified by the Department); and
e. At least one (1) 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.

4. 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 MA MCOs 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 is 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 may 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.
g. Identify best practices and challenges from the prior year's RHTP.

H. The PH-MCO shall coordinate with other MA and CHIP MCOs and Behavioral Health Primary Contractors in the PH-MCO's HealthChoices Zone to begin implementing the strategies outlined in the RHTP, after the RHTP is approved by the Department.

# EXHIBIT M(2)

## EXHIBIT M(2)

## EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1902(a), (30), (c) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations, including the evaluation of quality outcomes, timeliness and access to services. The requirements for EQR were further outlined in 42 CFR Part 438; External Quality Review of Medicaid Managed Care Organizations; Final Rule issued on May 6, 2016. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members. "Quality", as it pertains to EQR, means the degree to which a PH-MCO maintains or improves the health outcomes of its Members through its structural and operational characteristics and through the provision of services. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight. The Department requires that the PH-MCOs:

A. Actively participate in planning and developing the measures to be utilized with the Department and the EQRO. The Medical Assistance Advisory Committee will be given an opportunity to provide input into the measures to be utilized.

B. Accurately, completely and within the required timeframe identify eligible Members to the EQRO.

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

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

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

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

G. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Part 438.

H. Ensure that data, clinical records and workspace located at the PH-MCO's work site are available to the independent review team and to the Department, upon request.

I. Participate in Performance Improvement Projects whose target areas are dictated by the Department to address key quality areas of focus for improvements. The PH-MCO will comply with the timelines as prescribed by the EQRO.

# EXHIBIT M(3)

# EXHIBIT M(4)

## EXHIBIT M(4)

## HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

HEDIS® is a set of standardized performance measures designed to reliably compare health plan performance. HEDIS® performance measures are divided into five domains of care:

- Effectiveness of care,
- Access/availability of care,
- Experience of care (Adult and Child CAHPS®),
- Utilization and Relative resource use, and
- Health plan descriptive information.

The Department requires that the PH-MCOs:

A. Must produce rates for all Medicaid reporting measures, with the exclusion of the behavioral health measures, unless otherwise specified by the Department.

B. Must follow NCQA specifications as outlined in the HEDIS® Technical Specifications clearly identifying the numerator and denominator for each measure.

C. Must have all HEDIS® results validated by an NCQA-licensed vendor. The Department currently contracts with an NCQA-licensed entity to validate the MCOs' HEDIS® results used in public reporting. The MCO may utilize these validation results for other purposes such as pursuit of accreditation. The Department may at some future date relinquish the direct contracting of NCQA validation activities.

D. Must assist with the HEDIS® validation process by the Department's NCQA licensed contractor.

E. Must demonstrate how HEDIS® results are incorporated into the MCO's overall Quality Improvement Plan.

F. Must submit validated HEDIS® results annually on June 15th unless otherwise specified by the Department.

Measures publicly reported in the HealthChoices Consumer Guide are based on the Department's NCQA-licensed organization's validated findings.

## Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS® surveys (Adult and Child) are subsets of HEDIS® reporting required by the Department. For HEDIS®, MCOs must contract with an NCQA-certified vendor to administer the survey according to the HEDIS® survey protocol that is designed to produce standardized results. The survey is based on a randomly selected sample of Members from the MCO and summarizes satisfaction with the experience of care through ratings and composites.

In addition to the Adult survey, HEDIS® incorporates a CAHPS® survey of parental experiences with their child's care. The separate survey is necessary because children's health care frequently requires different Provider Networks and addresses different consumer concerns (e.g. child growth and development).

The HEDIS® protocol for administering CAHPS® surveys consists of a mail protocol followed by telephone administration to those not responding by mail. MCOs must contract with a certified vendor to administer both the Adult and Child CAHPS® surveys. The MCO must generate a sample frame for each survey sample and arrange for an NCQA-certified auditor to verify the integrity of the sample frame before the certified vendor draws the sample and administers the survey. The MCOs are also required to have the certified vendor submit Member level data files to NCQA for calculation of HEDIS® and CAHPS® survey results. The Department requires that the MCOs:

A. Must conduct both an Adult and Child CAHPS® survey using the current version of CAHPS®.
B. Must include all Medicaid core questions in both surveys.
C. Must add the additional three adult dental, four child dental and two (2) equity questions for the child and the adult sections listed below.,

**Additional Adult CAHPS® dental and equity questions:**

1. C1. In the last 6 months, did you get care from a dentist's office or dental clinic?

   1☐ Yes
   2☐ No

2. C2. In the last 6 months, how many times did you go to a dentist's office or dental clinic?

   00☐ None (If None, the Adult dental questions are complete. Thank you.)
   01☐ 1
   02☐ 2
   03☐ 3
   04☐ 4
   05☐ 5 to 9

06☐ 10 or more

3. C3. We want to know your rating of all your dental care from all dentists and other dental providers in the last 6 months. Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate your dental care?

00☐ 0 Worst dental care possible
01☐ 1
02☐ 2
03☐ 3
04☐ 4
05☐ 5
06☐ 6
07☐ 7
08☐ 8
09☐ 9
10☐ 10 Best dental care possible

4. C4. In the last 6 months, how often was it hard to find a personal doctor who speaks your language?

00☐ 0 Not Applicable
01☐ 1 I did not have a problem
02☐ 2 I do not have a personal doctor
03☐ 3 Never
04☐ 4 Sometimes
05☐ 5 Usually
06☐ 6 Always

5. C5. In the last 6 months, how often was it hard to find a personal doctor who knows your culture?

00☐ 0 Not Applicable
01☐ 1 I did not have a problem
02☐ 2 I do not have a personal doctor
03☐ 3 Never
04☐ 4 Sometimes
05☐ 5 Usually
06☐ 6 Always

**Additional Child CAHPS® dental and equity questions:**

6. D1. In the last six months, did you get care from a dentist's office or dental clinic?

   1☐ Yes
   2☐ No

7. D2. In the last six months, how many times did you go to a dentist's office or dental clinic?

   00☐ None (If None, the Adult dental questions are complete. Thank you.)
   01☐ 1
   02☐ 2
   03☐ 3
   04☐ 4
   05☐ 5 to 9
   06☐ 10 or more

8. D3. We want to know your rating of your dental care from all dentists and other dental providers in the last six months. How would you rate your dental care (on a scale of 1 to 10)?

   00☐ 0 Worst dental care possible
   01☐ 1
   02☐ 2
   03☐ 3
   04☐ 4
   05☐ 5
   06☐ 6
   07☐ 7
   08☐ 8
   09☐ 9
   10☐ 10 Best dental care possible

9. D4. Which of the following would help your child see the dentist more often?

   a☐ Help with transportation to the dentist
   b☐ Reminders to visit the dentist
   c☐ More dentists to choose from
   d☐ More convenient office hours
   e☐ Dentists that speak my language
   f☐ Help in finding a dentist
   g☐ Better communication about benefits from my child's health plan
   h☐ Education about good dental care

i☐ None of the above. My child sees the dentist as often as I like.
j☐ Other (write in)

10. D5. In the last 6 months, how often was it hard to find a personal doctor who speaks your language?

00☐ 0 Not Applicable
01☐ 1 I did not have a problem
02☐ 2 I do not have a personal doctor
03☐ 3 Never
04☐ 4 Sometimes
05☐ 5 Usually
06☐ 6 Always

11. D6. In the last 6 months, how often was it hard to find a personal doctor who knows your culture?

00☐ 0 Not Applicable
01☐ 1 I did not have a problem
02☐ 2 I do not have a personal doctor
03☐ 3 Never
04☐ 4 Sometimes
05☐ 5 Usually
06☐ 6 Always

D. Must forward CAHPS® data to the Department both electronically in an Excel and .csv file.

E. Must submit validated CAHPS® results annually on June 15th unless otherwise specified by the Department.

The Department annually releases an Ops Memo that contains detailed information regarding the submission of HEDIS® and CAHPS®.

EXHIBIT N

# EXHIBIT N

## NOTICE OF DENIAL

A written notice of denial must be issued to the Member for the following:

a. The denial or limited authorization of a requested service, including the type or level of service.

b. The reduction, suspension or termination of a previously authorized service.

c. The denial of a requested service because it is not a covered service for the Member.

d. The denial of a requested service but approval of an alternative service

Please refer to Templates N(1) through N(6) for denial notice templates and Template N(7) Request for Additional Information Letter template which are available in Docushare.

EXHIBIT O

# EXHIBIT O

## DESCRIPTION OF FACILITIES AND RELATEDSERVICES

### Intermediate Care Facility For Individuals with Intellectual Disabilities And Other Related Conditions (ICF/ID/ORCs)

The PH-MCO is responsible to provide the full range of Physical Health Services to Members residing in private ICF/ID/ORC, except that the PH-MCO is not responsible to provide services to a Member to the extent services are covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCO.

### Residential Treatment Facility (RTF)

The PH-MCO is responsible to provide the full range of Physical Health Services to Members residing in RTFs. The PH-MCO is not responsible to provide any services that are currently covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

### Extended Acute Psychiatric Facility

The PH-MCO is responsible to provide the full range of physical health services to Members residing in extended acute psychiatric facilities. The PH-MCO is not responsible to provide any services that are currently covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

### Non-Hospital Residential Detoxification, Rehabilitation, and Half-Way House Facilities for Drug/Alcohol Dependence/ Addiction

The PH-MCO is responsible to provide the full range of physical health services to Members admitted to non-hospital residential detoxification, rehabilitation and halfway house facilities for drug/alcohol dependence/addiction. The PH-MCO is not responsible to provide any services that are currently covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

### Functional Eligibility Determinations (FED) and Pre-admission Screening Requirements

A Functional Eligibility Determinations (FED) must be completed to assess an individual's need for Nursing Facility services. The PH-MCO must contact Aging Well PA to initiate the FED assessment. This must occur prior to a Member's admission to a Nursing Facility. The PH-MCO must abide by the decision of the FED assessment related to the need for Nursing Facility services. The PH-MCO is not responsible for providing or paying for the FED assessment.

The PH-MCO must also comply with pre-admission screening requirements contained in 42 U.S.C. Section 1396r(e)(7) and 42 C.F.R. 483.100-483.138 regarding individuals with Mental Retardation/Other Related Conditions or mental illness.

**Members Admitted to Juvenile Detention Centers (JDCs)**

Any child receiving MA benefits will continue to receive those benefits during placement in a JDC. Children enrolled in a PH-MCO prior to placement at a JDC either inside or outside the HealthChoices Zone will continue to be covered by the PH-MCO from the date of placement for a maximum of thirty-five (35) consecutive days. The child will be disenrolled from the PH-MCO after the thirty-fifth (35th) consecutive day of placement. During the thirty-five (35) consecutive days, MA eligible services provided to the child on-site at the JDC will be covered under the Medical Assistance Fee-for-Service Program. Any services that are covered by the PH-MCO and provided outside of the JDC site are the responsibility of the PH-MCO. Should a child either be voluntarily disenrolled from a PH-MCO or become ineligible for enrollment due to a change in status, coverage of the child will remain consistent with enrollment policies. If during the period of placement the child transfers from one PH-MCO to another, the child will receive benefits through the new PH-MCO from the new PH-MCO effective date through the thirty-fifth (35th) consecutive day of placement.

A child already residing in a JDC will not be permitted to newly enroll in a PH-MCO until after release from the JDC. All other applicable coverage rules will apply.
EPSDT screening results or other health care needs detected during the period of the JDC placement should be reported to the effective PH-MCO. Should a covered service be identified that cannot be provided at the JDC site, the JDC must contact the PH-MCO in order to arrange for the covered service to be provided.

**Dual Eligibles (Medicare/Medicaid) Under the Age of Twenty-One (21)**

Recipients, under the age of twenty-one (21) who receive both Medicare as their primary health care coverage and Medicaid (MA) as a supplemental coverage, will be required to enroll in the HealthChoices Program and choose both a PH-MCO and PCP within the PH-MCO. See Section V.F., Member Enrollment and Disenrollment, of the Agreement for enrollment information into HealthChoices Zone.

Due to their Medicare eligibility, many of these recipients may require special assistance with the coordination of their Medicare/Medicaid benefits. Therefore, these dually eligible Recipients are classified as having Special Needs and should fall under the guidelines outlined in Section V.P., Special Needs Unit (SNU), of the Agreement.

Recipients who are dually eligible are not required to go to their PH-MCO for services that are covered by Medicare. If appropriate, Recipients who are Dual Eligible are required to comply with the PH-MCO's referral and authorization requirements if they have exhausted their Medicare benefit for a Medicare covered service.

The PH-MCO is responsible to provide prescriptions written by Medicare Providers for a Member as long as the Member goes to a pharmacy within the PH-MCO's Provider Network. Prescription coverage for Recipients who are dually eligible is subject to the PH-MCO's authorization protocols, with the exception of drugs covered by Medicare. In addition, the provisions outlined in Section V.B., Prior Authorization of Services, of this Agreement, will apply.

**The PH-MCO's financial responsibility for Dual Eligibles is outlined in Section VII. of the Agreement.**

EXHIBIT P

# EXHIBIT P

## OUT-OF-PLAN SERVICES

Out of Plan Services include, but are not limited to:

A. Transitional Care Homes

The PH-MCO will only be responsible to provide medical services to children upon the child leaving the transitional care home to reside with family or other caretakers living within the HealthChoices Zone. The PH-MCO must ensure continuity of care, as well as coordination with necessary Providers and interagency teams once they are notified that the child has become enrolled in the PH-MCO.

B. Medical Foster Care Services

Medical foster care services are provided to children with special or chronic medical conditions or physical disabilities in the custody of the County Children and Youth Agency and placed in foster family care. Medical foster care services enable the child to be treated by a licensed practitioner on an outpatient rather than an inpatient or institutional basis. Medical foster care services include both supportive and supervisory activities as well as direct care of children. Such tasks include but are not limited to: medical management, nutritional care, hygiene and personal care and developmental education.

Medical foster care services are provided by both county and private children and youth social service agencies. The foster parents who are under contract with the agency provide direct care. The licensed foster care agency is enrolled as a Provider Type 40, Specialty 400, Medically Fragile Foster Care, and claims reimbursement is through the Medical Assistance Fee-for-Service Program according to the maximum daily fees for the four levels of medical foster care as established by the Office of Medical Assistance Programs. Even though the PH-MCO is responsible to provide Medically Necessary services to children residing in medical foster care homes, the PH-MCO is not responsible for the medical foster care services identified in the four levels of care. These four levels of medical foster care are described as Level(s) I - IV with each level progressively requiring increased care.

1. Level I
    a. The Child has one or more medical conditions or physical disabilities that can be relieved, alleviated, or controlled by a regimen of medical supervision and consistent non-specialized care. No life-threatening situations are anticipated.
    b. Some specialized training may be required for the foster parent to care for the child, such as the preparation and control of special diets and the administration of non-oral medications.
    c. Wheel chairs, ramps, and/or prostheses may be required but sophisticated technological equipment usually will not be necessary. Few special medical supplies are necessary.

2. Level II
    a. The child has one or more acute medical conditions or physical disabilities that can be relieved, alleviated, or controlled by specialized intervention and a regimen of medical supervision and consistent care. No immediate life-threatening situations are anticipated.
    b. Some special medical procedures training may be required for the foster parent for the management of tracheostomies, ileostomies, NG feeding tubes, catheters, etc.
    c. Use of sophisticated technological equipment will be minimal. Some special medical supplies will be necessary.
    d. The child will usually require special therapeutic interventions and special social, educational, and vocational planning.
3. Level III
    a. The child has a combination of acute temporary, chronic, or permanent medical conditions or physical disabilities which require intensive, home-based medical intervention on a constant basis to sustain life. Life threatening situations are anticipated.
    b. Considerable special medical procedures training will be required for the foster parent.
    c. Use of sophisticated technological equipment will be necessary. Special medical supplies will be necessary.
    d. Because the child will usually be home-bound, all developmental areas will require special planning.
4. Level IV
    a. The child has a combination of acute, chronic, or permanent medical conditions or physical disabilities whose life can be sustained only by intensive, home-based medical intervention on a 24-hour basis. Life threatening situations are constantly present.
    b. Extensive special medical procedures training will be required for the foster parent.
    c. Use of a variety of sophisticated technological equipment will be necessary. Special medical supplies will be necessary.
    d. Because the child will be home-bound, all developmental areas will require special planning.

When children in the custody of the County Children and Youth Agency are placed in medical foster care homes, the PH-MCO's Special Needs Unit must work with the medical foster care agency to ensure that necessary medical and ancillary services are provided in the amount and level that enable the child to be maintained in the foster care home and minimize hospitalization/institutionalization of the child.

C. Early Intervention Services

An infant or toddler may receive services under both the HealthChoices Program and the Early Intervention Program, but the services are separate and distinct. The HealthChoices Program consists of Medically Necessary services prescribed by the Primary Care Practitioner. Early intervention services consist of a range of family-centered habilitation services and supports as defined by each family's individualized family service plan.

D. OLTL/OBRA Waiver: The Home and Community Based Waiver Program

This program provides services to people with developmental physical disabilities to allow them to live in the community and remain as independent as possible.

The Department's Office of Long-Term Living, (OLTL) currently operates a Home and Community-Based Waiver that provides services to Pennsylvania residents age 18 and older with a severe developmental physical disability requiring an Intermediate Care Facility / Other Related Conditions (ICF/ORC) level of care. The disability must result in substantial functional limitations in three or more of the following major life activities: mobility, communication, self-care, self-direction, capacity for independent living, and learning.

Other related conditions (ORCs) include physical, sensory, or neurological disabilities which manifested before age 22, are likely to continue indefinitely, and result in substantial functional limitations in three or more of the following areas of major life activity: capacity for independent living, mobility, self-direction, learning, understanding and use of language, and self-care.

Recipients receiving these home and community based services through the OLTL/ OBRA Waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the OLTL/ OBRA Waiver. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is not responsible to provide any medical services that are determined to fall under the scope of Behavioral Health Services or is the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook.

E. Office of Developmental Programs (ODP) Waivers: Person/Family Directed Support Waiver (P/FDS), Consolidated Waiver and Community Living Waiver

The Home and Community Based Waiver Program for Persons with Intellectual Disabilities and Autism: The Department's Office of Developmental Programs currently operates Home and Community Based Services Waivers (P/FDS, Consolidated and Community Living) which provide services to individuals with intellectual disabilities and autism of any age and children with developmental disabilities from birth through age eight. The waivers are designed to help individuals with an intellectual disability, autism or developmental disability to live more independently in their homes and communities and to provide a variety of services that promote community living and family support. Eligibility determinations require a recommendation for an Intermediate Care Facilities (Intellectual Disabilities (ICF/ID) or Other Related Conditions (ICF/ORC)) level of care based on a medical evaluation.

Recipients receiving community based services through these waivers will be enrolled in the HealthChoices Program. The PH-MCO is responsible to ensure a family with a child who has or is at risk of a developmental delay is referred to the County Intellectual Disabilities office for a determination of eligibility for home and community based services. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the ODP Waivers. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is also not responsible to provide any medical services that fall under the scope of Behavioral Health Services, or are the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook .

F. Community HealthChoices Waiver

The Community HealthChoices Waiver targets individuals 21 and over who require a Nursing Home Level of Care and are in need of long term services and supports (LTSS), and meet the other requirements of the waiver as determined by the Office of Long Term Living. HealthChoices members who qualify for the Community HealthChoices Waiver will be disenrolled from HealthChoices and enrolled into the Community HealthChoices program. The PH-MCO shall be required to provide assistance to these members in transitioning their care between the HealthChoices and the Community HealthChoices program as stated in section V.D of the agreement.

G. ODP Autism Waiver: The Home and Community Based Waiver program for Persons with Autism Spectrum Disorder.

The Adult Autism Waiver is a Home and Community Based Waiver program. The Office of Developmental Programs administrates this waiver which provides home and community based services specifically designed to help adults, 21 and older, who possess an autism spectrum disorder. The overriding goal of the Waiver is to aid the recipients with participation in their communities in the manners which they desire. Eligibility determinations require a recommendation for an Intermediate Care Facilities for Other Related Conditions (ICF/ORC) level of care based on a medical evaluation.

Recipients receiving community-based services through this waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the Autism. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is also not responsible to provide any medical services that fall under the scope of Behavioral Health Services, or are the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook.

EXHIBIT Q

## EXHIBIT Q

## SAMPLE MODEL AGREEMENT

This sample model Agreement is illustrative only and is designed for use by the county children and youth agencies but can be adapted by other community agencies. Letters of Agreement must contain the information found in Exhibit S, Written Agreements Between PH-MCO and Service Providers.

[COUNTY AGENCY]/OFFICE

HEALTH SERVICES COORDINATION AGREEMENT

This County Office Health Services Coordination Agreement is entered into and effective this _____ day of _____, _____, by and between [Plan], a corporation, and the [County Agency] for _____ County, and the _____ Office of _____ County, Pennsylvania (collectively [County Agency]).

WHEREAS, [Plan], a licensed health maintenance organization in the Commonwealth of Pennsylvania, has entered into an agreement with the Pennsylvania Department of Human Services ("DHS") to furnish Medical Assistance-covered services ("covered services") to Medical Assistance (MA) recipients under the [Plan] Medical Assistance product (MA product"), in accordance with the Commonwealth's Medical Assistance programs, and in accordance with the agreements between [Plan] and DHS ("MA Agreements"); and

WHEREAS, [Plan] and [County Agency] wish to ensure that Medical Assistance recipients who are children in substitute care ("MA covered persons"), and served by the parties, receive the necessary and appropriate covered services; and

WHEREAS, since covered services can be delivered more efficiently and more timely if [County Agency] and [Plan] coordinate the identification and treatment of MA covered persons, DHS requires that [Plan] enter into agreements with county agencies] and county offices to set forth the terms on which they will coordinate the delivery of covered services to MA covered persons; and

WHEREAS, the parties explicitly acknowledge, understand and agree that the common purpose of this cooperative relationship is to ensure that access to covered services and the quality of covered services provided will not be diminished or compromised because of an MA covered person's placement in substitute care.

NOW, THEREFORE, in consideration of the mutual covenants and premises, and for other good and valuable consideration, and intending to be legally bound, the parties agree as follows:

## 1.0 DEFINITIONS

For the purposes of this Agreement, the following terms shall have the meanings set forth below:

1.1 **Covered Services** means those health care services MA covered persons are entitled to receive under the state and federal law. It also means those services that a PH-MCO is required to provide under its agreement with the Department of Human Services to MA covered persons.

1.2 **DOH** means the Pennsylvania Department of Health.

1.3 **DHS** means the Pennsylvania Department of Human Services.

1.4 **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person 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.

1.5 **EPSDT** means the Early and Periodic Screening, Diagnosis, and Treatment Program that provides medical services for individuals under the age of 21 administered under the Medical Assistance Program.

1.6 **MA Covered Person** means: (1) any Medical Assistance recipient that (a) is under the age of 18; or (b) over the age of 18 up to age 21 and under the jurisdiction of [County Agency] care and custody; and (2) for whom [Plan] and [County Agency] have agreed to coordinate the provision of covered services.

1.7 **Medical Assistance (MA)** means the Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. §1396 *et seq*., and regulations promulgated thereunder, and Title 62, Chapter 1, Article 4 of the Pennsylvania Statutes and regulations promulgated thereunder.

1.8 **MA Agreements** means the contracts between [Plan] and DHS under any of Pennsylvania's Medical Assistance managed care programs, including DHS's HealthChoices Program, pursuant to which [Plan] arranges for the provision of certain services covered by Medical Assistance to MA covered persons.

1.9 **MA Product** means [Plan's] Medical Assistance HMO product.

1.10 **MA Recipient** means an individual eligible to receive services under Pennsylvania's MA Program, including the HealthChoices Managed Care Program, and is enrolled in the MA product.

1.11 **Medically Necessary** means that condition or procedure defined as medically necessary by DHS as delineated in DHS's HealthChoices Agreement between the [Plan] and DHS.

1.12 **PID** means the Pennsylvania Insurance Department.

Terms not defined hereinabove shall be given the meanings ascribed to them in the MA Agreements or the RFP.

## 2.0 MUTUAL [PLAN] AND [COUNTY AGENCY] OBLIGATIONS RELATIVE TO COORDINATION OF CARE

2.1 The parties, and their liaisons where applicable agree to communicate with the MA covered person's Primary Care Physicians (PCPs), coordinate services, exchange relevant enrollment and individual health-related information and services needs of MA covered persons, including the institution of a process to monitor such activity, and a process to monitor the quality management and utilization management responsibilities of each party.

2.2 The parties agree to develop policies, within 60 days of the effective date, on referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, continuity of care, and other treatment issues necessary for optimal health and disease prevention, including policies on coordination of specialized service plans for MA covered persons with special health needs.

2.3 The parties agree to interact with the PCPs for prompt treatment and coordination of care.

2.4 The parties agree to jointly monitor the quality of the covered services delivered.

2.5 The parties agree to work cooperatively to establish programmatic responsibility for each MA covered person.

2.6 The parties agree to serve on interagency teams, when requested by either of the parties hereto.

2.7 The parties agree to cooperate in the coordination of covered services with the applicable Behavioral Health Managed Care Organizations in the HealthChoices Zone (HC Zone), including Pharmacy Coordination, to the extent permitted by law.

2.8 Where the parties have identified an issue, the parties mutually agree to undertake intensive outreach efforts to MA covered persons identified as needing covered services.

2.9 To assure the effectiveness of this Agreement and the services provided hereunder, the parties will review the Agreement for accuracy at least [insert time frame] or, if necessary, more often. Additionally, the parties agree to set up a forum to discuss opportunities to assess training needs, consultation, and sharing

of information between the parties to facilitate the cost-effective use of resources. The parties also agree to meet [insert time frame], or as requested by either party, to resolve any outstanding issues existing between them.

2.10 The parties agree to assist, when appropriate, in the development of an adequate provider network to serve special needs populations.

2.11 The parties agree to develop and implement a work plan to address issues or actions so as to bring said issues and actions into compliance with the term(s) of this Agreement.

2.12 The parties agree to adhere to the Americans with Disabilities Act, as amended, and the Rehabilitation Act of 1973.

2.13 The parties agree to collaborate on identifying and reducing the frequency of fraud, abuse, over use, under use, and inappropriate or unnecessary medical care.

2.14 The parties will work cooperatively to develop processes to ensure that:

(i) The [County Agency] caseworker will contact a participating provider or attempt to contact the PCP, when the [County Agency] caseworker can identify the PCP, when admission or discharge physical examinations are required due to the initial placement or discharge of an MA covered person or if the MA covered person is relocated. When it is not possible to contact the PCP, the [County Agency] shall coordinate with the plan's Special Needs Unit to arrange to use other providers within the [Plan's] network. In cases of suspected abuse, [County Agency] shall contact the appropriate medical provider for the examination without having to obtain prior approval from the PCP or [Plan]. If the enrollment of the MA recipient cannot be determined at the time the exam is required, the exam may be performed in an emergency room or through a provider affiliated with [County Agency]. Within 24 hours, or as soon as it can be reasonably determined that the MA recipient is eligible for the MA Product and eligible to be an MA covered person, [County Agency] will notify [Plan's] Special Needs Unit and/or the PCP in order that necessary follow-up care can be coordinated.

(ii) Information related to suspected abuse cases obtained from a PCP or [Plan] provider, including diagnostic tests, is shared with [County Agency].

(iii) Physical assessments needed by the MA covered persons entering emergency shelters are being performed within the time frames established by law. The same procedure set forth in 2.14(i) above applies.

(iv) Medically necessary home health services are being provided to MA covered persons in medical foster care.

(v) [County Agency] will be notified by [Plan] of denial of services to MA covered persons, including explicit steps on how to file an appeal, which has the right to file, and how denials will be processed.

2.15 [Plan] and [County Agency] will work together to determine the post-discharge needs of any MA covered person placed in substitute care, and to develop a care plan that will maintain continuity of care through the MA covered person's transition from substitute care to home.

2.16 [Plan] and [County Agency] will work together to develop policies and procedures on the identification of individuals who have the authority to represent MA covered persons to request PCP selections and changes; receive MA covered person information including identification cards, MA covered person notices, or filing MA covered person complaints, grievances or appeals on behalf of the MA covered persons.

2.17 [Plan] and [County Agency] will work together to develop and implement joint education and training programs related to requirements of both. This training will be provided to [County Agency] caseworkers, staff, or private agencies and [Plan's] Special Needs Unit staff and participating providers throughout the implementation of HealthChoices and as specific needs are identified.

2.18 [Plan] and [County Agency] will cooperate in the identification of opportunities for improvement of processes or procedures identified in this Agreement and the need for additional processes or procedures. At a minimum, representatives from [Plan] and [County Agency] will meet to discuss identified opportunities and to establish a work plan to address those issues. This process will be coordinated through the designated contact persons.

2.19 [Plan] shall provide to [County Agency] at [County Agency's] address set forth hereinafter, any notification that [Plan] is required to provide to MA covered persons, in lieu of providing it to MA covered persons, and [County Agency] shall then be obligated to provide any such notification to MA covered persons, and MA covered persons' caretaker, provider, or guardian.

2.20 [County Agency] and [Plan] shall cooperate with each other and shall share medical information for children entering placement who are covered persons and if appropriate.

## 3.0. [PLAN] OBLIGATIONS

3.1 [Plan] will be responsible for the payment of physical health services as set forth in the RFP, including eye care, dental care, hearing exams, and immunizations. [Plan] shall not be obligated to pay for medical services currently covered by Fee-For-Service Medical Assistance and for which [County Agency] contracts directly with providers of medical care. [Plan] shall not be obligated to pay for medical services for children who are not MA covered persons. Medical services provided to children who are currently being evaluated for Medicaid eligibility shall be paid for by DHS under Fee-For-Service Medical Assistance programs. [Plan] shall not be obligated to pay for inpatient hospital days that are not a medical necessity, as determined by [Plan], including the situation where [County Agency] is in the

process of placing the child in a foster or similar home and is having difficulty doing so. [Plan] shall not be obligated to pay for psychological evaluations for any purpose whatsoever.

3.2 [Plan] shall be responsible to provide or arrange for the provision of medically necessary covered services to any MA covered person upon his or her discharge from substitute care to his/her family or other primary caretaker (i.e. legal guardian), provided that the MA covered person is discharged to a location in the HC Zone.

3.3 [Plan] has a Special Needs Unit that will deal, in a timely manner, with issues relating to MA covered persons with special needs.

3.4 [Plan] shall identify a contact person for coordination with [County Agency] and further shall define the roles and responsibilities of the contact person to address mass change situations such as enrollment and incorrect PCP designations, which affect all MA covered persons, and individual requirements such as emergency physical exams, PCP selections or change, or EPSDT screens that are due.

3.5 For MA covered persons with complex medical needs, the designated contact person at [Plan's] Special Needs Unit will coordinate requests for specialists to serve as PCP with the contact person at [County Agency]. The procedures will include a timeline for submission of requests, tracking of requests, and decisions on requests. The procedures will include the selection of an accessible PCP until a decision has been provided. If the request has been denied, any request for a change in PCP will be coordinated with the [County Agency] contact person.

3.6 [Plan] shall coordinate notification and scheduling of EPSDT screens that are due with the [County Agency] contact person or the appropriate foster parent if [County Agency] notifies [Plan's] Special Needs Unit of the foster parent. [Plan] shall provide [County Agency] with EPSDT data on MA covered persons on a mutually agreed upon reporting, time frame, and format.

3.7 [Plan] shall provide [County Agency] with its provider directories when they are produced on no less than an annual basis.

3.8 [Plan's] Special Needs Unit shall provide information in writing to [County Agency] describing [Plan's] operations, including the manner in which [County Agency] may contact [Plan] regarding benefit coverage rules and access to additional information or resources on behalf of an MA covered person placed in substitute care.

3.9 [Plan's] Special Needs Unit staff shall provide education to [County Agency] staff on the [Plan's] requests for accessing medically necessary services.

3.10 All denials by [Plan] of requests for services shall be provided to [County Agency] via telefax and regular mail.

## 4.0 [COUNTY AGENCY'S] OBLIGATIONS

4.1 Within four months after the implementation of this Agreement, and, at a minimum, quarterly as new providers are identified by [County Agency], [County Agency] shall provide to [Plan] the names of the health care providers [County Agency] uses for exams on an annual basis.

4.2 [County Agency] shall identify a contact person to [Plan], and further shall define the roles and responsibilities of the contact person, to address mass change situations such as enrollment, which affect all MA covered persons, and individual requirements such as emergency physical exams, PCP selection or change, or EPSDT screens which are due.

4.3 [County Agency] will attempt to determine a Medical Assistance recipient's eligibility including physical health plan enrollment by utilizing DHS's Eligibility Verification System (EVS). If EVS is not available in the [County Agency] office, [County Agency] will secure an EVS terminal or educate staff on how to contact DHS to verify eligibility.

4.4 [County Agency] shall arrange for the provision of any medically necessary physical health services by [Plan] contract providers unless the situation is an emergency. [County Agency] will arrange for the provision of any EPSDT screening exams, immunizations, tests or follow-up medical care with [Plan's] Special Needs Unit or PCP. [Plan] shall consider all DHS-required EPSDT services covered services as set forth in DHS's EPSDT guidelines.

4.5 [County Agency] shall advise [Plan] of all new placements or relocations of MA recipients within 15 days or as soon as it can be determined that the recipient is an MA covered person. [County Agency] will coordinate PCP selection or change with [Plan's] Special Needs Unit contact person upon notification of the MA covered person's need to timely access to a PCP.

4.6 [County Agency] will notify [Plan] within 15 days of new placements, changes in placement, or removals from placement of an MA covered person.

4.7 As appropriate, [Plan's] Special Needs Unit will contact [County Agency's] Managed Care Unit [or its equivalent] to request assistance in gathering medical information on the MA covered person. The medical information can include that collected as part of the [County Agency's] intake function or obtained from past medical records. The [County Agency's] Managed Care Unit and the Special Needs Unit [or its equivalent] will work together to obtain the necessary medical information and to share this information with [Plan's] participating provider as appropriate.

4.8 [County Agency] will assist in obtaining required consent-to-treat documents from the MA covered person's parent, legal guardian, or through the court system, if necessary.

4.9 [County Agency] will require any private contracted agencies to cooperate with [Plan]. [County Agency] will require each private contracted agency to identify a

contact person to [Plan's] Special Needs Unit designated contact person. [County Agency] will coordinate training and education of private contracted agencies with [Plan].

## 5.0 SPECIAL NEEDS UNIT

5.1 [County Agency] shall notify [Plan's] Special Needs Unit of the planned transition for the MA covered person within 15 days of discharge from substitute care. Included in these arrangements will be the transfer of all relevant medical information/records to a [Plan] PCP to which the MA covered person will be assigned if different from the current PCP.

5.2 As part of the joint [County Agency] and [Plan] discharge planning, and based on the individual needs of the MA covered person, the [County Agency] case worker and the [Plan's] Special Needs Unit will identify those MA covered persons who could benefit from Special Needs Unit case management. [Plan] case managers will cooperate with the PCP and the [County Agency] caseworker in the development of an appropriate care plan. The [Plan] case manager will assist in the coordination of services required to meet the needs of the MA covered person including any non- MA covered services.

5.3 In the event that [Plan] does not receive notice of an MA covered person's discharge from substitute care until after the discharge has occurred, a care coordinator from [Plan's] Special Needs Unit will be assigned to the case upon [Plan's] receipt of such notification. This care coordination will then work with the MA covered person's PCP and a [County Agency] Managed Care Unit, or its equivalent liaison, to make appropriate arrangements for the MA covered person's care.

## 6.0 DATA COLLECTION/REPORTING/SHARING

6.1 The parties agree to develop procedures on the collection of information on the covered services delivered, which information shall be shared with DHS upon request.

6.2 The parties agree to develop provisions for the notification of reportable conditions experienced by any MA covered persons to the appropriate regulatory agency as required by law.

6.3 The parties agree to share necessary data to ensure delivery of appropriate covered services.

## 7.0 COORDINATION OF CARE

If an MA covered person is placed by [County Agency] outside the HC services area, the [County Agency] contact person will notify the DHS County Assistance Office. DHS shall disenroll the MA covered person from [Plan]. The MA covered person will then either be enrolled in another HealthChoices service area or covered by the Fee-For-Service Medical Assistance Program. The [County Agency] contact person will notify [Plan's] Special Needs Unit contact person of the placement outside of the HC service area. [Plan] and [County Agency] will coordinate the transfer of the medical information to the new HealthChoices health plan or selected PCP.

## 8.0 CONFIDENTIALITY

8.1 The parties recognize and acknowledge that performance of this Agreement may result in the disclosure to the other party of trade secrets, proprietary information, and confidential information (collectively referred to as "Confidential Information"). The non-disclosing party agrees that it and its employees, representatives, and agents shall treat confidential information as strictly confidential and shall: (i) protect the confidential information from unauthorized use or disclosure either directly or indirectly, and keep it confidential; (ii) use the confidential information only for purposes related to this Agreement; (iii) not disclose or otherwise permit any third person or party access to the confidential information without prior written authorization by the disclosing party; and (iv) limit disclosure to necessary individuals and ensure that individuals exposed to confidential information are advised of its confidential nature and their obligations hereunder.

8.2 This Section, (8.0 Confidentiality) shall survive termination of this Agreement. The parties agree that the breach or prospective breach of this provision will cause irreparable harm of which money damages may not be adequate. The parties agree that in addition to any other remedies, the non-breaching party shall be entitled to injunctive or other equitable relief to restrain the breach hereof.

## 9.0 MEDICAL RECORDS

9.1 The parties agree to obtain the appropriate releases necessary to share clinical information and provide health records to each other as requested, consistent with all applicable laws.

9.2 The parties agree to maintain the confidentiality of all covered persons' medical records in accordance with all applicable state and federal laws.

9.3 DHS and/or its authorized agents shall be afforded prompt access to all MA covered persons' medical records whether electronic or paper. All medical record copies are to be forwarded to the requesting party within 15 calendar days of such request and at no expense to the requesting party. DHS is not required to obtain written approval from an MA covered person before requesting the MA covered person's medical record from the parties or any other agency.

## 10.0 EMERGENCY CARE

[County Agency] has the right to proceed in an emergency without obtaining prior authorization from [Plan]. An emergency will not require an authorization at any time. [County Agency] shall contact the PCP to authorize urgent care or any follow-up care related to the emergency.

## 11.0 TERM AND TERMINATION

11.1 This Agreement shall become effective on the later of the effective date set forth above or DHS's approval thereof, and shall continue in effect until ___Date_____, or until the earlier termination of the HealthChoices MA Agreement. This Agreement shall renew upon the mutual consent of the parties and the renewal of the HealthChoices MA Agreement for a term consistent with the HealthChoices MA Agreement.

11.2 Either party may terminate this Agreement for cause by giving the other party and DHS 90 days written notice of a breach of this Agreement. Any such termination shall be effective on the date stated in the notice of termination unless the other party cures the breach prior to the expiration of the 90-day notice period. In the event the breach is cured to the reasonable satisfaction of the other party, the Agreement shall not be so terminated, and DHS shall be notified of the same.

11.3 This Agreement may also be terminated by mutual agreement of both parties with notice to DHS, and by either party upon 120 days advance written notice to the other party and DHS.

## 12.0 IMPLEMENTATION AND REVIEW OF AGREEMENT

The parties will jointly develop an implementation plan for the coordination of covered services and will appoint representatives who will meet regularly to carry out such plan. To assure the effectiveness of this Agreement and the services to be provided hereunder, the parties will review the Agreement at least once each year, or more often if necessary.

## 13.0 DISPUTE RESOLUTION

Any controversy, dispute, or disagreement arising out of or relating to the Agreement, or breach thereof, that cannot be resolved at the meetings described in Section 2.9 above, shall first be mediated, which shall be conducted in [enter appropriate county] County, Pennsylvania, in accordance with the American Health Lawyers' Association Alternative Dispute Resolution Service Rules of Procedure. In the event the parties cannot resolve their differences through mediation, the parties shall have the right to undertake proceedings in a court of proper jurisdiction. No regulatory order or requirement of DOH shall be subject to such mediation.

## 14.0 MISCELLANEOUS

14.1 **Compliance with Federal and State Laws.** Throughout the term of this Agreement, it shall be each party's responsibility to maintain compliance with all state and federal laws and regulations that affect its respective operations and the furnishing of covered services under this Agreement.

14.2 **Assignment.** This Agreement shall not in any manner be assigned, delegated, or transferred by either party without the prior written consent of the other party, provided, however, that [Plan] may assign this Agreement to another party that controls, is controlled by, or is under common control with [Plan].

14.3 **Notices.** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and if such notice relates to a modification to this Agreement or the MA product, it shall be sent by certified mail, return receipt requested, to the parties at the addresses set forth below, or personally delivered, delivered by facsimile, or regular or overnight mail. If mailed by regular mail, any such notice shall be deemed given on the fifth day following the date of mailing.

If to [Plan]
[Address]
[Fax #]

If to [County Agency]
_____ County _____ Agency
[Address]
Attention: _____

14.4 **Relationship of Parties.** The relationship between [Plan] and [County Agency] is that of independent contractors and neither shall be considered an agent or representative of the other for any purpose.

14.5 **Non-Exclusivity.** [County Agency] may enter into independent contracts with any payor or participate in other organizations that have purposes identical or similar to the purposes of [Plan].

14.6 **No Third Party Beneficiaries.** This Agreement shall be construed to give rights and place obligations solely upon the parties to this Agreement.

14.7 **Section Headings.** The headings and captions in this Agreement are for ease of reference only and shall not affect in any way the meaning or interpretation of this Agreement.

14.8 **Severability/Invalid Provisions.** The provisions of this Agreement are independent of and separate from each other. If any one provision is determined to be invalid or unenforceable, it shall not render any other provision invalid or unenforceable.

14.9 **Waiver/Compliance with Terms.** Waiver of any part of this Agreement shall not be considered a waiver of any other part of this Agreement. Failure to insist upon strict compliance with any terms of this Agreement (by way of waiver or breach) by either party hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.

14.10 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania and all applicable federal laws.

14.11 **Inconsistencies.** In the event of any inconsistency between the provisions of this Agreement and the provisions of any MA Agreement or the RFP, or any exhibit thereto, the provisions of the HealthChoices MA Agreement or the RFP, respectively, shall govern.

14.12 **Entire Agreement and Amendments.** This Agreement, and all attachments and amendments hereto, constitute the entire understanding and agreement of the parties hereto and supersede any prior written or oral agreement pertaining to the subject matter hereof. This Agreement may be amended by the parties upon the written consent of both parties and DHS. In the event the parties are unable to agree to the content or the wording of an amendment, the proposed amendment and the facts related thereto shall be conveyed to DHS for guidance and direction on how to proceed.

IN WITNESS WHEREOF, the parties have caused their duly authorized representatives to affix their signatures to this Agreement as of the date written above.

| | |
|---|---|
| _____County<br>[County Agency] | [Plan] |
| By: _____ | By: _____ |
| Title: _____ | Title: _____ |
| Witness: | Witness: |
| By: _____ | By: _____ |
| Title: _____ | Title: _____ |
| Date: _____ | Date: _____ |
| [County/Agency] Primary Contact: | [Plan] Primary Contact |
| Name: _____ | Name: _____ |

Address: _____

_____

Telephone: _____

Fax: _____

Address: _____

_____

Telephone: _____

Fax: _____

[County/Agency] Office

By: _____

Title: _____

Witness:

By: _____

Title: _____

Date: _____

EXHIBIT R

# EXHIBIT R

## COORDINATION WITH BH-MCOS

The HealthChoices PH-MCOs and the BH-MCOs are required to develop and implement written agreements regarding the interaction and coordination of services provided to Recipients enrolled in the HealthChoices Program. These agreements must be submitted and approved by the Department. The PH-MCOs and BH-MCOs in the HealthChoices Zone are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services. A sample coordination agreement (which does not include all required procedures) can be found in Exhibit Q, Sample Model Agreement. Complete agreements, including operational procedures, must be available for review by the Department upon request. The agreements must be submitted for final review and approval to the Department at least thirty (30) days prior to the implementation of the HealthChoices Program. The written agreements must include, but not be limited to:

- Procedures which govern referral, collaboration and coordination of diagnostic assessment and treatment, prescribing practices, the provision of emergency room services and other treatment issues necessary for optimal health and prevention of disease. The PH-MCO and the BH-MCO must collaborate in relation to the provision of emergency room services. Emergency services provided in general hospital emergency rooms are the responsibility of the Member's PH-MCO, regardless of the diagnosis or services provided. The only exception is for emergency room evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act which is 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;

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

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

- 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;

- Procedures for training and consultation to each other to facilitate continuity of care and cost-effective use of resources;

- A mechanism for timely resolution of any clinical and fiscal payment disputes, including procedures for entering into binding arbitration to obtain final resolution;

- Procedures for serving on interagency teams, as necessary;

- 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, Behavioral Health Service Provider(s) and the PH-MCO PCP for Members with special health needs (e.g., Behavioral Health Services for individuals under the age of twenty-one (21) in medical foster care and older adults with coexisting physical and behavioral health disorders);

- The BH-MCO is required to provide behavioral health crisis intervention and other necessary In-Plan Services to Members with behavioral health Emergency Conditions. The PH-MCO and BH-MCO must establish clear procedures for coordinating the transport and treatment of persons with behavioral health emergencies who initially present themselves at general hospital emergency rooms to appropriate behavioral health facilities;

- Procedures for the coordination and payment of emergency and non-emergency medically necessary ambulance transportation of Members. All emergency and non-emergency medically necessary ambulance transportation for both physical and behavioral health covered services is the responsibility of the Member's PH-MCO even for a behavioral health diagnosis.

- Procedures for the coordination of laboratory services;

- Mechanisms and procedures to ensure coordination between the BH-MCO service managers, Member services staff and BH-MCO network Providers with the PH-MCO's Special Needs Unit. The effectiveness of these mechanisms shall be included as an area for review by the BH-MCO's Quality Assurance Program and the PH-MCO's Quality Management Program;

- Procedures for the PH-MCO to provide physical examinations required for the delivery of Behavioral Health Services, within designated time frames for each service;

- Procedures for the interaction and coordination of pharmacy.

To ensure that there is support for the coordination of care between the PCP and the behavioral health Provider, appropriate county contacts can be found at the following Internet addresses:

**County MH/ID Administrators**:

https://www.dhs.pa.gov/providers/Providers/Pages/County-Mental-Health-System.aspx

**Single County Authorities (SCA's)**:

https://www.ddap.pa.gov/Get%20Help%20Now/Pages/County-Drug-and-Alcohol-Offices.aspx

https://www.health.pa.gov/topics/programs/PDMP/Pages/Clinical.aspx

EXHIBIT S

# EXHIBIT S

## WRITTEN COORDINATION AGREEMENTS BETWEEN PH-MCO AND SERVICE PROVIDERS

Any written coordination agreements entered into between the PH-MCO and service Providers must contain, at a minimum:

- Provisions for ongoing communications; exchange of relevant enrollment and individual health related information; service needs among the PH-MCO, PCP and the community Provider, including a process to monitor such activity; and the Quality Management and Utilization Management program responsibilities of each entity.

- Provisions which govern referral, collaboration and coordination of diagnostic assessment and treatment, prescribing practices and other treatment issues necessary for optimal health and disease prevention, including coordination of specialized service plans for Members with special health needs.

- Provisions for requiring interaction by the PCP for prompt treatment, coordination of care or referral of Members for other identified services that are not the responsibility of the community Provider.

- Provisions for jointly identifying the services to be delivered and monitoring by the PH-MCO to determine the quality of the service delivered.

- Provisions for the PH-MCO and the community Provider to work cooperatively to establish programmatic responsibility for each HealthChoices Member.

- Provisions for serving on interagency teams, when requested.

- Provisions for assisting, when appropriate, in the coordination of services with the BH-MCO, including Pharmacy Coordination, to the extent permitted by law.

- Provisions for mutual intensive outreach efforts to Members identified as needing service (processes to conduct outreach and the measurement of the outreach efforts must be documented in the procedures governing the execution of the written agreement).

- Provisions for a timely resolution of any disputes.

- Provisions for training and consultations between both parties to facilitate continuity of care and the cost-effective use of resources.

- Provisions for assisting, when appropriate, in the development of an adequate Provider Network to serve Special Needs populations.

- Provisions for obtaining the appropriate releases necessary to share clinical information and provide health records to each other as requested consistent with state and federal laws.

- Provisions for the designation of a PH-MCO representative who will function as the liaison between the PH-MCO and the community Provider, if appropriate.

- Provisions for the development and implementation of corrective action plans in the event the provisions of the agreement are not being met.

- Provisions for the adherence to the Americans with Disabilities Act (ADA) (42 U.S.C. Section 12101 et seq) and the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et seq).

- Provisions for the maintenance and confidentiality of medical records and other information considered confidential, including provisions for resolving confidentiality problems.

- Provisions for the collection of information on the service(s) delivered to be shared with the Department, upon request.

- Provisions for collaboration on identifying and reducing the frequency of Fraud, Abuse, overuse, under use, inappropriate or unnecessary medical care.

- Provisions for the reporting of health related information to the appropriate regulatory agency, if necessary.

EXHIBIT T

EXHIBIT U

# EXHIBIT U

## BEHAVIORAL HEALTH SERVICES

No mental health or drug and alcohol services, except ambulance, pharmacy, OUD-COE services pursuant to Exhibit G of this Agreement, and emergency room services, will be covered by the PH-MCOs.

*Behavioral Health Services Excluded from PH-MCO Covered Services*

The following services are not the responsibility of the PH-MCO, under the HealthChoices Program.

The BH-MCO will provide timely access to diagnostic, assessment, referral, and treatment services for members for the following benefits:

- Inpatient psychiatric hospital services, except when provided in a state mental hospital;
- Inpatient drug and alcohol detoxification;
- Psychiatric partial hospitalization services;
- Inpatient drug and alcohol rehabilitation;
- Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol dependence/addiction;
- Emergency room evaluations for voluntary and involuntary commitments pursuant to the Mental Health Procedures Act of 1976, 50 P.S. 7101 et seq.;
- Psychiatric outpatient clinic services, licensed psychologist, and psychiatrist services;
- Behavioral health rehabilitation services (BHRS) for individuals under the age of 21 with psychiatric, substance abuse or intellectual disability disorders;
- Residential treatment services for individuals under the age of 21 whether treatment is provided in facilities that are Joint Commission for the Accreditation for Healthcare Organizations [JCAHO] accredited and/or without JCAHO accreditation;
- Outpatient drug and alcohol services, including Methadone Maintenance Clinic;
- Methadone when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services provider;
- Laboratory studies ordered by behavioral health physicians and clozapine support services;

- Crisis intervention with in-home capability;
- Family-based mental health services for individuals under the age of 21;
- Targeted mental health case management (intensive case management and resource coordination)

In addition to the in-plan mental health, drug and alcohol and behavioral services covered, supplemental mental health and drug and alcohol services may be made available pursuant to coordination agreements between the BH-MCO and the county mental health, intellectual disability, and drug and alcohol authorities. Supplemental services are not part of the capitated, in-plan benefit package. The BH-MCO may, however, choose to purchase such services in lieu of or in addition to an in-plan service.

The supplemental benefits may include:

- Partial hospitalization for drug and alcohol dependence/addiction;
- Psychiatric Rehabilitation: Site Based, Clubhouse or Mobile
- Targeted drug and alcohol case management and Intensive Outpatient Services;
- Supported living services;
- Assistance in obtaining and retaining housing, employment, and income support services to meet basic needs;
- Continuous community based treatment teams;
- Adult residential treatment (including long term structured residences and residential treatment facilities for adults);
- Consumer operated/directed self-help programs; e.g., drop-in centers, 12-step programs, double trouble groups;
- Drug and alcohol prevention/intervention services, including student assistance programs;
- Support groups for individuals under the age of 21; e.g., ALATEEN, peer groups;
- Social rehabilitation and companion programs, e.g., Compeer;
- Drug and alcohol transitional housing; and
- Drug and alcohol drop-in centers.

# EXHIBIT V

## Exhibit V

## TELEPHONIC PSYCHIATRIC CONSULTATION TEAM SERVICES

The HealthChoices MCO has the responsibility to coordinate the care of children who require therapeutic interventions and medication to treat mental health conditions especially those children in foster care. In order to improve the quality of care for children that require psychotropic medication, the MCO will contract with a telephonic Psychiatric Consultation Team (PCT) that will provide real time telephonic consultative services to PCPs and other prescribers of psychotropic medications for children (referred to as PCPs throughout this document). **The MCO will work with all other BH and PH-MCOs within the HC region to collaboratively choose one PCT for each HC region.**

The PCT must consist of a team of staff including one (1) full-time equivalent child psychiatrist, one (1) full-time equivalent behavioral health therapist, and one (1) full-time equivalent care coordinator.

Qualifications and key responsibilities for team staff are listed below:

(i) Child Psychiatrist

The full-time equivalent position of child psychiatrist may consist of one or more individuals as follows- child psychiatrists must be Board certified or Board eligible and skilled in psychopharmacology. At least one child psychiatrist shall be on call providing continuous coverage from 9:00 a.m. to 5:00 p.m., Monday through Friday, and shall at all times while on call carry a pager and/or cell phone and be accessible to a caller within thirty (30) minutes. The on-call team member shall not be engaged in any activity from which he/she cannot be interrupted within thirty (30) minutes. A child psychiatrist team member shall make an on-site visit to high volume participating PCPs defined by the MCOs in the HC region at least once per year. One child psychiatrist will be designated as the PCT's lead medical director with responsibility to assure consistent quality of care, convene periodic team meetings, assure team productivity and timely regional coverage of PCPs, and participate in quarterly meetings with all BH and PH MCOs within the HC region.

(ii) Behavioral Health Therapist

The one (1) full-time equivalent position of behavioral health therapist may consist of one or more individuals as follows: licensed clinical social workers ("LCSW"), licensed mental health counselor, or licensed psychologists. The behavioral health therapist team member's activities must be limited to consultative or short-term transitional care. The therapist(s) must be knowledgeable of local behavioral health resources and work as a team with the care coordinator to match a specific youth/family with the most appropriate and available community resource.

(iii) Care Coordinator

The care coordinator supports the team members by coordinating and maintaining schedules, managing registration and billing of patients requiring face-to-face visits, arranging appointments with local behavioral health providers and oversees collection of any encounter data. The care coordinator must be in constant contact with the BH and PH MCOs.

The PCT will perform consultative services and provider outreach services as described below.

**Consultation Services**

The PCT will be available at all times between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding Provider's holidays), to PCPs and other designated providers in the HC region to provide immediate consultations by telephone concerning children and adolescent behavioral health matters. In the event that PCT is unable to consult with the PCP at the time of the PCP's initial inquiry, the PCT shall respond to the PCP within thirty (30) minutes of PCP's initial inquiry call. The telephone consultation will result in one of the following outcomes dependent upon the needs of the PCP's patient and patient's family- resolution of the PCP's inquiry to the satisfaction of the PCP; referral to the PCT care coordinator to assist the family in accessing routine local behavioral health services with such referral stating the average anticipated wait time for visits; referral to PCT's child psychiatrist for an acute psychopharmacological or diagnostic consultation within two (2) weeks or as agreed with the patient's family; or referral to the PCT's social worker to provide diagnostic consultation and/or transitional face-to-face care or telephonic support to the patient and family until the family can access routine local behavioral health services.

The PCT shall maintain an appropriate clinical setting for its staff to care for patients needing face-to-face consultative or transitional services.

The PCT shall maintain records on all consultations and maintain a single designated telephone number with paging ability or PCT person answering the telephone for PCPs to access consultation services.

For all encounters requiring the care coordinator to assist the family with access to routine local behavioral health services, the PCT will follow up with the family to ascertain whether the appointment was made and continue to assist the family as appropriate if the appointment was not made. The care coordinator will contact the BH-MCO to make it aware of any barriers to timely care.

The PCT will send to PCPs a written or electronic record of all face-to-face visits including results of any follow up contacts within 48 hours of the visit. The PCT is encouraged to provide verbal feedback to the PCP from all face-to-face visits requiring follow up. The

PCT will also send to PCPs a written or electronic record of all telephonic care coordination encounters including results or any follow up contact within 48 hours of encounter.

The PCT will generate quarterly reports detailing the activity of participating PCPs and identifying which PCPs are not utilizing the service. The PCT will outreach to engage PCPs who are not utilizing the service. This may include but is not limited to outreach by telephone, e-mail, continuing education sessions, or visits to the office. The quarterly reports will detail the number of telephonic and face to face encounters, the number of unique recipients using the service, the number referred for additional services with community BH providers, the number of recipients who showed up for referred services, the number of unique members discussed with the BH-MCO, and the number of unique members discussed with the PH MCO.

**Provider Outreach Services**

The PCT will sequentially contact PCPs and other targeted prescribers of psychotropic medications in the HC Region to inform them of the PCT program and encourage them to participate. The PCT will provide PCPs in the HC Region with training and behavioral health continuing education at PCP offices on how to access and use the consultation program, orientation to community behavioral health services, and guidelines for prescribing and monitoring side effects of common psychotropic medications.

EXHIBIT W

EXHIBIT X

# EXHIBIT X

## HEALTHCHOICES PH-MCO GUIDELINES FOR ADVERTISING, SPONSORSHIPS, AND OUTREACH

## I. Overview

The PH-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with the guidelines outlined in this exhibit.

## II. HealthChoices Outreach Procedures

HealthChoices (HC) Managed Care Organizations (MCOs) must adhere to the following guidelines and all the requirements specified in Section V.F.2, PH-MCO Outreach Materials, and V.F.3, PH-MCO Outreach Activities, of the Agreement when submitting outreach materials, policies and procedures to the Department.

### A. Submission of PH-MCO Outreach Material

Purpose: To obtain Department approval of new or revised outreach materials, plans or procedures.

Objectives:

1. To assure that PH-MCO outreach materials are accurate.

2. To prevent the PH-MCO from distributing outreach materials that mislead, confuse or defraud either the Member or the Department.

Process:

1. The PH-MCO submits outreach materials to the Department for prior approval using the HealthChoices Educational Materials Approval Request form (form attached).

2. The Department's contract monitoring Core Team will review and forward to the PH-MCO a preliminary response within thirty (30) calendar days from date of receipt of the request form.

   **Exception:** Should the materials require comments or approval from offices outside the Department contract monitoring Core Team, the turnaround time would be as soon as possible.

3. The PH-MCO will submit a final copy of the outreach materials to the Department contract monitoring Core Team for a final written approval prior to circulating the materials.

4. The Department review agency will forward a final written approval to the PH-MCO within ten (10) business days.

5. Outreach material usage:

   a. Direct outreach materials will be used only by the HealthChoices Independent Enrollment Assistance Program personnel after final written approval is received by the PH-MCO from the Department.

   b. Indirect outreach materials, i.e. advertisements, may be utilized immediately after final written approval is received by the PH-MCO from the Department.

## B. Criteria for Review of PH-MCO Outreach Material

Purpose: To assure that printed materials, advertising, promotional activities and new Member orientations coordinated through the HealthChoices Independent Enrollment Assistance Program are designed to enable the Medical Assistance consumer to make an informed choice.

Objectives:

1. To assure that the information complies with all federal and state requirements.

2. To determine if the information is grammatically correct and appropriate for Pennsylvania's Medical Assistance population.

3. To ensure that outreach materials are accurate and do not mislead, confuse, or defraud the Member or the Department with the assertion or statement that the Member must enroll in the PH-MCO in order to obtain Medical Assistance benefits, or in order to not lose Medical Assistance benefits.

4. To ensure that there are no assertions or statements that the PH-MCO is endorsed by CMS, the Federal or State government, or similar entity.

Process:

1. Receive a written overall outreach plan annually if the PH-MCO anticipates participation in outreach activities. Requests for specific indirect advertising must be submitted thirty (30) calendar days in advance for written Department approval.

2. Determine if approval is necessary from other offices.

3. Review the information with the following criteria:

   a. Is the PH-MCO identified?
   b. Does the information comply with all federal and state regulations?
   c. Is the information presented in grammatically correct, precise, appropriate and unambiguous language, easily understood by the target audience (e.g., age and language) and does it avoid the use of industry jargon?
   d. Is the information fair, relevant, accurate and not misleading or disparaging to competitors?
   e. Can the information be easily understood by a person with a sixth grade education?
   f. Does the information include symbols or pictures that are discriminating because of race, color, age, religion, sex, national origin, physical handicap or otherwise? and
   g. Does the information create a negative image of the traditional Fee-for-Service system?

4. The Department will forward a final written response to the PH-MCO within ten (10) business days.

## C. HC PH-MCO Participating In or Hosting an Event

The PH-MCO may submit requests to sponsor or participate in health fairs or community events; the request should demonstrate that the PH-MCO will participate in such fairs or events through activities, including approved outreach activities that are primarily health-care related. The PH-MCO must receive advance written approval from the Department prior to the event date. All requests must be submitted to the Department at least thirty 30 calendar days in advance of the event, on the forms which are included as part of this attachment.

Purpose: To clarify for PH-MCOs that Pennsylvania laws and regulations prohibit certain kinds of offers or payments to consumers as inducements or incentives for consumers to use the PH-MCO's services.

Objectives:

1. To provide amenities that create an environment that is comfortable and convenient for Recipients but is not offered as an artificial outreach inducement or incentive.

2. To eliminate fraudulent, abusive and deceptive practices that may occur as incentives or inducements to obtain specific covered services from the PH-MCO.

Process:

1. The PH-MCO must submit a request, using the applicable HealthChoices PH-MCO Outreach Approval Request Form or the HealthChoices Education Materials Request Form, to the appropriate Department review agency to host an event thirty (30) calendar days in advance of the event (see attached). Should the event require approval from other offices, the approval process may extend beyond thirty (30) calendar days.

2. The Department review agency considers the request confidential information.

## D. PH-MCO Outreach Request Form

1. HealthChoices PH-MCO Outreach Approval Request Form

## E. Health Education Materials Request Form

1. HealthChoices Educational Materials Approval Request Form

# HEALTHCHOICES EDUCATIONAL MATERIALS APPROVAL FORM

PH-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject:

_____

Who:

_____

What:

_____

When:

_____

Where:

_____

Any Fees:

_____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

***DHS USE ONLY:***

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

# HEALTHCHOICES PH-MCO OUTREACH APPROVAL FORM

PH-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject:

_____

Who:

_____

What:

_____

When:

_____

Where:

_____

Any Fees:

_____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

***DHS USE ONLY:***

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

# EXHIBIT Y

# EXHIBIT Z

# EXHIBIT Z

## AUTOMATIC ASSIGNMENT

Any Consumer who does not select a physical health-managed care organization (PH-MCO) and is mandated into the HealthChoices Program will be subject to the auto-assignment process as described below. The auto-assignment process does not negate the Consumer's option to change his/her PH-MCO. An eligible Consumer who has not made a PH-MCO selection and who has a case record that also includes another active member in the case with an active PH-MCO record will be assigned to that same PH-MCO. These Consumers will not count toward the percentages designated for auto-assignment. Consumers in a family unit will be assigned together to a PH-MCO. All remaining eligible Consumers, who have not voluntarily selected a PH-MCO, will be considered in the pool of Consumers who will be equally auto-assigned to PH-MCOs. The formula will direct an equal distribution of the auto-assignment pool in all HealthChoices Zones monthly based on the number of PH-MCOs in the Zone. For example, if there are five PH-MCOs in the Zone, each PH-MCO would receive 20%.

A. Consumer Re-Assignment Following Resumption of Eligibility: Consumers who lose eligibility and regain it within six (6) months will automatically be re-enrolled in their previously selected PH-MCO, as long as the Consumer's eligibility status or geographical residence is still valid for participation in that same PH-MCO.

   If the Consumer loses eligibility and regains it after six (6) months, s/he may be enrolled in the same PH-MCO as the payment name, the case payment name or any other Member in the case that has an active PH-MCO record. If there is no active PH-MCO record in the case, s/he will automatically become enrolled in a PH-MCO through the automatic assignment process.

   Prior to the future begin date for the auto-assigned PH-MCO, the Consumer may select a different PH-MCO and override the auto-assigned PH-MCO by contacting the EAP Contractor. When the Consumer contacts the EAP Contractor to make this change, it will be the EAP Contractor's responsibility to enroll the Consumer in the PH-MCO of his/her choice. The EAP Contractor will process the enrollment into the new PH-MCO through the weekly enrollment process.

B. Continuing Enrollment When Moving Between Zones: Eligible Consumers who move from one HealthChoices Zone to another will remain in the PH-MCO in which they were enrolled prior to their move, if the PH-MCO is also operational in the Zone to which they move.

C. Continuing Enrollment When Transferring from a CHC-MCO: Consumers who transfer from a CHC-MCO and the affiliate PH-MCO is also contracted as a PH-MCO, and the consumer has not made a PH-MCO selection, the consumer will be enrolled in the affiliated PH-MCO.

***The Department reserves the right to reassess the distribution process and to modify it in accordance with sound programmatic management principles. The Department shall institute such modifications at any time following appropriate notification to the PH-MCOs via executive correspondence.***

# EXHIBIT AA

# EXHIBIT AA

## MANAGED CARE DEFINITIONS FOR MEMBER COMMUNICATIONS

The 2016 CMS "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability" final rule established a requirement (42 C.F.R. § 438.10(c)(4)(i)) that mandated that all states which contract with MCOs for delivery of Medicaid services must develop standardized definitions for a set of managed care related terms to be utilized by MCOs in communications with Members. The state developed definitions were required to be written at no higher than a sixth-grade reading level and are to be utilized by PH-MCOs for communications with Members such as newsletters, informational pamphlets, Member handbooks, etc.

When using any of the terms below in communications to Members, PH-MCOs must utilize the terms with the same intent as defined by the state.

### Managed Care Definitions

1) **Appeal-** To file a Complaint, Grievance, or request a Fair Hearing.

2) **Complaint**- When a Member tells an MCO that he or she is unhappy with the MCO or his or her provider or does not agree with a decision by the MCO.

3) **Co-Payment-** A co-payment is the amount a Member pays for some covered services. It is usually only a small amount.

4) **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.

5) **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.

6) **Emergency Medical Transportation**- Transportation by an ambulance for an emergency medical condition.

7) **Emergency Room Care**- Services needed to treat or evaluate an emergency medical condition in an emergency room.

8) **Emergency Services**- Services needed to treat or evaluate an emergency medical condition.

9) **Excluded Services**- Term should not be used. MCO should use "Services That Are Not Covered" instead.

10) **Grievance**- When a Member tells an MCO that he or she disagrees with an 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.

11) **Habilitation Services and Devices**- Term should not be used by MCO. MCO should define specific service.

12) **Health Insurance**- A type of insurance coverage that pays for certain health care services. (If used by MCO, should be used to refer only to private insurance.)

13) **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.

14) **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.

15) **Hospitalization-** Care in a hospital that requires admission as an inpatient.

16) **Hospital Outpatient Care**- Care provided by a hospital or hospital-based clinic that does not require admission to the hospital.

17) **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][participant] 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.

18) **Network**- Contracted providers, facilities, and suppliers that provide covered services to MCO Members.

19) **Non-Participating Provider**- When referring to a provider that is not in the network, MCOs should use the term "Out-of-Network Provider."

20) **Physician Services**- Health care services provided or directed by a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

21) **Plan**- A health care organization that provides or pays for the cost of services or supplies.

22) **Preauthorization or Prior Authorization**- Approval of a service or item before a Member receives the service or item.

23) **Participating Provider**- When referring to a provider that is in the network, MCOs should use “Network Provider.”

24) **Premium**- The amount a Member pays for health care coverage.

25) **Prescription Drug Coverage**- A benefit that pays for prescribed drugs or medications.

26) **Prescription Drugs**- Drugs or medications that require a prescription for coverage.

27) **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.

28) **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.

29) **Provider**- An individual or entity that delivers health care services or supplies.

30) **Rehabilitative Services and Devices**- Term should not be used by MCO. MCO should define specific service.

31) **Skilled Nursing Care**- Services provided by a licensed nurse.

32) **Specialist**- A doctor, a doctor’s group, or a certified registered nurse practitioner who focuses his or her practice on treating one disease or medical condition or a specific part of the body.

33) **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.

34) **Network Provider**- A provider, facility, or supplier that has a contract with an MCO to provide services to Members.

35) **Out-of-Network Provider**- A provider that does not have a contract with an MCO to provide services to Members.

EXHIBIT BB

# EXHIBIT BB

## PH-MCO RECIPIENT COVERAGE DOCUMENT

This Recipient Coverage Document (RCD) includes descriptions of policies supported by the Department's data systems and processes. In cases where policies in this document conflict with another provision of the Managed Care Organization's (PH-MCO) Agreement, the Agreement will take precedence.

PH-MCO coverage as detailed in this document does not imply coverage under a BH-MCO, or CHC-MCO. Refer to the BH-MCO RCD for behavioral health coverage guidelines and CHC-MCO PCD for Community Health Choices coverage guidelines.

The Department will provide sufficient information to the PH-MCO to reconcile PH-MCO membership data and amounts paid to and recovered from the PH-MCO. The Department will pay capitation to only one PH-MCO per recipient per month.

### Coverage Rules

A PH-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, and G.

Refer to the HealthChoices Intranet site for additional information on Recipient coverage, clarifications, examples, and Membership Enrollment/Disenrollment procedures.

A. Responsibility to Provide MA Benefits - Unless otherwise specified, the PH-MCO is responsible for providing MA benefits to its Members in accordance with eligibility information included on the Daily or Monthly 834 Eligibility File, which is provided by the Department to each PH-MCO.

B. Membership Files/Coverage Dates/Eligibility - Daily and Monthly 834 Eligibility Files are provided to each PH-MCO containing information and changes that apply to its Members. The PH-MCO is responsible for providing services for each PH-MCO Member identified on the Daily or Monthly 834 Eligibility File from the first day of the calendar month or the PH-MCO Start Date, whichever is later, through the last day of the calendar month or the PH-MCO coverage end date, if different. The Department will pay Capitation to the PH-MCO from the first day of coverage in a month through the last day of the calendar month, except when transferring to a CHC-MCO. If a PH-MCO member transfers to a CHC-MCO the Department will pay capitation to the PH-MCO only through the day prior to the CHC begin date. PH-MCO coverage dates beyond the last day of the month are preliminary information that is subject to change.

   eCIS will retain a Member's PH-MCO selection for six (6) months after a Member becomes ineligible for MA. These Members will become the responsibility of the same PH-MCO if they regain MA eligibility during that six-month period and their

category of assistance and geographic location are valid for that PH-MCO. Upon regaining MA eligibility, the PH-MCO Start Date will be the MA eligibility Start Date on Client Information System (eCIS) or the date MA eligibility was reopened in eCIS, whichever is later.

C. Benefit Packages - The Department has established two benefit packages based on age: Adult and Children's. The Adult package includes individuals age 21 years old or older. The Children's package includes individuals under age 21 years. Refer to the Daily and Monthly 834 Eligibility Files to determine benefits during a month based on these criteria.

D. Exceptions and Clarifications - The Department will recover Capitation payments made for Members who the Department has determined the PH-MCO was not responsible for providing services.

The PH-MCO will not be responsible for and will not be paid when the Department notifies the PH-MCO of Members for whom they are not responsible.

1. Errors in PH-MCO coverage identified from any source must be reported to the Department within forty-five (45) days of receipt of the Daily 834 Eligibility File for changes to be considered.

   If a Recipient is enrolled in a PH-MCO in error, that PH-MCO is responsible for covering the Recipient until the Department is notified and the correction is applied to the eCIS eligibility record.

   If at the time of notification to the Department, the Member was disenrolled in error from a PH-MCO and the Member is enrolled in a different PH-MCO, the Member will be reenrolled in the previous PH-MCO effective the first of the next month. However, if at the time of notification, the Recipient is covered by FFS, the Recipient will be reenrolled into the same PH-MCO effective the day following notification to the Department.

2. If eCIS shows an exemption code or a facility/placement code that precludes PH-MCO coverage, the Recipient will not be enrolled in a PH-MCO.

3. If eCIS shows Fee-For-Service (FFS) coverage that coincides with PH-MCO coverage, the Member may use either coverage and there will be no monetary adjustment between the Department and the PH-MCO. (This is subordinate to #7 below.)

4. If a PH-MCO has actual knowledge that a Member is deceased, and if such Member shows on either the Daily or Monthly 834 Eligibility File as active, the PH-MCO is required to notify the County Assistance Office (CAO) and the Department. The Department will recover Capitation payments made for up to twenty-one (21) months after the service month in which the date of death occurred.

5. The Department will recover Capitation payments for Members who were later determined to be ineligible for PH-MCO coverage or who were placed in a setting that results in the termination of PH-MCO coverage by the Department. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (e.g., today's date is 9/18/2020 and central office staff end date managed care coverage 9/30/2020 – payments are recouped for 10/2019 through 9/2020. See Section F for examples of placements that result in termination of coverage).

6. The Department is not responsible for making a Capitation payment for a month in which a Member aged twenty-one through sixty-four (21 – 64) resides in a free-standing IMD at least sixteen (16) days in that calendar month and the Member's condition is not related to a Substance Use Disorder (SUD). This applies without regard to the number of days in the month in which the Member is enrolled in the PH-MCO. Recovery of capitation payments that meet these criteria is limited to 18 (eighteen) months. Additionally, the Department will make a separate payment to the PH-MCO for the days the Member does not reside in the freestanding IMD during a calendar month as noted in Section VII.E.13 of the Agreement.

7. A newborn is the responsibility of the PH-MCO that covered the mother on the newborn's date of birth. Where eCIS does not reflect this, the PH-MCO must notify the Department to correct coverage. The Department will generate Capitation payments as appropriate. Limitations in Sections E-2 and E-3 applicable to the mother will apply to the newborn.

   Exception #1: If mother is in a PH-MCO, and C&Y assumes custody of the newborn at birth and places the child in a county within the same HC zone as the mother, the child's coverage will mirror the mother's PH-MCO coverage.

   Exception #2: If mother is in a PH-MCO, and C&Y assumes custody of the newborn at birth and places the child in a county outside of the same HC zone where the mother resides, the child will be FFS until auto-assignment or the selected PH-MCO is effective in the new HC County.

8. A Member's change of residence out of a PH-MCO's service area does not necessarily exempt the PH-MCO from the responsibility to provide MA benefits. It is the PH-MCO's responsibility to inform the CAO of the address change upon receipt of information that a Member is residing outside the PH-MCO service area.

9. Pursuant to the rules outlined in the RCD, the absence of MA eligibility indicated on eCIS for a certain date does not necessarily exempt the PH-MCO from its responsibility to provide MA benefits for that date. Refer to Section E, Coverage During Inpatient Hospital Stays, for applicable rules.

10. Dual Eligibles who are enrolled in Medicare Part D and who turn 21 years of age will be identified by the Department on the first Friday of each month, and will be disenrolled from the PH-MCO effective the end of the month in which the Department identifies that the Member turned 21 years of age. In addition, newly identified Dual Eligibles age 21 and over will be disenrolled the end of the month following the month in which Medicare Part D is posted to their eligibility record. The PH-MCO remains responsible for these Members through the disenrollment date.

11. The Department reserves the right to intercede in requests for expedited enrollments when Medically Necessary. The Department's determination for the expedited enrollment will be final. The Capitation rate will be retroactively adjusted for each PH-MCO based on the effective date of the expedited enrollment.

12. The PH-MCO must provide Out-Of-Area Covered Services for a Member as long as they remain a resident of the Commonwealth and the zone. The PH-MCO remains responsible for a Member who is:

    - attending a college or university in a state other than Pennsylvania,
    - attending a college or university in a zone other than their zone of residence, or
    - traveling outside of the zone.

    At the sole discretion of the Department, the Member may be disenrolled from the PH-MCO and enrolled in FFS. The Department will take into consideration such factors as distance from Pennsylvania, the intensity and duration of medically required services, and whether the PH-MCO has a business presence nearby.

E. Change in PH-MCO Coverage During Inpatient Hospital Stays - Payment responsibility when an MA Recipient has managed care coverage during part of a hospital stay is detailed in the Rules below. Note that one or more of these rules may apply during a particular hospital stay.

| **RULE: E-1.** | |
|---|---|
| ***Condition*** | **A Recipient who is covered by FFS when admitted to a hospital becomes eligible for PH-MCO coverage while still in the hospital.** |
| **PH-MCO Coverage Responsibility** | As of the PH-MCO start date, the PH-MCO is responsible for physician, DME, and all other covered services not included in the hospital bill. |
| **MA FFS Coverage Responsibility** | The FFS program is responsible for the hospital bill through the date of discharge.<br><br>Note: If the Recipient is discharged from the initial hospital and admitted to another hospital (acute or rehabilitation) after the PH-MCO Start Date, FFS is only responsible for the stay in the initial hospital through the date of discharge. The PH-MCO is responsible for the stay in the subsequent hospital upon admission. |

| **RULE: E-2.** |
|---|

| *Condition* | **A Recipient who is covered by a PH-MCO when admitted to a hospital loses PH-MCO coverage and assumes FFS coverage while still in the hospital.** |
|---|---|
| **PH-MCO Coverage Responsibility** | The PH-MCO is responsible for the hospital stay with the following exceptions:<br><br>EXCEPTION #1: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is the first day of the month, the PH-MCO is financially responsible for the stay through the last day of that month.<br><br>Example:<br>If a Recipient covered by the PH-MCO is admitted to a hospital on June 21 and the FFS coverage begin date is July 1, the FFS program assumes payment responsibility for the stay on August 1. The PH-MCO remains financially responsible for the stay through July 31.<br><br>EXCEPTION #2: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is any day other than the first day of the month, the PH-MCO is financially responsible for the stay through the last day of the following month.<br><br>Example:<br>If a Recipient covered by a PH-MCO is admitted to a hospital on June 21 and the FFS program coverage begin date is July 15, the FFS program assumes payment responsibility for the stay on September 1. The PH-MCO program remains financially responsible for the stay through August 31. |
| **MA FFS Coverage Responsibility** | Starting with the FFS coverage begin date, FFS is responsible for physician, DME, and other bills not included in the hospital bill.<br><br>EXCEPTION #1: The FFS program is financially responsible for the stay beginning on the first day of the next month.<br><br>EXCEPTION #2: The FFS program is financially responsible for the stay beginning on the first day of the month following the next month. |

| **RULE: E-3.** | |
|---|---|
| *Condition* | **A Recipient covered by a PH-MCO when admitted to a hospital transfers to another PH-MCO while still in the hospital.** |
| **PH-MCO Coverage Responsibility** | The surrendering PH-MCO is responsible for the hospital stay with the exceptions below. As of the gaining PH-MCO's Start Date, it is responsible for the physician, DME, and all other covered services not included in the hospital bill.<br><br>EXCEPTION #1: If the Recipient is still in the hospital on the gaining PH-MCO Start Date, and the Recipient's gaining PH-MCO Start Date is the first day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month.<br><br>Example:<br>If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO start date is July 1, the gaining PH-MCO assumes payment responsibility for the stay on August 1. The surrendering PH-MCO remains financially responsible for the stay through July 31.<br><br>EXCEPTION #2: If the Recipient is still in the hospital on the gaining PH-MCO coverage begin date, and the gaining PH-MCO Start Date is any day other than the first day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the following month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the month following the next month.<br><br>Example:<br>If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO start date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The surrendering PH-MCO remains financially responsible for the stay through August 31. |
| **MA FFS Coverage Responsibility** | There is no FFS coverage in this example. |

| RULE: E-4a. | |
|---|---|
| *Condition* | **A Recipient covered by a PH-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Recipient is not discharged), resulting in a break in PH-MCO coverage. The Department's Division of Medicaid Management Information Systems (MMIS) Operations becomes aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.** |
| **PH-MCO Coverage Responsibility** | MMIS Operations will reopen the Recipient's PH-MCO coverage retroactive to the day it was end-dated on eCIS and adjust the Capitation payment accordingly. The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services.<br><br>Example:<br>A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22 and regains it on April 9 retroactive to March 22. The PH-MCO coverage on eCIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new PH-MCO begin date of April 9. On April 25, MMIS Operations becomes aware of the situation.<br><br>Because MMIS Operations is aware of the loss of MA eligibility within the month following the month in which it was lost, MMIS Operations reopens the PH-MCO coverage retroactive to April 1, the day after the PH-MCO end-date is posted on eCIS (March 31). The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services. |
| **MA FFS Coverage Responsibility** | There would be no FFS coverage in this example. |

| RULE: E-4b. | |
|---|---|
| *Condition* | **A Recipient covered by a PH-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Recipient is not discharged), resulting in a break in PH-MCO coverage. MMIS Operations does not become aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.** |
| **PH-MCO Coverage Responsibility** | Example:<br>Same as in RULE: E-4a except, because MMIS Operations is not aware of the break in PH-MCO coverage by the end of the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on eCIS (March 31). The PH-MCO is only responsible for covering the Recipient through the end of March. |
| **MA FFS Coverage Responsibility** | FFS is responsible effective April 1. |

| RULE: E-4c. | |
|---|---|
| *Condition* | **A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility while in the hospital (Recipient is not discharged). The Recipient regains MA eligibility retroactively after the month following the month in which the MA eligibility was ended, regardless of when MMIS Operations became aware of the action.** |
| **PH-MCO Coverage Responsibility** | Example:<br>A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient regains MA eligibility on May 15 retroactive to March 22. The PH-MCO coverage on eCIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new start date of May 15.<br>Because the MA eligibility was not reopened within the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on eCIS (March 31). The PH-MCO is only responsible for covering the Recipient through the end of March. |
| **MA FFS Coverage Responsibility** | FFS is responsible effective April 1. |

| RULE: E-4d. | |
|---|---|
| *Condition* | **A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility while in the hospital. The Recipient is discharged from the hospital after the month in which the MA eligibility was lost but before the MA eligibility is regained by the Recipient and reopened retroactively, regardless of when MMIS Operations became aware of the situation.** |
| **PH-MCO Coverage Responsibility** | Example:<br>A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient is discharged from the hospital April 3. The Recipient regains MA eligibility on April 22 retroactive to March 22. The PH-MCO coverage on eCIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new begin date of April 22.<br><br>Because the Recipient was discharged from the hospital before the MA eligibility was reopened, which resulted in a 3-day period of FFS coverage on eCIS, MMIS Operations does not reopen the PH-MCO coverage retroactive to April 1. The PH-MCO is only responsible for the stay through the end of March. |
| **MA FFS Coverage Responsibility** | FFS is responsible effective April 1. |

| RULE: E-4e. | |
|---|---|
| *Condition* | **A hospitalized Recipient never regains MA eligibility.** |
| **PH-MCO Coverage Responsibility** | If the Recipient is never determined retroactively eligible for MA, the PH-MCO is only responsible for covering the Recipient through the end of the month in which MA eligibility ended. |
| **MA FFS Coverage Responsibility** | FFS is not responsible for coverage since the Recipient has not regained MA eligibility. |

| RULE: E-5. | |
|---|---|
| *Condition* | **A Recipient who is covered by PH-MCO when admitted to a hospital loses PH-MCO and assumes CHC-MCO while still in the hospital.** |
| **PH-MCO Coverage Responsibility** | The surrendering PH-MCO is responsible for the hospital stay with the exceptions below. As of the gaining CHC-MCO's Start Date, the gaining CHC-MCO is responsible for the physician, DME, and all other Covered Services not included in the hospital bill.<br><br>EXCEPTION #1: If the Recipient is still in the hospital on the gaining CHC-MCO Start Date, and the Recipient's gaining CHC-MCO Start Date is the first (1st) day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the next month.<br><br>Example:<br>If a Recipient is admitted to a hospital on June 21 and the gaining CHC-MCO Start Date is July 1, the gaining CHC-MCO assumes payment responsibility for the stay on August 1. The surrendering PH-MCO remains financially responsible for the stay through July 31.<br><br>EXCEPTION #2: If the Recipient is still in the hospital on the gaining CHC-MCO Start Date, and the Recipient's gaining CHC-MCO start date is any day other than the first day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the following month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the month following the next month.<br><br>Example:<br>If a Recipient is admitted to a hospital on June 21 and the gaining CHC-MCO start date is July 15, the gaining CHC-MCO assumes payment responsibility for the stay on September 1. The surrendering PH-MCO remains financially responsible for the stay through August 31. |

| | |
|---|---|
| **MA FFS Coverage Responsibility** | There is no FFS coverage in this example. |

| **RULE: E-6.** | |
|---|---|
| ***Condition*** | **Recipient who is covered by CHC-MCO when admitted to a hospital loses CHC-MCO and assumes PH-MCO while still in the hospital.** |
| **PH-MCO Coverage Responsibility** | The surrendering CHC-MCO is responsible for the hospital stay with the exceptions below. Starting with the gaining PH-MCO's Start Date, the gaining PH-MCO is responsible for the physician, DME, and all other Covered Services not included in the hospital bill.<br><br>EXCEPTION #1: If the Recipient is still in the hospital on the gaining PH-MCO Start Date, and the Recipient's gaining PH-MCO Start Date is the first (1st) day of the month, the surrendering CHC-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month.<br><br>Example:<br>If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO Start Date is July 1, the gaining PHC-MCO assumes payment responsibility for the stay on August 1. The surrendering CHC-MCO remains financially responsible for the stay through July 31.<br><br>EXCEPTION #2: If the Recipient is still in the hospital on the gaining PH-MCO Start Date, and the Recipient's gaining PH-MCO Start Date is any day other than the first day of the month, the surrendering CHC-MCO is financially responsible for the stay through the last day of the following month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the month following the next month.<br><br>Example:<br>If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO Start Date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The surrendering CHC-MCO remains financially responsible for the stay through August 31. |
| **MA FFS Coverage Responsibility** | There is no FFS coverage in this example. |

F. Other Causes for Coverage Termination and Involuntary Disenrollment**.** If a condition described in the following sections occurs, the PH-MCO must notify the Department. In accordance with the Department's disenrollment guidelines, MMIS Operations will take action to disenroll the Member. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards. For example, today's date is 9/18/2020 and central office staff end date managed care coverage 9/30/2019 – payments are recouped for 10/2019 through 9/2020).

If a Recipient is placed in a setting listed in these sections and is under FFS prior to the PH-MCO's Start Date, PH-MCO coverage will be voided and adjustments will be processed for any Capitation payments made.

The PH-MCO must notify the Department within sixty (60) days following the satisfaction of the Department's disenrollment guidelines in order for MMIS Operations to end-date the member's enrollment. Failure on the part of the PH-MCO to notify MMIS Operations within the sixty (60) days will result in the end date being delayed, thereby extending the PH-MCO's responsibility for covering the Recipient. The PH-MCO should not hold and then later submit the notifications.

| RULE: F-1a. | |
|---|---|
| *Condition* | **A Member who is covered by a PH-MCO when admitted to a Nursing Facility transfers to a CHC-MCO.** |
| **PH-MCO Coverage Responsibility** | Residence in a nursing facility is not cause for disenrollment from a PH-MCO. If eCIS provides a CHC start date, and if the PH-MCO's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an earlier date in the month of the CHC start date, or a later date, the last day of the PH-MCO's responsibility to provide benefits is the date prior to the CHC start date. Refer to the Agreement, Section VII., E.12. |
| **MA FFS Coverage Responsibility** | FFS is not responsible for coverage. |

| RULE: F-1b. | |
|---|---|
| *Condition* | **A Member who is covered by a PH-MCO when admitted to a Nursing Facility transfers to another PH-MCO.** |
| **PH-MCO Coverage Responsibility** | The losing PH-MCO is responsible for the Nursing Facility stay with the following exceptions. Starting with the gaining PH-MCO's begin date, the gaining PH-MCO is responsible for the physician, DME and all other covered services not included in the Nursing Facility bill.<br><br>Recipients who have facility codes 35 or 36 assigned prior to a plan transfer request being processed will have the plan transfer denied with code 53, Enrollment Conflicts with Facility/Waiver Code.<br><br>EXCEPTION #1: If the Recipient is still in the Nursing Facility on the gaining PH-MCO coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month.<br><br>Example:<br>If a Recipient is admitted to a Nursing Facility on June 21 and the gaining PH-MCO coverage begin date is July 1, the gaining PH-MCO assumes payment responsibility for the stay on August 1. The losing PH-MCO remains financially responsible for the stay through July 31. |
| **MA FFS Coverage Responsibility** | FFS is not responsible for coverage. |

| RULE: F-1d. | |
|---|---|
| *Condition* | **A Member is admitted to an out of state Nursing Facility (regardless of who places the Member in the facility).** |
| **PH-MCO Coverage Responsibility** | The PH-MCO is not responsible for Members who are placed in a Nursing Facility outside of Pennsylvania. A Member who is placed in an out-of-state Nursing Facility is disenrolled from the PH-MCO the day before the admission date. |
| **MA FFS Coverage Responsibility** | FFS is not responsible for coverage in an out of state Nursing Facility. |

| RULE: F-1f. | |
|---|---|
| *Condition* | **A member is admitted to a Veteran's Home (MA provider type/specialty 03/042).** |
| **PH-MCO Coverage Responsibility** | The PH-MCO is not responsible for Members who are admitted to a Veteran's Home. A Member who is admitted to a Veteran's Home is disenrolled from the PH-MCO the day before the admission date. |
| **MA FFS Coverage Responsibility** | FFS coverage is effective on the admission date. |

| RULE: F-1g. | |
|---|---|
| ***Condition*** | **A member is placed into Hospice care while in a Nursing Facility.** |
| **PH-MCO Coverage Responsibility** | If Hospice care begins during the Nursing Facility placement, the member remains the responsibility of the PH-MCO. |
| **MA FFS Coverage Responsibility** | FFS is not responsible for coverage. |

| RULE: F-2a. | |
|---|---|
| ***Condition*** | **A Member is enrolled in the CHC Waiver.** |
| **PH-MCO Coverage Responsibility** | If eCIS provides a CHC start date, and if the PH-MCO's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an earlier date in the month of the CHC start date, or a later date, the last day of the PH-MCO's responsibility to provide benefits is the date prior to the CHC start date. |
| **MA FFS Coverage Responsibility** | FFS is not responsible for coverage. |

| RULE: F-3. | |
|---|---|
| ***Condition*** | **A Member is admitted to a State Facility (MA Provider Type/Specialty Codes 01/23 - Public Psychiatric Hospital and 03/37 - State LTC Unit located at State Mental Hospitals).** |
| **PH-MCO Coverage Responsibility** | The PH-MCO is not responsible for Members in a state facility. A Member admitted to a state facility is disenrolled from the PH-MCO the day before the admission date. |
| **MA FFS Coverage Responsibility** | FFS coverage is effective on the admission date. |

| RULE: F-4. | |
|---|---|
| ***Condition*** | **A Member is incarcerated in a Penal Facility, Correctional Institution (including work release), or Youth Development Center.** |
| **PH-MCO Coverage Responsibility** | The PH-MCO is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility. The Member is disenrolled from the PH-MCO effective the day before incarceration in the facility or institution. |
| **MA FFS Coverage Responsibility** | FFS is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility, except for inpatient hospital services. |
| **NOTE:** | This rule is based upon section 392.2 of the MA Eligibility Handbook which states,<br>"For purposes of MA eligibility, other than eligibility for inpatient hospital services, the needs of an inmate in a correctional institution are the responsibility of the governmental authority exercising administrative control over the facility.". |

| RULE: F-5. | |
|---|---|
| ***Condition*** | **A Member is placed in a Juvenile Detention Center (JDC).** |
| **PH-MCO Coverage Responsibility** | During the first thirty-five (35) days of a Member's placement in a JDC, the PH-MCO is responsible for all covered services that are provided to the Member *outside* of the JDC site.<br><br>A Member who is placed in a JDC is disenrolled from the PH-MCO after thirty-five (35) days. |

| | |
|---|---|
| **MA FFS Coverage Responsibility** | Services provided to the Member *onsite* at the JDC during the first thirty-five (35) days will be covered under the MA FFS Program.<br><br>FFS coverage is effective on the 36th day. |

| **RULE: F-6.** | |
|---|---|
| ***Condition*** | **A Member becomes eligible for the Health Insurance Premium Payment Program (HIPP).** |
| **PH-MCO Coverage Responsibility** | A Member determined to be HIPP eligible (Employer Group Health Plan) is disenrolled from the PH-MCO. HIPP-eligible MA Recipients are prevented from enrolling in PH-MCOs. |
| **MA FFS Coverage Responsibility** | FFS benefits with HIPP insurance coverage begin the day after the disenrollment date. |

| **RULE: F-7.** | |
|---|---|
| ***Condition*** | **A Member is enrolled in the Living Independence for the Elderly Program (LIFE) (MA Provider Type/Specialty Code 07/70 – LIFE)**<br><br>LIFE is Pennsylvania's managed care option for individuals who are Nursing Home Clinically Eligible (NFCE) and age 55 and older. It provides fully integrated acute care, long-term care, behavioral health, and pharmacy services to individuals who wish to remain in the community. |
| **PH-MCO Coverage Responsibility** | A Member enrolled in LIFE is disenrolled from the PH-MCO effective the day before the start date in the LIFE program. |
| **MA FFS Coverage Responsibility** | LIFE coverage begins the day after the disenrollment date. |

G. Other Facility Placement Coverage - The following rules provide information relating to PH-MCO coverage of Recipients placed in other types of facilities.

| **RULE: G-1.** | |
|---|---|
| ***Condition*** | **A Member is admitted to a state ICF-ID (MA Provider Type/Specialty Code 03/38 – State Intellectual Disability Center).** |
| **PH-MCO Coverage Responsibility** | A Member admitted to a state ICF-ID is disenrolled from the PH-MCO the day before the admission date. |
| **MA FFS Coverage Responsibility** | FFS coverage is effective on the admission date. |

| **RULE: G-2.** | |
|---|---|
| ***Condition*** | **A Member is admitted to a private ICF-ID/ICF-ORC (MA Provider Type/Specialty Code 03/32 – ICF/ID 8 Beds or Less, 03/33 – ICF/ID 9 Beds or More, and 03/39 – ICF/ORC).** |
| **PH-MCO Coverage Responsibility** | A Member admitted to a private ICF-ID or ICF-ORC facility will continue to be covered by their selected PH-MCO for all covered physical health services with the exception of those services the ICF-ID or ICF-ORC has historically and customarily provided to residents of the facility or those services covered under the facility's per diem payment.<br><br>The residential and treatment costs that are the responsibility of the ICF-ID or ICF-ORC under its agreement with DHS are not the responsibility of the BH-MCO. All other Behavioral Health Services are the responsibility of the BH-MCO. |
| **MA FFS Coverage Responsibility** | FFS is responsible for the residential and treatment costs. DHS will make direct payments to the ICF-ID or ICF-ORC facility to cover room, board, ID-specific non-MA services, and physical and |

| | |
|---|---|
| | behavioral health services to the extent these services have been customarily and historically provided to residents of the facility. |

| **RULE: G-3.** | |
|---|---|
| ***Condition*** | **A. A Member is admitted to a JCAHO-approved Residential Treatment Facility (RTF) (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital).**<br><br>**B. A Member is admitted to a non-JCAHO approved Residential Treatment Facility (RTF) (MA Provider Type/Specialty Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified).** |
| **PH-MCO Coverage Responsibility** | A. With the exception of Children in Substitute Care who are placed in residential facilities by another government agency that has responsibility for these children, a Member placed in a JCAHO-approved RTF (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital) remains covered by their selected PH-MCO for all covered physical health services. The BH-MCO is responsible for the residential and treatment costs.<br><br>B. A Member placed in a non-JCAHO approved RTF (MA Provider Type/Specialty Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified) remains covered by their selected PH-MCO for all covered physical health services. The BH-MCO is responsible for the MA per diem. The Room & Board per diem can be the responsibility of the BH-MCO, Children and Youth, or another agency, depending on medical necessity and who places the Recipient. |
| **MA FFS Coverage Responsibility** | A. FFS is responsible for the residential and treatment costs.<br><br>B. FFS is responsible for the facility's per diem payment. |

| **RULE: G-4.** | |
|---|---|
| ***Condition*** | **A Member is admitted to an Extended Acute Psychiatric Care Hospital (MA Provider Type/Specialty Code 01/18 – Extended Acute Psych Inpatient Unit).** |
| **PH-MCO Coverage Responsibility** | A Member admitted to an extended acute psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. If the Recipient is placed in the facility by the BH-MCO, that BH-MCO is responsible for the residential and treatment costs. |
| **MA FFS Coverage Responsibility** | FFS is responsible for the residential/treatment costs. |

| **RULE: G-5.** | |
|---|---|
| ***Condition*** | **A Member is admitted to an Inpatient Private Psychiatric Facility (MA Provider Type/Specialty Code 01/11 – Private Psychiatric Hospital and 01/22 – Private Psychiatric Unit).** |
| **PH-MCO Coverage Responsibility** | A Member admitted to a private psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. The BH-MCO is responsible for the residential/treatment costs. |
| **MA FFS Coverage Responsibility** | FFS is responsible for the residential/treatment costs. |

# EXHIBIT CC

# EXHIBIT DD

## EXHIBIT DD

## PH-MCO MEMBER HANDBOOK

A. The PH-MCO must ensure that the Member handbook contains written information regarding Member rights and protections and is written at no higher than a sixth grade reading level. The PH-MCO must provide a Member handbook in the appropriate prevalent language, or alternate format, to all members within five (5) business days of being notified of a Member's enrollment, but no sooner than five (5) business days before the member's effective date of enrollment. The PH-MCO may provide the Member handbook in formats other than hard copy. If this option is exercised, the PH-MCO must inform Members what formats are available and how to access each. Upon request, the PH-MCO must provide a hard copy version of the Member handbook to the Member.

B. In compliance with 42 C.F.R. §438.10(g), the content of the member handbook must include information that enables the member to understand how to effectively use the managed care program. At a minimum, the Member handbook shall include:

1. Benefits provided by the PH-MCO.

2. How and where to access benefits provided by the Department, including any cost sharing, and how transportation is provided.

    a. In the case of a counseling or referral service that the PH-MCO does not cover because of moral or religious objections, the PH-MCO must inform Members that the service is not covered by the PH-MCO and provide information to Members about how to access the services

3. The amount, duration, and scope of benefits available in sufficient detail to ensure that Members understand the benefits to which they are entitled.

4. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Member's PCP.

5. The extent to which, and how, after-hours and emergency coverage are provided, including:

    a. What constitutes an emergency medical condition and emergency services.

    b. The fact that prior authorization is not required for emergency services.

    c. The fact that the Member has a right to use any hospital or other setting for emergency care.

6. Any restrictions on the Member's freedom of choice among network providers.

7. The extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the PH-MCO cannot require a Member to obtain a referral before choosing a family planning provider.

8. Any imposed cost sharing.

9. Member rights and responsibilities, including the elements specified in 42 C.F.R. §438.100.

10. The process of selecting and changing the Member's PCP.

11. Grievance, appeal, and fair hearing procedures and timeframes, consistent with 42 C.F.R. Subpart F §§ 438.400 – 438.424, in a DHS-developed or DHS-approved description. Such information must include:

    a. The right to file grievances and appeals.

    b. The requirements and timeframes for filing a grievance or appeal.

    c. The availability of assistance in the filing process.

    d. The right to request a DHS fair hearing after the PH-MCO has made a determination on a Member's appeal which is adverse to the Member.

    e. The fact that, when requested by the member, benefits that the PH-MCO seeks to reduce or terminate will continue if the Member files an appeal or a request for a DHS fair hearing within the timeframes specified for filing, and that the Member may, consistent with DHS policy, be required to pay the cost of services furnished while the appeal of DHS fair hearing is pending if the final decision is adverse to the Member.

12. How to exercise an advance directive, as set forth in 42 C.F.R. § 438.3(j).

13. How to access auxiliary aids and services, including additional information in alternative formats or languages.

14. The toll-free telephone number for member services, medical management, and any other unit providing services directly to Members.

15. Information on how to report suspected fraud or abuse.

16. Any other content required by DHS.

**C.** Information required by this exhibit to be provided by the PH-MCO will be considered to be provided if the PH-MCO:

1. Mails a printed copy of the information to the Member's mailing address;

2. Provides the information by email after obtaining the member's agreement to receive the information by email;

3. Posts the information on the Web site of the PH-MCO and advises the Member in paper or electronic form that the information is available on the Internet and includes 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. Provides the information by any other method that can reasonably be expected to result in the Member receiving that information.

**D.** In compliance with 42 C.F.R. §438.10(c)(4)(ii), the PH-MCO is required to use the Member handbook template provided within this exhibit. The PH-MCO must make modifications in the language contained in the Member handbook if ordered by the Department so as to comply with the requirements described in Section V.F.15.a. of this Agreement.

**[MCO – add cover sheet and taglines page]**

# Table of Contents

**Topic** **Page**
**[MCO to Complete]**

# Section – 1

# Welcome

# Introduction

## What is HealthChoices?

HealthChoices is Pennsylvania's Medical Assistance managed care program. The Office of Medical Assistance Programs (OMAP) in Pennsylvania's Department of Human Services (DHS) oversees the physical health portion of HealthChoices. Physical health services are provided through the physical health managed care organizations (PH-MCOs). Behavioral health services are provided through behavioral health managed care organizations (BH-MCOs). For more information on behavioral health services, see page **[MCO insert page number]**.

# Welcome to [MCO Name]

**[MCO Name]** welcomes you as a member in HealthChoices and **[MCO Name]**! **[MCO to provide a brief description of plan including a map of counties where the plan operates.]** **[MCO Name]** has a network of contracted providers, facilities, and suppliers to provide covered physical health services to members. **[MCO to provide explanation of the need/importance to get services from network providers]**

# Member Services

Staff at Member Services can help you with:

**[MCO to provide list and description of things that Member Services can help with and services offered]**

**[MCO Name]**'s Member Services are available:

**[MCO to provide hours of operation]**

And can be reached at **[MCO Member Services Phone Number and TTY]**

Member Services can also be contacted in writing at:

**[MCO address]**

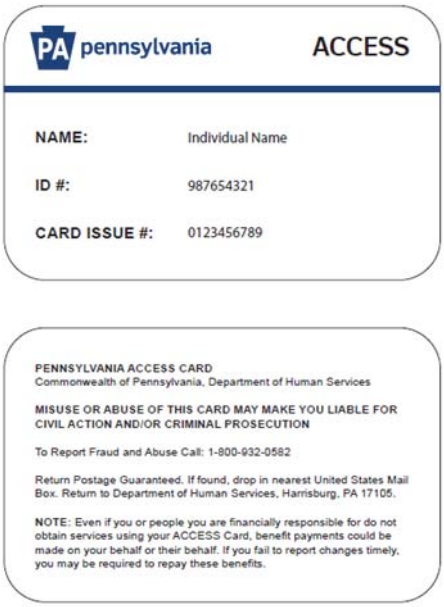
And

**[MCO to provide any additional means of contact (email, website, etc.)]**

## Member Identification Cards

**[MCO to provide description of member ID card and pharmacy card, if it has one, and image(s). The MCO should explain what information is on the card(s) and how they are used. It should also explain what to do if a card is lost or stolen, with a statement that explains services the member is receiving will continue and all services will continue to be available while the member waits for a new card to be delivered.]**

You will also get an ACCESS or EBT card. You will need to present this card along with your **[MCO Name] ID** card at all appointments. If you lose your ACCESS or EBT card, call your County Assistance Office (CAO). The phone number for the CAO is listed later in the **Important Contact Information** section. You will receive the following card.




Until you get your **[MCO Name]** ID card, use your ACCESS or EBT card for your health care services that you get through HealthChoices.

## Important Contact Information

The following is a list of important phone numbers you may need. If you are not sure who to call, please contact Member Services for help: **[MCO Member Services Phone Number and TTY]**.

## Emergencies

Please see Section 3, Covered Physical Health Services, beginning on page **[xx],** for more information about emergency services. If you have an emergency, you can get help by going to the nearest emergency department, calling 911, or calling your local ambulance service.

## Important Contact Information – At a Glance

| Name | Contact Information: Phone or Website | Support Provided |
|---|---|---|
| **Pennsylvania Department of Human Services Phone Numbers** | | |
| County Assistance Office/COMPASS | 1-877-395-8930<br>or<br>1-800-451-5886 (TTY/TTD)<br>or<br>www.compass.state.pa.us<br>or<br>myCOMPASS PA mobile app for smart phones | Change your personal information for Medical Assistance eligibility. See page **[page]** of this handbook for more information. |
| Fraud and Abuse Reporting Hotline, Department of Human Services | 1-844-DHS-TIPS (1-844-347-8477) | Report member or provider fraud or abuse in the Medical Assistance Program. See page **[page]** of this handbook for more information. |
| **Other Important Phone Numbers** | | |
| **[MCO Name]** Nurse Call Line | **[MCO Name Nurse Call Line Phone Number]** | Talk with a nurse 24 hours a day, 7 days a week, about urgent health matters. See page **[page]** of this handbook for information. |
| Enrollment Assistance Program | 1-800-804-3989<br>1-800-618-4255 (TTY) | Pick or change a HealthChoices plan. See page **[page]** of this handbook for more information. |
| Insurance Department, Bureau of Consumer Services | 1-877-881-6388 | Ask for a Complaint form, file a Complaint, or talk to a consumer services representative. |

| | | |
|---|---|---|
| Protective Services | 1-800-490-8505 | Report suspected abuse, neglect, exploitation, or abandonment of an adult over age 60 or an adult between age 18 and 59 who has a physical or mental disability. |

### Other Phone Numbers

**[MCO to provide list of relevant phone numbers (CAOs, MATP, etc.) in counties of operation here or make reference to an appendix at the end of the manual.]**
**[The following is a list of resources as an example of what may be included, as appropriate. This is not an exhaustive list.]**

| | |
|---|---|
| Childline | 1-800-932-0313 |
| County Assistance Office | **[MCO to provide]** |
| Crisis Intervention Services | **[MCO to provide]** |
| Legal Aid | **[MCO to provide]** |
| Medical Assistance Transportation Program | **[MCO to provide]** |
| Mental Health/Intellectual Disability Services | **[MCO to provide]** |
| National Suicide Prevention Lifeline | 1-800-273-8255 |

## Communication Services

**[MCO Name]** can provide this Handbook and other information you need in languages other than English at no cost to you. **[MCO Name]** can also provide your Handbook and other information you need in other formats such as compact disc, Braille, large print, DVD, electronic communication, and other formats if you need them, at no cost to you. Please contact Member Services at **[MCO Member Services Phone Number and TTY]** to ask for any help you need. Depending on the information you need, it may take up to 5 business days for **[MCO Name]** to send you the information.

**[MCO Name]** will also provide an interpreter, including for American Sign Language or TTY services, if you do not speak or understand English or are deaf or hard of hearing. These services are available at no cost to you. If you need an interpreter, call Member Services at **[MCO Member Services Phone Number and TTY]** and Member Services will connect you with the interpreter service that meets your needs. For TTY services, call our specialized number at **[MCO TTY Direct Number]** or call Member Services who will connect you to the next available TTY line.

If your PCP or other provider cannot provide an interpreter for your appointment, **[MCO Name]** will provide one for you. Call Member Services at **[MCO Member Services Phone Number and TTY]** if you need an interpreter for an appointment.

# Enrollment

In order to get services in HealthChoices, you need to stay eligible for Medical Assistance. You will get paperwork or a phone call about renewing your eligibility. It is important that you follow instructions so that your Medical Assistance does not end. If you have questions about any paperwork you get or if you are unsure whether your eligibility for Medical Assistance is up to date, call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]** or your CAO.

**[MCO to add enrollment information as necessary]**

## Enrollment Services

The Medical Assistance Program works with the Enrollment Assistance Program (EAP) to help you enroll in HealthChoices. You received information about the EAP with the information you received about selecting a HealthChoices plan. Enrollment specialists can give you information about all of the HealthChoices plans available in your area so that you can decide which one is best for you. If you do not pick a HealthChoices plan, a HealthChoices plan will be chosen for you. Enrollment specialists can also help you if you want to change your HealthChoices plan or if you move to another county.

Enrollment specialists can help you:

- Pick a HealthChoices plan
- Change your HealthChoices plan
- Pick a PCP when you first enroll in a HealthChoices plan
- Answer questions about all of the HealthChoices plans
- Determine whether you have special needs, which could help you decide which HealthChoices plan to pick
- Give you more information about your HealthChoices plan

To contact the EAP, call 1-800-440-3989 or 1-800-618-4225 (TTY).

## Changing Your HealthChoices Plan

You may change your HealthChoices plan at any time, for any reason. To change your HealthChoices plan, call the EAP at 1-800-440-3989 or 1-800-618-4225 (TTY). They will tell you when the change to your new HealthChoices plan will start, and you will stay in **[MCO Name]** until then. It can take up to 6 weeks for a change to your HealthChoices plan to take effect. Use your **[MCO Name]** ID card at your appointments until your new plan starts.

## Changes in the Household

Call your CAO and Member Services at **[MCO Member Services Phone Number and TTY]** if there are any changes to your household.

For example:

- Someone in your household is pregnant or has a baby
- Your address or phone number changes
- You or a family member who lives with you gets other health insurance
- You or a family member who lives with you gets very sick or becomes disabled
- A family member moves in or out of your household
- There is a death in the family

A new baby is automatically assigned to the mother's current HealthChoices plan. You may change your baby's plan by calling the EAP at **1-800-440-3989**. Once the change is made you will receive a new HealthChoices member ID card for your baby.

Remember that it is important to call your CAO right away if you have any changes in your household because the change could affect your benefits.

## What Happens if I Move?

If you move out of your county, you may need to choose a new HealthChoices plan. Contact your CAO if you move. If **[MCO Name]** also serves your new county, you can stay with **[MCO Name]**. If **[MCO Name]** does not serve your new county, the EAP can help you select a new plan.

If you move out of state, you will no longer be able to get services through HealthChoices. Your caseworker will end your benefits in Pennsylvania. You will need to apply for benefits in your new state.

## Loss of Benefits

There are a few reasons why you may lose your benefits completely.

They include:

- Your Medical Assistance ends for any reason. If you are eligible for Medical Assistance again within 6 months, you will be re-enrolled in the same HealthChoices plan unless you pick a different HealthChoices plan.
- You go to a nursing home outside of Pennsylvania.
- You have committed Medical Assistance fraud and have finished all appeals.
- You go to prison or are placed in a youth development center.

There are also reasons why you may no longer be able to receive services through a physical health MCO and you will be placed in the fee-for service program.

They include:

- You are placed in a juvenile detention center for more than 35 days in a row.
- You are 21 years of age or older and begin receiving Medicare Part D (Prescription Drug Coverage).
- You go to a state mental health hospital

You may also become eligible for Community HealthChoices. If you become eligible for Medicare coverage or become eligible for nursing facility or home and community based services, you will be eligible for Community HealthChoices. For more information on Community HealthChoices visit www.healthchoices.pa.gov.

You will receive a notice from DHS if you lose your benefits or if you are no longer able to receive services through a physical health MCO and will begin to receive services through the fee-for-service system or Community HealthChoices.

## Information About Providers

The **[MCO Name]**'s provider directory has information about the providers in **[MCO Name]**'s network. The provider directory is located online here: **[MCO Provider Directory Website link].** You may call Member Services at **[MCO Member Services Phone Number and TTY]** to ask that a copy of the provider directory be sent to you or

to request information about where a doctor went to medical school or their residency program. You may also call Member Services to get help finding a provider. The provider directory includes the following information about network providers:

- Name, address, website address, email address, telephone number
- Whether or not the provider is accepting new patients
- Days and hours of operation
- The provider's credentials and board certifications
- The provider's specialty and services offered by the provider
- Whether or not the provider speaks languages other than English and, if so, which languages
- Whether or not the provider locations are wheelchair accessible

*The information in the printed provider directory may change. You can call Member Services to check if the information in the provider directory is current. **[MCO Name]** updates the printed provider directory **[Frequency]**. The online directory is updated at least monthly.

## Picking Your Primary Care Provider (PCP)

Your PCP is the doctor or doctors' group who provides and works with your other health care providers to make sure you get the health care services you need. Your PCP refers you to specialists you need and keeps track of the care you get by all of your providers.

A PCP may be a family doctor, a general practice doctor, a pediatrician (for children and teens), or an internist (internal medicine doctor). You may also pick a certified registered nurse practitioner (CRNP) as a PCP. A CRNP works under the direction of a doctor and can do many of the same things a doctor can do such as prescribing medicine and diagnosing illnesses.

Some doctors have other medical professionals who may see you and provide care and treatment under the supervision of your PCP.

Some of these medical professionals may be:

- Physician Assistants

- Medical Residents
- Certified Nurse-Midwives

If you have Medicare, you can stay with the PCP you have now even if your PCP is not in **[MCO Name]**'s network. If you do not have Medicare, your PCP must be in **[MCO Name]**'s network.

If you have special needs, you can ask for a specialist to be your PCP. The specialist needs to agree to be your PCP and must be in **[MCO Name]**'s network.

Enrollment specialists can help you pick your first PCP with **[MCO Name].** If you do not pick a PCP through the EAP within 14 days of when you picked **[MCO Name],** we will pick your PCP for you.

**[MCO to provide any additional PCP information needed]**

### Changing Your PCP

If you want to change your PCP for any reason, call Member Services at **[MCO Member Services Phone Number and TTY]** to ask for a new PCP. If you need help finding a new PCP, you can go to **[MCO website address]**, which includes a provider directory, or ask Member Services to send you a printed provider directory.

**[MCO Name]** will send you a new ID card with the new PCP's name and phone number on it. The Member Services representative will tell you when you can start seeing your new PCP.

When you change your PCP, **[MCO Name]** can help coordinate sending your medical records from your old PCP to your new PCP. In emergencies, **[MCO Name]** will help to transfer your medical records as soon as possible.

If you have a pediatrician or pediatric specialist as a PCP, you may ask for help to change to a PCP who provides services for adults.

## Office Visits

### Making an Appointment with Your PCP

To make an appointment with your PCP, call your PCP's office. If you need help making an appointment, please call **[MCO Name]**'s Member Services at **[MCO Member Services Phone Number and TTY]**.

If you need help getting to your doctor's appointment, please see the Medical Assistance Transportation Program (MATP) section on page **[MCO insert page number of MATP information]**, of this Handbook or call **[MCO Name]**'s Member Services at the phone number above.

If you do not have your **[MCO Name]** ID card by the time of your appointment, take your ACCESS or EBT card with you. You should also tell your PCP that you selected **[MCO Name]** as your HealthChoices plan.

### Appointment Standards

**[MCO Name]**'s providers must meet the following appointment standards:

- Your PCP should see you within 10 business days of when you call for a routine appointment.
- You should not have to wait in the waiting room longer than 30 minutes, unless the doctor has an emergency.
- If you have an urgent medical condition, your provider should see you within 24 hours of when you call for an appointment.
- If you have an emergency, the provider must see you immediately or refer you to an emergency room.
- If you are pregnant and
    - In your first trimester, your provider must see you within 10 business days of **[MCO Name]** learning you are pregnant.
    - In your second trimester, your provider must see you within 5 business days of **[MCO Name]** learning you are pregnant.
    - In your third trimester, your provider must see you within 4 business days of **[MCO Name]** learning you are pregnant.
    - Have a high-risk pregnancy, your provider must see you within 24 hours of **[MCO Name]** learning you are pregnant.

## Referrals

A referral is when your PCP sends you to a specialist. A specialist is a doctor (or a doctor's group) or a CRNP who focuses his or her practice on treating one disease or medical condition or a specific part of the body. If you go to a specialist without a referral from your PCP, you may have to pay the bill.

If **[MCO Name]** does not have at least 2 specialists in your area and you do not want to see the one specialist in your area, **[MCO Name]** will work with you to see an out-of-

network specialist at no cost to you. Your PCP must contact **[MCO Name]** to let **[MCO Name]** know you want to see an out-of-network specialist and get approval from **[MCO Name]** before you see the specialist.

Your PCP will help you make the appointment with the specialist. The PCP and the specialist will work with you and with each other to make sure you get the health care you need.

Sometimes you may have a special medical condition where you need to see the specialist often. When your PCP refers you for several visits to a specialist, this is called a standing referral.

For a list of specialists in **[MCO Name]**'s network, please see the provider directory on our website at **[MCO Provider Directory Website link]** or call Member Services to ask for help or a printed provider directory.

### Self-Referrals

Self-referrals are services you arrange for yourself and do not require that your PCP arrange for you to receive the service. You must use a **[MCO Name]** network provider unless **[MCO Name]** approves an out-of-network provider.

The following services do not require referral from your PCP:

- Prenatal visits
- Routine obstetric (OB) care
- Routine gynecological (GYN) care
- Routine family planning services (may see out-of-network provider without approval)
- Routine dental services
- Routine eye exams
- Emergency services

You do not need a referral from your PCP for behavioral health services. You can call your behavioral health managed care organization for more information. Please see section 7 of the handbook, on page **[MCO to add page number]** for more information

## After-Hours Care

You can call your PCP for non-emergency medical problems 24 hours a day, 7 days a week. On-call health care professionals will help you with any care and treatment you need.

**[MCO Name]** has a toll-free nurse hotline at **[MCO Nurse Hotline Phone Number]** that you can also call 24 hours a day, 7 days a week. A nurse will talk with you about your urgent health matters.

# Member Engagement

## Suggesting Changes to Policies and Services

**[MCO Name]** would like to hear from you about ways to make your experience with HealthChoices better. If you have suggestions for how to make the program better or how to deliver services differently, please contact **[MCO Contact].**

## [MCO Name] Health Education Advisory Committee (HEAC)

**[MCO Name]** has a Health Education Advisory Committee (HEAC) that includes members and network providers. The Committee provides advice to **[MCO Name]** about the experiences and needs of members like you. For more information about the Committee, please call **[MCO phone number]** or visit the website at **[MCO Name website]**.

## [MCO Name] Quality Improvement Program

**[MCO to provide description of its quality improvement program including contact information]**

# Section – 2

# Rights and Responsibilities

# Member Rights and Responsibilities

**[MCO Name]** and its network of providers do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.

As a **[MCO Name]** member, you have the following rights and responsibilities.

## Member Rights

You have the right:

1. To be treated with respect, recognizing your dignity and need for privacy, by **[MCO Name]** staff and network providers.

2. To get information in a way that you can easily understand and find help when you need it.

3. To get information that you can easily understand about **[MCO Name]**, its services, and the doctors and other providers that treat you.
4. To pick the network health care providers that you want to treat you.
5. To get emergency services when you need them from any provider without **[MCO Name]**'s approval.
6. To get information that you can easily understand and talk to your providers about your treatment options, risks of treatment, and tests that may be self-administered without any interference from **[MCO Name]**.
7. To make all decisions about your health care, including the right to refuse treatment. If you cannot make treatment decisions by yourself, you have the right to have someone else help you make decisions or make decisions for you.
8. To talk with providers in confidence and to have your health care information and records kept confidential.
9. To see and get a copy of your medical records and to ask for changes or corrections to your records.
10. To ask for a second opinion.
11. To file a Grievance if you disagree with **[MCO Name]**'s decision that a service is not medically necessary for you.
12. To file a Complaint if you are unhappy about the care or treatment you have received.

13. To ask for a DHS Fair Hearing.
14. To be free from any form of restraint or seclusion used to force you to do something, to discipline you, to make it easier for the provider, or to punish you.
15. To get information about services that **[MCO Name]** or a provider does not cover because of moral or religious objections and about how to get those services.
16. To exercise your rights without it negatively affecting the way DHS, **[MCO Name],** and network providers treat you.
17. To create an advance directive. See Section 6 on page **[MCO to add page number]** for more information.
18. To make recommendations about the rights and responsibilities of **[MCO name]**'s members.

## Member Responsibilities

Members need to work with their health care service providers. **[MCO Name]** needs your help so that you get the services and supports you need.

These are the things you should do:

1. Provide, to the extent you can, information needed by your providers.
2. Follow instructions and guidelines given by your providers.
3. Be involved in decisions about your health care and treatment.
4. Work with your providers to create and carry out your treatment plans.
5. Tell your providers what you want and need.
6. Learn about **[MCO Name]** coverage, including all covered and non-covered benefits and limits.
7. Use only network providers unless **[MCO Name]** approves an out-of-network provider or you have Medicare.
8. Get a referral from your PCP to see a specialist.
9. Respect other patients, provider staff, and provider workers.
10. Make a good-faith effort to pay your co-payments.
11. Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

## Privacy and Confidentiality

**[MCO Name]** must protect the privacy of your protected health information (PHI). **[MCO Name]** must tell you how your PHI may be used or shared with others. This includes sharing your PHI with providers who are treating you or so that **[MCO Name]** can pay your providers. It also includes sharing your PHI with DHS. This information is included in **[MCO Name]**'s Notice of Privacy Practices. To get a copy of **[MCO Name]**'s Notice of Privacy Practices, please call **[MCO Privacy Contact]** or visit **[MCO Website]**.

## Co-payments

A co-payment is the amount you pay for some covered services. It is usually only a small amount. You will be asked to pay your co-payment when you get the service, but you cannot be denied a service if you are not able to pay a co-payment at that time. If you did not pay your co-payment at the time of the service, you may receive a bill from your provider for the co-payment.

Co-payment amounts can be found in the Covered Services chart starting on page **[MCO to insert page number]** of this Handbook.

The following members do not have to pay co-payments:

- Members under age 18
- Pregnant women (including 60 days after the child is born (the post-partum period))
- Members who live in a long-term care facility, including Intermediate Care Facilities for the Intellectually Disabled and Other Related Conditions or other medical institution
- Members who live in a personal care home or domiciliary care home
- Members eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program
- Members eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance

The following services do not require a co-payment:

- Emergency services
- Laboratory services
- Family planning services, including supplies
- Hospice services
- Home health services

- Tobacco cessation services
- **[MCO to identify any additional services exempt from co-payment]**

### What if I Am Charged a Co-payment and I Disagree?

If you believe that a provider charged you the wrong amount for a co-payment or a co-payment you believe you should not have had to pay, you can file a Complaint with **[MCO Name]**. Please see Section 8, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint, or call Member Services at **[MCO Member Services Phone Number and TTY]**.

## Billing Information

Providers in **[MCO Name]**'s network may not bill you for medically necessary services that **[MCO Name]** covers. Even if your provider has not received payment or the full amount of his or her charge from **[MCO Name]**, the provider may not bill you. This is called balance billing.

### When Can a Provider Bill Me?

Providers may bill you if:

- You did not pay your co-payment.
- You received services from an out-of-network provider without approval from **[MCO Name]** and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received services that are not covered by **[MCO Name]** and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received a service from a provider that is not enrolled in the Medical Assistance Program.

### What Do I Do if I Get a Bill?

If you get a bill from a **[MCO Name]** network provider and you think the provider should not have billed you, you can call Member Services at **[MCO Member Services Phone Number and TTY]**.

**[MCO may add additional steps it would like members to take (call provider, return bill with MCO ID number)]**

If you get a bill from a provider for one of the above reasons that a provider is allowed to bill you, you should pay the bill or call the provider.

## Third-Party Liability

You may have Medicare or other health insurance. Medicare or your other health insurance is your primary insurance. This other insurance is known as "third party liability" or TPL. Having other insurance does not affect your Medical Assistance eligibility. In most cases, your Medicare or other insurance will pay your PCP or other provider before **[MCO Name]** pays. **[MCO Name]** can only be billed for the amount that your Medicare or other health insurance does not pay.

You must tell both your CAO and Member Services at **[Member Services Phone Number and TTY]** if you have Medicare or other health insurance. When you go to a provider or to a pharmacy you must tell the provider or pharmacy about all forms of medical insurance you have and show the provider or pharmacy your Medicare card or other insurance card, ACCESS or EBT card, and your **[MCO Name]** ID card. This helps make sure your health care bills are paid timely and correctly.

### Coordination of Benefits

If you have Medicare and the service or other care you need is covered by Medicare, you can get care from any Medicare provider you pick. The provider does not have to be in **[MCO Name]**'s network**.** You also do not have to get prior authorization from **[MCO Name]** or referrals from your Medicare PCP to see a specialist. **[MCO Name]** will work with Medicare to decide if it needs to pay the provider after Medicare pays first, if the provider is enrolled in the Medical Assistance Program.

If you need a service that is not covered by Medicare but is covered by **[MCO Name]**, you must get the service from a **[MCO Name]** network provider. All **[MCO Name]** rules, such as prior authorization and specialist referrals, apply to these services.

If you do not have Medicare but you have other health insurance and you need a service or other care that is covered by your other insurance, you must get the service from a provider that is in both the network of your other insurance and **[MCO Name]**'s network. You need to follow the rules of your other insurance and **[MCO Name]**, such as prior authorization and specialist referrals. **[MCO Name]** will work with your other insurance to decide if it needs to pay for the services after your other insurance pays the provider first.

If you need a service that is not covered by your other insurance, you must get the services from a **[MCO Name]** network provider. All **[MCO Name]** rules, such as prior authorization and specialist referrals, apply to these services.

# Recipient Restriction/Lock-in Program

The Recipient Restriction/Member Lock-In Program requires a member to use specific providers if the member has abused or overused his or her health care or prescription drug benefits. **[MCO Name]** works with DHS to decide whether to limit a member to a doctor, pharmacy, hospital, dentist, or other provider.

## How Does it Work?

**[MCO Name]** reviews the health care and prescription drug services you have used. If **[MCO Name]** finds overuse or abuse of health care or prescription services, **[MCO Name]** asks DHS to approve putting a limit on the providers you can use. If approved by DHS, **[MCO Name]** will send you a written notice that explains the limit.

You can pick the providers, or **[MCO Name]** will pick them for you. If you want a different provider than the one **[MCO Name]** picked for you, call Member Services at **[Member Services Phone Number and TTY]**. The limit will last for 5 years even if you change HealthChoices plans.

If you disagree with the decision to limit your providers, you may appeal the decision by asking for a DHS Fair Hearing, within 30 days of the date of the letter telling you that **[MCO Name]** has limited your providers.

You must sign the **written** request for a Fair Hearing and send it to:

Department of Human Services
Office of Administration
Bureau of Program Integrity - DPPC
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

If you need help asking for a Fair Hearing, please call Member Services at **[MCO Member Services Phone Number and TTY]** or contact your local legal aid office.

If your appeal is postmarked within 10 days of the date on **[MCO Name]**'s notice, the limits will not apply until your appeal is decided. If your appeal is postmarked more than 10 days but within 30 days from the date on the notice, the limits will be in effect until your appeal is decided. The Bureau of Hearings and Appeals will let you know, in writing, of the date, time, and place of your hearing. You may not file a Grievance or Complaint through **[MCO Name]** about the decision to limit your providers.

After 5 years, **[MCO Name]** will review your services again to decide if the limits should be removed or continued and will send the results of its review to DHS. **[MCO Name]** will tell you the results of the review in writing.

## Reporting Fraud or Abuse

### How Do I Report Member Fraud or Abuse?

If you think that someone is using your or another member's **[MCO Name]** card to get services, equipment, or medicines, is forging or changing their prescriptions, or is getting services they do not need, you can call the **[MCO Name]** Fraud and Abuse Hotline at **[Insert Phone Number and TTY]** to give **[MCO Name]** this information. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

### How Do I Report Provider Fraud or Abuse?

Provider fraud is when a provider bills for services, equipment, or medicines you did not get or bills for a different service than the service you received. Billing for the same service more than once or changing the date of the service are also examples of provider fraud. To report provider fraud you can call the **[MCO Name]**'s Fraud and Abuse Hotline at **[Insert Phone Number]**. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

# Section 3 –

# Physical Health Services

# Covered Services

The chart below lists the services that are covered by **[MCO Name]** when the services are medically necessary. Some of the services have limits or co-payments, or need a referral from your PCP or require prior authorization by **[MCO Name]**. If you need services beyond the limits listed below, your provider can ask for an exception, as explained later in this section. Limits do not apply if you are under age 21 or pregnant.

**[MCO to complete table, including additional services that MCO covers]**

| Service | | Children | Adults |
|---|---|---|---|
| Primary Care Provider | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Specialist | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Certified Registered Nurse Practitioner | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Federally Qualified Health Center / Rural Health Center | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Outpatient Non-Hospital Clinic | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Outpatient Hospital Clinic | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Podiatrist Services | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Chiropractor Services | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Optometrist Services | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Hospice Care | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Dental Care Services | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |

| Service | | Children | Adults |
|---|---|---|---|
| Radiology (ex. X-rays, MRIs, CTs) | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Outpatient Hospital Short Procedure Unit | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Outpatient Ambulatory Surgical Center | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Non-Emergency Medical Transport | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Family Planning Services | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Renal Dialysis | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Emergency Services | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Urgent Care Services | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Ambulance Services | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Inpatient Hospital | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Inpatient Rehab Hospital | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Maternity Care | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Prescription Drugs | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Enteral/Parenteral Nutritional Supplements | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| | Limit | | |

| Service | | Children | Adults |
|---|---|---|---|
| Nursing Facility Services | Co-payment | | |
| | Prior Authorization / Referral | | |
| Home Health Care including Nursing, Aide, and Therapy Services | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Durable Medical Equipment | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Prosthetics and Orthotics | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Eyeglass Lenses | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Eyeglass Frames | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Contact Lenses | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Medical Supplies | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Therapy (Physical, Occupational, Speech) | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Laboratory | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |
| Tobacco Cessation | Limit | | |
| | Co-payment | | |
| | Prior Authorization / Referral | | |

**[MCO to add any additional information regarding covered services as necessary]**

## Services That Are Not Covered

There are physical health services that **[MCO Name]** does not cover. If you have any questions about whether or not **[MCO Name]** covers a service for you, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

MCOs may not cover experimental medical procedures, medicines, and equipment**.**

## Second Opinions

You have the right to ask for a second opinion if you are not sure about any medical treatment, service, or non-emergency surgery that is suggested for you. A second opinion may give you more information that can help you make important decisions about your treatment. A second opinion is available to you at no cost other than a co-pay.

Call your PCP to ask for the name of another **[MCO Name]** network provider to get a second opinion. If there are not any other providers in **[MCO Name]**'s network, you may ask **[MCO Name]** for approval to get a second opinion from an out-of-network provider.

## What is Prior Authorization?

Some services or items need approval from **[MCO Name]** before you can get the service. This is called Prior Authorization. For services that need prior authorization, **[MCO Name]** decides whether a requested service is medically necessary before you get the service. You or your provider must make a request to **[MCO Name]** for approval before you get the service.

### What Does Medically Necessary Mean?

Medically necessary means that a service, item, or medicine does one of the following:

- It will, or is reasonably expected to, prevent an illness, condition, or disability;
- It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;
- It will help you to get or keep the ability to perform daily tasks, taking into consideration both your abilities and the abilities or someone of the same age.

If you need any help understanding when a service, item, or medicine is medically necessary or would like more information, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

**[MCO to add additional prior authorization information as necessary]**

## How to Ask for Prior Authorization

**[Insert detailed steps that MCO requires for prior authorization here, including all contact information.]**

If you need help to better understand the prior authorization process, talk to your PCP or specialist or call Member Services at **[MCO Member Services Phone Number and TTY]**.

If you or your provider would like a copy of the medical necessity guidelines or other rules that were used to decide your prior authorization request, **[Insert MCO information here on how to obtain the information.]**

## What Services, Items, or Medicines Need Prior Authorization?

The following chart identifies some, but not all services, items, and medicines that require prior authorization.

**[Insert chart of covered services, items, and medicines that require prior authorization]**

**[TO BE ADDED IF MCO DOES NOT HAVE SEPARATE PA AND PE PROCESSES:]**

For those services that have limits, if you or your provider believes that you need more services than the limit on the service allows, you or your provider can ask for more services through the prior authorization process.

If you are or your provider is unsure about whether a service, item, or medicine requires prior authorization, call Member Services at **[MCO Member Services Phone Number and TTY].**

## Prior Authorization of a Service or Item

**[MCO Name]** will review the prior authorization request and the information you or your provider submitted. **[MCO Name]** will tell you of its decision within 2 business days of the date **[MCO Name]** received the request if **[MCO Name]** has enough information to decide if the service or item is medically necessary.

If **[MCO Name]** does not have enough information to decide the request, we must tell your provider within 48 hours of receiving the request that we need more information to decide the request and allow 14 days for the provider to give us more information.

**[MCO Name]** will tell you of our decision within 2 business days after **[MCO Name]** receives the additional information.

You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

### Prior Authorization of Outpatient Drugs

**[MCO Name]** will review a prior authorization request for outpatient drugs, which are drugs that you do not get in the hospital, within 24 hours from when **[MCO Name]** gets the request. You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

If you go to a pharmacy to fill a prescription and the prescription cannot be filled because it needs prior authorization, the pharmacist will give you a temporary supply unless the pharmacist thinks the medicine will harm you. If you have not already been taking the medicine, you will get a 72-hour supply. If you have already been taking the medicine, you will get a 15-day supply. Your provider will still need to ask **[MCO Name]** for prior authorization as soon as possible

The pharmacist will not give you the 15-day supply for a medicine that you have been taking if you get a denial notice from **[MCO Name]** 10 days before your prescription ends telling you that the medicine will not be approved again and you have not filed a Grievance.

### What if I Receive a Denial Notice?

If **[MCO Name]** denies a request for a service, item, or drug or does not approve it as requested, you can file a Grievance or a Complaint. If you file a Complaint or a Grievance for denial of an ongoing medication, **[MCO Name]** must authorize the medication until the Complaint or Grievance is resolved. See Section 8, Complaints, Grievances, and Fair Hearings, starting on page **[MCO to add page number]** of this Handbook for detailed information on Complaints and Grievances.

## Program Exception Process

For those services that have limits, if you or your provider believes that you need more services than the limits on the service allows, you or your provider can ask for a program exception (PE). The PE process is different from the Dental Benefit Limit Exception process described on page **[MCO to insert page number]**.

To ask for a PE, **[MCO to add information on how to request a PE]**

**[MCO to add additional Program Exception information as necessary]**

# Service Descriptions

## Emergency Services

Emergency services are services needed to treat or evaluate an emergency medical condition. An emergency medical condition is 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. If you have an emergency medical condition, go to the nearest emergency room, dial 911, or call your local ambulance provider. You do **not** have to get approval from **[MCO Name]** to get emergency services and you may use any hospital or other setting for emergency care.

Below are some examples of emergency medical conditions and non-emergency medical conditions:

<u>Emergency medical conditions</u>

- Heart attack
- Chest pain
- Severe bleeding
- Intense pain
- Unconsciousness
- Poisoning

<u>Non-emergency medical conditions</u>

- Sore throat
- Vomiting
- Cold or flu
- Backache
- Earache
- Bruises, swelling, or small cuts

If you are unsure if your condition requires emergency services, call your PCP or the **[MCO Name]** Nurse Hotline at **[MCO Nurse Hotline Phone Number]** 24 hours a day, 7 days a week.

**[MCO to add any additional information about emergency services as necessary]**

## Emergency Medical Transportation

**[MCO Name]** covers emergency medical transportation by an ambulance for emergency medical conditions. If you need an ambulance, call 911 or your local ambulance provider. Do not call MATP (described on page **[MCO to insert page number]** of this Handbook) for emergency medical transportation.

## Urgent Care

**[MCO Name]** covers urgent care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition. This is when you need attention from a doctor, but not in the emergency room.

If you need urgent care, but you are not sure if it is an emergency, call your PCP or the **[MCO Name]** Nurse Hotline at **[MCO Nurse Hotline phone number]** first. Your PCP or the hotline nurse will help you decide if you need to go to the emergency room, the PCP's office, or an urgent care center near you. In most cases if you need urgent care, your PCP will give you an appointment within 24 hours. If you are not able to reach your PCP or your PCP cannot see you within 24 hours and your medical condition is not an emergency, you may also visit an urgent care center or walk-in clinic within **[MCO Name]**'s network. Prior authorization is not required for services at an Urgent Care center.

Some examples of medical conditions that may need urgent care include:

- Vomiting
- Coughs and fever
- Sprains
- Rashes
- Earaches
- Diarrhea
- Sore throats
- Stomach aches

If you have any questions, please call Member Services at **[MCO Member Services Phone Number and TTY].**

**[MCO to add any additional information about urgent care services as necessary]**

## Dental Care Services

**[MCO to provide information on DBM if applicable]**

### Members Under 21 Years of Age

**[MCO Name]** provides all medically necessary dental services for children under 21 years of age. Children may go to a participating dentist within the **[DBM / MCO Name]** network.

Dental visits for children do not require a referral. If your child is 1 year old or older and does not have a dentist, you can ask your child's PCP to refer your child to a dentist for regular dental checkups. For more information on dental services, contact **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]**.

**[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]**

### Members 21 Years of Age and Older

**[MCO Name]** covers some dental benefits for members 21 years of age and older through dentists in the **[DBM / MCO Name]** network. Some dental services have limits.

**[MCO to include further details and specifics including process for choosing and changing a dentist, covered services, co-payments, and prior authorization and BLE requirements]**

### Dental Benefit Limit Exception

Some dental services are only covered with a Benefit Limit Exception (BLE). You or your dentist can also ask for a BLE if you or your dentist believes that you need more dental services than the limits allow.

**[MCO Name]** will approve a BLE if**:**

- You have a serious or chronic illness or health condition and without the additional service your life would be in danger; OR

- You have a serious or chronic illness or health condition and without the additional service your health would get much worse; OR
- You would need more expensive treatment if you do not get the requested service; OR
- It would be against federal law for **[MCO Name]** to deny the exception.

To ask for a BLE before you receive the service, you or your dentist can call **[MCO/DBM Name]** Member Services at **[MCO/DBM Member Services Phone Number and TTY]** or send the request to:

**[MCO/DBM Contact Address]**.

BLE requests must include the following information:

- Your name
- Your address
- Your phone number
- The service you need
- The reason you need the service
- Your provider's name
- Your provider's phone number

### Time Frames for Deciding a Benefit Limit Exception

If you or your provider asks for an exception before you get the service, **[MCO Name]** will let you know whether or not the BLE is approved within the same time frame as the time frame for prior authorization requests, described on page **[MCO to insert page number]**. **[or MCO can repeat the time frame]**.

If your dentist asks for an exception after you got the service, **[MCO Name]** will let you know whether or not the BLE request is approved within 30 days of the date **[MCO Name]** gets the request.

If you disagree with or are unhappy with **[MCO Name]**'s decision, you may file a Complaint or Grievance with **[MCO Name]**. For more information on the Complaint and

Grievance process, please see Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings on page **[MCO to insert page number]**.

## Vision Care Services

**[MCO to provide information on Vision Benefit Manager if applicable]**

### Members Under 21 Years of Age

**[MCO Name]** covers all medically necessary vison services for children under 21 years of age. Children may go to a participating vision provider within the **[MCO/VBM Name]** network.

**[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]**

### Members 21 Years of Age and Older

**[MCO Name]** covers some vision services for members 21 years of age and older through providers within the **[MCO/VBM Name]** network.

**[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]**

## Pharmacy Benefits

**[MCO Name]** covers pharmacy benefits that include prescription medicines and over-the-counter medicines and vitamins with a doctor's prescription.

## Prescriptions

When a provider prescribes a medication for you, you can take it to any pharmacy that is in **[MCO Name]**'s network. You will need to have your **[MCO Name]** prescription ID card with you and you may have a co-payment if you are over the age of 18. **[MCO Name]** will pay for any medicine listed on the Statewide PDL and **[MCO Name]**'s supplemental formulary and may pay for other medicines if they are prior authorized. Either your prescription or the label on your medicine will tell you if your doctor ordered refills of the prescription and how many refills you may get. If your doctor ordered refills, you may only get 1 refill at a time. If you have questions about whether a prescription medicine is covered, need help finding a pharmacy in **[MCO Name]**'s network, or have any other questions, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

**[MCO to add additional information on prescriptions as necessary]**

## Statewide Preferred Drug List (PDL) and [MCO Name] Supplemental Formulary

**[MCO Name]** covers medicines listed on the Statewide Preferred Drug List (PDL) and the **[MCO Name]** supplemental formulary. This is what your PCP or other doctor should use when deciding what medicines you should take. Both the Statewide PDL and [MCO Name] supplemental formulary cover both brand name and generic drugs. . Generic drugs contain the same active ingredients as brand name drugs. Any medicine prescribed by your doctor that is not on the Statewide PDL and **[MCO Name]**'s supplemental formulary needs prior authorization. The Statewide PDL and **[MCO Name]**'s supplemental formulary can change from time to time, so you should make sure that your provider has the latest information when prescribing a medicine for you.

If you have any questions or to get a copy of the the Statewide PDL and **[MCO Name]**'s supplemental formulary, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO to insert link to formulary on website]**.

**[MCO to add any additional information on the drug formulary as necessary]**

## Reimbursement for Medication

**[MCO to provide description of any potential reimbursement for medication]**

## Specialty Medicines

The Statewide PDL and **[MCO Name]**'s supplemental formulary includes medicines that are called specialty medicines. A prescription for these medicines needs to be prior authorized **[MCO may remove sentence if prior authorization is not required]**. You may have a co-payment for your medicine. To see the Statewide Preferred Drug List, the **[MCO Name]**'s supplemental formulary and a complete list of specialty medicines, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO to insert link to formulary on website]**.

You will need to get these medicines from a specialty pharmacy. A specialty pharmacy can mail your medicines directly to you and will not charge you for sending you your medicines. The specialty pharmacy will contact you before sending your medicine. The pharmacy can also answer any questions you have about the process. You can pick any specialty pharmacy that is in **[MCO Name]**'s network. For the list of network

specialty pharmacies, please call Member Services at **[MCO Member Services Phone Number and TTY]** or see the provider directory on **[MCO Name]**'s website at **[MCO to insert link to provider directory on website].** For any other questions or more information please call Member Services at **[MCO Member Services Phone Number and TTY]**.

## Over-the-Counter Medicines

**[MCO Name]** covers over-the-counter medicines when you have a prescription from your provider. You will need to have your **[MCO Name]** prescription ID card with you and you may have a co-payment. The following are some examples of covered over-the-counter medicines:

- Sinus and allergy medicine
- Tylenol or aspirin
- Vitamins
- Cough medicine
- Heartburn medicine
- **[MCO may add additional items]**

You can find more information about covered over-the-counter medicines by visiting **[MCO Name]**'s website at **[MCO website]** or by calling Member Services at **[Member Services phone number and TTY]**.

## Tobacco Cessation

### Do you want to quit smoking? [MCO Name] wants to help you quit!

If you are ready to be smoke free, no matter how many times you have tried to quit smoking, we are here to help you.

### Medicines

The Statewide PDL covers the following medicines to help you quit smoking.

**[MCO to insert chart of tobacco medicines covered and whether they require prior authorization]**

Contact your PCP for an appointment to get a prescription for a tobacco cessation medicine.

### Counseling Services

Counseling support may also help you to quit smoking. **[MCO Name]** covers the following counseling services: **[MCO to insert specific information on what is covered & how to receive counseling services here.]**

### Behavioral Health Treatment

Some people may be stressed, anxious, or depressed when they are trying to become smoke-free. **[MCO Name]** members are eligible for services to address these side effects, but these services are covered by your BH-MCO. You can find the BH-MCO in your county and its contact information on page **[xx]** in this Handbook. You can also call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]** for help in contacting your BH-MCO.

**[MCO to provide additional behavioral health treatment for tobacco cessation information as necessary]**

### Case Management Programs [If Applicable]

**[If the MCO offers tobacco cessation as part of any case management programs insert that specific information here.]**

### Other Tobacco Cessation Resources

**[Insert information on services provided by and contact information for tobacco cessation services offered by the PA Free Quit line, PA Cancer Society, and the American Heart Association and the American Lung Association.]**

Remember **[MCO Name]** is here to help support you in becoming healthier by becoming smoke-free. Do not wait! Please call Member Services at **[MCO Member Services Phone Number and TTY]** so we can help to get you started.

### Family Planning

**[MCO Name]** covers family planning services. You do not need a referral from your PCP for family planning services. These services include pregnancy testing, testing and treatment of sexually transmitted diseases, birth control supplies, and family

planning education and counseling. You can see any doctor that is a Medical Assistance provider, including any out-of-network provider that offers family planning services. There is no co-payment for these services. When you go to a family planning provider that is not in the **[MCO Name]** network, you must show your **[MCO Name]** and ACCESS or EBT card.

For more information on covered family planning services or to get help finding a family planning provider, call Member Services at **[MCO Member Services Phone Number and TTY].**

## Maternity Care

### Care During Pregnancy

Prenatal care is the health care a woman receives through her pregnancy and delivery from a maternity care provider, such as an obstetrician (OB or OB/GYN) or a nurse-midwife. Early and regular prenatal care is very important for you and your baby's health. Even if you have been pregnant before, it is important to go to a maternity care provider regularly through each pregnancy.

If you think you are pregnant and need a pregnancy test, see your PCP or a family planning provider. If you are pregnant, you can:

- Call or visit your PCP, who can help you find a maternity care provider in the **[MCO Name]**'s network.
- Visit a network OB or OB/GYN or nurse-midwife on your own. You do not need a referral for maternity care.
- Visit a network health center that offers OB or OB/GYN services.
- Call Member Services at **[MCO Member Services Phone Number and TTY]** to find a maternity care provider.

You should see a doctor as soon as you find out you are pregnant. Your maternity care provider must schedule an appointment to see you

- If you are in your first trimester, within 10 business days of **[MCO Name]** learning you are pregnant.
- If you are in your second trimester, within 5 business days of **[MCO Name]** learning you are pregnant.
- If you are in your third trimester, within 4 business days of **[MCO Name]** learning you are pregnant.

- If you have a high-risk pregnancy, within 24 hours of **[MCO Name]** learning you are pregnant.

If you have an emergency, go to the nearest emergency room, dial 911, or call your local ambulance provider.

It is important that you stay with the same maternity care provider throughout your pregnancy and postpartum care (60 days after your baby is born). They will follow your health and the health of your growing baby closely. It is also a good idea to stay with the same HealthChoices plan during your entire pregnancy.

**[MCO Name]** has specially trained maternal health coordinators who know what services and resources are available for you.

If you are pregnant and are already seeing a maternity care provider when you enroll in **[MCO Name]**, you can continue to see that provider even if he or she is not in **[MCO Name]**'s network. The provider will need to be enrolled in the Medical Assistance Program and must call **[MCO Name]** for approval to treat you.

**[MCO to add any additional information on maternity care as necessary]**

## Care for You and Your Baby After Your Baby is Born

You should visit your maternity care provider between **[MCO may choose preferred time frame]** after your baby is delivered for a check-up unless your maternity care provider wants to see you sooner.

Your baby should have an appointment with the baby's PCP when he or she is 3 to 5 days old, unless the doctor wants to see your baby sooner. It is best to pick a doctor for your baby while you are still pregnant. If you need help picking a doctor for your baby, please call Member Services at **[MCO Member Services Phone Number and TTY].**

## MCO Maternity Program [If applicable]

**[MCO Name]** has a special program for pregnant women called **[Program Name]**.

**[Insert information and details here about MCO Maternity Program if applicable].**

## Durable Medical Equipment and Medical Supplies

**[MCO Name]** covers Durable Medical Equipment (DME) and medical supplies. DME is a medical item or device that can be used many times in your home or in any setting

where normal life activities occur and is generally not used unless a person has an illness or injury. Medical supplies are usually disposable and are used for a medical purpose. Some of these items need prior authorization, and your physician must order them. DME suppliers must be in the **[MCO Name]** network. You may have a co-payment.

Examples of DME include:

- Oxygen tanks
- Wheelchairs
- Crutches
- Walkers
- Splints
- Special medical beds

Examples of medical supplies include:

- Diabetic supplies (such as syringes, test strips)
- Gauze pads
- Dressing tape
- Incontinence supplies (such as pull ups, briefs, underpads)

If you have any questions about DME or medical supplies, or for a list of network suppliers, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

## Outpatient Services

**[MCO Name]** covers outpatient services such as physical, occupational, and speech therapy as well as x-rays and laboratory tests. Your PCP will arrange for these services with one of **[MCO Name]**'s network providers.

**[MCO to include further details and specifics, including whether prior authorization is needed]**

## Nursing Facility Services

[**MCO Name]** covers up to 30 days of nursing facility services. If you need nursing facility services for more than 30 days and the Community HealthChoices Program is

available in the area where you live, you will be evaluated to see if you are eligible for participation in the Community HealthChoices Program. If Community HealthChoices is not available in the area where you live you will be disenrolled from **[MCO Name]** and will receive your services through the Medical Assistance fee-for-service system.

## Hospital Services

**[MCO Name]** covers inpatient and outpatient hospital services. If you need inpatient hospital services and it is not an emergency, your PCP or specialist will arrange for you to be admitted to a hospital in **[MCO Name]**'s network and will follow your care even if you need other doctors during your hospital stay. Inpatient hospital stays must be approved by **[MCO Name]**. To find out if a hospital is in the **[MCO Name]** network, please call Member Services at **[MCO Member Services Phone Number and TTY]** or check the provider directory on **[MCO Name]**'s website at **[website link to provider directory]**.

If you have an emergency and are admitted to the hospital, you or a family member or friend should let your PCP know as soon as possible but no later than 24 hours after you were admitted to the hospital. If you are admitted to a hospital that is not in **[MCO Name]**'s network, you may be transferred to a hospital in **[MCO Name]**'s network. You will not be moved to a new hospital until you are strong enough to be transferred to a new hospital.

It is very important to make an appointment to see your PCP within 7 days after you leave the hospital. Seeing your PCP right after your hospital stay will help you follow any instructions you got while you were in the hospital and prevent you from having to be readmitted to the hospital.

Sometimes you may need to see a doctor or receive treatment at a hospital without being admitted overnight. These services are called outpatient hospital services.

If you have any other questions about hospital services, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

**[MCO to include further details and specifics including if prior authorization or referral from a PCP is required]**

## Preventive Services

**[MCO Name]** covers preventive services, which can help keep you healthy. Preventive services include more than just seeing your PCP once a year for a check-up. They also include immunizations (shots), lab tests, and other tests or screenings that let you and your PCP know if you are healthy or have any health problems. Visit your PCP for

preventive services. He or she will guide your health care according to the latest recommendations for care.

Women can also go to a participating OB/GYN for their yearly Pap test and pelvic exam, and to get a prescription for a mammogram.

**[MCO can include further details and specifics]**

## Physical Exam

You should have a physical exam by your PCP at least once a year. This will help your PCP find any problems that you may not know about. Your PCP may order tests based on your health history, age, and sex. Your PCP will also check if you are up to date on immunizations and preventive services to help keep you healthy.

If you are unsure about whether or not you are up to date with your health care needs, please call your PCP or Member Services at **[MCO Member Services Phone Number and TTY].** Member Services can also help you make an appointment with your PCP.

## New Medical Technology

**[MCO Name]** may cover new medical technologies such as procedures and equipment if requested by your PCP or specialist**. [MCO Name]** wants to make sure that new medical technologies are safe, effective, and right for you before approving the service.

**[Insert MCO information on how new technologies are reviewed and approved. If MCO does not have information, remove entire New Medical Technology section]**

If you need more information on new medical technologies, please call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY].**

## Home Health Care

**[MCO Name]** covers home health care provided by a home health agency. Home health care is care provided in your home and includes skilled nursing services; help with activities of daily living such as bathing, dressing, and eating; and physical, speech, and occupational therapy. Your physician must order home health care.

If you are over age 21, there are **[no-MCO to insert whatever is correct]** limits on the number of home health care visits that you can get **[MCO to add the following if has limits: unless you or your provider asks for an exception to the limits.]**

**OR**

**[MCO Name]** has a program that includes home health care visits directly relating to a special health care need such as **[MCO to identify programs]**.

**OR BOTH**

You should contact Member Services at **[MCO Member Services Phone Number and TTY]** if you have been approved for home health care and that care is not being provided as approved.

**[MCO to add any additional information as necessary]**

## Patient Centered Medical Homes

A patient-centered medical home or health home is a team approach to providing care. It is not a building, house, or home health care service.

**[MCO to add information on their Patient Centered Medical Home program]**

## Disease Management

**[MCO Name]** has voluntary programs to help you take better care of yourself if you have one of the health conditions listed below. **[MCO Name]** has care managers who will work with you and your providers to make sure you get the services you need. You do not need a referral from your PCP for these programs, and there is no co-payment.

**[MCO should list and provide a brief description of each of their specific programs here, including HIV/AIDS programs].**

By following your provider's plan of care and learning about your disease or condition, you can stay healthier. **[MCO Name]** care managers are here to help you understand how to take better care of yourself by following your doctor's orders, teaching you about your medicines, helping you to improve your health, and giving you information to use in your community. If you have any questions or need help, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

## Expanded Services

**[MCO to provide list and description of any enhanced benefits offered to all members, including requirements for coverage and how to access.]**

## Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT services are available for children under the age of 21. They are sometimes also referred to as well-baby or well-child checkups. Your child may be seen by a pediatrician, family practice doctor, or CRNP. The provider you choose for your child will be your child's PCP. The purpose of this service is to detect potential health problems early and to make sure your child stays healthy. If you have questions or want more information, contact Member Services at **[MCO Member Services Phone Number and TTY]**.

### When Should an EPSDT Exam be Completed?

Children and young adults should have their examinations completed based on the schedule listed below. It is important to follow this schedule even if your child is not sick. Your provider will tell you when these visits should occur. Infants and toddlers will need several visits per year, while children between the ages of 3 to 20 will need just 1 visit per year.

| **Recommended Screening Schedule** | | | |
|---|---|---|---|
| 3-5 Days | 0-1 Months | 2-3 Months | 4-5 Months |
| 6-8 Months | 9-11 Months | 12 Months | 15 Months |
| 18 Months | 24 Months | 30 Months | |
| Children ages 3-20 should be screened yearly | | | |

### What Will the Provider Do During the EPSDT Exam?

Your provider will ask you and your child questions, perform tests, and check how much your child has grown. The following services are some of the services that may be performed during an exam depending on the child's age and needs of the child:

- A complete physical exam
- Immunizations
- Vision test
- Hearing test
- Autism screening
- Tuberculosis screening

- Oral health examination
- Blood pressure check
- Health and safety education
- Check of the child's body mass index (BMI)
- Screen and/or counsel for tobacco and alcohol use and substance use starting at age 11
- Urinalysis screening
- Blood lead screening test
- Developmental screening
- Depression screening starting at age 12
- Maternal depression screening

**[MCO Name]** covers services that are needed to treat health problems that are identified during the EPSDT exam.

Additional services are available for children with special needs. Talk to your provider about whether or not your child may need these additional services.

# Section 4 –

# Out-of-Network
# and
# Out-of-Plan Services

## Out-of-Network Providers

An out-of-network provider is a provider that does not have a contract with **[MCO Name]** to provide services to **[MCO Name]**'s members. There may be a time when you need to use a doctor or hospital that is not in the **[MCO Name]** network. If this happens, you can ask your PCP to help you. Your PCP has a special number to call to ask **[MCO Name]** that you be allowed to go to an out-of-network provider. **[MCO Name]** will check to see if there is another provider in your area that can give you the same type of care you or your PCP believes you need. If **[MCO Name]** cannot give you a choice of at least 2 providers in your area, **[MCO Name]** will cover medically necessary services provided by an out-of-network provider.

## Getting Care While Outside of [MCO Name]'s Service Area

If you are outside of **[MCO Name]**'s service area and have a medical emergency, go to the nearest emergency room or call 911. For emergency medical conditions, you do not have to get approval from **[MCO Name]** to get care. If you need to be admitted to the hospital, you should let your PCP know.

If you need care for a non-emergency condition while outside of the service area, call your PCP or Member Services at **[MCO Member Services Phone Number and TTY]** who will help you to get the most appropriate care.

**[MCO Name]** will not pay for services received outside of the United States and its territories.

## Out-of-Plan Services

You may be eligible to get services other than those provided by **[MCO Name]**. Below are some services that are available but are not covered by **[MCO Name]**. If you would like help in getting these services, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

### Non-Emergency Medical Transportation

**[MCO Name]** does not cover non-emergency medical transportation for most HealthChoices members. **[MCO Name]** can help you arrange transportation to covered service appointments through programs such as Shared Ride or the MATP described below.

**[MCO Name]** does cover non-emergency medical transportation if:

- You live in a nursing home, and need to go to any medical appointment or an urgent care center or a pharmacy for any Medical Assistance service, DME or medicine
- You need specialized non-emergency medical transportation, such as if you need to use a stretcher to get to your appointment

If you have questions about non-emergency medical transportation, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

## Medical Assistance Transportation Program

MATP provides non-emergency transportation to medical appointments and pharmacies. This service is provided at no cost to you. The MATP in the county where you live will determine your need for services and provide the right type of transportation for you. Transportation services are typically provided in the following ways:

- Where public transportation such as buses, subways or trains is available, MATP provides tokens or passes or repays you for the public transportation fare.
- If you or someone else has a car that you can use to get to your appointment, MATP may pay you an amount per mile plus parking and tolls with valid receipts.
- Where public transportation is not available or is not right for you, MATP provides rides in paratransit vehicles, which include vans, vans with lifts, or taxis. Usually the vehicle will have more than 1 rider with different pick-up and drop-off times and locations.

If you need transportation to a medical appointment or to the pharmacy, contact your local MATP to get more information and to register for services. **[MCO to provide list of MATP contacts in counties served or direction to page of handbook were MATP contact list can be found]** A complete list of county MATP contact information can be found here: http://matp.pa.gov/CountyContact.aspx. **(OR)** Please see page _____of this handbook for a complete list of county MATP contact information.

MATP will confirm with **[MCO Name]** or your doctor's office that the medical appointment you need transportation for is a covered service. **[MCO Name]** works with MATP to help you arrange transportation. You can also call Member Services for more information at **[MCO Member Services Phone Number and TTY].**

## Women, Infants, and Children Program

The Women, Infants, and Children Program (WIC) provides healthy foods and nutrition services to infants, children under the age of 5, and women who are pregnant, have given birth, or are breastfeeding. WIC helps you and your baby eat well by teaching you about good nutrition and giving you food vouchers to use at grocery stores. WIC

helps babies and young children eat the right foods so they can grow up healthy. You can ask your maternity care provider for a WIC application at your next visit or call 1-800-WIC-WINS (1-800-942-9467). For more information visit the WIC website at www.pawic.com

## Domestic Violence Crisis and Prevention

Domestic violence is a pattern of behavior where one person tries to gain power or control over another person in a family or intimate relationship.

There are many different types of domestic violence. Some examples include:

- Emotional abuse
- Physical violence
- Stalking
- Sexual violence
- Financial abuse
- Verbal abuse
- Elder Abuse
- Intimate partner violence later in life
- Intimate partner abuse
- Domestic Violence in the LGBTQ+ Community

There are many different names used to talk about domestic violence. It can be called: abuse; domestic violence; battery; intimate partner violence; or family, spousal, relationship or dating violence.

If any of these things are happening to you, or have happened, or you are afraid of your partner, you may be in an abusive relationship.

Domestic violence is a crime and legal protections are available to you. Leaving a violent relationship is not easy, but you can get help.

**Where to get help:**

National Domestic Violence Hotline

1-800-799-7233 (SAFE)
1-800-787-3224 (TTY)

Pennsylvania Coalition Against Domestic Violence

The services provided to domestic violence victims include: crisis intervention; counseling; going along to police, medical, and court appointments; and temporary emergency shelter for victims and their dependent children. Prevention and educational programs are also provided to lower the risk of domestic violence in the community.

1-800-932-4632 (in Pennsylvania)

## Sexual Violence and Rape Crisis

Sexual violence includes any type of unwanted sexual contact, words or actions of a sexual nature that is against a person's will. A person may use force, threats, manipulation, or persuasion to commit sexual violence. Sexual violence can include:

- Rape
- Sexual assault
- Incest
- Child sexual assault
- Date and acquaintance rape
- Grabbing or groping
- Sexting without permission
- Ritual abuse
- Commercial sexual exploitation (for example: prostitution)
- Sexual harassment
- Anti-LGBTQ+ bullying
- Exposure and voyeurism (the act of being viewed, photographed, or filmed in a place where one would expect privacy)
- Forced participation in the production of pornography

Survivors of sexual violence can have physical, mental or emotional reactions to the experience. A survivor of sexual violence may feel alone, scared, ashamed, and fear that no one will believe them. Healing can take time, but healing can happen.

**Where to get help:**

Pennsylvania rape crisis centers serve all adults and children. Services include:

- Free and confidential crisis counseling 24 hours a day.
- Services for a survivor's family, friends, partners or spouses.
- Information and referrals to other services in your area and prevention education programs.

Call **1-888-772-7227** or visit the link below to reach your local rape crisis center.

Pennsylvania Coalition Against Rape (www.pcar.org/)

## Early Intervention Services

While all children grow and develop in unique ways, some children experience delays in their development. Children with developmental delays and disabilities can benefit from the Early Intervention Program.

The Early Intervention Program provides support and services to families with children birth to the age of 5 who have developmental delays or disabilities. Services are provided in natural settings, which are settings where a child would be if the child did not have a developmental delay or disability.

Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family. These services and supports address the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

Parents who have questions about their child's development may contact the CONNECT Helpline at 1-800-692-7288 or visit www.papromiseforchildren.org. The CONNECT Helpline assists families in locating resources and providing information regarding child development for children from birth to age 5. In addition, CONNECT can help parents with contacting their county Early Intervention Program or local preschool Early Intervention Program.

# Section 5 –

# Special Needs

## Special Needs Unit

**[MCO Name]** wants to make sure all of our members get the care they need. We have trained case managers in the **[MCO Name]** Special Needs Unit that help our members with special needs have access to the care they need. The case managers of the unit help members with physical or behavioral disabilities, complex or chronic illnesses, and other special needs. **[MCO Name]** understands that you and your family may need help with issues that may not be directly related to your health care needs. The Special Needs Unit is able to assist you with finding programs and agencies in the community that can help you and your family address these needs.

**[MCO to add any additional information on its special needs unit as necessary]**

If you think you or someone in your family has a special need, and you would like the Special Needs Unit to help you, please contact them by calling **[SNU Hotline #, please note if the member has to choose a specific menu option to reach the SNU].** The Special Needs Unit staff members are available **[days and hours of operation].** If you need assistance when the Special Needs Unit staff are not available you may call **[alternate MCO contact]**.

## Coordination of Care

The **[MCO Name]** Special Needs Unit will help you coordinate care for you and your family who are members of **[MCO Name]**. In addition, **[MCO Name]** can assist in connecting you with other state and local programs.

If you need help with any part of your care, your child's care, or coordinating that care with another state, county, or local program, please contact the **[MCO Name]** Special Needs Unit for assistance.

The **[MCO Name]** Special Needs Unit will also assist members in transitioning care from services received in a hospital or temporary medical setting to care received at home. We want our members to be able to move back home as soon as possible. Please contact the **[MCO Name]** Special Needs Unit for assistance in help receiving care in your home.

## Care Management

**[MCO to add language specific to any Care Management]**

## Home and Community-Based Waivers and Long-Term Services and Supports

The Office of Developmental Programs (ODP) administers the Consolidated Waiver, Community Living Waiver, Person/Family Directed Supports Waiver, Adult Autism Waiver, and the Adult Community Autism Program (ACAP) for individuals with intellectual disabilities or autism. If you have questions regarding any of these programs, you may contact ODP's Customer Service Hotline at 1-888-565-9435, or request assistance from the Special Needs Unit at **[MCO Name].**

The Office of Long-Term Living (OLTL) administers programs for seniors and individuals with physical disabilities. This includes the Community HealthChoices Program (CHC). The CHC Program is a Medical Assistance managed care program for individuals who also have Medicare coverage or who need the services of a nursing facility or home-and community-based wavier.

If you have questions regarding what services are available and how to apply, you may contact OLTL's Participant Helpline at 1-800-757-5042 or request assistance from the **[MCO Name]** Special Needs Unit at **[SNU Contact Information]**.

## Medical Foster Care

The Office of Children, Youth, and Families has oversight of medical foster care for children under the authority of county children and youth programs. If you have questions about this program, please contact the Special Needs Unit at **[SNU Contact Information]**.

# Section 6 –

# Advance Directives

## Advance Directives

There are 2 types of advance directives: Living Wills and Health Care Powers of Attorney. These allow for your wishes to be respected if you are unable to decide or speak for yourself. If you have either a Living Will or a Health Care Power of Attorney, you should give it to your PCP, other providers, and a trusted family member or friend so that they know your wishes.

If the laws regarding advance directives are changed, **[MCO Name]** will tell you in writing what the change is within 90 days of the change. For information on **[MCO Name]**'s policies on advance directives, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO Website]**.

## Living Wills

A Living Will is a document that you create. It states what medical care you do, and do not, want to get if you cannot tell your doctor or other providers the type of care you want. Your doctor must have a copy and must decide that you are unable to make decisions for yourself for a Living Will to be used. You may revoke or change a Living Will at any time.

## Health Care Power of Attorney

A Health Care Power of Attorney is also called a Durable Power of Attorney. A Health Care or Durable Power of Attorney is a document in which you give someone else the power to make medical treatment decisions for you if you are physically or mentally unable to make them yourself. It also states what must happen for the Power of Attorney to take effect. To create a Health Care Power of Attorney, you may but do not have to get legal help. You may contact **[MCO Contact]** for more information or direction to resources near you.

## What to Do if a Provider Does Not Follow Your Advance Directive

Providers do not have to follow your advance directive if they disagree with it as a matter of conscience. If your PCP or other provider does not want to follow your advance directive, **[MCO Name]** will help you find a provider that will carry out your wishes. Please call Member Services at **[MCO Member Services Phone Number and TTY]** if you need help finding a new provider.

If a provider does not follow your advance directive, you may file a Complaint. Please see page **[xx]** in Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint; or call Member Services at **[MCO Member Services Phone Number and TTY]**.

# Section 7 –

# Behavioral Health Services

# Behavioral Health Care

Behavioral health services include both, mental health services and substance use disorder services. These services are provided through behavioral health managed care organizations (BH-MCOs) that are overseen by the Department of Human Services' Office of Mental Health and Substance Abuse Services (OMHSAS).
Contact information for the BH-MCO is listed below **[MCO to insert BH-MCO contact list below]**. You can also call Member Services at **[MCO Member Services Phone Number and TTY]** to get contact information for your BH-MCO.

You can call your BH-MCO toll-free 24 hours a day, 7 days a week.

You do not need a referral from your PCP to get behavioral health services, but your PCP will work with your BH-MCO and behavioral health providers to help get you the care that best meets your needs. You should let your PCP know if you, or someone in your family, is having a mental health or drug and alcohol problem.

The following services are covered:

- Behavioral health rehabilitation services (BHRS) (children and adolescent)
- Clozapine (Clozaril) support services
- Drug and alcohol inpatient hospital-based detoxification services (adolescent and adult)
- Drug and alcohol inpatient hospital-based rehabilitation services (adolescent and adult)
- Drug and alcohol outpatient services
- Drug and alcohol methadone maintenance services
- Family based mental health services
- Laboratory (when related to a behavioral health diagnosis and prescribed by a behavioral health practitioner)
- Mental health crisis intervention services
- Mental health inpatient hospitalization
- Mental health outpatient services
- Mental health partial hospitalization services
- Peer support services
- Residential treatment facilities (children and adolescent)
- Targeted case management services

If you have questions about transportation to appointments for any of these services, contact your BH-MCO.

# Section 8 –

# Complaints, Grievances, and Fair Hearings

# Complaints, Grievances, and Fair Hearings

If a provider or **[MCO Name]** does something that you are unhappy about or do not agree with, you can tell **[MCO Name]** or the Department of Human Services what you are unhappy about or that you disagree with what the provider or **[MCO Name]** has done. This section describes what you can do and what will happen.

## Complaints

### What is a Complaint?

A Complaint is when you tell **[MCO Name]** you are unhappy with **[MCO Name]** or your provider or do not agree with a decision by **[MCO Name]**.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that **[MCO Name]** has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

## First Level Complaint

### What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Complaint, or
- Write down your Complaint and send it to **[MCO Name]** by mail or fax, or
- If you received a notice from **[MCO Name]** telling you **[MCO Name]**'s decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to **[MCO Name]** by mail or fax.

**[MCO Name]**'s address and fax number for Complaints:
**[MCO address]**
**[MCO fax number]**

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

### When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that

- **[MCO Name]** has decided that you cannot get a service or item you want because it is not a covered service or item.
- **[MCO Name]** will not pay a provider for a service or item you got.
- **[MCO Name]** did not tell you its decision about a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.
- **[MCO Name]** has denied your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

| **New member appointment for your first examination…** | **We will make an appointment for you…** |
|---|---|
| members with HIV/AIDS | with PCP or specialist no later than 7 days after you become a member in **[MCO Name]** unless you are already being treated by a PCP or specialist. |
| members who receive Supplemental Security Income (SSI) | with PCP or specialist no later than 45 days after you become a member in |

| | |
|---|---|
| members under the age of 21 | **[MCO Name]**, unless you are already being treated by a PCP or specialist. |
| | with PCP for an EPSDT exam no later than 45 days after you become a member in **[MCO Name],** unless you are already being treated by a PCP or specialist. |
| all other members | |
| **Members who are pregnant:** | with PCP no later than 3 weeks after you become a member in **[MCO Name]**. |
| pregnant women in their first trimester | **We will make an appointment for you . . .** with OB/GYN provider within 10 business days of **[MCO Name]** learning you are pregnant. |
| pregnant women in their second trimester | with OB/GYN provider within 5 business days of **[MCO Name]** learning you are pregnant. |
| pregnant women in their third trimester | with OB/GYN provider within 4 business days of **[MCO Name]** learning you are pregnant. |
| pregnant women with high-risk pregnancies | with OB/GYN provider within 24 hours of **[MCO Name]** learning you are pregnant. |
| **Appointment with…** | **An appointment must be scheduled . . . . .** |
| **PCP** | |
| urgent medical condition | within 24 hours. |
| routine appointment | within 10 business days. |
| health assessment/general physical examination | within 3 weeks. |
| **Specialists (when referred by PCP)** | |
| urgent medical condition | within 24 hours of referral. |
| routine appointment with one of the following specialists: | |

- Otolaryngology — within 15 business days of referral
- Dermatology
- Pediatric Endocrinology
- Pediatric General Surgery
- Pediatric Infectious Disease
- Pediatric Neurology
- Pediatric Pulmonology
- Pediatric Rheumatology
- Dentist
- Orthopedic Surgery
- Pediatric Allergy & Immunology
- Pediatric Gastroenterology
- Pediatric Hematology
- Pediatric Nephrology
- Pediatric Oncology
- Pediatric Rehab Medicine
- Pediatric Urology
- Pediatric Dentistry

routine appointment with all other specialists — within 10 business days of referral

You may file **all other Complaints at any time.**

## What Happens After I File a First Level Complaint?

After you file your Complaint, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Complaint, and about the First Level Complaint review process.

You may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **[MCO Name]**.

You may attend the Complaint review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more **[MCO Name]** staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. **[MCO Name]** will mail you a notice within **[date that is no more than 30 days from receipt of the Complaint]** days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page _____ **[MCO to insert page number of help section]**.

**What to do to continue getting services:**

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

## What if I Do Not Like [MCO Name]'s Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- **[MCO Name]**'s decision that you cannot get a service or item you want because it is not a covered service or item.
- **[MCO Name]**'s decision to not pay a provider for a service or item you got.

- **[MCO Name]**'s failure to decide a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.
- You not getting a service or item within the time by which you should have received it
- **[MCO Name]**'s decision to deny your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice**.

You must ask for a Fair Hearing within **120 days from the mail date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice**.

For information about Fair Hearings, see page _____
For information about external Complaint review, see page ___
If you need more information about help during the Complaint process, see page _____
**[MCO to insert page number]**.

## Second Level Complaint

### What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Second Level Complaint, or
- Write down your Second Level Complaint and send it to **[MCO Name]** by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to **[MCO Name]** by mail or fax.

**[MCO Name]**'s address and fax number for Second Level Complaints
**[MCO address]**
**[MCO fax number]**

### What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Complaint, and about the Second Level Complaint review process.

You may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **[MCO Name]**.

You may attend the Complaint review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for **[MCO Name]**, will meet to decide your Second Level Complaint. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. **[MCO Name]** will mail you a notice within **[date that is no more than 45 days from receipt of the Second Level Complaint]** days from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page _____ **[MCO to insert page number of help section]**.

### What if I Do Not Like [MCO Name]'s Decision on My Second Level Complaint?

You may ask for an external review by either the Department of Health or the Insurance Department.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice.**

## External Complaint Review

### How Do I Ask for an External Complaint Review?

You must send your request for an external review of your Complaint in writing to either:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, PA 17120-0701
Telephone Number: 1-888-466-2787

**or**

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120

Telephone Number: 1-877-881-6388

If you ask, the Department of Health will help you put your Complaint in writing.

The Department of Health handles Complaints that involve the way a provider gives care or services. The Insurance Department reviews Complaints that involve **[MCO Name]**'s policies and procedures. If you send your request for an external review to the wrong Department, it will be sent to the correct Department.

### What Happens After I Ask for an External Complaint Review?

The Department of Health or the Insurance Department will get your file from **[MCO Name]**. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

**What to do to continue getting services:**

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Complaint review is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you, the services or items will continue until a decision is made.

## GRIEVANCES

### What is a Grievance?

When **[MCO Name]** denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you **[MCO Name]**'s decision.

A Grievance is when you tell **[MCO Name]** you disagree with **[MCO Name]**'s decision.

## What Should I Do if I Have a Grievance?

To file a Grievance:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or
- Write down your Grievance and send it to **[MCO Name]** by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from **[MCO Name]** and send it to **[MCO Name]** by mail or fax.

**[MCO Name]**'s address and fax number for Grievances:
**[MCO address]**
**[MCO fax number]**

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

## When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

## What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Grievance, and about the Grievance review process.

You may ask **[MCO Name]** to see any information that **[MCO Name]** used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to **[MCO Name]**.

You may attend the Grievance review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. **[MCO Name]** will mail you a notice within **[date that is no more than 30 days from receipt of the Grievance]** days from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page _____ **[MCO to insert page number of help section]**.

**What to do to continue getting services:**

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

### What if I Do Not Like [MCO Name]'s Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for **[MCO Name].**

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see page _____
For information about external Grievance reviews, see below
If you need more information about help during the Grievance process, see page _____ **[MCO to insert page number]**.

## External Grievance Review

### How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or

- Write down your Grievance and send it to **[MCO Name]** by mail to: **[MCO address]**.

**[MCO Name]** will send your request for external Grievance review to the Department of Health.

### What Happens After I Ask for an External Grievance Review?

The Department of Health will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

**[MCO Name]** will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within 15 days of filing the request for an external Grievance review.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

**What to do to continue getting services:**

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a letter that is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s Grievance decision, the services or items will continue until a decision is made.

## Expedited Complaints and Grievances

### What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **[30, unless the MCO will be using a shorter time frame to provide notice of 1st Level Complaint or Grievance decisions or 45, unless the MCO will be using a shorter time frame to provide notice of 2nd Level Complaint decisions]** days to get a decision about your Complaint or Grievance, could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask **[MCO Name]** for an early decision by calling **[MCO Name]** at **[Member Services Phone Number and TTY]**, faxing a letter or the Complaint/Grievance Request Form to **[MCO fax number],** or sending an email to **[PH-MCO e-mail]**.

- Your doctor or dentist should fax a signed letter to **[MCO fax number]** within 72 hours of your request for an early decision that explains why **[MCO Name]** taking **[30, unless the MCO will be using a shorter time frame for 1st Level Complaint or Grievance decisions or 45, unless the MCOS will be issuing a shorter time frame for 2nd level Complaint decisions]** days to tell you the decision about your Complaint or Grievance could harm your health.

If **[MCO Name]** does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, **[MCO Name]** will decide your Complaint or Grievance in the usual time frame of **[45, unless the MCO will be using a shorter time frame to provide notice of 1st Level Complaint or Grievance decisions]** days from when **[MCO Name]** first got your Complaint or Grievance.

### Expedited Complaint and Expedited External Complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference **[MCO to include videoconferencing only if available]** because **[MCO Name]** has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

**[MCO Name]** will tell you the decision about your Complaint within 48 hours of when **[MCO Name]** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within 72 hours from when **[MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[MCO Name]** to take more time to decide your Complaint. You can ask **[MCO Name]** to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Department of Health within **2 business days from the date you get the expedited Complaint decision notic**e. To ask for expedited external review of a Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Complaint, or

- Send an email to **[MCO Name]** at **[MCO email address]**, or
- Write down your Complaint and send it to **[MCO Name]** by mail or fax: **[MCO Address and fax number for requesting expedited external review of a Complaint]**.

### Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference **[MCO to include videoconferencing only if available**] because **[MCO Name]** has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

**[MCO Name]** will tell you the decision about your Grievance within 48 hours of when **[MCO Name]** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when **[MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[MCO Name]** to take more time to decide your Grievance. You can ask **[MCO Name]** to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review by the Department of Health within **2 business days from the date you get the expedited Grievance decision notic**e. To ask for expedited external review of a Grievance:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or
- Send an email to **[MCO Name]** at **[MCO email address]**, or
- Write down your Grievance and send it to **[MCO Name]** by mail or fax: **[MCO address and fax number for requesting expedited external review of a Grievance]**.

**[MCO Name]** will send your request to the Department of Health within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

## What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of **[MCO Name**] will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell **[MCO Name]**, in writing, the name of that person and how **[MCO Name]** can reach him or her.

You or the person you choose to represent you may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call **[MCO Name]**'s toll-free telephone number at **[Member Services Phone Number and TTY]** if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at **[MCO insert Phone Number]** or call the Pennsylvania Health Law Project at 1-800-274-3258.

### Persons Whose Primary Language Is Not English

If you ask for language services, **[MCO Name]** will provide the services at no cost to you.

### Persons with Disabilities

**[MCO Name]** will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;

- Providing information submitted by **[MCO Name]** at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

## DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something **[MCO Name]** did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after **[MCO Name]** decides your First Level Complaint or decides your Grievance.

### What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked within **120 days from the date on the notice** telling you **[MCO Name]**'s decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- **[MCO Name]**'s failure to decide a First Level Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name**] got your Complaint or Grievance.
- The denial of your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that **[MCO Name]** failed to decide a First Level Complaint or Grievance you told

**[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.

## How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter, it needs to include the following information:

- Your (the member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair hearings
PO Box 2675
Harrisburg, PA 17105-2675

## What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

**[MCO Name]** will also go to your Fair Hearing to explain why **[MCO Name]** made the decision or explain what happened.

You may ask **[MCO Name]** to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

### When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **[MCO Name]**, not including the number of days between the date on the written notice of the **[MCO Name]**'s First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because **[MCO Name]** did not tell you its decision about a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer]** days from when **[MCO Name]** got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **[MCO Name]**, not including the number of days between the date on the notice telling you that **[MCO Name]** failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

**What to do to continue getting services:**

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

## Expedited Fair Hearing

### What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339 or by faxing a letter or the Fair Hearing Request Form to 717-772-6328. Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your Fair Hearing

could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call **[MCO Name]**'s toll-free telephone number at **[MCO Number]** if you need help or have questions about Fair Hearings, you can contact your local legal aid office at **[MCO insert Phone Number]** or call the Pennsylvania Health Law Project at 1-800-274-3258.

# EXHIBIT EE

# EXHIBIT FF

# EXHIBIT FF

## PCP, DENTISTS, SPECIALISTS AND PROVIDERS OF ANCILLARY SERVICES DIRECTORIES

A. PCP and Dentist Directories

The PH-MCO shall be required to provide its Members with PCP and Dentist directories upon request, which include, at a minimum, the following information:

- The names, addresses, and telephone numbers of participating PCPs.
- The hospital affiliations of the PCP.
- Identification of whether the PCP is a Doctor of Medicine or Osteopathy, and whether the PCP is a Pediatrician.
- Identification of whether PCPs are Board-certified and, if so, in what area(s).
- Identification of PCP Teams which include physicians, Certified Registered Nurse Practitioners (CRNPs), Certified Nurse Midwives and physicians' assistants.
- Indication of whether dentist is DDS or DMD, and whether dentist is a periodontist.
- Identification of whether dentists possess anesthesia certificates.
- Identification of whether the dentist is able to serve adults with developmental disabilities.
- Identification of languages spoken by Health Care Providers at the primary care and dental sites.
- Identification of sites which are wheelchair accessible.
- Identification of the days of operation and the hours when the PCP or dentist office is available to Members.

The PH-MCO, at the request of the PCP or dentist, may include the PCP’s or dentist’s experience or expertise in serving individuals with particular conditions.

B. Specialist and Providers of Ancillary Services Directories

The specialist and providers of ancillary services directories shall include, at a minimum, the following information:

- The names, addresses and telephone numbers of specialists and their hospital affiliations.
- Identification of the specialty area of each specialist's practice.
- Identification of whether the specialist is Board-certified and, if so, in what area(s).
- Experience or expertise in serving individuals with particular conditions.

EXHIBIT GG

# EXHIBIT GG

## COMPLAINT, GRIEVANCE, AND FAIR HEARING PROCESSES

### A. General Requirements

1. The PH-MCO must obtain the Department's prior written approval of its Complaint, Grievance, and Fair Hearing policies and procedures.

2. The PH-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances as they relate to the MA population and must make these policies and procedures available to members upon request.

3. The PH-MCO must maintain an accurate written record of each Complaint and Grievance and the actions taken by the PH-MCO to resolve each Complaint and Grievance. The record must include at least the following:

    a. The name of the Member on whose behalf the Complaint or Grievance was filed;

    b. The date the Complaint or Grievance was received;

    c. A description of the reason for the Complaint or Grievance;

    d. The date of each review or review meeting;

    e. The date of resolution of the Complaint or Grievance and how the Complaint or Grievance was resolved; and

    f. A copy of any documents or records reviewed.

    The PH-MCO must provide the record of each Complaint and Grievance and the actions taken by the PH-MCO to resolve each Complaint and Grievance to the Department and CMS upon request.

4. The PH-MCO must submit a log of all Complaint and Grievance decisions in a format specified by the Department and must include review of the Complaint and Grievance processes in its QM and UM programs as outlined in Exhibit M(1) Quality Management and Utilization Management Program Requirements.

5. The PH-MCO must have a data system to process, track, and trend all Complaints and Grievances.

6. The PH-MCO must designate and train sufficient staff as reported in the Operating Procedures Report (OPS) 11 Provider Education, to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements specified in this Exhibit.

7. PH-MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training, and experience to make an informed, accurate and impartial determination regarding issues assigned to them.

8. The PH-MCO must provide information about the Complaint and Grievance process to all Providers and Subcontractors when the PH-MCO enters into a contract or agreement with the Provider or Subcontractor..
9. The PH-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.

10. The PH-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 an individual who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

11. The PH-MCO may not charge Members a fee for filing a Complaint or a Grievance.

12. The PH-MCO must allow the Member and the Member's representative to have access to all relevant documentation pertaining to the subject of the Complaint or Grievance free of charge and sufficiently in advance of the time frame for resolution of the Complaint or Grievance outlined in this Exhibit.

13. The PH-MCO must maintain the following information in the Member's case file:

    a. Medical records;

    b. Any documents or records relied upon or generated by the PH-MCO in connection with the Complaint or Grievance, including any Medical Necessity guidelines used to make a decision or information on coverage limits relied upon to make a decision; and

    c. Any new or additional evidence considered, relied upon, or generated by the PH-MCO in connection with the Complaint or Grievance.

14. The PH-MCO must ask the Member if the Member needs interpreter services. The PH-MCO must provide language interpreter services at no cost when requested by a Member. The PH-MCO must include in the Complaint or Grievance record documentation that the Member was asked if the Member needed an interpreter and if an interpreter was provided.

15. The PH-MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/TDD for telephone inquiries and Complaints and Grievances from Members who are deaf or hearing impaired; Braille; tape; computer disk; and other commonly accepted alternative forms of communication. The PH-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitations of Members with disabilities or language barriers, so they treat these individuals with patience, understanding, and respect.

16. The PH-MCO must provide Members with disabilities assistance in 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 PH-MCO at the Complaint or Grievance review in an alternative format accessible to the Member or Member's representative, filing the Complaint or Grievance. The alternative format version must be supplied to the Member at or before the review, so the Member can discuss and/or refute the content during the review; and

    c. Providing personal assistance to a Member filing the Complaint or Grievance who has other physical limitations in copying and presenting documents and other evidence.

17. The PH-MCO must offer Members the assistance of a PH-MCO staff member throughout the Complaint and Grievance processes at no cost to the Member.

18. The PH-MCO must provide Members with a toll-free number to file a Complaint or Grievance, request information about the Complaint or Grievance process, and ask any questions the Member may have about the status of a Complaint or Grievance.

19. The PH-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances at one location within each of its zones of operation. If a Member requests an in-person review, the PH-MCO must notify the Member of the location of the review and who will be present at the review, using the template specified by the Department.

20. The PH-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.

21. The PH-MCO must notify the Member when the PH-MCO fails to decide a first level Complaint or a Grievance within the time frames specified in this Exhibit, using the template specified by the Department. The PH-MCO must mail this notice to the Member one (1) day following the date the decision (day 31).

22. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

23. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the service or item provided is not a covered service for the Member, using the template specified by the Department. The PH-

MCO must mail this notice to the Member on the day the decision is made to deny payment.

24. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the PH-MCO determined that the service or item was not Medically Necessary, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

25. The PH-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 enrollee financial liabilities, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

26. The PH-MCO must use all templates specified by the Department, which are available in Docushare. The PH-MCO may not modify the templates. The PH-MCO must follow the instructions in the templates for including detailed, specific information related to the Complaint or Grievance.

## B. Complaint Requirements

**Complaint**: A dispute or objection regarding a particular Provider or the coverage operations, or management of a PH-MCO, which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with PID's Bureau of Managed Care (BMC), including, but not limited to:

- a denial because the requested service or item is not a covered service; which does not include BLE;
- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Member; or
- 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 term does not include a Grievance.

**1. First Level Complaint Process**

a. A PH-MCO must permit a 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, to file a first level Complaint either in writing or verbally. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member and must provide the written Complaint to the Member or Member's representative for signature. The signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process.

b. If the first level Complaint disputes one of the following, the Member must file a Complaint within sixty (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 service or item is not a covered service;

ii. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;

iii. the failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames;

iv. a denial of payment after the service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;

v. a denial of payment after the service or item has been delivered because the service or item provided is not a covered service 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 first level Complaint.

c. A Member who files a first level Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not a covered service must continue to receive the disputed service or item at the previously authorized level pending resolution of the first level Complaint, if the first level Complaint is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.

d. Upon receipt of the Complaint, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a first level Complaint acknowledgment letter, using the template specified by the Department. The first level Complaint acknowledgment letter must be sent no later than three (3) business days after receipt of the Complaint.

e. The first level Complaint review for Complaints not involving a clinical issue must be conducted by a first level Complaint review committee, which must include one or more employees of the PH-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.

f. The first level Complaint review for Complaints involving a clinical issue must be conducted by a first level Complaint review committee, which must include one or more employees of the PH-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. The first level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the first level Complaint.

g. A committee member who does not personally attend the first level Complaint review meeting may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

h. The PH-MCO must afford the Member or Member's representative, a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

i. The PH-MCO must give the Member at least ten (10) days advance written notice of the first level Complaint review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the first level Complaint review committee by telephone or videoconference.

j. The Member may elect not to attend the first level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present. All Complaint review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the Complaint record.

k. If a Member requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review is held and the other members of the first level Complaint review committee must participate in the review through the use of videoconferencing.

l. The decision of the first level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered in the initial determination of the issue.

m. Prior to the start of the first level Complaint review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the Complaint review committee (including the Member's comments) being recorded, the testimony must be recorded and transcribed verbatim and maintained as part of the Complaint record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the Complaint record and the first level Complaint review meeting must proceed without the testimony being recorded.

n. The first level Complaint review committee must complete its review of the Complaint as expeditiously as the Member's health condition requires.

o. The first level Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.

p. The PH-MCO must send a written notice of the first level Complaint decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date the PH-MCO received the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Member.

q. 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 service or item is not a covered service;

    ii. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;

    iii. the failure of the PH-MCO to decide the Complaint or Grievance within the specified time frames;

iv. a denial of payment by the PH-MCO after the service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;

v. a denial of payment by the PH-MCO after the service or item has been delivered because the service or item provided is not a covered service 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 one hundred and twenty (120) days from the mail date on the written notice of the PH-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 fifteen (15) days from the date the Member receives written notice of the PH-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 or verbally within forty-five (45) days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

**2. Second Level Complaint Process**

a. A PH-MCO must permit a 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, to file a second level Complaint either in writing or verbally for any Complaint for which a Fair Hearing and external review is not available.

b. Upon receipt of the second level Complaint, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a second level Complaint acknowledgment letter using the template specified by the Department. The second level Complaint acknowledgement letter must be sent no later than three (3)business days after the receipt of the second level Complaint.

c. The second level Complaint review for Complaints not involving a clinical issue must be conducted by a second level Complaint review committee made up of three (3) or more individuals 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.

d. The second level Complaint review for Complaints involving a clinical issue must be conducted by a second level Complaint review committee made up of three (3) or more individuals 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. The second level Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician must decide the second level Complaint.

e. At least one-third of the second level Complaint review committee members may not be employees of the PH-MCO or a related subsidiary or Affiliate.

f. 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 committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

g. The PH-MCO must afford the Member a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

h. The PH-MCO must give the Member at least fifteen (15) days advance written notice of the second level Complaint review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the second level Complaint review committee by telephone or videoconference.

i. 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. All second level Complaint review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the second level Complaint record.

j. If a Member requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review is held and the other members of the second level Complaint review committee must participate in the review through the use of videoconferencing.

k. 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 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.

l. Prior to the start of the second level Complaint review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the second level Complaint review committee (including the Member's comments) being recorded, the testimony must be tape-recorded and transcribed verbatim and maintained as part of the second level Complaint record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the second level Complaint record and the second level Complaint review meeting must proceed without the testimony being recorded.

m. The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Member's health condition requires.

n. The PH-MCO must send a written notice of the second level Complaint decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within forty-five (45) days from the date the PH-MCO received the second level Complaint.

o. The Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization of the representative to be involved and/or act of 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 fifteen (15) days from the date the Member receives the written notice of the PH-MCO's second level Complaint decision.

**3. 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 or item that the Member has been receiving on the basis that the service or item is not a covered service, the Member must continue to receive the disputed service or item at the previously authorized level pending resolution of the external review, if the request for external review is hand-delivered or post-marked within ten (10) days from the mail date on the written notice of the PH-MCO's first or second level Complaint decision.

b. Upon the request of PID's BMC, the PH-MCO must transmit all records from the PH-MCO's Complaint review to PID's BMC within thirty (30) days

from the request in the manner prescribed by PID's BMC. The Member, the Provider, or the PH-MCO may submit additional materials related to the Complaint.

**4. Expedited Complaint Process**

a. The PH-MCO must conduct expedited review of a Complaint if the PH-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 Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, provides the PH-MCO with a 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 in writing, by fax, orally, or by email.

c. Upon receipt of an oral or written request for expedited review, the PH-MCO must inform the Member of the right to present evidence and testimony 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 PH-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 PH-MCO must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Member's request for expedited review, the PH-MCO must decide the Complaint within the standard time frames as set forth in this Exhibit, unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Member. If the PH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the PH-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 two (2) business days of the decision to deny expedited review, using the template specified by the Department.

e. A Member who files a request for expedited review of a Complaint that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not

a covered service must continue to receive the disputed service or item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is made verbally, hand delivered, faxed, emailed, or post-marked within ten (10) days from the mail date on the written notice of decision.

f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. If the Complaint is related to dental services, the expedited Complaint review committee must include a dentist. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint. 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.

g. Prior to the start of the expedited Complaint review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the Complaint review committee (including the Member's comments) being recorded, the testimony must be recorded and transcribed verbatim and maintained as part of the Complaint record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the Complaint record and the expedited review meeting must proceed without the testimony being recorded.

h. The PH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (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 fourteen (14) days at the request of the Member. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one in writing, the service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

i. The Member or the Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the PH-MCO's expedited Complaint decision.

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 PH-MCO within two (2) business days from the date the Member receives the PH-MCO's expedited Complaint decision. A Member who files a request for an

expedited Complaint review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Complaint review.

k. A request for an expedited external Complaint review may be filed in writing, by fax, orally, or by email.

l. The PH-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external Complaint reviews.

m. The PH-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

**Grievance:** A request to have a PH-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 PH-MCO's decision to

1. deny, in whole or in part, payment for a service or item;

2. deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item;

3. reduce, suspend, or terminate a previously authorized service or item;

4. deny the requested service or item but approve an alternative service or item; and

5. deny a request for a BLE.

The term does not include a Complaint.

### 1. Grievance Process

a. A PH-MCO must permit a 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, to file a Grievance either in writing or verbally. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member and must provide the written Grievance to the Member or the Member's representative for signature. The signature may be obtained at any point in the process, and the failure to obtain a signed Grievance may not delay the Grievance process.

b. A Member must file a Grievance within sixty (60) days from the date the Member receives written notice of decision.

c. A Member who files a Grievance that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the Grievance is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.

d. Upon receipt of the Grievance, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a Grievance acknowledgment letter, using the template specified by the Department. The Grievance acknowledgement letter must be sent no later than three (3) business days after receipt of the Grievance.

e. A Member who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Member may rescind consent throughout the process upon written notice to the PH-MCO and the Provider.

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 PH-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 PH-MCO identification number of the Provider to whom the Member is providing consent;

   iv. The name and address of the PH-MCO to which the Grievance will be submitted;

   v. An explanation of the specific service or item 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 service or item listed in this consent form unless the Member or the

Member's representative rescinds consent in writing. The Member or the 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 conducted by a Grievance review committee made up of three (3) or more individuals 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 Grievance.

h. At least one-third of the Grievance review committee may not be employees of the PH-MCO or a related subsidiary or Affiliate.

i. The Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. If the Grievance is related to dental services, the Grievance review committee must include a dentist. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.

j. A committee member who does not personally attend the Grievance review may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.

k. The PH-MCO must afford the Member or Member's representative a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

l. The PH-MCO must give the Member at least ten (10) days advance written notice of the review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in

person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the Grievance review committee by telephone or videoconference.

m. 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. All Grievance review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the Grievance record.

n. If a Member requests an in-person Grievance review, at a minimum, a member of the Grievance review committee must be physically present at the location where the Grievance review is held and the other members of the Grievance review committee must participate in the review through the use of videoconferencing.

o. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative 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.

p. Prior to the start of the Grievance review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the Grievance review committee (including the Member's comments) being recorded, the testimony must be recorded and transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the Grievance record and the Grievance review meeting must proceed without the testimony being recorded.

q. The Grievance review committee must complete its review of the Grievance as expeditiously as the Member's health condition requires.

r. The PH-MCO must send a written notice of the Grievance decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date the PH-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Member.

s. 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.

The Member or Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the PH-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 a representative to be involved and/or act on the Member's behalf, may file a request with the PH-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed byPID's BMC. The request must be filed in writing or verbally within fifteen (15) days from the date the Member receives the written notice of the PH-MCO's Grievance decision.

**2. External Grievance Process:**

a. The PH-MCO must process all requests for external Grievance review. The PH-MCO must follow the protocols established by PID's BMCin meeting all time frames and requirements necessary in 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 an external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of the PH-MCO's Grievance decision.

c. Within five (5) business days of receipt of the request for an external Grievance review, the PH-MCO must notify the Member, the Member's representative, if the Member has designated one in writing, the Provider if the Provider filed the request for the external Grievance review, and PID's BMC that the request for external Grievance review has been filed.

d. The external Grievance review must be conducted by a CRE not affiliated with the PH-MCO.

e. Within two (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 and notify the PH-MCO and assigned CRE of the assignment.

f. Within two (2) business days of receipt of notice of the assignment of the CRE, the PH-MCO must notify the member, using the template as suggested 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 two (2) business days from receipt of a request for an external Grievance review, the PH-MCO may designate a CRE to conduct a review from the list of CREs approved byPID's BMC. The PH-MCO may not select a CRE that has a current contract or is negotiating a contract with the PH-MCO or its Affiliates or is otherwise affiliated with the PH-MCO or its Affiliates.

h. The PH-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 PH-MCO must transmit this information within fifteen (15) days from receipt of the Member's request for an external Grievance review.

i. Within fifteen (15) days from receipt of the request for an external Grievance review by the PH-MCO, the Member or the Member's representative, or the Member's Provider, may supply additional information to the CRE conducting the external Grievance review for consideration. Copies must also be provided at the same time to the PH-MCO so that the PH-MCO has an opportunity to consider the additional information.

j. Within sixty (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 PH-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 or item is Medically Necessary and appropriate under the terms of this Agreement.

k. The external Grievance decision may be appealed by the Member, the Member's representative, or the Provider to a court of competent jurisdiction (Commonwealth Court) within sixty (60) days from the date the Member receives notice of the external Grievance decision.

**3. Expedited Grievance Process**

a. The PH-MCO must conduct expedited review of a Grievance if the PH-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 Member representative, with proof of the Member's written authorization for a representative to be involved and/or act on the Member's behalf, provides the PH-MCO with a 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 expedited review of a Grievance may be filed in writing, by fax, by email, or 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 PH-MCO must inform the Member of the right to present evidence and testimony 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 within the request for an expedited review and the PH-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 PH-MCO must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Member's request for expedited review, the PH-MCO must decide the Grievance within the standard time frames as set forth in this Exhibit, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Member. If the PH-MCO decides that expedited consideration with the initial or extended time frame is not warranted, the PH-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 two (2) business days of the decision to deny expedited review, using the template specified by the Department.

f. A Member who files a request for expedited review of a Grievance that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is made verbally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.

g. Expedited review of a Grievance must be conducted by a Grievance review committee made up of three (3) or more individuals 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 Grievance.

h. At least one-third of the expedited Grievance review committee may not be employees of the PH-MCO or a related subsidiary or Affiliate.

i. The expedited Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. If the Grievance is related to dental services, the expedited Grievance review committee must include a dentist. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.

j. Prior to the start of the expedited Grievance review meeting, the Member must be told that the testimony will be recorded. If the Member agrees to the testimony taken by the Grievance review committee (including the Member's comments) being recorded, the testimony must be recorded and transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record. If the Member objects to the testimony being recorded, the Member's objection must be documented in the expedited Grievance record and the expedited Grievance review meeting must proceed without the testimony being recorded.

k. The PH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Member. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

l. The Member or the Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the PH-MCO's expedited Grievance decision.

m. 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 expedited external Grievance review with the PH-MCO within two (2) business days from the date the Member receives the PH-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 or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Grievance review.

n. A request for an expedited external Grievance review may be filed in writing, by fax, orally, or by email.

o. The PH-MCO must follow PID's BMC guidelines relating to submission of requests for expedited external Grievance reviews.

p. The PH-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

**Fair Hearing:** A hearing conducted by the Department's Bureau of Hearings and Appeals (BHA) or a Department designee.

### 1. Fair Hearing Process

a. A Member or Member's representative must file a Complaint or Grievance with the PH-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the PH-MCO fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, 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 one hundred and twenty (120) days from the mail date on the written notice of the PH-MCO's first level Complaint decision or Grievance decision for any of the following:

i. the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;

ii. the denial of a requested service or item because the service or item is not a covered service;

iii. the reduction, suspension, or termination of a previously authorized service or item;

iv. the denial of a requested service or item but approval of an alternative service or item;

v. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;

vi. the failure of a PH-MCO to decide a Complaint or Grievance within the specified time frame;

vii. the denial of payment after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;

viii. the denial of payment after a service or item has been delivered because the service or item is not a covered service for the Member;

ix. the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

c. 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 PH-MCO failed to provide written notice of the Complaint or Grievance decision within the time frames specified in this Exhibit.

d. A Fair Hearing may be requested as follows:

i. Fax: 1-717-772-6328

ii. Mail: Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

e. A Member who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered, faxed, or post-marked within ten (10) days from the mail date on the written notice of decision.

f. Upon receipt of the request for a Fair Hearing, BHA or the Department's designee will schedule a hearing. The Member and the PH-MCO will receive notification of the hearing date by letter at least ten (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.

g. The PH-MCO is a party to the hearing and must be present. The PH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. BHA's decision is based solely on the evidence presented at the hearing. The absence of the PH-MCO from the hearing will not be reason to postpone the hearing.

h. The PH-MCO must provide Members, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

i. BHA will issue an adjudication within ninety (90) days of the date the Member filed the first level Complaint or the Grievance with the PH-MCO,

not including the number of days before the Member requested the Fair Hearing. If BHA fails to issue an adjudication within ninety (90) days of receipt of the initial request of the first level complaint or grievance, less the time it took the member to request a Fair Hearing, the PH-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 BHA must issue the adjudication prior to interim assistance being afforded will be extended by the length of the delay attributed to the Member.

j. BHA's adjudication is binding on the PH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) days from the date of the BHA 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 PH-MCO.

**2. 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 in writing or orally.

b. A Member must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.

c. BHA 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 frames 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 or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is made orally, hand delivered, or post-marked within ten (10) days from the mail date on the written notice of decision.

e. Upon the receipt of the request for an expedited Fair Hearing, BHA or the Department's designee will schedule a hearing.

f. The PH-MCO is a party to the hearing and must be present. The PH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The absence of the PH-MCO from the hearing will not be reason to postpone the hearing.

g. The PH-MCO must provide the Member, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

h. BHA will issue an adjudication within three (3) business days from receipt of the Member's oral or written request for an expedited review.

i. BHA's adjudication is binding on the PH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (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 PH-MCO.

## E. Provision of and Payment for Service or Item Following Decision

1. If the PH-MCO, BHA, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair Hearing process, the PH-MCO must authorize or provide the disputed service or item as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed. If the PH-MCO requests reconsideration, the PH-MCO must authorize or provide the disputed service or item pending reconsideration unless the PH-MCO requests a stay of the BHA decision and the stay is granted.

2. If the PH-MCO, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Member received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, the PH-MCO must pay for the service or item that the Member received.

If a Member requests both an external appeal/review and a Fair Hearing, and the decisions rendered as a result of the external review and Fair Hearing are in conflict with one another, the PH-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 PH-MCO must submit the matter to the Department's Grievance and Appeals Coordinator for review and resolution.

EXHIBIT HH

# EXHIBIT II

## EXHIBIT II

## REQUIRED CONTRACT TERMS FOR ADMINISTRATIVE SUBCONTRACTORS

All subcontracts must be in writing and must include, at a minimum, the following provisions:

- The specific activities and report responsibilities delegated to the subcontractor;
- A provision for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
- All subcontractors shall comply with all applicable requirements of the Agreement between the PH-MCO and the Department concerning the HealthChoices Program;
- Meet the applicable requirements of 42 C.F.R. Subsection 434.6;
- Include nondiscrimination provisions;
- Include the provisions of the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq);
- Contain a provision in all subcontracts with any individual firm, corporation or any other entity which provides medical services and receives reimbursement from the PH-MCO either directly or indirectly through capitation, that data for all services provided will be reported timely to the PH-MCO. Penalties and sanctions will be imposed for failure to comply. The data is to be included in the utilization and encounter data provided to the Department in the format required;
- Contain a provision in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to HealthChoices members, that the subcontractor will report all new third party resources to the PH-MCO identified through the provision of medical services, which previously did not appear on the Department's recipient information files provided to the PH-MCO;
- Contain a hold harmless clause that stipulates that the PH-MCO subcontractor agrees to hold harmless the Commonwealth, all Commonwealth officers and employees and all PH-MCO members in the event of nonpayment by the PH-MCO to the subcontractor. The subcontractor shall further indemnify and hold harmless the Commonwealth and their agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Commonwealth or their agents, officers or employees, through the intentional conduct, negligence or omission of the subcontractor, its agents, officers, employees or the PH-MCO;
- Contain a provision in all subcontracts that the subcontractor agrees to comply with all applicable Medicaid, federal and state laws and regulations; including sub-regulatory guidance;

- Contain provisions in all subcontracts with any individual firm, corporation or any other entity which provides medical services to HealthChoices members, that prohibits gag clauses which limit the subcontractor from disclosure of medical necessary or appropriate health care information or alternate therapies to members, other health care professionals or the Department;

- Contain provisions in all employee contracts prohibiting gag clauses which limit said employees from the disclosure of information pertaining to the HealthChoices Program; and

- Contain provisions in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to HealthChoices members, that limits incentives to those permissible under the applicable Federal regulation.

The PH-MCO shall require as a written provision in all subcontracts that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Medical Assistance consumers.

The PH-MCO and its subcontractor(s) 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 PH-MCO and its subcontractor(s) also must agree to comply with all standards for practice and medical records keeping specified by the Commonwealth.

The PH-MCO and its subcontractor(s) and the subcontractor's contractor(s) shall, at their own expense, make all books, records, contracts, computers, or other electronic systems available for audit, review, evaluation or inspection by the Commonwealth, its designated representatives, CMS, the HHS Inspector General, the Comptroller General or their designees. Access must be granted either on-site, electronically or through the mail at the discretion of the reviewing entity. The right to audit exists for ten (10) years from the final date of the contract period; or from the date of completion of any audit, whichever is longer. The PH-MCO must fully cooperate with any and all reviews and/or audits by state or federal agencies or their agents, such as the Independent Assessment Contractor, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

If the Commonwealth, CMS, or the HHS Inspector General or their designees determine that there is a reasonable possibility of fraud or similar risk, the Commonwealth, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

The PH-MCO and its subcontractor(s) shall maintain books, records, documents and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to

this contract as well as to all required programmatic activity and data pursuant to this contract. 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 ten (10) years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all tasks are completed.

The PH-MCO and its subcontractor(s) must agree to retain the source records for its data reports for a minimum of ten (10) years and must have written policies and procedures for storing this information.

The PH-MCO shall require, as a written provision in all subcontracts that the subcontractor recognize that payments made to the subcontractor are derived from federal and state funds. Additionally, the PH-MCO shall require, as a written provision in all contracts for services rendered to Recipient, that the subcontractor shall be held civilly and/or criminally liable to both the PH-MCO and the Department, in the event of nonperformance, misrepresentation, fraud, or abuse. The PH-MCO shall notify its PCPs and all subcontractors of the prohibition and sanctions for the submission of false claims and statements.

The PH-MCO shall require, as a written provision in all subcontracts that the subcontractor cooperate with Quality Management/Utilization Management Program requirements.

The PH-MCO shall monitor the subcontractor's performance on an on-going basis and subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State laws and regulations. If the PH-MCO identifies deficiencies or areas needing improvement, the PH-MCO and the subcontractor must take corrective action.

EXHIBIT JJ

# EXHIBIT KK

# EXHIBIT KK

## REPORTING SUSPECTED FRAUD, WASTE, AND ABUSE

The following requirements are adapted from 55 PA Code §1101, General Provisions for the Medical Assistance Program, specifically 55 PA Code §1101.75(a) and (b), Provider Prohibited Acts, which are directly adapted from the 62 PS §1407, (also referred to as Act 105 of 1980, Fraud and Abuse Control Act) and Federal Regulations 42 C.F.R. §§438.608(a)(7-8) and 455.23(a).The basis for Recipient referrals is 55 PA Code §1101.91 and §1101.92, Recipient Misutilization and Abuse and Recipient Prohibited Acts. For information on these regulations, go to the Pennsylvania Code and Bulletin website.

**Reporting Requirements:**

PH-MCOs are required to report to the Department any act by Providers/Recipients/Caregivers/Employees that may affect the integrity of the HealthChoices Program under the Medical Assistance Program. Specifically, if the PH-MCO suspects that either Fraud, Abuse or Waste (as discussed in Section V.O.4, Fraud and Abuse, of the Agreement) may have occurred, the PH-MCO must report the issue to the Department's Bureau of Program Integrity (BPI). In addition to referrals to the Department, the PH-MCO is required to simultaneously submit fraud referrals to the Pennsylvania Office of Attorney General Medicaid Fraud Control Section in accordance with 42 C.F.R. §438.608(a)(7). The referrals shall be submitted \ using the Department's PH-MCO Referral Form. Fraud referrals submitted to the Department using the PH-MCO Referral Form will be automatically sent to the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section. The PH-MCO must have a process to notify BPI of any adverse actions and/or provider disclosures taken during the credentialing/re-credentialing process. Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review or suspend payments to avoid unnecessary expenditures during the review process.

In addition to referrals to the Department, the PH-MCO is required to simultaneously submit fraud referrals directly to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section as provided in 42 C.F.R. §438.608(a)(7). Fraud referrals to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section will be submitted by using the Department's PH-MCO Referral Form. Fraud referrals submitted to the Department using the PH-MCO Referral Form will be automatically forwarded by the Department to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section. After the referral form is submitted, the PH-MCO is required to upload the supporting documentation to the Department using DocuShare. The PH-MCO is also required to upload the same supporting documentation to the Office of Attorney General, Medicaid Fraud Control Section through ShareFile.

The PH-MCO must also notify the Department if it recovers overpayments or improper payments related to Fraud, Waste or Abuse of Medical Assistance funds from non-administrative overpayments or improper payments made to Network Providers, or otherwise takes an adverse action against a Provider, e.g. restricting the Members or services of a PCP.

PH-MCOs are also required to report quality issues to the Department for further investigation. Quality issues are those which, on an individual basis, affect the Recipient's health (e.g. poor-quality services, inappropriate treatment, aberrant and/or abusive prescribing patterns, and withholding of Medically Necessary services from Recipient).

All Fraud, Abuse, Waste or quality referrals must be made promptly, within thirty (30) days of the identification of the problem/issue. The PH-MCO must conduct a preliminary investigation to the level of an indication of indicia of fraud. The PH-MCO may informally consult with other state agencies or law enforcement to reach this determination. The PH-MCO must send to BPI all relevant documentation collected to support the referral. Such information includes, but is not limited to, the materials listed on the "Checklist of Supporting Documentation for Referrals" located at the end of this exhibit. The Fraud and Abuse Coordinator, or the responsible party completing the referral, should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form to indicate the supporting documentation that is sent with each referral. A copy of the completed checklist and all supporting documentation should accompany each referral. Any egregious situation or act (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 the Department's Bureau of Program Integrity for further investigation.

Failure to comply with the requirements of Exhibit KK will result in sanctions and or corrective action as stated in the HealthChoices Agreement. The Department must suspend all Medicaid payments to a provider after a determination that there is a credible allegation of fraud for which an investigation is pending against an individual or entity unless the Department has good cause not to suspend payments or to suspend payments in part. (42 C.F.R. 455.23 (a)). Upon notification from the Department of the imposition of a payment suspension, the PH-MCO, at a minimum, must also suspend payments to the provider.

The following processes are required for Provider/Caregiver and Employee referrals, unless prior approval is received from BPI. Reports must be submitted online using the PH-MCO Referral Form. Fraud allegations will result in an automatic dual referral to the Office of Attorney General and the Department. The instructions and form templates are located on the HealthChoices extranet website under Managed Care Programs/Fraud and Abuse.

Once completed, the PH-MCO must electronically submit the form to BPI. Additionally, the following information must be submitted to BPI electronically using a DocuShare folder designated by BPI:

- Checklist of Supporting Documentation for Referrals, accessible on the PH-MCO Referral Form,
- A copy of the confirmation page which will appear after the "Submit" button is clicked, submitting the PH-MCO Referral Form, and
- All supporting documentation. Referrals will not be processed but will be returned for further development if they are received without all supporting documentation.

The same information must be uploaded to the Office of Attorney General, Medicaid Fraud Control Section ShareFile system.

If DocuShare is inaccessible for any reason, the PH MCO will notify the BPI contract monitor, then mail the supporting information above to the below address:

Department of Human Services
Bureau of Program Integrity – DPPC/DPR
P.O. Box 2675
Harrisburg, PA 17105-2675

All suspected member fraud, abuse and/or waste should be reported directly to the Bureau of Program Integrity's Recipient Restriction Section by the PH-MCO's Recipient Restriction Coordinator using the established restriction referral process.

In the event member fraud is suspected but the criteria for restriction is not met, the PH-MCO's Restriction Coordinator should forward all supporting documentation, including a narrative description of the alleged fraud, to the Department's Recipient Restriction Section.

All subsequent information should also be sent to the Recipient Restriction Section at:

Department of Human Services
Bureau of Program Integrity
Recipient Restriction Program
P.O. Box 2675
Harrisburg, PA 17105-2675
717-772-4627 (office)
717- 214-1200 (fax)

## Checklist of Supporting Documentation for Referrals

- All referrals should have the confirmation page from online referral attached.
- Please check the appropriate boxes that indicate the supporting documentation included with your referral.

Example of materials for provider, caregiver or staff person referrals –

- ☐ confirmation page from online referral
- ☐ FEIN#
- ☐ encounter forms (lacking signatures or forged signatures)
- ☐ timesheets
- ☐ attendance records of recipient
  written statement from parent, provider, caregiver, recipient or other individual that services were not rendered or a signature was forged
- ☐ progress notes
- ☐ internal audit report
- ☐ interview findings
- ☐ sign-in log sheet
- ☐ complete medical records
- ☐ résumé and supporting résumé documentation (college transcripts, copy of degree)
- ☐ credentialing file (DEA license, CME, medical license, board certification, Department of Health certification, Medicare certification)
- ☐ copies of complaints filed by members
- ☐ admission of guilt statement
- ☐ other: _____

Example of materials for pharmacy referrals –

- ☐ paid claims
- ☐ prescriptions
- ☐ signature logs
- ☐ encounter forms
- ☐ purchase invoices
- ☐ EOB's
- ☐ delivery slips
- ☐ licensing information
- ☐ other: _____

Example of materials for RTF referrals –

- ☐ complete medical records
- ☐ discharge summary
- ☐ progress notes from providers, nurses, other staff
- ☐ psychological evaluation
- ☐ other: _____

Example of materials for behavioral health referrals –

- ☐ complete medical and mental health record
- ☐ results of treatment rendered/ ordered, including the results of all lab tests and diagnostic studies
- ☐ summaries of all hospitalizations all
- ☐ psychiatric examinations
- ☐ all psychological evaluations
- ☐ treatment plans
- ☐ all prior authorizations request packets and the resultant prior authorization number
- ☐ encounter forms (lacking signatures or forged signatures)
- ☐ plan of care summaries
- ☐ documentation of treatment team or Interagency Service Planning Team meetings
- ☐ progress notes
- ☐ other: _____

Example of materials for DME referrals –

- ☐ orders, prescriptions, and/or certificates of medical necessity (CMN for the equipment)
- ☐ delivery slips and/or proof of delivery of equipment copies
- ☐ of checks or proof of copay payment by recipient
- ☐ diagnostic testing in the records
- ☐ copy of company's current licensure
- ☐ copy of the Policy and Procedure manual applicable to DME items
- ☐ other:_____

_____

EXHIBIT LL

# EXHIBIT LL

## GUIDELINES FOR SANCTIONS REGARDING FRAUD, WASTE AND ABUSE

The Department recognizes its responsibility to administer the HealthChoices Program and ensure that the public funds which pay for this program are properly spent.

To maintain the integrity of the HealthChoices Program and to ensure that PH-MCOs comply with pertinent provisions and related state and federal policies, including rules and regulations involving Fraud, Waste and Abuse issues, the Department will impose sanctions on the PH-MCOs as deemed appropriate where there is evidence of violations involving Fraud, Waste and Abuse issues in the HealthChoices Program. To that end, program compliance and improvement assessments, including financial assessments payable to BPI, will be applied by BPI for the PH-MCO's identified program integrity compliance deficiencies. Note that the Department also retains discretion to impose additional remedies available under applicable law and regulations.

## FRAUD, WASTE AND ABUSE ISSUES WHICH MAY RESULT IN SANCTIONS

The Department may impose sanctions, for non-compliance with Fraud, Waste and Abuse requirements which include, but are not limited to, the following:

A. Failure to implement, develop, monitor, continue and/or maintain the required compliance plan and policies and procedures directly related to the detection, prevention, investigation, referral or sanction of Fraud, Waste and Abuse by providers, caregivers, members or employees.

B. Failure to cooperate with reviews by oversight agencies or their designees, including the Department, Pennsylvania Office of Attorney General Medicaid Fraud Control Unit , Office of Inspector General of the U.S. DHHS, and other state or federal agencies and auditors under contract to CMS or the Department 42 C.F.R. §438.3(h).

C. Failure to adhere to applicable state and federal laws and regulations.

D. Failure to adhere to the terms of the HealthChoices Agreement, and the relevant Exhibits which relate to Fraud, Waste and Abuse issues.

E. If a PH-MCO fails to provide the relevant operating agency, upon its written request, encounter data, claims data and information, payment methodology, policies and/or other data required to document the services and items delivered by or through the PH-MCO to Members 42 C.F.R. §438.604.

F. PH-MCO engaging in actions that indicate a pattern of wrongful denial of payment for a health-care benefit, service or item that the organization is required to provide under its agreement.

G. If a PH-MCO or associate fails to furnish services or to provide members a health benefit, service or item that the organization is required to provide under its Agreement 42 C.F.R. § 438.700(b)(1).

H. PH-MCO engaging in actions that indicate a pattern of wrongful delay of at least for 45 days or a longer period specified in the Agreement (not to exceed 60 days) in making payment for a health-care benefit, service or item that the organization is required to provide under its Agreement.

I. Discriminating against Members or prospective Members on any basis including without limitation, age, gender, ethnic origin or health status 42 C.F.R. §438.3(d)(3-4)

J. The PH-MCO must conduct a preliminary investigation and may consult with other state agencies or law enforcement to determine credible allegations of fraud for which an investigation is pending under the Medicaid program against an individual, a provider, or other entity (42 C.F.R. §455.23(a)). Allegations are to be considered credible when there is indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case by case basis (42 C.F.R. §455.2).

K. PH-MCO failure to pay overpayments to DHS as identified through network provider audits, reviews, investigations conducted by BPI or its designee and other state and federal agencies.

**RANGE OF SANCTIONS**

The Department may impose any of the sanctions indicated in Section VIII.H. of the Agreement including, but not limited to, the following:

A. Preclusion or exclusion of the PH-MCO, its officers, managing employees or other individuals with direct or indirect ownership or control interest in accordance with 42 U.S.C. §1320a-7, 42 C.F.R. Parts 1001 and 1002; 62 P.S. §1407 and 55 Pa. Code §§1101.75 and 1101.77.

These sanctions may, but need not be, progressive. The Department's intends to maintain an effective, reasonable and consistent sanctioning process as deemed necessary to protect the integrity of the HealthChoices Program.

EXHIBIT MM

# EXHIBIT NN

# EXHIBIT NN

## SPECIAL NEEDS UNIT

A member with Special Needs is based upon a non-categorical or generic definition of Special Needs. This definition will include but not be limited to key attributes of ongoing physical, developmental, emotional or behavioral conditions or life circumstance which may serve as a barrier to the member's access to care or services. Examples of members with Special Needs will include but not be limited to: Children with Special Health Care Needs including those requiring skilled or unskilled home shift care, Children in Substitute Care, those with limited English Proficiency, or special communication needs due to sensory deficits those with Physical and/or Intellectual/ Developmental Disabilities, those with HIV/AIDS, those with significant behavioral challenges, or members requiring transportation assistance. Examples of factors in the determination of a member with Special Need(s) include but are not limited to the following:

- Require care and/or services of a type or amount that is beyond what is typically required;
- Require extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve the level of functioning for the individual;
- May require that primary care be managed by a specialist, due to the nature of the condition;
- May incur higher morbidity without intervention and coordination in the care of the individual;
- Require care and/or services that necessitate coordination and communication among Network Providers and/or Out-of-Network Providers including, but not limited to, housing, food, and employment challenges;
- Require care and/or services that necessitate coordination and collaboration with public and private community services organizations outside the PH-MCO;
- Require coordination of care and/or services between the acute inpatient setting and other facilities and Community Providers;
- Result in the Member requiring assistance to schedule or make arrangements for appointments or services, including arranging for transportation to and from appointments;
- Result in the need for language, communication, or mobility accommodations; or
- Result in the need for a Member to be accompanied or assisted while seeking or receiving care by an individual who may act on the Member's behalf.

- Require assistance in discharge planning from an inpatient or long-term care or pediatric residential setting to ensure the member will receive services in the least restrictive environment possible.

- Children who are in the custody of Office of Children, Youth and Families (OCYF) or known to have an open case with OCYF.

- Any condition, event or life circumstance that as a result inhibits a member's access to any necessary service or support needed to address their medical condition or maintain their current level of functioning.

**Structure and Staffing Requirements of the Special Needs Unit**

The PH-MCO will be required to develop, train, and maintain a unit within its organizational structure that will be responsible to provide support and case management services to members with Special Needs in a timely manner.

This unit will be headed by a Special Needs Coordinator who must have access to and periodically consult with the Medical Director.

The PH-MCO Special Needs Unit case manager must function as the single point of contact to coordinate all health care needs including social determinates of health needs for vulnerable populations.

The case management staff must follow the Case Management Society of America standards of practice.

Individual case management staff that are eligible should be certified case managers or be working toward certification. Staff who are not currently certified or are not eligible to become certified must be supervised by a certified case manager.

The staff members will work in close collaboration with the BMCO SNU and the Enrollment Assistance Program Contractor's Special Needs contact person.

The Department expects the PH-MCO's Special Needs Unit to be staffed by individuals with either a medical and/or social services background, in sufficient number to initiate a response to a Member's inquiry within two (2) Business Days or sooner in urgent situations.

The Department expects the core staff members of the Special Needs Unit to be responsible primarily for the functions and operations associated with the unit, including the primary case management and care coordination for members and families receiving special needs services.

The Department also expects that at times the Special Needs Unit staff will have access to the resources of other departments within the PH-MCO to supplement the Special Needs Unit in assisting Members with Special Needs. The PH-MCO must show evidence of their access to and use of individuals with expertise in the treatment of Members with Special Needs to provide consultation to the Special Needs Unit staff, as needed.

The PH-MCO shall use knowledgeable and independent organizations such as consumer groups, disability advocacy groups, Special Needs consumers, and the Department of Health District Offices, when providing training to its Special Needs Unit staff, whenever possible.

**Special Needs Unit Functions and Requirements**

The primary purpose of the Special Needs Unit is to ensure that each Member with Special Needs receives access to appropriate primary care, access to specialists trained and skilled in the needs of the Member including behavioral health and substance use disorder services, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the Member's condition or circumstance, including pharmaceuticals and DME, and access to needed community services to support housing, food and employment needs.

The Special Needs Unit must have a direct link to the Utilization Management functions of the PH-MCO and have input into the case review process. The PH-MCO must have procedures in place that ensure the proactive identification of and outreach to Members with Special Needs who may not self-identify as having a Special Need.

The PH-MCO Special Needs Unit case manager must function as the single point of contact to coordinate all health care needs including social determinates of health needs for vulnerable populations.

In the event that a Member is not satisfied with PH-MCO performance in any area, the Special Needs Unit case manager will be responsible for facilitating dispute resolution and for informing the Member of the Complaint, Grievance, and DHS Fair Hearing mechanisms that are available and assisting in that process as needed or requested.

Members with Special Needs determined to have ongoing needs for assistance will be assigned to a particular Special Needs Unit case manager and will have ready access to their Special Needs Unit case manager as long as they are enrolled in the PH-MCO. This case manager will be responsible to develop and maintain a Plan of Care (POC) for the member according to standards set forth in the CMSA standards of case management.

Members with Special Needs are permitted to change case managers as needed during their enrollment.

The Special Needs Unit will perform the following functions:

- Conduct necessary training for all PH-MCO staff to acquaint them with the purpose and function of the Special Needs Unit and the need to coordinate within departments to serve Members with Special Needs.

- Work towards education and training in the use of LifeCourse™ tools.

Meet face-to-face at least twice a year with the child and family and/or caregivers for the most complex members receiving shift care services. At least one of the face-to-face visits must be at the time of initial or recertification of shift care services. The PH-MCO staff must be appropriate licensed Special Needs Unit case management staff.

- Provide case management services for children in the custody of OCYF or known to have an active case.

- Ensure coordination between the PH-MCO and other health, education, and human services systems including County Children and Youth Services Offices, County Office of Intellectual Disability Services Offices and Juvenile Justice Offices. For a more inclusive list see Exhibit OO.

- The coordination between the PH-MCO and other health education, and human services systems may include coordination with the state level offices for these agencies as well. For example, the PH-MCOs would be expected to work with the Office of Developmental Programs (ODP) state office and the Family Facilitator on efforts to discharge children in a pediatric residential setting.

- Educate families with children in a pediatric residential setting on the role of ODP's Family Facilitator and the support that can be provided to the family and the member to ensure the best long-term plan for their child.

- Ensure adherence to state and federal laws, regulations, Departmental agreements and court requirements relating to individuals with Special Needs.

- A contact within the Special Needs Unit must be designated to act as a liaison with the BMCO SNU staff and the Enrollment Assistance Program contractor's Special Needs contact person.

- The PH-MCO must develop an appropriate automated process to operationalize the information on Special Needs individuals supplied by the Enrollment Assistance Program contractor.

- Sufficient telephone and alternative communication channels must be established to allow ready and timely interactions between the PH-MCO Special Needs Unit Coordinator, case managers, the Office of Medical Assistance Programs, the Enrollment Assistance Program contractor, Members with Special Needs, Providers (Network and Out-of-Network) and other health, education, and human services systems servicing Members with Special Needs and involved agencies.

- The PH-MCO Special Needs Unit must have a resource account email box in place for receipt of transition of care documentation to ensure timely access to all medically necessary services. The Special Needs Unit Coordinator and multiple staff must have access to this resource account.

- Appropriate arrangements must be made to effectively assist Members with Special Needs who speak languages other than English in accordance with the

RFP and Agreement requirements. In addition, efforts must be made to match Members with communication barriers due to disability or linguistic background with Providers with whom they can effectively communicate.

- Serve on interagency teams upon request by a Member or their family to facilitate and coordinate delivery of Physical Health Services contained in treatment plans for children and/or adults including, but not limited to, Individual Family Service Plans, Individual Educational Plans, Individual Habilitation Plans, and Individual Behavioral Health Treatment Plans.

- Special Needs Unit case managers must have a working knowledge of Children and Adolescent Support Services Program (CASSP) and the Community Support Program (CSP) principles and principles of drug and alcohol treatment.

- Ensure cooperation of the PH-MCO's Provider Network. Special Needs Unit case managers must facilitate communication and coordinate service delivery between primary care, specialty, ancillary, substance use disorder and behavioral health Providers to ensure Member's timely and uninterrupted access to care.

- Assist in the development of adequate Provider Networks, such as pediatric specialists, to serve Special Needs populations. Special Needs Unit case managers must assist and support Members with Special Needs in making an informed choice between Providers of equivalent services within the network. When adequate network capacity does not exist to allow for choice between network Providers of equivalent services, case managers must facilitate and coordinate services rendered by Out-of-Network Providers.

- Conduct necessary training for PCPs to assist them in providing services to diverse populations including the identification of the PH-MCO's Special Needs Unit contact persons.

- Provide ongoing coordination with PCPs to continually serve Special Needs population’s Members.

- Attend ad hoc meetings, workgroups, etc., hosted by the Department that require mandatory attendance by Special Needs Unit staff.

- Attend public/community sponsored meetings with the Department’s representative(s) at the discretion of the PH-MCO.

- If the PH-MCO chooses to subcontract any of the Special Needs Unit functions, the PH-MCO must maintain accountability by assigning responsibility for oversight of the subcontract to a senior executive within the organization.

- Conduct necessary training for all PH-MCO providers to acquaint them with the purpose and function of the Special Needs Unit and identify a contact within the Special Needs Unit as a direct contact for any provider to refer a member with special needs for assistance.

- Provide assistance to any member needing help in filing a Complaint, Grievance, or Fair hearing, and serve in an advocacy role to assist the member in obtaining any information necessary from any PH-MCO provider in support of a Complaint, Grievance or DHS Fair Hearing.

- Provide assistance to any member needing additional help to access the Department's Medical Assistance Transportation Program.

- Provide assistance to any member needing help transitioning from a pediatric to an adult provider. Proactively identify individuals between the ages of 18 and 21 that may be considered to be medically fragile members and provide enhanced assistance to them in transitioning to an adult provider. During this transitioning process ensure that they can receive care from a Pediatrician and adult Primary Care Provider at the same time to facilitate a seamless transition to adult care. These youth should be provided case management, at a minimum, until a successful transition is complete.

- Work in coordination with the Department's Resource Facilitation Team (RFT), other Department of Human Services Program Offices, and Service Coordinators to provide transition assistance to members receiving home shift care services under EPSDT into Home and Community Based Waivers and adult systems of support. This will include functioning as a liaison between the RFT and the member and family.

- For members in inpatient or residential facilities, the SN case manager will be responsible to take the lead with discharge planning to ensure the member is transitioning not only to the most appropriate and community-based environment for the child as possible , but to ensure that the environment and supports such as shift care, DME, and available community supports are in place in the new setting prior to any discharge occurring. Provide all necessary oversight including home or site visits with family or other caregivers to ensure adequate supports are in place for a safe discharge. Members in residential facilities will be required to be in active case management by a SNU PH-MCO case manager until the member is successfully discharged home or to another community or other care setting.

- Conduct face-to-face case management activities with members for whom telephonic case management has proven ineffective, and desired goals have not been attained. Utilize and interface with community-based care management staff to maintain a person-centered approach and to ensure that member-specific needs are being met.

The PH-MCO will develop, implement, and maintain a targeted Quality Management component focused on Members with Special Needs that is integrated into the Quality Management/Utilization Management Program as outlined in Exhibit M(1), Quality Management and Utilization Management Program Requirements.

The Special Needs Unit will provide data as required for special needs related to existing and new Operations (OPS) Reports and ad hoc requests concerning members with special needs.

The PH-MCO must collaborate with the Department to implement recommendations put forth in the white paper “Improving Pennsylvania’s Pediatric Shift Care Nursing Through Collaboration”.

EXHIBIT NN(1)

## Exhibit NN(1)

## SPECIAL NEEDS UNIT CASE MANAGEMENT STANDARDS

This Exhibit NN(1) defines and supports the requirements for operationalization of Special Needs Unit (SNU) case management services within the PH-MCO. National case management standards and Pennsylvania specific standards were used in the development of the criteria set forth in this exhibit.

While these standards apply to any member who needs case management services, Section F. provides additional detail related to children residing in a residential care facility or in an extended hospital stay.

The SNU Case Manager (CM) is required to utilize needs assessments that have been completed to determine the member's immediate needs, encourage participation in case management, and establish a working relationship with the member or caretaker.

A. Assessment

1. The assessment must include at a minimum medical, behavioral, substance use, social determinate of health needs and sufficient information to perform risk stratification of the member/family/caregiver needs.

2. The SNU CM must review the needs assessment for the member/family/caregiver to determine areas of needs and develop a plan of care.

3. The SNU CM must ensure a culturally sensitive approach to all communication with member/family/caregiver.

4. The SNU CM must utilize and/or perform re-assessments at a minimum on a semi-annual basis in order to identify changing needs and incorporate the newly identified needs to the plan of care. The PH-MCO should perform a re-assessment if there is diagnosis of a new chronic health condition or an inpatient stay that would be indicative of a change in status or needs.

The SNU CM is required to work with the member/family/caregiver to develop a comprehensive plan of care that will guide all members of the care team to reach the goals outlined therein.

B. Plan of Care includes:

1. Documentation and prioritization of identified care needs, barriers, care gaps and solutions. This may include needs of family members/caregivers as these will impact member's success in reaching identified goals.

2. Evidence of member focused plan of care developed with member/family/caregiver and documentation of input from the care team.

3. The use of the LifeCourse™ framework, life span planning and other appropriate tools to assist with the development of a comprehensive plan of care.

4. Identify and document preferred methods of communication, including best contact modalities.

5. Incremental goals developed, documented, and assessed on a regular basis to meet the overarching goal of the plan of care as identified for and by the member/family/caregiver. The overarching goal may focus on prevention of emergency room visits, hospital, or long-term facility admissions, and of allowing the member to reside safely in the least restrictive setting.

6. Evidence and documentation of the coordination with individual(s) and/or local/community-based organization(s) responsible for the activities necessary to meet the goals.

7. Timeframes for achievement of goals.

The SNU CM is required to lead the implementation and coordination of care necessary to ensure progress is made towards member's goals.

C. Implementation and Coordination of Plan of Care includes:

1. Evidence of SNU CM involvement in the implementation of the steps necessary to meet the goals identified in the plan of care, including educational and training needs.

2. Evidence of SNU CM lead on the active and ongoing coordination of services and resources needed to mitigate the barriers and care gaps.

3. Documentation of coordination with the entire care team to provide successful outcomes.

The SNU CM is required to provide consistent monitoring, updating and evaluation of the steps essential to meet the goals documented in the plan of care.

D. Monitoring and Evaluation of Plan of Care includes:

1. Ongoing communication with the member/family/caregiver and entire care team to discuss progress towards meeting goals.

2. Monitoring activities of the care team to determine any need for modification of interventions to ensure progress towards goals. The monitoring should be done according to timeframes outlined in the plan of care.

3. Regular review of goals for revision to ensure goals continue to meet the needs of the member/family/caregiver. The review should be based on timeframes outlined in the plan of care.

The SNU CM is required to communicate and maintain case management services until such time the member/family/caregiver and the care team determine that the services are no longer necessary.

E. Closure of Case Management Services:

1. Upon completion of all goals identified as part of the plan of care, member/family/caregiver and all team members agree that regular SNU CM services are no longer necessary.

2. At member/family/caregiver request to no longer participate in CM activities.

3. Understanding that member can access SNU CM services at any time even after the plan of care has been closed.

F. Specifics for Children in a Residential Facility or Extended Inpatient Hospital Stay (facilities). An Extended Inpatient Hospital Stay is defined for the purpose of this requirement as any inpatient stay in a hospital or other type of inpatient facility that extends beyond 30 days.

1. The PH-MCO will establish and maintain a working relationship with facilities and the Office of Developmental Programs' Family Facilitator.

2. In addition to the requirements specified in the previous Sections of this Exhibit the plan of care must identify and address services to achieve childhood milestones in the areas of:

a. physical development/mobility,

b. language/communication,

c. emotional/social development,

d. behavioral health needs,

e. cognitive development per the CDC Child Development Checklist/Milestone Checker App,

f. education,

g. nutrition status,

h. medical needs.

3. The care plan must provide a clear plan of communication with the facility and the SNU CM as well as with the member/family/caregiver.

4. The SNU CM must monitor children in facilities at least quarterly to determine that services identified in the plan of care are being delivered according to the plan and that the environment is conducive to the health and safety of the child. This includes services that may be reimbursed and overseen by other organizations, for example, Respiratory, Physical, Occupational and Speech Therapy, behavioral health, Nutritionist or Dietitian.

5. Discharge planning for each child must begin upon admission, updated as care needs change, and have the primary goal of going home to family or a family model alternative. The discharge plan must include:

    a. encouraging and assisting all families to register the child with the County ID agency;

    b. detailed steps for family/caregiver training and preparation for discharge;

    c. identification of needed clinical and other services including home modifications, medical and other equipment, nursing, educational services, physical, occupational and speech therapy;

    d. quarterly or more frequent activity to assure the planning process is accurately reflective of the members/family/caregiver needs;

    e. evidence of active involvement with the County ID agency and/or County CYF agency;

    f. a period of appropriate post discharge follow-up to ensure all necessary services and equipment are in place.

    For children who have been in the facility for more than twelve (12) months, demonstrate an increased level of effort for permanency planning and support for discharge including notifying OMAP of barriers or reasons for continued stay.

EXHIBIT OO

## EXHIBIT OO

## COORDINATION OF CARE ENTITIES

Examples of coordination of care entities are listed below. This list is not inclusive of all coordination of care entities.

- Community HealthChoices Managed Care Organizations (CHC-MCOs)
- HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs)
- County Office of Drug and Alcohol Programs
- Department of Drug and Alcohol Programs (DDAP)
- Office of Children, Youth, and Families (OCYF)
- County Children and Youth Agencies
- Office of Developmental Programs (ODP)
- County Intellectual Disability (ID) Agencies and County ID Health Care Coordination Units
- Intermediate Care Facility Providers
- Office of Mental Health and Substance Abuse Services (OMHSAS)
- Office of Long Term Living (OLTL)
- County Mental Health Agencies
- PA. Department of Health's Community Health District Offices
- County and Municipal Health Departments
- Special Kids Network Helpline
- Childhood Lead Poisoning Prevention Projects (CLPPPs)
- School Districts and Intermediate Units
- School Based Health Centers
- Juvenile Detention Centers
- Juvenile Probation Offices
- Area Agency on Aging (AAA)
- Community Service Organizations
- Public Health Entities
- Consumer Advocacy Groups
- WIC Agencies, Head Start Agencies, and Family Centers
- Public Housing Authorities
- Opioid Use Disorder Centers of Excellence
- Career Link
- Office of Vocational Rehabilitation

EXHIBIT PP

# EXHIBIT PP

## PROVIDER MANUALS

The PH-MCO shall develop, distribute prior to implementation and maintain a Provider manual. In addition, the PH-MCO and/or PH-MCO Subcontractors will be expected to distribute copies of all manuals and subsequent policy clarifications and procedural changes to participating Providers following advance written approval of the documents by the Department. Provider manuals must be updated to reflect any program or policy change(s) made by the Department via MA Bulletin within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the MA Bulletin, whichever is later, when such change(s) affect(s) information that the PH-MCO is required to include in its provider manual, as set forth in this Exhibit. The Provider manual must include, at a minimum, the following information:

A. A description of the case management system and protocols;

B. A description of the role of a PCP as described in Section II, Definitions, and Section V.S.3, Primary Care Practitioner (PCP) Responsibilities, of the Agreement;

C. Information on how Members may access specialists, including standing referrals and specialists as PCPs;

D. A summary of the guidelines and requirements of Title VI of the Civil Rights Act of 1964 and its guidelines, and how Providers can obtain qualified interpreters familiar with medical terminology;

E. Contact information to access the PH-MCO, DHS, advocates, other related organizations, etc;

F. A copy of the PH-MCO's Formulary, Prior Authorization, and Program Exception process;

G. Contact follow-up responsibilities for missed appointments;

H. Description of role of Special Needs Unit and how to refer patients via the Special Needs Unit hotline and listing of the SNU hotline number;

I. Description of drug and alcohol treatment available and how to make referrals;

J. Complaint, Grievance and DHS Fair Hearing information;

K. Information on Provider Disputes;

L. PH-MCO policies, procedures, available services, sample forms, and fee schedule applicable to the Provider type;

M. A full description of covered services, listing all applicable services under the Medical Assistance Fee-for-Service Program;

N. Billing instructions;

O. Information regarding applicable portions of 55 PA Code, Chapter 1101, General Provisions;

P. Information on self-referred services and services which are not the responsibility of the PH-MCO but are available to Members on a Fee-for-Service basis;

Q. Provider performance expectations, including disclosure of Quality Management and Utilization Management criteria and processes;

R. Information on procedures for sterilizations, hysterectomies and abortions (if applicable);

S. Information about EPSDT screening requirements and EPSDT services, including information on the dental referral process );

T. A description of certain Providers' obligations, under law, to follow applicable procedures in dealing with Members on "Advance Directives" ( durable health care power of attorney and living wills). This includes notification and record keeping requirements;

U. Information on ADA and Section 504 of the Rehabilitation Act of 1973, other applicable laws, and available resources related to the same;

V. A definition of “Medically Necessary” consistent with the language in the Agreement;

W. Information on Member confidentiality requirements;

X. Information regarding school-based/school-linked services in this HealthChoices zone; and

Y. The Department’s MA Provider Compliance Hotline (formerly the Fraud and Abuse Hotline) number and explanatory statement.

Z. Explanation of Contractor’s and DHS’s Recipient Restriction Program.

AA. Information regarding written translation and oral interpretation services for Members with LEP and alternate methods of communication for those requesting communication in alternate formats.

BB. List and scope of services for referral and Prior Authorization.

CC. Information about the Pennsylvania MA Provider Self Audit Protocol which allows Providers to voluntarily disclose overpayments or improper payments of MA funds.

The PH-MCO is required to provide documented training to its Providers and their staffs and to Subcontractors, regarding the contents and requirements of the Provider manuals.

# EXHIBIT QQ

EXHIBIT RR

EXHIBIT SS

# EXHIBIT TT

EXHIBIT UU

EXHIBIT VV

EXHIBIT WW

# EXHIBIT WW

## HEALTHCHOICES AUDIT CLAUSE

## AUDITS

### Annual Agreement Audits

The PH-MCO shall cause, and bear the costs of, an annual Agreement audit to be performed by an independent, licensed Certified Public Accountant. The Agreement audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The Agreement audit shall be digitally submitted to OMAP, BFM, Division of Financial Analysis and Reporting via the E-FRM system no later than June 30 after the Agreement year is ended.

If circumstances arise in which the Commonwealth or the PH-MCO invoke the contractual termination clause or determine the Agreement will cease, the Agreement audit for the period ending with the termination date or the last date the PH-MCO is responsible to provide Medical Assistance benefits to HealthChoices recipients shall be submitted to the Commonwealth within 180 days after the Agreement termination date or the last date the PH-MCO is responsible to provide Medical Assistance benefits.

The PH-MCO shall ensure that audit working papers and audit reports are retained by the PH-MCO's auditor for a minimum of ten (10) years from the date of final payment under the Agreement, unless the PH-MCO'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 PH-MCO's auditor.

### Annual Entity-Wide Financial Audits

The PH-MCO 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. Such audit shall be submitted to the OMAP, BFM, Division of Financial Analysis and Reporting via E-FRM within 30 days after the Auditors signature date.

### 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 PH-MCO, its subcontractors or Providers. Any such additional audit work will rely on work already performed by the PH-MCO'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 PH-MCO, its subcontractors or Providers may be performed by the Commonwealth or its designated representatives and include, but are not limited to:

1. 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 Agreement;

2. 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 Agreement terms and conditions; and

3. Program audits and reviews to measure the economy, efficiency and effectiveness of program operations under this Agreement.

4. The Commonwealth must periodically, but no less frequently than once every three (3) years, conduct or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the PH-MCO.

Audits performed by the Commonwealth shall be in addition to any federally-required audits or any monitoring or review efforts. Commonwealth audits of the PH-MCO or its 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 subcontractors or Providers will be performed at the Commonwealth's discretion.

The following provisions apply to the PH-MCO, its subcontractors and Providers:

1. Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the entity at least three (3) weeks advance written notice of the start date, expected staffing, and estimated duration of the audit. In the event of a claims processing audit, the Commonwealth will strive to provide advance written notice of a minimum of thirty (30) calendar days. 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 PH-MCO 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, Agreements or other documents or information requested by the audit team.

2. 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 PH-MCO shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site, during normal business hours, or through the mail. During the Agreement and record retention period, these records shall be available at the PH-MCO's chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within fifteen (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 PH-MCO 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 Agreement period and ten years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed.

**Audits of Subcontractors**

The PH-MCO shall include in all risk sharing PH-MCO subcontract agreements clauses, which reflect the above provisions relative to "Annual Agreement Audits", "Annual Entity-Wide Financial Audits", "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

The PH-MCO 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."

EXHIBIT XX

# EXHIBIT XX

## ENCOUNTER DATA SUBMISSION REQUIREMENTS AND PENALTY APPLICATIONS

The submission of timely and accurate Encounter Data is critical to the Department's ability to establish and maintain cost effective and quality managed care programs. Consequently, the requirements for submission and metrics for measuring the value of the data for achieving these goals are crucial.

### CERTIFICATION REQUIREMENTS

All PH-MCOs must be certified through the Department's MMIS prior to the submission of live Encounter Data. The certification process is detailed on the Pennsylvania HealthChoices Extranet.

### SUBMISSION REQUIREMENTS

- Timeliness:

  With the exception of NCPDP Encounters, all PH-MCO approved Encounters and those specified PH-MCO-denied Encounters must be approved in the Department's MMIS by the last day of the third month following the month of initial PH-MCO adjudication. NCPDP Encounters must be submitted and approved in the Department's MMIS within thirty (30) days following the PH-MCO adjudication.

  - Metric:

    During the six months following the month of the initial MMIS adjudication, Encounters will be analyzed for timely submission.

    - Failure to achieve the Department's MMIS approved status for 98% of all PH-MCO paid and specified PH-MCO denied Encounters by the last day of the third month following initial PH-MCO adjudication may result in a penalty.

    - Any Encounter Data corrected or initially submitted after the last day of the third month following initial PH-MCO adjudication may be subject to a penalty.

Accuracy and Completeness:

Accuracy and completeness are based on consistency between Encounter Data submitted to the Department's MMIS and information for the same service maintained by the PH-MCO in their Claims/service history database.

- Metric:

Accuracy and completeness will be determined through a series of analyses of PH-MCO Claims history data and Encounters received and processed through the Department's MMIS. This analysis will be done at least yearly but no more than twice a year and will consist of making comparisons between encounter samples and what is found in the PH-MCO's claims history. Samples may also be drawn from the PH-MCO's service history and compared with Encounters processed through the Department's MMIS.

Samples will be drawn proportionally based on the PH-MCO financial expenditures for each transaction type submitted during the review period. Each annual or semi-annual analysis will be based on a statistically valid sample of no less than 200 records.

**PENALTY PROVISION**

Timeliness:

Failure to comply with timeliness requirements will result in a sanction of up to $10,000 for each program month.

Completeness and Accuracy:

Errors in accuracy or completeness that are identified by the Department in an annual or semi-annual analysis will result in sanctions as follows. An error in accuracy or completeness or both, in one sample record, counts as one error.

| Percentage of the sample that includes an error | Sanction |
|---|---|
| Less than 1.0 percent | None |
| 1.0 – 1.4 percent | $4,000 |
| 1.5 – 2.0 percent | $10,000 |
| 2.1 - 3.0 percent | $16,000 |
| 3.1 – 4.0 percent | $22,000 |
| 4.1 – 5.0 percent | $28000 |
| 5.1 – 6.0 percent | $34,000 |
| 6.1 – 7.0 percent | $40,000 |
| 7.1 – 8.0 percent | $46,000 |
| 8.1 – 9.0 percent | $52,000 |
| 9.1 – 10.0 percent | $58,000 |
| 10.1 percent and higher | $100,000 |

# EXHIBIT YY

# EXHIBIT ZZ

# EXHIBIT AAA

# EXHIBIT AAA

## PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

### 1. Network Composition

The PH-MCO must consider the following in establishing and maintaining its Provider Network:

- The anticipated MA enrollment,
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the PH-MCO,
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted MA services,
- The number of Network Providers who are not accepting new MA patients, and
- 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.

The PH-MCO must adhere to CMS network adequacy standards as outlined in 42 C.F.R. §438.68(b)(1)(viii), 438.68(b)(3), and 438.206. The PH-MCO must ensure that its Provider Network is adequate to provide its Members in this HealthChoices Zone with access to quality Member care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the PH-MCO must supply geographic access maps using Member level data detailing the number, location and specialties of their Provider Network to the Department in order to verify accessibility of Providers within their Network in relation to the location of its Members. The Department may require additional numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The PH-MCO must also have a process in place which ensures that the PH-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The PH-MCO must make all reasonable efforts to honor a Member's choice of Providers who are credentialed in the Network. If the PH-MCO is unable to ensure a Member's access to provider or specialty provider services within the PH-MCO's network, within the travel times set forth in this Exhibit, the PH-MCO must make all reasonable efforts to ensure the Member's access to these services within the travel times herein through out-of-network providers. In locations where the PH-MCO can provide evidence that it has conducted all reasonable efforts to contract with providers and specialists and can provide verification that no providers or specialists exist to ensure a Member's access to these services within the travel times set forth in this Exhibit, the PH-MCO

must work with Members to offer reasonable provider alternatives. Additionally, the PH-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire HealthChoices Zone in which the PH-MCO operates if providers exist:

**a. PCPs**

Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available. Members may, at their discretion, select PCPs located further from their homes.

**b. Pediatricians as PCPs**

Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (30 minutes Urban, 60 minutes Rural).

**c. Specialists**

i. For the following provider types, the PH-MCOs operating in Lehigh Capital, Southeast, and Southwest must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

| | |
|---|---|
| General Surgery | Cardiology |
| Obstetrics & Gynecology | Pharmacy |
| Oncology | Orthopedic Surgery |
| Physical Therapy | General Dentistry |
| Radiology | Pediatric Dentistry |

PH-MCOs operating in Northeast and Northwest must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

| | |
|---|---|
| General Surgery | Cardiology |
| Obstetrics & Gynecology | Pharmacy |
| Orthopedic Surgery | Pediatric Dentistry |
| General Dentistry | |

ii. For the following provider types, the PH-MCOs operating in Lehigh/Capital, Southeast, and Southwest must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the HealthChoices Zone:

| | |
|---|---|
| Oral Surgery | Urology |
| Nursing Facility | Neurology |
| Dermatology | Otolaryngology |

The PH-MCOs operating in Northeast and Northwest must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice within the HealthChoices Zone:

| | |
|---|---|
| Oral Surgery | Urology |
| Nursing Facility | Neurology |
| Dermatology | Otolaryngology |
| Oncology | Radiology |
| Physical Therapy | |

iii. For all other specialists and subspecialists, the PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.

**d. Hospitals**

Ensure at least one (1) hospital within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice within the HealthChoices Zone.

**e. Special Health Needs**

Ensure the provision of services to persons who have special health needs or who face access barriers to health care. If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services. For children with special health needs, the PH-MCO must offer at least two (2) pediatric specialists or pediatric sub-specialists.

**f. Anesthesia for Dental Care**

For Members needing anesthesia for dental care, the PH-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay out of Network.

**g. Rehabilitation Facilities**

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this HealthChoices Zone.

**h. CNMs / CRNPs, Other Health Care Providers**

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. In accordance with RX for PA Principles, the PH-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

**i. Qualified Providers**

The PH-MCO must limit its PCP Network to appropriately qualified Providers. The PH-MCO's PCP Network must meet the following:

- No less than seventy-five percent (75) of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics; and

- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

**j. Members Freedom of Choice**

The PH-MCO must demonstrate its ability to offer its Members freedom of choice in selecting a PCP. At a minimum, the PH-MCO must have

or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Recipients. For the purposes of this section, a full- time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Members to the panel. The number of Members assigned to a PCP may be decreased by the PH-MCO if necessary to maintain the appointment availability standards.

**k. PCP Composition and Location**

The PH-MCO and the Department will work together to avoid the PCP having a caseload or medical practice composed predominantly of HC Members. In addition, the PH-MCO must organize its PCP Sites so as to ensure continuity of care to Members and must identify a specific PCP or PCP group for each Member. The PH-MCO may apply to the Department for a waiver of these requirements. The Department may waive these requirements for good cause demonstrated by the PH-MCO. The PH- MCO will comply with the program standards regarding PCP assignment as set forth in Section V.Q. of the Agreement, Assignment of PCPs.

**l. FQHCs / RHCs**

The PH-MCO must include in its Provider Network every FQHC and RHC that are willing to accept PPS rates as payment in full and are located within the operational HealthChoices Zones in which the PH-MCO has an agreement. If the PH-MCO's primary care Network includes FQHCs and RHCs, these sites may be designated as PCP sites.

**m. Medically Necessary Emergency Services**

The PH-MCO must comply with the provisions of Act 112 of 1996 (H.B. 1415, P.N. 3853, signed July 11, 1996), the Balanced Budget Reconciliation Act of 1997 and Act 68 of 1998, the Quality Health Care Accountability and Protection Provisions, 40 P.S. 991.2101 et seq. pertaining to coverage and payment of Medically Necessary Emergency Services. The definition of such services is set forth herein at Section II of this Agreement, Definitions.

**n. ADA Accessibility Guidelines**

The PH-MCO must inspect the office of any PCP or dentist who seeks to participate in the PH-MCO's Provider Network (excluding offices located in hospitals) to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

The PH-MCO must submit quarterly reports to the Department, in a format to be specified by the Department, on the results of the inspections.

If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the PH-MCO's Provider Network provided that the PCP or dentist: 1) requests and is determined by the PH-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within six (6) months after the PH-MCO identified the barrier.

The PH-MCO must document its efforts to determine architectural accessibility. The PH-MCO must submit this documentation to the Department upon request.

**o. Laboratory Testing Sites**

The PH-MCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number in accordance with CLIA 1988. Those laboratories with certificates of waiver will provide only the eight (8) types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The PCP must provide all required demographics to the laboratory when submitting a specimen for analysis.

**p. PH-MCO Discrimination**

The PH-MCO must not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph must not be construed to prohibit a PH-MCO from including Providers only to the extent necessary to meet the needs of the organization's Members or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the PH-MCO.

**q. Declined Providers**

If the PH-MCO declines to include individual Providers or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision.

**r. Second Opinions**

The PH-MCO must provide for a second opinion from a qualified Health Care Provider within the Network, at no cost to the Member. If a qualified Health Care Provider is not available within the Network, the PH-MCO must assist the Member in obtaining a second opinion from a qualified Health Care Provider outside the Network, at no cost to the Member, unless co-payments apply.

**s. American Indians and Indian Healthcare Providers**

Consistent with 42 C.F.R. §438.14(b)(1-3), The PH-MCO must:

- Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the Agreement for Indian enrollees who are eligible to receive services from such providers;

- Pay I/T/U providers, whether participating in the network or not, for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either at a rate negotiated between the PH-MCO and the I/T/U provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

- Permit any Indian who is enrolled in a non-Indian MCO and eligible to receive services from a participating I/T/U provider to choose to receive covered services from that I/T/U provider and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services.

Consistent with 42 C.F.R. §438.14(b)(5-6), the PH-MCO must permit American Indian members to access out of state IHCPs; or permit an out-of-network IHCP to refer an American Indian member to a network provider.

When an IHCP is enrolled in Medicaid as an FQHC, but not a participating

provider of the PH-MCO, the IHCP must be paid an amount equal to the amount the PH-MCO would have paid to a network FQHC. When the IHCP is not enrolled in Medicaid as an FQHC, the PH-MCO must reimburse the IHCP at the same rate as the IHCP's applicable encounter rate published annually in the Federal Register by the Indian Health Service. If there is no published encounter rate, the IHCP must receive the amount it would have been reimbursed if the services were provided under the Pennsylvania MA FFS FQHC payment methodology.

## 2. Appointment Standards

The PH-MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

### a. General

PCP scheduling procedures must ensure that:

i. Emergency Medical Condition cases must be immediately seen or referred to an emergency facility.

ii. Urgent Medical Condition cases must be scheduled within twenty- four (24) hours.

iii. Routine appointments must be scheduled within ten (10) Business Days.

iv. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.

v. The PH-MCO must provide the Department with its protocol for ensuring that a Member's average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical need. The Member must be informed of scheduling time frames through educational outreach efforts.

vi. The PH-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room

visits.

**b. Persons with HIV/AIDS**

The PH-MCO must have adequate PCP scheduling procedures in place to ensure that an appointment with a PCP or specialist must be scheduled within seven (7) days from the effective date of Enrollment for any person known to the PH-MCO to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the Member is already in active care with a PCP or specialist.

**c. Supplemental Security Income (SSI)**

The PH-MCO must make a reasonable effort to schedule an appointment with a PCP or specialist within forty-five (45) days of Enrollment for any Member who is an SSI or SSI-related consumer unless the Member is already in active care with a PCP or specialist.

**d. Specialty Referrals**

For specialty referrals, the PH-MCO must be able to provide for:

i. Emergency Medical Condition appointments immediately upon referral.

ii. Urgent Medical Condition care appointments within twenty-four (24) hours of referral.

iii. Scheduling of appointments for routine care within fifteen (15) business days for the following specialty provider types:

Otolaryngology Orthopedic Surgery
Dermatology Pediatric Allergy &
Immunology Pediatric Endocrinology Pediatric
Gastroenterology Pediatric General Surgery Pediatric
Hematology
Pediatric Infectious Disease Pediatric Nephrology
Pediatric Neurology Pediatric Oncology
Pediatric Pulmonology Pediatric Rehab
Medicine Pediatric Rheumatology Pediatric Urology
Dentist Pediatric Dentistry

iv. Scheduling of appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.

**e. Pregnant Women**

Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members as follows:

i. First trimester — within ten (10) Business Days of the Member being identified as being pregnant.

ii. Second trimester — within five (5) Business Days of the Member being identified as being pregnant.

iii. Third trimester — within four (4) Business Days of the Member being identified as being pregnant.

iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the PH-MCO or maternity care Provider, or immediately if an emergency exists.

**f. EPSDT**

EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations.

The PH-MCO must distribute quarterly lists to each PCP in its Provider Networks which identify Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in this Exhibit, or Members who have not complied with EPSDT periodicity and immunization schedules for children. The PH-MCO must contact such Members, documenting the reasons for noncompliance and documenting its efforts for bringing the Members' care into compliance.

**3. Policies and Procedures for Appointment Standards**

The PH-MCO will comply with the program standards regarding service accessibility standards that are set forth in this Exhibit and in Section V.S. of the Agreement, Provider Agreements.

The PH-MCO must have written policies and procedures for disseminating

its appointment standards to all Members through its Member handbook and through other means. In addition, the PH-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The PH-MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

**4. Compliance with Access Standards**

**a. Mandatory Compliance**

Per 42 C.F.R. §438.68(b)(1)(viii), the PH-MCO must adhere to any time and distance access standards established by CMS. The PH-MCO must comply with the access standards in accordance with this Exhibit and Section V.S of the Agreement, Provider Agreements. If the PH-MCO fails to meet any of the access standards by the dates specified by the Department, the Department may terminate this Agreement.

**b. Reasonable Efforts and Assurances**

The PH-MCO must make reasonable efforts to honor a Member's choice of Providers among Network Providers as long as:

i. The PH-MCO's agreement with the Network Provider covers the services required by the Member; and

ii. The PH-MCO has not determined that the Member's choice is clinically inappropriate.

The PH-MCO must provide the Department adequate assurances that the PH-MCO, with respect to each zone of operation, has the capacity to serve the expected Enrollment in each zone of operation. The PH-MCO must provide assurances that it will offer the full scope of covered services as set forth in this Agreement and access to preventive and primary care services. The PH-MCO must also maintain a sufficient number, mix and geographic distribution of Providers and services in accordance with the standards set forth in this Exhibit and Section V.S. of the Agreement, Provider Agreements.

**c. PH-MCO's Corrective Action**

The PH-MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a termination action or other sanction by the Department, the PH-MCO will be given the opportunity to institute a corrective action plan. The PH-MCO must submit a corrective action plan to the Department for

approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the PH-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the PH-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the PH-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the PH-MCO must submit a revised corrective action plan within fifteen (15) days of notification. If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the PH-MCO, in accordance with Section VIII.H. of the Agreement, Sanctions. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in this Agreement.

EXHIBIT BBB

## EXHIBIT BBB

## DRUG SERVICES

### 1. General Requirements

a. All requirements in this Exhibit apply to all Covered Drugs regardless of the setting in which the drug is dispensed or administered, the billing provider type, or how the PH-MCO makes payment for the drug (pharmacy benefit and/or medical benefit).

b. The amount, duration, and scope of Covered Drugs must be consistent with coverage under the Fee-for-Service (FFS) program. The PH-MCO must cover all Covered Drugs listed on the Center for Medicare and Medicaid Services (CMS) Quarterly Drug Information File when determined to be Medically Necessary, unless otherwise excluded from coverage. (See 2. Coverage Exclusions below for exclusions.) This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers enrolled in the MA program, and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.

c. The PH-MCO must provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C.A. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature.

d. Unless financial responsibility is otherwise assigned, all Covered Drugs are the payment responsibility of the Member's PH-MCO. The only exception is that the behavioral health managed care organization (BH-MCO) is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO service Providers.

e. All Covered Drugs must be dispensed through PH-MCO Network Providers. This includes Covered Drugs prescribed by both the PH- MCO and the BH-MCO Providers.

f. Under no circumstances will the PH-MCO permit the therapeutic substitution of an drug by a pharmacist without explicit authorization from the licensed prescriber.

g. All proposed Covered Drug policies, programs and drug utilization management programs, such as but not limited to prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, mail order, 90-day supply programs, limited pharmacy networks, outcomes based contracting, medication therapy management programs, etc. must be submitted to the Department for review and written approval prior to implementation, prior to implementation of any changes,

and annually thereafter.

h. The PH-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Drugs, such as, but not limited to, prior authorization

(including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will,

i. Apply, regardless of whether the Covered Drug is provided as an drug benefit or as a "medical benefit" incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).

ii. Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-reviewed medical literature, Statewide Preferred Drug List (PDL) prior authorization guidelines, if applicable, and FFS guidelines to determine medical necessity of drugs that require prior authorization in the MA FFS Program, when designated by the Department.

i. The PH-MCO must submit for review and approval a policy for each section of Exhibit BBB that includes the requirements in the respective section and the PH-MCO's procedures to demonstrate compliance.

j. The PH-MCO must agree to adopt the same requirements for prior authorization and some or all of the same guidelines to determine medical necessity of selected drugs or classes of drugs as those adopted by the MA FFS Program when designated by the Department.

k. The PH-MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2117 regarding continuity of care requirements and 28 PA Code Ch. 9. The PH-MCO must also comply with the procedures outlined in MA Bulletin 99-03-13 and MA Bulletin # 99-96-01. The PH-MCO policy and procedures for continuity of care for drugs, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the PH-MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to drugs that the Member was prescribed before enrolling in the PH-MCO.

l. The PH-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Drug either by addition to the Statewide PDL or MCO Formulary for drugs and products not included in the Statewide PDL, or through prior authorization, within ten (10) days from their availability in the marketplace.

m. The PH-MCO must comply with 1902(a)(85); Section 1004 of the Substance UseDisorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The PH-MCO will implement prospective safety edits on subsequent fills of opioid prescriptions, as specified by the state, which may include edits to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness.

## 2. Coverage Exclusions

a. In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. 1396r-8, the PH-MCO must exclude coverage for any drug marketed by a drug company (or labeler) who does not participate in the Medicaid Drug Rebate Program. The PH-MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide rebates to the Medicaid agency. This requirement does not apply to vaccines, compounding materials, certain vitamins and minerals or diabetic supplies.

b. The PH-MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

c. The PH-MCO must exclude coverage of noncompensable drugs in accordance with 55 PA Code §1121.54.

## 3. Formularies and Preferred Drug Lists (PDLs)

a. The PH-MCO must utilize the Statewide PDL developed by the Department's Pharmacy and Therapeutics (P&T) Committee.
If the PH-MCO fails to meet Statewide PDL quarterly compliance of 95% (excluding TPL) a financial sanction consistent with the difference in net cost using PH-MCO actual compliance rate and the net cost if compliance rate was 95%. The minimum penalty of $25,000 per quarter will be imposed. The PH-MCO is responsible for submitting prior authorization approval and denial information in a format designated by the Department.

b. The PH-MCO must implement use of the Statewide PDL, any changes to the Statewide PDL, the Statewide PDL prior authorization guidelines, and any changes to the Statewide PDL prior authorization guidelines on the effective date provided by the Department.

c. The PH-MCO must apply Statewide PDL prior authorization guidelines to all drugs and products included on the Statewide PDL. The PH-MCO may not impose additional prior authorization requirements for drugs and products included on the Statewide PDL. Quantity limits can be no more restrictive than the Department's quantity limits.

The PH-MCO must submit the policies, procedures, and guidelines to determine medical necessity of drugs included on the Statewide PDL to the Department. Submissions must occur prior to the effective date of the changes as determined by the Department and at least annually.

d. The PH-MCO may use a Formulary or PDL to manage MA covered drugs and products that are outside the scope of the Statewide PDL as long as the Department has prior approved it and the Formulary or PDL meets the clinical needs of the MA population.

   The Formulary or PDL must be developed and reviewed at least annually by the PH-MCO's P&T Committee, as defined in Section 6 of this Exhibit.

e. The PH-MCO must allow access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy), in accordance with Prior Authorization of Services Section V. B.1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and this Exhibit.

f. The PH-MCO must receive written approval from the Department of the Formulary or PDL, the list of specialty drugs, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs and products not included on the Statewide PDL that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred, prior to implementation of the Formulary or PDL, the designation of specialty, and the requirements. PH-MCOs may add drugs to the specialty drug list that are in therapeutic classes already included on the specialty drug list prior to receiving approval from the Department. However, these additions must be included in the specialty drug designations submitted to the Department for written approval. Submissions for annual reviews must occur at least thirty (30) days before effective date of the updated information.

g. The PH-MCO must submit all Formulary or PDL deletions for drugs and products outside the scope of the Statewide PDL to the Department for review and written approval prior to implementation.

h. The PH-MCO must submit written notification of any Formulary or PDL additions for drugs outside the scope of the statewide PDL to the Department within fifteen (15) days of implementation.

i. In addition to providing a link to the Statewide PDL on the PH-MCO's website, the PH-MCO must make available on the website in a machine readable file and format, information about its drug formulary or PDL, listing which medications are covered, including both brand and generic names.

## 4. Prior Authorization of Drugs

a. For Covered Drugs that require Prior Authorization (including step therapy) as a condition of coverage or payment:

   i. The PH-MCO must provide a response to the request for prior authorization by telephone or other telecommunication device indicating approval or denial of the prescription within twenty-four (24) hours of the request, and

   ii. If a Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the PH-MCO must instruct the pharmacist to dispense either a:

   - Fifteen (15) day supply if the prescription qualifies as an Ongoing Medication, unless the PH-MCO or its designated subcontractor issued a proper written notice of benefit reduction or termination at least ten (10) days prior to the end of the period for which the medication was previously authorized and a Grievance or DHS Fair Hearing request has not been filed, or

   - A seventy-two (72) hour supply of a new medication.

b. For drugs not able to be divided and dispensed into individual doses, the PH-MCO must instruct the pharmacist to dispense the smallest amount that will provide at least a seventy-two (72) hour or fifteen (15) day supply, whichever is applicable.

c. The requirement that the Member be given at least a seventy-two (72) hour supply for a new medication or a fifteen (15) day supply for an Ongoing Medication does not apply when a pharmacist determines that the taking of the prescribed medication, either alone or along with other medication that the Member may be taking, would jeopardize the health or safety of the Member.

d. In such an event, the PH-MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber.

e. If the PH-MCO denies the request for prior authorization, the PH-MCO must issue a written denial notice, using the appropriate Drug Denial Notice template within twenty-four (24) hours of receiving the request for prior authorization.

f. If the Member files a Grievance or DHS Fair Hearing request from a denial of an Ongoing Medication, the PH-MCO must authorize the medication until the

Grievance or DHS Fair Hearing request is resolved.

g. Requests for prior authorization will not be denied for lack of medical necessity unless a physician reviews the request for a medical necessity determination. Such a request for prior authorization must be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the Member.

h. In addition, for children under the age of twenty-one (21), requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Member's condition or disease determines:

    i. That the prescriber did not make a good faith effort to submit a complete request, or

    ii. That the service or item is not medically necessary, after making a reasonable effort to contact the prescriber prior to issuing a denial for the requested service. The reasonable effort to contact the prescriber must be documented in writing.

i. When medication is authorized due to the PH-MCO's obligation to continue services while a Member's Grievance or Fair Hearing is pending, and the final binding decision is in favor of the PH-MCO, a request for subsequent refill of the prescribed medication does not constitute an Ongoing Medication.

j. The PH-MCO guidelines to determine medical necessity of Covered Drugs outside the scope of the Statewide PDL cannot be more stringent than the FFS guidelines. The PH-MCO must follow the Statewide PDL Prior Authorization guidelines for drugs and products included on the Statewide PDL.

k. The PH-MCO must comply with the requirements for Prior Authorization of Services, Section V. B. 1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and receive written approval from the Department prior to implementation and annually thereafter. If a PH-MCO covers a specific drug through both their medical and pharmacy benefits, the PH-MCO must apply the same Department approved prior authorization guidelines to prior authorization requests.

**5. Provider and Member Notification**

The PH-MCO must have policies and procedures for notification to Providers and Members of changes to the Statewide PDL or MCO Formulary used by the PH-MCO for drugs and products outside the scope of the Statewide PDL, Prior Authorization requirements and other requirements for Covered Drugs such as, but not limited to, specialty program requirements.

a. Written notification for changes to requirements must be provided to all affected Providers and Members at least thirty (30) days prior to the effective date of the change.

b. The PH-MCO must provide all other Providers and Members written notification of changes to the requirements upon request.

c. The PH-MCO also must generally notify Providers and Members of changes through Member and Provider newsletters, its web site, or other regularly published media of general distribution.

d. Member notices must be submitted to the Department for review and approval prior to mailing.

**6. PH-MCO Pharmacy & Therapeutics (P&T) Committee**

a. The P&T Committee membership must include physicians, including a minimum of two (2) behavioral health physicians, pharmacists, MA program consumers and other appropriate clinicians. MA program consumer representative membership must include the following:

i. One (1) physical health consumer representative. The physical health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, or a physical health consumer advocate designated by consumers enrolled in the PH-MCO to represent them.

ii. One (1) behavioral health consumer representative. The behavioral health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, a behavioral health consumer advocate, or a family member designated by consumers enrolled in the PH-MCO to represent them.

b. The PH-MCO must submit a P&T Committee membership list for Department review and approval upon request.

c. When the P&T Committee addresses specific drugs or entire drug classes requiring medical expertise beyond the P&T Committee membership, specialists with knowledge appropriate to the drug(s) or class of drugs being addressed must be added as non-voting, ad hoc members.

d. The minutes from each PH-MCO P&T Committee meeting must be posted for public view on the PH-MCO's website within thirty (30) days of the date of the meeting at which the minutes are approved. Minutes will include vote totals.

## 7. Pharmacy Provider Network

a. The PH-MCO or Subcontractor must contract on an equal basis with any pharmacy qualified to participate in the MA Program that is willing to comply with the PH-MCO's payment rates and terms and to adhere to quality standards established by the PH-MCO as required by 62 P.S. 449.

i. The provisions for any willing pharmacy apply if the PH-MCO or Subcontractor enters into agreements with specific pharmacies to provide defined drugs or services such as but not limited to, specialty, mail order, and 90-day supplies. PH-MCOs are required to contract on an equal basis with any pharmacy qualified to participate in the MA program that is willing to accept the same payment rate(s) and comply with the same terms and conditions for quality standards and reporting.

ii. Subcontracts and agreements with specific pharmacies contracted to provide defined drugs or services must be submitted to the Department for advance written approval. Any changes to subcontracts or agreements must also be submitted to the Department for advance written approval.

iii. The PH-MCO must submit annually the list of specific pharmacies contracted to provide defined drugs or services, and a list of the drugs or services each pharmacy is contracted to provide, to the Department for review and written approval. Submissions for annual reviews must occur at least thirty (30) days before the effective date of the updated information.

iv. The PH-MCO must notify the Department on an ongoing basis of the following: (1) specific pharmacies that are no longer contracted to provide defined drugs or services and the reason why, (2) pharmacies that request contracting to provide defined drugs or services but are not admitted into the specific pharmacy network and the reason why, (3) any pharmacies that are only contracted to provide a limited scope of defined drugs or services and the reason why.

b. The PH-MCO must develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy's acquisition cost, professional services and cost to dispense the prescription to a Medicaid beneficiary. The PH-MCO must submit to the Department the policies and procedures for development of network pharmacy payment methodology including the process to ensure that brand and generic payment rates reflect the pharmacy's acquisition cost (from a readily available distributor doing business in Pennsylvania) and the professional dispensing fee accurately reflects the pharmacist's professional services and cost to dispense the prescription to a Medicaid beneficiary.

c. The PH-MCO or subcontractor must submit to the Department for review and approval all changes to the payment methodology prior to implementation.

d. The PH-MCO or subcontractor must report all changes to the payment methodology and rates, including but not limited to the maximum allowable cost rates, to network pharmacy providers.

e. (1) If a network pharmacy's claim is approved through the adjudication process, the PH-MCO and any subcontractor may not retroactively deny or modify the payment unless any of the following:

i. The claim was fraudulent.
ii. The claim was duplicative of a previously paid claim.
iii. The pharmacy did not render the service.

(2) Nothing in 7.e.(1) shall be construed to prohibit the modification of or recovery of an adjudicated claim that was determined to be an overpayment or underpayment resulting from audit, review or investigation by a federal or state agency or PH MCO.

f. The PH-MCO and any subcontractor will not charge a fee related to a network pharmacy's claim unless the amount of the fee is disclosed and applied at the time of claim adjudication.

**8. Drug Rebate Program**

Under the provisions of Section 1927 of the Social Security Act 42 U.S.C.A. 1396r-8, drug companies that wish to have their products covered through the MA Program (both FFS and managed care) must sign an agreement with the federal government to provide rebates to the State. The Affordable Care Act (ACA) provides for federal drug rebates for drugs paid for by the PH-MCOs.

a. In order to ensure full compliance with the provisions of the ACA, PH-MCOs must report the necessary Drug Encounter Data in order for the Department to invoice drug manufacturers for rebates for all Covered Drugs. This includes physician-administered drugs, drugs dispensed by 340B covered entities or contract Pharmacies, and drugs dispensed to PH-MCO Members with private or public pharmacy coverage and the PH-MCO provided secondary coverage.

b. The PH-MCO must report all drug information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by the Department.

If the PH-MCO fails to submit Drug Encounter Data when invoiced to manufacturers for rebate, at least 90% are collectable within 90 calendar days of invoicing by the Commonwealth a sanction of $25,000 per quarter shall be imposed until the PH-MCO reaches the 90% threshold.

The PH-MCO or subcontractor may not negotiate rebates and discounts for Covered Drugs. The PH-MCO or subcontractor may not negotiate its own rebates

and discounts for non-drug products included on the Statewide PDL. If the PH-MCO negotiates and collects its own rebates and discounts for non-drug products that are not included on the Statewide PDL, the PH-MCO must report to the Department the full value of the rebates and discounts in a format designated by the Department. If the PH-MCO assigns responsibility for negotiating and/or collecting the rebates and discounts for non-drug products not included on the Statewide PDL to a subcontractor, the subcontractor must pass the full value of all rebates and discounts on drugs dispensed to the PH-MCO's Members back to the PH-MCO. The subcontractor may not retain any portion of the rebates or discounts. The PH-MCO must report the full value of all the rebates and discounts to the Department in a format designated by the Department.

The PH-MCO or subcontractor may negotiate outcomes-based contracts for Covered Drugs. The PH-MCO must submit the contract to DHS for review and approval prior to implementation and report to the Department the full value of the financial impact of the outcomes-based contract in a format designated by the Department.

**9. Drug Encounters**

a. The PH-MCO shall submit all Drug Encounters to the Department within 30 days (for NCPDP) and 90 days (for 837P and 837I) of the adjudication date of the claim to the MCO for payment.

b. The PH-MCO shall provide all Drug Encounter data and supporting information as specified by the Department to collect rebates through the Medicaid Drug Rebate Program and the Statewide PDL. For all Drug Encounter data including pharmacy point-of-sale (NCPDP), physician-administered drugs (837P), hospital drugs (837I), and drugs dispensed by 340B covered entities and contract pharmacies, the following data elements are required:

i. Valid NDC for the drug dispensed.

- The PH-MCO shall also include the HCPCS code associated with the NDC for all 837P and 837I encounters where payment was made by the MCO based on the HCPCS code and HCPCS code units.

- The PH-MCO shall also include the diagnosis codes associated with the NDC for all 837P and 837I encounters where payment was made by the PH-MCO based on the HCPCS code and HCPCS code units.

ii. Valid NDC units for the drug dispensed

- The PH-MCO shall also include the HCPCS units associated with the NDC for all 837P and 837I encounters where payment was made by the PH-MCO based on the HCPCS code and HCPCS code units.

iii. Actual paid amount by the PH-MCO, or the PH-MCO's PBM, to the provider

for the drug dispensed.

iv. Actual TPL amount paid by the Member's primary pharmacy coverage to the provider for the drug dispensed.

v. Actual copayment paid by the Member to the provider for the drug dispensed.

vi. Actual dispensing fee paid by the PH-MCO, or the PH-MCO's PBM, to the provider for the drug dispensed.

vii. The billing provider's:

- NPI and/or Medical Assistance Identification Number
- Full address and phone number associated with the NPI

viii. The prescribing provider's:

- NPI and/or Medical Assistance Identification Number
- Full address and phone number associated with the NPI

ix. The date of service for the dispensing of the drug by the billing provider.

x. The date of payment by the PH-MCO, or the PH-MCO's PBM, to the provider for the drug.

xi. Any other data elements identified by the Department to invoice for drug rebates.

c. The PH-MCO shall edit and validate claim transaction submissions and Drug Encounter data for completeness and accuracy in accordance with claim standards such as NCPDP. The actual paid amount by the PH-MCO, or the PH-MCO's PBM, to the dispensing provider must be accurately submitted on each Drug Encounter to the Department.

d. The PH-MCO shall ensure that the NDC on all Drug Encounters is appropriate for the HCPCS code based on the NDC and units billed.

e. The Department will review the Drug Encounters and remove applicable 340B covered entity encounters from the drug rebate invoicing process.

f. The PH-MCO shall meet Drug Encounter Data accuracy requirements by submitting PH-MCO paid Drug Encounters with no more than a 3% error rate, calculated for a month's worth of Encounter submissions. The Department will monitor the PH-MCO's corrections to denied Encounters by random sampling performed quarterly and over the term of this Agreement. The PH-MCO shall

have corrected and resubmitted 75% of the denied Encounters for services covered under this Agreement included in the random sample within 30 calendar days of denial.

g. If the PH-MCO fails to submit Drug Encounter data within timeframes specified, the Department shall assess civil monetary penalties upon the PH-MCO. These penalties shall be $2,000 for each calendar day that the Drug Encounter data is not submitted. The Department may waive these sanctions if it is determined that the PH-MCO was not at fault for the late submission of the data.

**10. Prospective Drug Utilization Review (Pro-DUR)**

a. The PH-MCO must provide for a review of drug therapy before each prescription is filled or delivered to a Member at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.

b. The PH-MCO must provide for counseling of Members receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

**11. Retrospective Drug Utilization Review (Retro-DUR)**

a. The PH-MCO must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and Members.

b. The PH-MCO shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.

c. The PH-MCO shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.

**12. Annual Drug Utilization Review (DUR) Report**

The PH-MCO must submit an annual report on the operation of its Pennsylvania Medicaid Drug Utilization Review (DUR) program in a format designated by the Department. The format of the report will include a description of the nature and

scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

## 13. Drug Utilization Review Board (DUR Board)

The Department maintains a DUR Board that reflects the structure of the health care delivery model that includes both a managed care and a fee-for-service delivery system. Each PH-MCO and BH-MCO is required to include a representative to serve as a member of the DUR Board. The DUR Board is a standing advisory committee that recommends the application of predetermined standards related to Pro-DUR, Retro-DUR, and related administrative and educational interventions designed to protect the health and safety of the MA program recipients. The Board reviews and evaluates pharmacy claims data and prescribing practices for efficacy, safety, and quality against predetermined standards using nationally recognized drug compendia and peer reviewed medical literature as a source. The Board recommends appropriate utilization controls and protocols including prior authorization, automated prior authorization, system edits, guidelines to determine medical necessity, generic substitution, and quantity limits for individual medications or for therapeutic categories.

## 14. Pharmacy Benefit Manager (PBM)

The PH-MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions in Section XII: Subcontractural Relationships, and has received advance written approval by the Department. The standards for Network composition and adequacy for drug services includes the requirements for any willing pharmacy as described above. The PH-MCO must indicate the intent to use a PBM, and identify the proposed PBM Subcontract, the PH-MCO's payment methodology or methodologies (ingredient cost and dispensing fee) for payment to the PBM Subcontractor, the PBM's payment methodology or methodologies (ingredient cost and dispensing fee) for actual payment to the providers of covered drugs, and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly, in part, or by the same parent company as a PH-MCO, retail pharmacy Provider, chain drug store or pharmaceutical manufacturer, the PH-MCO must submit a written description of the assurances and procedures that will be put in place under the proposed PBM Subcontract, such as an independent audit, to assure confidentiality of proprietary information. These assurances and procedures must be submitted and receive advance written approval by the Department prior to initiating the PBM Subcontract. The Department will allow the continued operation of existing PBM Subcontracts while the Department is reviewing new contracts.

The PH-MCO must:

a. Report the PBM's payment methodology, or methodologies for actual payment to all network pharmacy providers of covered drugs, including community pharmacies, long-term care pharmacies, network pharmacies contracted to provide specialty drugs, and dispensing prescribers for existing PBM Subcontractors and new PBM Subcontractors.

b. Include on each drug encounter the PBM received amount (amount paid to the PBM by the PH-MCO [ingredient cost and dispensing fee]) and the provider received amount (the actual amount paid by the PBM [ingredient cost and dispensing fee] to the dispensing pharmacy or prescribing provider).

c. Report differences between the amount paid by the PH-MCO to the PBM and the amount paid by the PBM to the providers of covered drugs as administrative fees.

d. Report all PBM administrative fees, including the differences in amounts paid as described in d. above, in a format designated by the Department.

e. Submit a written description of the procedures that the PH-MCO will put in place to monitor the PBM for compliance with the term and conditions of the Agreement related to covered drugs and actual payments to the providers of covered drugs.

f. Upon request by the Department, conduct an independent audit of the PBM's transparent pricing arrangement in compliance with the provision in Exhibit WW HealthChoices Audit Clause.

g. Ensure that the PBM is fully compliant with the requirements in Section V. K. Provider Dispute Resolution System.

h. Develop, implement, and maintain a Second Level PBM Provider Pricing Dispute Resolution Process that provides for settlement of a PBM network Provider's pricing dispute with the PBM, on the condition that the PBM's network Provider exhausted all of its remedies against the PBM.

i. Submit to the Department, prior to implementation, the PH-MCO's policies and procedures relating to the resolution of PBM Provider pricing disputes.

    i. The PH-MCO must submit any changes to the policies and procedures to the Department for approval prior to implementation of the changes.

    ii. The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures that have been prior approved by the Department for operation in a HC Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until the Department approves the new or revised version.

j. At a minimum, include in the PH-MCO's Second Level PBM Provider Pricing Dispute Resolution policies and procedures the following:

i. The process for submission and settlement of Second Level PBM Provider Pricing Disputes;

ii. A requirement that the PBM Provider must exhaust all of its remedies against the PBM before requesting a PH-MCO Second Level PBM Provider Pricing Dispute Resolution;

iii. Acceptance and usage of the Department's definition/delineation of Provider Disputes;

iv. Timeframes for submission and resolution of Second Level PBM Provider Pricing Disputes;

v. Processes to ensure equal treatment of all PBM providers in the resolution of pricing disputes.

vi. Process to ensure the paid amount reflects the pharmacy's drug acquisition cost, professional services, and cost to dispense the prescription to an MA beneficiary.

vii. A requirement for both the PBM Provider and the PBM to provide documentation supporting each entity's position(s) related to the pricing dispute;

viii. Designation of PH-MCO staff responsible for resolution of the PBM Provider Pricing Dispute who have:

- The knowledge and expertise to address and resolve PBM Provider Pricing Disputes;
- Access to data and documentation of the informal resolution of the PBM Provider Dispute and the formal PBM Provider Appeal and decisions necessary to assist in making decisions; and

ix. Mechanisms and time-frames for reporting PH-MCO PBM Provider Pricing Dispute decisions to the PBM Provider, the PBM and the Department. If the dispute is denied by the PH-MCO, the Provider Pricing Dispute decisions must include the specific rationale for the denial;

k. Require the PBM and the PBM provider to abide by the final decision of the PH-MCO. If the Provider Pricing Dispute is overturned by the PH-MCO, adjustment must be made to the appealed claim and to future claims for the appealed drug. The PBM/PH-MCO must update their payment methodology for the appealed drug; and

l. Require the PBM to inform all PBM providers of the process and conditions to request a Second Level PBM Provider Pricing Dispute.

**15. Requirements For PH-MCO and BH-MCO Interaction and Coordination of Drug Services**

a. BH-MCO prescribing Providers must comply with the PH-MCO requirements for utilization management of behavioral health drugs.

b. The BH-MCO will be required to issue an initial list of BH-MCO Providers to the PH-MCO, and quarterly updates that include additions and terminations. Should the PH-MCO receive a request to dispense medication prescribed by a BH Provider not listed on the BH-MCO's Provider file, the PH-MCO must work through the appropriate BH-MCO to identify the Provider. The PH-MCO is prohibited from denying prescribed medications solely on the basis that the BH-MCO Provider is not clearly identified on the BH-MCO Provider file.

c. Payment for inpatient pharmaceuticals during a BH admission is the responsibility of the BH-MCO and is included in the hospital charge.

d. The PH-MCO may deny payment of a claim for a Covered Drug prescribed by a BH-MCO Provider only if one of the following occurs:

   i. The drug is not being prescribed for the treatment of substance abuse/dependency/ addiction or mental illness and any side effects of psychopharmacological agents. Those drugs are to be prescribed by the PH-MCO's PCP or specialists in the Member's PH-MCO Network.

   ii. The prescription has been identified as a case of Fraud, Abuse, or gross overuse, or the dispensing pharmacist determined that taking the medication either alone or along with other medications that the Member may be taking, would jeopardize the health and safety of the Member.

e. The PH-MCO must receive written approval from the Department of the policies and procedures for the PH-MCO and BH-MCO to:

   i. When deemed advisable, require consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records.

   ii. Timely resolve disputes which arise from the payment for or use of drugs, including a mechanism for timely, impartial mediation when resolution between the PH-MCO and BH-MCO does not occur.

   iii. Share independently developed Quality Management/Utilization Management information related to drug services, as applicable.

iv. Collaborate in adhering to a drug utilization review program approved by the Department. Collaborate in identifying and reducing the frequency of patterns of Fraud, Abuse, gross overuse, inappropriate or medically unnecessary care among physicians, pharmacists and Members associated with specific drugs.

f. The PH-MCO must send data files, via the Department's file transfer protocol (FTP), containing records of detailed drug services as provided to individual enrollees of the BH-MCOs contracted with the Department. The PH-MCO must adhere to the file delivery schedule established at the implementation of the data exchange process or notify the Department in advance of schedule changes. Files must be sent directly to the Department for distribution by the Department.

EXHIBIT BBB(1)

EXHIBIT BBB(2)

EXHIBIT BBB(3)

EXHIBIT BBB(4)

EXHIBIT BBB(5)

EXHIBIT BBB(6)

# EXHIBIT CCC

## EXHIBIT CCC

## PHYSICAL HEALTH MCO (PH-MCO) PROVIDER AGREEMENTS

The PH-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Member access to all Medically Necessary services covered by the HealthChoices Program. The PH-MCO is also required to ensure that its participating providers are enrolled in Medical Assistance, and to require that their information is kept up to date in the DHS PROMISe™ system.

The PH-MCO's Provider Agreements must include the following provisions:

a. A requirement that the PH-MCO must not exclude or terminate a Provider from participation in the PH-MCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

b. A requirement that the PH-MCO must not exclude a Provider from the PH-MCO's Provider Network because the Provider advocated on behalf of a Member for Medically Necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable Health Care Provider practicing according to the applicable legal standard of care.

c. A provision that prohibits the Provider from denying services to a Member during the MA FFS eligibility window prior to the effective date of the PH-MCO Enrollment.

d. Notification of the prohibition and sanctions for submission of false Claims and statements.

e. The definition of Medically Necessary as defined in Section II of this Agreement, Definitions.

f. A requirement that the PH-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member including; information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

g. A requirement that the PH-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or nontreatment.

h. A requirement that the PH-MCO cannot terminate a contract or employment with a Health Care Provider for filing a Grievance on a Member's behalf.

i. A clause which specifies that the agreement will not be construed as requiring the PH-MCO to provide, reimburse for, or provide coverage of, a counseling or referral service if the Provider objects to the provision of such services on moral or religious grounds.

j. A requirement securing cooperation with the QM/UM Program standards outlined in Exhibit M(1) of this Agreement, Quality Management and Utilization Management Program Requirements.

k. A requirement for cooperation for the submission of Encounter Data for all services provided within the time frames required in Section VIII of this Agreement, Reporting Requirements, no matter whether reimbursement for these services is made by the PH-MCO either directly or indirectly through capitation.

l. A continuation of benefits provision which states that the Provider agrees that in the event of the PH-MCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the PH-MCO's Members, including Members in an inpatient setting, through the period for which the Capitation has been paid.

m. A requirement that the PCPs who serve Members under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another Network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Member's PCP medical record. For details on access requirements, see Exhibit AAA of this Agreement, Provider Network Composition/Service Access, as applicable.

n. A requirement that PCPs who serve Members under the age of twenty-one (21) report Encounter Data associated with EPSDT screens, using a format approved by the Department, to the PH-MCO within ninety (90) days from the date of service.

o. A requirement that PCPs contact new Members identified in the quarterly Encounter lists who have not had an Encounter during the first six (6) months of Enrollment, or who have not complied with the scheduling requirements outlined in the RFP and this Agreement. The PH-MCO must require the PCP to contact Members identified in the quarterly Encounter lists as not complying with EPSDT periodicity and immunization schedules for children. The PCP must be required to identify to the PH-MCO any such Members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such notification to the site by the PH-MCO. The PCP must also be

required to document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards. PCPs shall be required to contact all Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in Exhibit AAA of this Agreement, Appointment Standards, as applicable, to arrange appointments.

p. A requirement that the PH-MCO include in all capitated Provider Agreements a clause which requires that should the Provider terminate its agreement with the PH-MCO, for any reason, that the Provider provide services to the Members assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.

q. A requirement that ensures each physician providing services to Members eligible for Medical Assistance under the State Plan to have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act.

r. Language which requires the Provider to disclose annually any Physician Incentive Plan or risk arrangements it may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no Substantial Financial Risk between the PH-MCO and the physician or physician group.

s. A requirement for cooperation with the PH-MCO's and DHS's Recipient Restriction Program.

t. A requirement that health care facilities and ambulatory surgical facilities develop and implement, in accordance with P.L.154, No. 13 known as the Medical Care Availability and Reduction of Error (Mcare) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures for the detection, control and prevention of Health Care-Associated Infections.

u. A provision that the PH-MCO's Utilization Management (UM) Departments are mandated by the Department to monitor the progress of a member's inpatient hospital stay. This must be accomplished by the PH-MCO's UM department receiving appropriate clinical information from the hospital that details the member's admission information, progress to date, and any pertinent data within two (2) business days from the time of admission. The PH-MCOs providers must agree to the PH-MCO's UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the PH-MCO's Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the PH-MCO must receive all clinical information

on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

v. Requirements regarding coordination with Behavioral Health Providers (if applicable):

- Comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written member consents to disclose confidential medical records.

- Make referrals for social, vocational, education or human services when a need for such service is identified through assessment.

- Provide health records if requested by the Behavioral Health Provider.

- Notify BH Provider of all prescriptions, and when deemed advisable, check with BH Provider before prescribing medication. Make certain BH clinicians have complete, up-to-date record of medications.

- Be available to the BH Provider on a timely basis for consultations.

w. The PH-MCO must require that participating ER staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for the county.

x. The PH-MCO must require that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.

The PH-MCO may not enter into a Provider Agreement that prohibits the Provider from contracting with another PH-MCO or that prohibits or penalizes the PH-MCO for contracting with other Providers.

The PH-MCO must make all necessary revisions to its Provider Agreements to be in compliance with the requirements set forth in this section. Revisions may be completed as Provider Agreements become due for renewal provided that all Provider Agreements are amended within one (1) year of the effective date of this Agreement with the exception of the Encounter Data requirements which must be amended immediately, if necessary, to ensure that all Providers are submitting Encounter Data to the PH-MCO within the time frames specified in Section VIII.B.1 of this Agreement, Encounter Data Reporting.

EXHIBIT DDD

## Exhibit DDD

## PATIENT CENTERED MEDICAL HOME (PCMH) PROGRAM

The PCMH model of care includes key components such as: whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team-based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care.

The PH-MCO will contract with high volume providers in their network who meet the requirements of a PCMH, make payments to their contracted PCMHs, collect quality related data from the PCMHs, reward PCMHs with quality-based enhanced payments, develop a learning network that includes PCMHs and other PH-MCOs, and report annually on the clinical and financial outcomes of their PCMH program.

A. The PH-MCO will educate members what the PCMH model is and inform members of the resources available through the PCMH.

B. The PH-MCO will ensure the PCMH provider meets the following requirements:

1. Will be a high-volume Medicaid practice already participating in the PH-MCO provider pay for performance program or a defined set of practices willing to share care management resources,

2. Will accept all new patients or be open for face-to-face visits at least 45 hours per week,

3. Will join a Pennsylvania Patient and Provider Network (P3N) certified health information organization (HIO) in order to share health related data as directed below:

    - For an existing PCMH, the PCMH must connect to a P3N certified HIO by 06/30/2022. If the existing PCMH is not connected to a P3N certified HIO by this date, they will no longer be eligible to participate in the PCMH program and are no longer eligible for a PCMH incentive payment.

    - For a new PCMH, the PCMH will have six (6) months to connect to a P3N certified HIO. If the PCMH is not connected to a P3N certified HIO within six (6) months, the PCMH will no longer be eligible to participate in the PCMH program and are no longer eligible for a PCMH incentive payment.

4. Will deploy a community-based care management team as described below:

The PCMH must deploy a community-based care management (CBCM) team that consists of licensed professionals such as nurses, pharmacists or social workers and unlicensed professionals such as peer recovery specialists, peer specialists, community health workers or medical assistants. The CBCM team's activities can replicate but not duplicate already existing and CBCM reimbursed care management services. The care management team will work within their local community to accept individuals with complex care needs from local emergency departments, physical and behavioral health hospitals, specialty providers, and PH-MCO. Through actively engaging patients and taking into account their preferences and personal health goals, the CBCM team will develop care plans that help individuals with complex chronic conditions to stay engaged in comprehensive treatment regimens that include, but are not limited to physical health, substance use disorder and mental health treatments. The CBCM team will also connect individuals as needed to community resources and social support services through "warm hand off" referrals for assistance with problems such as food insecurity and housing instability.

5. Will collect and report annual quality data and outcomes pertinent to their patient population as defined by the current PH-MCO provider pay for performance program, the Integrated Care Plan pay for performance program, and additional population specific measures defined by the Department,

6. Will conduct internal clinical quality data reviews on a quarterly basis, report results and discuss improvement strategies with the PH-MCO,

7. Will measure patient satisfaction using a validated low literacy appropriate tool to assess individual and family/caregiver experience,

8. Will include as part of the health care team patient advocates or family members to support the patients' health goals and advise practices,

9. Will see 75% of patients within seven days of discharge from the hospital with an ambulatory sensitive condition. This includes a follow-up visit with a Specialist provider. The Specialist provider must share the patient's follow-up visit notes with the PCMH to meet this requirement,

10. Will participate in a PCMH learning network,

11. Will complete a Social Determinants of Health assessment, at least annually and more frequent for patients who screen positive, using a Nationally recognized tool focusing on the following domains: food insecurity; health care/medical access/affordability; housing; transportation; childcare; employment; utilities; clothing and financial strain and submit ICD-10 diagnostic codes for all patients with identified needs. For patients with identified needs, the PCMH must assist the member with obtaining the needed services and monitor the outcome of the referral The PCMH must track referrals and outcomes and be able to submit to

the PH-MCO via claims submission the outcome of every Social Determinants of Health assessment performed using the HCPCS codes of G9919 (positive screening result) or G9920 (negative screening result) as well as providing the PH-MCO and Department a report of the SDOH assessment outcomes as may be requested,

12. Will educate and disclose to patients through low-literacy appropriate material the practice is a PCMH that has a community-based care management team available to help patients manage complex care needs,

13. Will refer any patient who reports having a special need to the patient's PH-MCO's Special Needs Unit, and

14. Will provide Tobacco Cessation Counseling (TCC) services or demonstrate referral of patients who are seeking TCC services.

C. The PH-MCO will make monthly payments to each PCMH based on factors such as: clinical complexity, age, medical costs, and composition of the care management team.

D. The PH-MCO's PCMH network will include high volume adult and pediatric providers that serve the percentage of total membership and percentage of members that fall within the top 5$^{th}$ percentile of medical costs.

- Calendar year 2022 – PCMHs' must serve at least 20% of their total membership and at least 33% of members that fall within the top 5$^{th}$ percentile of medical costs.

E. The PH-MCO will collect key quality metrics from the PCMHs and report those results annually to the Department.

F. The PH-MCO will reward PCMHs with quality-based enhanced payments focusing on key performance measures defined by the Department. Current provider pay for performance dollars may be used for these quality-based payments.

G. The PH-MCO will develop a quarterly regional learning network that includes all PCMHs, patient advocates or family team members, and PH-MCOs in a HealthChoices region. At least one of the PCMH Learning Collaboratives needs to be face-to-face.

H. The PH-MCO will report annually on the clinical and financial outcomes of their PCMH program. The report will address key quality, utilization, and financial outcomes as well as a return on investment calculation. The report will also describe the number of PCMHs that have gain share arrangements, risk arrangements, payments made for quality, and payments made for gain share or risk arrangements. The report will also list the total medical costs of the patients attributed to the PCMHs.

I. Data Sharing

The PH-MCO must provide timely and actionable data to its PCMHs. This data should include, but is not limited to, the following:

1. Identification of high risk patients;

2. Comprehensive care gaps inclusive of gaps related to quality metrics used in the value-based payment arrangement; and

3. Service utilization and claims data across clinical areas such as inpatient admissions, outpatient facility (SPU/ASC), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.

J. The PH-MCO must work towards developing a value-based arrangement with Person-Centered Ambulatory Intensive Care Centers (PC-AICCs) in each zone they operate, unless the PH-MCO demonstrates to OMAP's satisfaction that the PH-MCO is not able to reach an agreement with the PC-AICC. A PC-AICC is a practice that provide comprehensive physical and behavioral health care to those individuals who are high cost and in high need of medical and social services. These practices serve individuals who demonstrate non-episodic impactable medical costs over $30,000 and are typically the costliest 2 - 3% of individuals who account for up to 40% of the PH-MCOs medical spend.

# EXHIBIT EEE

# EXHIBIT EEE

## COMMONWEALTH OF PENNSYLVANIA
## BUSINESS ASSOCIATE ADDENDUM

**WHEREAS,** the Pennsylvania Department of Human Services (Covered Entity) and 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 contract 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) 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) 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.