

COMMUNITY HEALTHCHOICES AGREEMENT

SECTION II: DEFINITIONS

Abuse — Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medical Assistance Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or agreement obligations (including the RFP, agreement, and the requirements of state or federal regulations) for healthcare in a managed care setting. The Abuse can be committed by the CHC-MCO, subcontractor, Provider, State employee, or a Participant, among others. Abuse also includes Participant practices that result in unnecessary cost to the Medical Assistance Program, the CHC-MCO, a subcontractor, or Provider.

Abuse of a Participant. – The occurrence of any of the following acts against a Participant: (1) The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. (2) The willful deprivation by a caregiver of goods or services which are necessary to maintain physical or mental health. (3) Sexual harassment, rape or abuse. The term includes physical, psychological, sexual and verbal abuse. The term also includes seclusion of a Participant. The term does not include environmental factors which are beyond the control of a Participant or a caregiver, including, but not limited to, inadequate housing, furnishings, income, clothing or medical care.

ACCESS Card — An identification card issued by the Department to each Medical Assistance Recipient.

Activities of Daily Living (ADL) – Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility and eating. The extent to which a person requires assistance to perform one or more ADLs is often a level of care criteria.

Actuarially Sound Rates — Rates that reflect, among other elements:

- the populations and Covered Services.
- the rating groups.
- the projected Participant months for each category of aid.
- the historical and projected future medical costs expected to be incurred by an efficiently and effectively operated Medicaid managed care program in the respective county/zone.
- program changes to the extent they impact actuarial soundness of the rates;
- trend levels for each type of service.
- administrative costs expected to be incurred by an efficiently and effectively operated Medicaid managed care program, including assessment costs and profit consideration.

Adjudicated Claim — A Claim that has been processed to payment or denial.

Adult Protective Services (APS) - A program of protective services administered by the Department to detect, prevent, reduce and eliminate abuse, neglect, exploitation and abandonment of adults between 18 and 59 years of age who have a physical or mental impairment that substantially limits one or more major life activity.

Advanced Healthcare Directive - A healthcare power of attorney, living will or a written combination of a healthcare power of attorney and living will.

Adverse Action – Any action taken by the CHC-MCO, whether in response to a request for approval or otherwise, to deny, reduce, terminate, delay or suspend a Covered Service which serves to: disapprove a request completely; or approve provision of the requested service(s), but for a lesser amount, scope or duration than requested; or disapprove provision of the requested service(s), but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service. An approval of a requested service which includes a requirement for a Concurrent Review by the CHC-MCO during the authorized period does not constitute a denial of service. Also includes any other acts or omissions of the CHC-MCO which impair the quality, timeliness or availability of such Covered Services.

Affiliate — Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization ("Person"), controlling, controlled by or under common control with the CHC-MCO or its parent(s), whether such control be direct or indirect. Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interests of CHC-MCO or its parent(s), directors or subsidiaries of CHC-MCO or parent(s) are Affiliates. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, other ownership interests, or by contract or otherwise, including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust.

Behavioral Health Managed Care Organization (BH-MCO)— An entity, operated by county government or licensed by the Commonwealth as a risk-bearing HMO or PPO, which manages the purchase and provision of Behavioral Health Services under an agreement with the Department.

Behavioral Health Rehabilitation Services for Children and Adolescents (formerly EPSDT "Wraparound") — Individualized, therapeutic mental health, substance use disorder or behavioral interventions and services

Behavioral Health Services — Mental health and substance use disorder services.

Capitation Payment – A fee the Department pays per month to a CHC-MCO for each Participant enrolled in its managed care plan to provide coverage of all Covered Services, whether or not the Participant receives the services during the period covered by the fee.

Centers for Medicare & Medicaid Services (CMS) — The federal agency within the Department of Health and Human Services responsible for oversight of the Medicare and Medicaid Programs.

Certificate of Authority — A document issued jointly by the Departments of Health and Insurance authorizing a corporation to establish, maintain and operate an HMO in Pennsylvania.

Certified Nurse Midwife — Any person, other than a regularly licensed physician or osteopath, who shall attend a woman in childbirth for hire, or who shall make a practice of attending women in childbirth gratuitously or for hire.

Certified Registered Nurse Practitioner (CRNP) — A registered nurse licensed in the Commonwealth of Pennsylvania who is certified in a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in Pennsylvania.

Children in Substitute Care — Children who have been adjudicated dependent or delinquent and who are in the legal custody of a public agency or under the jurisdiction of the juvenile court and are living outside their homes, in any of the following settings: shelter homes, foster homes, group homes, supervised independent living, and Residential Treatment Facilities (RTFs).

CHC-MCO Coverage Period — A period of time during which an individual is eligible for Medicaid coverage and enrolled with a CHC-MCO.

Claim — A bill from a Provider of a medical service or product that is assigned a unique identifier (i.e. Claim reference number). A Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.

Clean Claim — A Claim that can be processed without obtaining additional information from the Provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in the CHC-MCO's Claims system. Claims under investigation for Fraud or Abuse or under review to determine if they are Medically Necessary are not Clean Claims.

Client Information System (CIS) — The Department's database of Recipients, including Participants. The data base contains demographic and eligibility information for all Participants.

Complaint — A dispute or objection regarding a participating Provider or the coverage, operations, or management policies of a CHC-MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with the Department of Health or the Pennsylvania Insurance Department, including but not limited to:

- a denial because the requested service/item is not a Covered Service; or
- a failure of the CHC-MCO to meet the required time frames for providing a service/item; or
- a failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames; or
- a denial of payment by the CHC-MCO after a service has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or
- a denial of payment by the CHC-MCO after a service has been delivered because the service/item provided is not a covered service/item for the Participant.

The term does not include a Grievance.

Concurrent Review — A review conducted by the CHC-MCO during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether any service, a different service or lesser level of service is Medically Necessary.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – A comprehensive and evolving family of survey instruments to evaluate participant experience and quality of care on various aspects of services.

County Assistance Office (CAO) — The county offices of the Department that determine eligibility for all benefit programs, including MA, on the local level.

Covered Pharmacy -- In accordance with 42 U.S.C.A. 1396r-8(k)(2) and 55 PA code Chapter 1121, the term means a brand name drug, a generic drug, or an over-the-counter drug (OTC) which:

1. Is approved by the Federal Food and Drug Administration.
2. Is distributed by a manufacturer that entered into a Federal Drug Rebate Program agreement with the Centers for Medicare and Medicaid Services (CMS).
3. May be dispensed only upon prescription in the Medical Assistance Program.
4. Has been prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice.
5. Is dispensed or administered in an outpatient setting.

The term includes biological products and insulin.

Covered Services - Services which CHC-MCOs are required to offer to Participants under Community HealthChoices as specified in Exhibits DDD(1) and DDD(2).

Cultural Competency — The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations.

Daily Participant File — An electronic file in a HIPAA compliant 834 format using data from DHS/CIS that is transmitted to the CHC-MCO on state work days. This 834 Daily File includes TPL information and is transmitted via the Department's PROMISe™ contractor.

Day — Indicates a calendar day unless specifically denoted otherwise.

Deliverables — Those documents, records and reports required to be furnished to the Department for review and/or approval pursuant to the terms of the RFP and this agreement.

Denied Claim — An Adjudicated Claim that does not result in a payment obligation to a Provider.

Dental Services Manager – An entity responsible for the provision and administration of dental services.

Department — The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.

Disability Competency – The demonstration that an entity or individual has the capacity to understand the diverse nature of disabilities and the impact that different disabilities can have on a Participant, access to services, and experience of care. It includes a demonstrated willingness and ability to make necessary accommodations in providing services, to employ appropriate language when referring to and talking with people with disabilities, and to understand communication, transportation, scheduling, structural, and attitudinal barriers to accessing services.

Disease Management — An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education, and outpatient care; and that includes evaluation of the appropriateness of the scope, setting, and level of care

in relation to clinical outcomes and cost of a particular condition.

Disenrollment — The process by which a Participant's ability to receive services from a CHC-MCO is terminated.

Drug Efficacy Study Implementation (DESI) — Drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA).

Dual Eligible — An individual who is enrolled in both Medicare and Medicaid.

Dual Eligible Special Needs Plan (D-SNPs) – A Medicare Advantage Plan that primarily or exclusively enrolls individuals who are entitled to both Medicare and Medicaid from a State Plan under Title XIX (Medicaid).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) — Items and services which must be made available to persons under the age of twenty- one (21) upon a determination of medical necessity and required by federal law at 42 U.S.C. §1396d(r).

Eligibility Period — A period of time during which an individual is eligible to receive Medical Assistance benefits. An Eligibility Period is indicated by the eligibility start and end dates in CIS. A blank eligibility end date signifies an open-ended Eligibility Period.

Eligibility Verification System (EVS) — An automated system available to Providers and other specified organizations for automated verification of Medical Assistance eligibility, CHC-MCO Enrollment, PCP assignment, Third Party Resources, and scope of benefits.

Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

Emergency Participant Issue — A problem of a CHC-MCO Participant (including problems related to whether an individual is a Participant), the resolution of which should occur immediately or before the beginning of the next business day in order to prevent a denial or significant delay in care to the Participant that could precipitate an Emergency Medical Condition or need for urgent care.

Emergency Services — Covered inpatient and outpatient services that: (a) are furnished by a Provider that is qualified to furnish such service under Title XIX of the Social Security Act and (b) are needed to evaluate or stabilize an Emergency Medical Condition.

Encounter — Any covered healthcare service provided to a CHC-MCO Member, regardless of whether it has an associated Claim.

Encounter Data — A record of any Covered Service provided to a CHC-MCO Participant and includes Encounters reimbursed through Capitation, Fee-for-Service, or other methods of compensation regardless of whether payment is due or made.

Enrollment — The process by which a Participant is enrolled in a CHC Plan.

Enrollment Specialist — The individual(s) working for the Independent Enrollment Entity who are responsible to assist Participants with selecting a CHC-MCO and PCP as well as providing information regarding Covered Services and Participating Providers under CHC.

Expanded Services — Any Medically Necessary service, covered under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., but not included in the State's Medicaid Plan, which is provided to Participants.

External Quality Review (EQR) — A requirement under Section 1902(a)(30)(C) of Title XIX of the Social Security Act, 42 U.S.C. 1396u-2(c)(2) 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.

External Quality Review Organization (EQRO) - An independent organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review of managed care organizations as well as other EQR-related activities as set forth in 42 CFR 438.358, or both.

Family Planning Services — Services which enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies. Such services are made available without regard to marital status, age, sex or parenthood.

Federally Qualified Health Center (FQHC) — An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under the above-mentioned sections of the Act.

Fee-for-Service (FFS) — Payment to Providers on a per-service basis for healthcare services provided to Recipients.

Formulary — A Department-approved list of pharmacies determined by the CHC-MCO's Pharmacy and Therapeutics (P&T) Committee to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, and

cost for the CHC-MCO Participants.

Fraud — Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The Fraud can be committed by many entities, including the CHC-MCO, a subcontractor, a Provider, a State employee, or a Participant, among others.

Full Dual Eligible - An individual, who is (i) entitled to Medicare Part A, enrolled in or eligible for Medicare Part B, and enrolled in or eligible to enroll in Part D and (ii) full Medicaid eligible.

Generally Accepted Accounting Principles (GAAP) — A technical term in financial accounting. It encompasses the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time.

Government Liaison — The Department's primary point of contact within the CHC-MCO. This individual acts as the day-to-day manager of contractual and operational issues and works within the CHC-MCO and with DHS to facilitate compliance, solve problems, and implement corrective action. The Government Liaison negotiates internal CHC-MCO policy and operational issues.

Grievance — A request to have a CHC-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a healthcare service. A Grievance may be filed regarding a CHC-MCO decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item. 5) deny a request for a benefit limit exception (BLE).

This term does not include a complaint.

Healthcare-Acquired Condition (HCAC) — A condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of Health and Human Services under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis(DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Healthcare-Associated Infection — A localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that:

- 1) occurs in a patient in a healthcare setting.
- 2) was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting.
- 3) if occurring in a hospital setting, meets the criteria for a specific infection site as defined by the Centers for Disease Control and Prevention and its National Healthcare Safety Network.

Healthcare Provider — A licensed hospital or healthcare facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide healthcare services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician’s assistant, chiropractor, dentist, dental hygienist, pharmacist or an individual accredited or certified to provide behavioral health services.

Healthcare Effectiveness Data and Information Set (HEDIS) –The set of managed care performance measures maintained by the National Committee for Quality Assurance (NCQA).

Health Maintenance Organization (HMO) — A Commonwealth licensed risk-bearing entity which combines delivery and financing of healthcare and which provides basic health services to enrolled Participants for a fixed, prepaid fee.

Holdback — A CHC-MCO capitation payment reduction taken by the Department that is subsequently paid to the CHC-MCO as provided by the agreement.

Home and Community-Based Services (HCBS) — A range of services and supports provided to Participants in their homes and communities. These services include assistance with ADLs and IADLs, which promote the ability for older adults and adults with disabilities to live independently to the greatest degree and remain in their homes for the longest time as is possible.

Hospice - A coordinated program of home and inpatient care that provides non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six (6) months or less. Hospice programs provide Participants and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement. Hospice services provided to Participants by Medicare approved hospice Providers are directly reimbursed by Medicare.

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

Independent Enrollment Entity (IEE) — An independent and conflict-free entity contracted with the Department, which is responsible for providing choice counseling and enrollment services to Participants.

Individualized Back-Up Plan – An individualized plan that is developed as part of the Person-Centered Service Plan development process, which identifies the

strategies to be taken in the event that routine services are not able to be delivered to a Participant which, depending on the Participant's preferences and choice, may include, but are not limited to the use of family and friends of the Participant's choice, and/or agency staff.

Indian — An individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f), 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Healthcare Improvement Act, to receive healthcare services from Indian healthcare Providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization – I/T/U) or through referral under Contract Health Services (CHS).

Indian Healthcare Provider — A healthcare program, including CHS, operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Healthcare Improvement Act (25 U.S.C. 1603).

Information Resource Management (IRM) — A program planned, developed, implemented, and managed by DHS's Bureau of Information Systems, the purpose of which is to ensure the coordinated, effective, and efficient employment of information resources in support of DHS business goals and objectives.

In-Plan Services — Services which are the payment responsibility of the PH-MCO under the HealthChoices Program

Inquiry — Any Participant's request for administrative service, information or to express an opinion.

Instrumental Activities of Daily Living (IADL) - Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication. The extent to which a person requires assistance in performing IADLs is often assessed in conjunction with the evaluation of level of care.

Intermediate Care Facility for the Intellectually Disabled and Other Related Conditions (ICF/ ID/ORC) — An institution (or distinct part of an institution) that 1) is primarily for the diagnosis, treatment or rehabilitation for persons with Intellectually Disabilities or persons with Other Related Conditions; and 2) provides, in a residential setting, ongoing evaluation, planning, twenty-four (24) hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his/her maximum capacity.

Juvenile Detention Center (JDC) — A publicly or privately administered, secure residential facility for:

- Children alleged to have committed delinquent acts who are awaiting a court hearing.

- Children who have been adjudicated delinquent and are awaiting disposition or awaiting placement.
- Children who have been returned from some other form of disposition and are awaiting a new disposition (i.e., court order regarding custody of child, placement of child, or services to be provided to the child upon discharge from the Juvenile Detention Center).

Level of Care Determination – A determination of an individual’s clinical eligibility for LTSS.

Linguistic competency – The demonstration that an entity or individual has the capacity to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency (LEP), those who have low literacy skills or are not literate, and individuals with disabilities that require communication accommodations.

Living Independence for the Elderly (LIFE) - A comprehensive service delivery and financing program model in Pennsylvania (which is known nationally as the Program of All-Inclusive Care for the Elderly (PACE)) that provides comprehensive healthcare services under dual capitation agreements with Medicare and the Medical Assistance Program to individuals age 55 and over who are Nursing Facility Clinically Eligible NFCE and reside in a LIFE service area.

Lock-In — The restriction of a Participant who is involved in fraudulent activities or who is identified as abusing Medical Assistance services to one or more specific Provider(s) to obtain all of his/her services in an attempt to ensure appropriately managed care.

Long-Term Services and Supports (LTSS) – A broad range of services and supports designed to assist an individual with ADLs and IADLs which can be provided in a home and community-based setting, a nursing facility, or other residential setting. LTSS may include, but are not limited to: self-directed care; adult day health; personal emergency response systems; home modification and environmental accessibility options; home and personal care; home health; nursing services; specialized medical equipment and supplies; chore services; social work and counseling; nutritional consultation; home-delivered meals and alternative meal service; and nursing facility services.

Managed Care Organization (MCO) — An entity which manages the purchase and provision of Physical or Behavioral Health Services under the Community HealthChoices Program.

Market Share — The percentage of Participants enrolled with a particular CHC-MCO when compared to the total of Participants enrolled in all the CHC-MCOs within a Community HealthChoices zone.

Marketing – Any communication from the CHC-MCO, or any of its agents or independent contractors, with a Participant or Potential Participant, who is not enrolled in the CHC-MCO that can reasonably be interpreted as intended to influence that individual to enroll in the CHC-MCO or remain enrolled in that particular CHC-MCO, or to disenroll from or not enroll in another CHC-MCO.

Marketing Materials – Any materials that are produced in any medium, by or on behalf of a CHC-MCO, that can reasonably be interpreted as intended to be marketing to Participants or Potential Participants.

Master Provider Index (MPI) — A component of PROMISe™ which is a central repository of Provider profiles and demographic information that registers and identifies Providers uniquely within the Department of Human Services.

Medical Assistance (MA) — 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 62 P.S. §441.1 et seq. and regulations at 55 PA Code Chapters 1101 et seq.

Medical Assistance Transportation Program (MATP) — A non-emergency medical transportation service provided to eligible persons who need to make trips to or from any Medical Assistance service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

Medical Home – A model for care provided by physician practices aimed at strengthening the physician-patient relationship by replacing episodic care based on illness and patient complaints with coordinated care and a long-term healing process.

Medically Necessary — A Covered Service is Medically Necessary if it is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- The Covered Service will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The Covered Service will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The Covered Service will assist the Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age.

MIPPA Agreement – An agreement required under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 between a Dual Eligible Special Needs Plan (D-SNP) and a State Medicaid Agency which

documents entity's roles and responsibilities with regard to Dual Eligible individuals and describes the D-SNP's responsibility to integrate and/or coordinate Medicare and Medicaid benefits.

Monthly Participant File — An electronic file in a HIPAA compliant 834 format using data from DHS/CIS that is transmitted to the CHC-MCO on a monthly basis via the Department's PROMISe™ contractor.

Network — All contracted or employed Providers in the CHC-MCO who are providing Covered Services to Participants.

Network Provider — A Medical Assistance enrolled Healthcare Provider who has a written Provider Agreement with and is credentialed by a Community HealthChoices CHC-MCO and who participates in the CHC-MCO's Provider Network to serve Community HealthChoices Members.

Net Worth (Equity) — The residual interest in the assets of an entity that remains after deducting its liabilities.

Non-participating Provider — A Provider, whether a person, firm, corporation or other entity, either not enrolled in the Pennsylvania Medical Assistance Program or not participating in the CHC-MCO's Network.

Nursing Facility (NF) — A general, county or hospital-based nursing facility, which is licensed by the DOH, enrolled in the Medical Assistance Program.

Nursing Facility Clinically Eligible (NFCE) – Having clinical needs that require the level of care provided in a Nursing Facility.

Nursing Facility Ineligible (NFI) – Having clinical needs that do not require the level of care provided in a Nursing Facility.

Older Adult Protective Services (OAPS) – A program of activities, resources, services and supports, administered by the Pennsylvania Department of Aging, and implemented and delivered by the Area Agencies on Aging (AAAs) to detect, prevent, reduce or eliminate abuse, neglect, exploitation and abandonment of adults age 60 or older.

Ongoing Medication — A medication that has been previously dispensed to the Participant for the treatment of an illness that is chronic in nature or for an illness for which the medication is required for a length of time to complete a course of treatment, until the medication is no longer considered necessary by the physician/prescriber, and that has been used by the Participant without a gap in treatment. If the current prescription is for a higher dosage than previously prescribed, the prescription is for an Ongoing Medication at least to the extent of the previous dosage. When payment is authorized due to the obligation to cover pre-existing services while a Grievance or DHS Fair Hearing is pending, a request to refill that prescription, made after the Grievance or DHS Fair Hearing has been

finally concluded in favor of the MCO, is not an Ongoing Medication.

Open-ended — A period of time that has a start date but no definitive end date.

Other Related Conditions (ORC) — A physical disability such as cerebral palsy, epilepsy, spina bifida or similar conditions which occur before the age of twenty-two (22), is likely to continue indefinitely and results in three (3) or more substantial functional limitations in the following area: self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living.

Other Resources — With regard to TPL, Other Resources include, but are not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance, and accident indemnity insurance.

Out-of-Area Covered Services — Covered Services provided to a Participant under one (1) or more of the following circumstances:

- An Emergency Medical Condition that occurs while outside the CHC zone covered by this agreement.
- The health of the Participant would be endangered if the Participant returned to the CHC zone covered by this agreement for needed services.
- The Participant is attending a college or university in a state other than Pennsylvania or a zone other than their zone of residence or who is travelling outside of the CHC zone but remains a resident of the Commonwealth and the CHC zone and requires Covered Services, as identified in their Person-Centered Service Plan or otherwise.
- The Provider is located outside the CHC zone, but nonetheless, regularly provides Covered Services to Participants at the request of the CHC-MCO.
- The needed Covered Services are not available in the CHC zone.

Out-of-Network Provider — A Provider who has not been credentialed by and does not have a signed Provider Agreement with a CHC-MCO.

Out-of-Plan Services — Services which are non-capitated and are not the responsibility of the CHC-MCO under the Community HealthChoices Program comprehensive Covered Services package.

Participant — An eligible individual who is enrolled with a CHC-MCO under the CHC Program.

Participant Advisory Committee (PAC) — A group convened in person, at least quarterly by the CHC-MCO to solicit input for consideration by the CHC-MCO's governing board which is open to all Participants and which reflects the diversity of the CHC-MCO's Participant population.

Participant-Directed Budget – An amount of waiver funds that is under the control and direction of the waiver participant who has chosen the Budget Authority Participant Direction option. The Participant-Directed Budget is sometimes called the individual budget.

Participant-Directed Service – A waiver service that the state specifies may be directed by the Participant using the Employer Authority, the Budget Authority or both.

Participant-Direction – The opportunity for a Participant to exercise choice and control in identifying, accessing, and managing LTSS Covered Services and other supports in accordance with his or her needs and personal preferences.

Participant Record — A record contained on the Daily Participant Enrollment File or the Monthly Participant Enrollment File that contains information on Medical Assistance eligibility, managed care coverage, and the category of assistance, which help establish the Covered Services for which a Participant is eligible.

Participant Restriction Program – The program to Lock-In Participants who abuse or misuse services to obtain services for a period of time from designated Providers.

Pay for Performance (P4P) - Compensation given to CHC-MCOs for increased productivity or results that exceed anticipated targets.

Pennsylvania Open Systems Network (POSNet) — A peer-to-peer network based on open systems products and protocols that was previously used for the transfer of information between the Department and the MCOs. The Department is currently using Information Resource Management (IRM) Standards.

Performance Improvement Project - Projects wherein CHC-MCO administrators assess their organizations and make changes to meet their goals through assessment, systematic gathering of information and making improvements in care or services that need attention.

Person-Centered Planning Team (PCPT) — The team of individuals that will participate in Person-Centered Service Planning with and provide person-centered coordinated services to Participants. Each Participant who has LTSS needs must have a PCPT.

Person-Centered Service Plan - A written description of Participant-specific healthcare, LTSS, and wellness goals to be achieved, and the amount, duration, frequency and scope of the Covered Services to be provided to a Participant in order to achieve such goals, which is based on the comprehensive needs assessment of the Participant's healthcare, LTSS and wellness needs. The Person-Centered Service Plan is developed by the Service Coordinator and the Participant

and his/her supports. The Person-Centered Service Plan will consider the current and unique psycho-social and medical needs and history of the Participant, as well as the Participant's functional level and support systems and clinical and non-clinical needs. The Person-Centered Service Plan addresses how non-Covered Services necessary to support the healthcare and other goals of the Person-Centered Service Plan will be accessed or coordinated. For Participants receiving LTSS, the PCPT is included in the development of the plan.

Person-Centered Service Planning (Service Planning) – The process of developing an individualized Person-Centered Service Plan based on an assessment of needs and preferences of the Participant. Service Planning considers both in and Out-of-Network Covered Services to support the individual in the environment of their choice and includes caregivers support needs.

Physician Incentive Plan — Any compensation arrangement between a CHC-MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid Participants enrolled in the CHC-MCO.

Plan Transfer - The processes by which a Participant changes CHC-MCOs.

Post-Stabilization Services — Medically Necessary non-emergency services furnished to a Participant after the Participant is stabilized following an Emergency Medical Condition.

Potential Participant — An individual who either 1) is an Eligible Individual or 2) is not yet an Eligible Individual but may become an Eligible Individual in the foreseeable future.

Preadmission Screening and Resident Review (PASRR) process – A Federally mandated process to determine whether individuals who have a Mental Illness (MI), Intellectual Disability (ID), or an Other Related Condition (ORC) require NF Services and if they also require Specialized Services to treat their condition(s), based on the criteria established by Centers for Medicare & Medicaid Services (CMS). The screening process applies to all individuals seeking admission to any MA-certified NF, regardless of payment source (private pay, third party insurance and/or MA). The PASRR process must be completed prior to admission and no later than the day of admission.

Preferred Drug List — A list of Department-approved pharmacies designated as preferred products because they were determined to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness and cost for the CHC-MCO Participants by the CHC-MCO's Pharmacy and Therapeutics (P&T) Committee.

Primary Care - All healthcare services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician acting within the scope of

his/her licensure.

Primary Care Practitioner (PCP) — A specific physician, physician group or a CRNP operating under the scope of his/her licensure, who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services, and maintaining continuity of care on behalf of a Participant.

Primary Care Practitioner (PCP) Site — The location or office of PCP(s) where Participant care is delivered.

Prior Authorization — A determination made by the CHC-MCO to approve or deny payment for a Provider's request to provide a Covered Service or course of treatment of a specific duration and scope to a Participant prior to the Provider's initiation or continuation of the requested service.

Prior Authorization Review Panel (PARP) — A panel of representatives from within the Department who have been assigned organizational responsibility for the review, approval and denial of all CHC-MCO Prior Authorization policies and procedures.

Prior Authorized Services — Covered Services, determined to be Medically Necessary, the utilization of which the CHC-MCO manages in accordance with Department-approved Prior Authorization policies and procedures.

PROMISE™ Provider ID — A 13-digit number consisting of a combination of the 9-digit base MPI Provider Number and a 4-digit service location.

Provider — A licensed hospital or healthcare facility, medical equipment supplier, person, firm, corporation, or other entity who is licensed, certified or otherwise authorized to provide healthcare services under the laws of the Commonwealth or other state(s). The term includes but is not be limited to the following: physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist, home care agency, durable medical equipment supplier, LTSS provider, or behavioral health service provider.

Provider Agreement — Any Department-approved written agreement between the CHC-MCO and a Provider to provide medical or professional services to Participants to fulfill the requirements of this agreement.

Provider Appeal — A request from a Provider for reversal of a denial by the CHC-MCO, with regard to the three (3) major types of issues that are to be addressed in a Provider Appeal system as outlined in this agreement under Provider Dispute Resolution System. The three (3) types of Provider Appeals issues are:

- Provider credentialing denial by the CHC-MCO.

- Claims denied by the CHC-MCO for Providers participating in the CHC-MCO's Network. This includes payment denied for services already rendered by the Provider to the Participant.
- Provider Agreement termination by the CHC-MCO.

Provider Dispute — A written communication to a CHC-MCO, made by a Provider, expressing dissatisfaction with a CHC-MCO decision that directly impacts the Provider. This does not include decisions concerning medical necessity.

Provider-Preventable Condition (PPC) — A condition that meets the definition of a healthcare-acquired condition (HCAC) or other provider-preventable condition (PPC) as defined in 42 CFR 447.26(b).

Provider Reimbursement (and) Operations Management Information System electronic (PROMISE™) — A claims processing and management system implemented by the Department of Human Services that supports the Fee-for-Service and Managed Care Medical Assistance delivery programs.

Quality Management/Quality Improvement (QM/QI) — An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.

Recipient — A person eligible to receive Physical and/or Behavioral Health Services under the Medical Assistance Program of the Commonwealth of Pennsylvania.

Rejected Claim — A non-claim that has erroneously been assigned a unique identifier and is removed from the claims processing system prior to adjudication.

Related Parties — Any entity that is an Affiliate of the CHC-MCO or subcontracting CHC-MCO and (1) performs some of the CHC-MCO or subcontracting CHC-MCO's management functions under contract or delegation; or (2) furnishes services to Participants under a written agreement; or (3) leases real property or sells materials to the CHC-MCO or subcontracting CHC-MCO at a cost of more than \$2,500.00 during any year of a CHC contract with the Department.

Residential Treatment Facility (RTF) — A facility licensed by the Department of Human Services that provides twenty-four (24) hour out-of-home care, supervision and Medically Necessary mental health services for individuals under twenty-one (21) years of age with a diagnosed mental illness or severe emotional disorder.

Restraint — Any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which limit an individual's movement, a person's

access to other individuals, locations or activities, or restricts participant rights.

Retrospective Review — A review conducted by the CHC-MCO to determine whether services were delivered as prescribed and consistent with the CHC-MCO's payment policies and procedures.

Routine Care — Care for conditions that generally do not need immediate attention and minor episodic illnesses that are not deemed urgent. This care may lead to prevention or early detection and treatment of conditions. Examples of preventive and routine care include immunizations, screenings and physical exams.

Seclusion – The involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.

Service Area – The zone or zones in which the CHC-MCO has been approved to operate.

Service Coordination – Activities to identify, coordinate and assist participants to gain access to needed Covered Services and non-Covered Services such as social, housing, educational and other services and supports. Service Coordination includes the primary functions of providing information to Participants and facilitating access, locating, coordinating and monitoring needed services and supports for Participants.

Service Coordinator - An appropriately qualified professional who is the CHC-MCO's designated accountable point of contact for each Participant's Person-Centered Service Planning and Service Coordination.

Services My Way (SMW) – The Budget Authority model of service, which provides participants with a broader range of opportunities for Participant-Direction under which Participants have the opportunity to hire and manage staff that performs personal assistance type services, manage a flexible spending plan, and purchase allowable goods and services through their spending plan.

Sexual Abuse of a Participant - Intentionally, knowingly or recklessly causing or attempting to cause the rape of, involuntary deviate sexual intercourse with, sexual assault of, statutory sexual assault of, aggravated indecent assault of, indecent assault of, or incest with a Participant.

School-Based Health Center — A healthcare site located on school building premises which provides, at a minimum, on-site, age-appropriate primary and preventive health services with parental consent, to children in need of primary healthcare and which participates in the MA Program and adheres to EPSDT standards and periodicity schedule.

Special Needs Individual under Medicare – For purposes of Special Needs Plan eligibility, a Special Needs Individual is a Medicare Advantage eligible individual who (i) is institutionalized (as defined by the Secretary); (ii) is entitled to Medical Assistance under a State plan under subchapter XIX of this chapter; or (iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan for individuals with severe or disabling chronic conditions.

Special Needs Plan (SNP) - Medicare Advantage Plans that primarily or exclusively enroll Special Needs Individuals.

Start Date — The first date on which Participants are eligible for Covered Services under this agreement, and on which the CHC-MCOs are operationally responsible and financially liable for the provision of Medically Necessary services to Participants.

Step Therapy — A form of Prior Authorization whereby one or more prerequisite medications, which may or may not be in the same drug class, must be tried first before a Step Therapy medication will be approved.

Stop-Loss Protection — Coverage designed to limit the amount of financial loss experienced by a Provider.

Subcapitation — A fixed per capita amount that is paid by the CHC-MCO to a Network Provider for each Participant identified as being in their capitation group, whether or not the Participant received medical services.

Subcontract — Any contract between the CHC-MCO and an individual, business, university, governmental entity, or nonprofit organization to perform part or all of the CHC-MCO's responsibilities under this agreement. Exempt from this definition are salaried employees, utility agreements and Provider Agreements, which are not considered Subcontracts for the purpose of this agreement and, unless otherwise specified herein, are not subject to the provisions governing Subcontracts.

Sustained Improvement — Improvement in performance documented through continued measurement of quality indicators after the performance project/study/quality initiative is completed.

Substantial Financial Risk — Financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term “potential payments” means the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. The cost of referrals, then, must not exceed that twenty-five percent (25%) level, or else the financial arrangement is considered to put the physician or group at Substantial Financial Risk.

Third Party Liability (TPL) — The financial responsibility for all or part of a

Participant's healthcare or LTSS expenses of an individual entity or program (e.g., Medicare) other than the CHC-MCO.

Third Party Resource (TPR) — Any individual, entity or program that is liable to pay all or part of the medical or service cost of injury, disease or disability of a Participant. Examples of Third Party Resources include: government insurance programs such as Medicare or CHAMPUS (Civilian Health and Medical Program of the Uniformed Services); private health insurance companies, or carriers; liability or casualty insurance; and court-ordered medical support.

Title XVIII (Medicare) — A federally-financed health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 U.S.C. 1395 et seq., covering almost all Americans sixty-five (65) years of age and older and certain individuals under sixty-five (65) who are disabled or have chronic kidney disease.

Transitional Care Home — A tertiary care center which provides medical and personal care services to children upon discharge from the hospital that require intensive medical care for an extended period of time. This transition allows for the caregiver to be trained in the care of the child, so that the child can eventually be placed in the caregiver's home.

Urgent Medical Condition — Any illness, injury or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The term also includes situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

Utilization Management (UM) — An objective and systematic process for planning, organizing, directing and coordinating healthcare resources to provide Medically Necessary, timely and quality healthcare services in the most cost-effective manner.

Utilization Review Criteria — Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the factors to be considered relevant to making determinations of need for services including, but not limited to, level of care, place of service, scope of service, and duration of service.

Value Based Purchasing Strategies (VBP) — A model which aligns more directly to the quality and efficiency of care provided, by rewarding Providers for their measured performance across the dimensions of quality.

VBP strategies for the Community HealthChoices Program may include, but not be limited to gain sharing contracts, risk contracts, episodes of care payments, bundled payments, and contracting with Centers of Excellence and Accountable Care Organizations.

Vital documents — Documents which contain information that is critical for obtaining benefits. This includes provider directories, member handbooks, appeal and grievance notices and other notices that are critical to obtaining services, and, therefore, would have to be made available in each prevalent non-English language in its service area.

Voided Participant Record — A Participant Record used by the Department to advise the CHC-MCO that a certain related Participant Record previously submitted by the Department to the CHC-MCO should be voided. A Voided Participant Record can be recognized by its illogical sequence of CHC-MCO enrollment start and end dates with the end date preceding the Start Date.

Waiver – One of many options available to states to allow the provision of long-term services and supports in home and community-based settings under the Medicaid Program.

AGREEMENT and RFP ACRONYMS

For the purpose of this agreement and RFP, the acronyms set forth shall apply.

ACA — Affordable Care Act.
AIDS — Acquired Immunodeficiency Syndrome.
ADA — Americans with Disabilities Act.
BBS — Bulletin Board System.
BH — Behavioral Health.
BHA — Bureau of Hearings and Appeals.
BH-MCO — Behavioral Health Managed Care Organization.
CAHPS — Consumer Assessment of Healthcare Providers and Systems.
CAO — County Assistance Office.
CASSP — Children and Adolescent Support Services Program.
CD --- Compact disc.
CDC — Centers for Disease Control (and Prevention).
CFO — Chief Financial Officer.
CFR — Code of Federal Regulations.
CHC – Community HealthChoices.
CHC-MCO – Community HealthChoices MCO.
CHS — Contract Health Services.
CIS — Client Information System.
CLIA — Clinical Laboratory Improvement Amendment.
CME — Continuing Medical Education.
CMN — Certificate of Medical Necessity.
CMS — Centers for Medicare and Medicaid Services.
CNM — Certified Nurse Midwife.
COB — Coordination of Benefits.
CSP — Community Support Program.
CRNP — Certified Registered Nurse Practitioner.
CRR — Community Residential Rehabilitation.
DEA — Drug Enforcement Agency.
DESI — Drug Efficacy Study Implementation.
DME — Durable Medical Equipment.
DOH — Department of Health (of the Commonwealth of Pennsylvania).
DHS — Department of Human Services.
DRG — Diagnosis Related Group.
DSH — Disproportionate Share Hospital.
DSNP – Dual Eligible Special Needs Plan.
DUR — Drug Utilization Review.
EMS — Emergency Medical Services.
EOB — Explanation of Benefits.
EQR — External Quality Review.
EQRO — External Quality Review Organization.
EVS — Eligibility Verification System.
EPSDT — Early and Periodic Screening, Diagnosis and Treatment.
ER — Emergency Room.
ERISA — Employees Retirement Income Security Act of 1974.
FDA — Food and Drug Administration.

FFP — Federal Financial Participation.
FFS — Fee-for-Service.
FQHC — Federally Qualified Health Center.
FTE — Full Time Equivalent.
FTP — File Transfer Protocol.
GAAP — Generally Accepted Accounting Principles.
GME — Graduate Medical Education.
HBP — Healthy Beginnings Plus.
HCAC — Healthcare-Acquired Condition.
HCRP — High Cost Risk Pool.
HCRPAA — High Cost Risk Pool Allocation Amount.
HEDIS — Healthcare Effectiveness Data and Information Set.
HIPAA — Health Insurance Portability and Accountability Act.
HIPP — Health Insurance Premium Payment.
HIV — Human Immunodeficiency Virus.
HMO — Health Maintenance Organization.
IBNR — Incurred But Not Reported.
ICF/ID — Intermediate Care Facility for the Intellectually Disabled.
ICF/ORC — Intermediate Care Facility for Other Related Conditions.
IEE – Independent Enrollment Entity.
IHS — Indian Health Service.
IRM — Information Resource Management.
I/T/U — Indian Tribe, Tribal Organization, or Urban Indian Organization.
LTSS – Long-Term Services and Supports.
JCAHO — Joint Commission for the Accreditation of Healthcare Organizations.
LIFE—Living Independence for the Elderly.
MAAC — Medical Assistance Advisory Committee.
MAGI — Modified Adjusted Gross Income.
MATP — Medical Assistance Transportation Program.
MCO — Managed Care Organization.
MIPPA - Medicare Improvements for Patients and Providers Act of 2008.
MIS — Management Information System.
MPI — Master Provider Index.
NCPDP — National Council for Prescription Drug Programs.
NCQA — National Committee for Quality Assurance.
NF – Nursing Facility.
NHT – Nursing Home Transition.
NPDB — National Practitioner Data Bank.
NPI — National Provider Identifier.
OBRA — Omnibus Budget Reconciliation Act.
OCDEL — Office of Child Development and Early Learning.
OCYF — Office of Children, Youth and Families.
ODP — Office of Developmental Programs.
OIP — Other Insurance Paid.
OLTL – Office of Long-Term Living.
OMAP — Office of Medical Assistance Programs.
OMHSAS — Office of Mental Health and Substance Abuse Services.
ORC — Other Related Conditions.

OTC — Over-the-Counter.
P&T — Pharmacy & Therapeutics.
PARP — Prior Authorization Review Panel.
PBM — Pharmacy Benefit.
PCP — Primary Care Practitioner.
PCSP – Person-Centered Service Plan.
PDA — Pennsylvania Department of Aging.
PDL — Preferred Drug List.
PID — Pennsylvania Insurance Department.
PIP — Physician Incentive Plan.
PMPM — Per Member, Per Month.
POSNet — Pennsylvania Open Systems Network.
PPC — Provider Preventable Condition.
PROMISe™ — Provider Reimbursement (and) Operations Management
.Information System electronic (format).
QA — Quality Assurance.
QARI — Quality Assurance Reform Initiative.
QM — Quality Management.
QMC — Quality Management Committee.
RFP — Request for Proposal.
RHC — Rural Health Clinic.
RPAA — Risk Pool Allocation Amount.
RTF — Residential Treatment Facility.
SAP — Statutory Accounting Principles.
SMI – Serious Mental Illness.
SNP – Special Needs Plan.
SPR — Systems Performance Review.
SSA — Social Security Act.
SSI — Supplemental Security Income.
STD — Sexually Transmitted Disease.
TANF — Temporary Assistance for Needy Families.
TPL — Third Party Liability.
TTY — Text Telephone Typewriter.
UM — Utilization Management.
URCAP — Utilization Review Criteria Assessment Process.
U.S. DHHS — United States Department of Health and Human Services.
VBP — Value Base Purchasing.
WIC — Women's, Infants' and Children (Program).

SECTION V: PROGRAM REQUIREMENTS

A. Covered Services

The CHC-MCO must ensure that all physical health services provided are Medically Necessary and that all LTSS provided are approved in accordance with the requirements of the CHC 1915(c) Waiver. CHC-MCOs only operate in CHC zones approved by the Department. The CHC-MCO must require that determinations of Medically Necessary Covered Services be documented in writing and that they be based on medical information provided by a Participant, the Participant's family or caretaker and PCP, as well as other Providers, programs or agencies that have evaluated the Participant. A determination of Medically Necessary services must be made by qualified and trained Providers with clinical expertise comparable to the prescribing Provider.

The Deputy Secretary for OLTL will notify the CHC-MCO of those zones for which it has been approved to provide services. This approval will become part of this agreement.

1. Amount, Duration and Scope

At a minimum, the CHC-MCO must provide Covered Services in Exhibit DDD in the amount, duration and scope available in the Medical Assistance FFS Program unless otherwise specified by the Department. The CHC-MCO must provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. If services are added to the Pennsylvania Medical Assistance Program or the CHC Program, or if Covered Services are expanded or eliminated, implementation by the CHC-MCO must be on the same day as the Department's, unless the CHC-MCO is notified by the Department of an alternative implementation date.

2. In-Home and Community-Based Services

The CHC-MCO may not deny personal assistance services for Participants under the age of 21 based on the Participant's diagnosis or because the need for personal assistance services is the result of a cognitive impairment. The personal assistance services may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self.

The CHC-MCO may not deny a request for Medically Necessary in-home nursing services, home health aide services, or personal assistance services for a Participant under the age of 21 on the basis that a live-in caregiver can perform the task, unless there is a determination that the live-in caregiver is actually able and available to provide the level or extent of care that the Participant needs, given the caregiver's work schedule or other responsibilities, including

other responsibilities in the home.

3. Program Exceptions

The CHC-MCO is required to establish a program exception process, reviewed and approved by the Department, whereby a Provider or Participant may request coverage for items or services, which are included in the Member's benefit package but are not currently listed on the MA Program Fee Schedule. The PH-MCO must also apply the program exception process to requests to exceed limits for items or services that are on the Fee Schedule if the limits are not based in statute or regulation. These requests are recognized by the Department as a Program Exception and are described in 55 PA Code §1150.63.

4. Expanded Services

The CHC-MCO may provide expanded services subject to advance written approval by the Department. These must be services that are generally considered to have a direct relationship to the maintenance or enhancement of a Participant's health status, and may include various seminars and educational programs promoting healthy living or illness prevention, memberships in health clubs and facilities promoting physical fitness and expanded eyeglass or eye care benefits. These services must be generally available to all Participants and must be made available by all appropriate Network Providers. Such services cannot be tied to specific Participant performance; however, the Department may grant exceptions when it believes that such performance shall produce significant health improvements for Participants. Once approved, expanded services will continue to remain in effect under this agreement, unless the CHC-MCO is notified, in writing, by the Department, to discontinue the expanded service.

In order for information about expanded services to be included in any Participant information provided by the CHC-MCO, the CHC-MCO must make the expanded services available for a minimum of one full year or until the Participant information is revised, whichever is later. Upon sixty (60) days advance notice to the Department, the CHC-MCO may modify or eliminate any expanded service. The CHC-MCO must send written notice to Participants and affected Providers at least thirty (30) days prior to the effective date of the change in Covered Services and must simultaneously amend all written materials describing its Expanded Services.

CHC-MCOs are permitted and encouraged to offer LTSS Covered Services to Participants who are not yet NFCE. These services will not be reimbursed by the Department.

5. Referrals

The CHC-MCO must establish and maintain a referral process to

effectively utilize and manage the care of its Participants. The CHC-MCO may require a referral for any medical services that cannot be provided by the PCP except where specifically provided for in this agreement.

6. Self-Referral/Direct Access

A Participant may self-refer for vision, dental care, Indian Healthcare Providers, obstetrical and gynecological (OB/GYN) services, providing the Participant obtains the services within the Provider Network. A Participant may access chiropractic services in accordance with the process set forth in Medical Assistance Bulletin 15-07-01, and physical therapy services in accordance with the amended Physical Therapy Act (63 P.S. §§1301 et seq.). The CHC-MCO may request Department approval to allow other Covered Services to be directly available without referral.

The CHC-MCO may not use either the referral process or Prior Authorization to manage the utilization of Family Planning Services. The CHC-MCO may not restrict the right of a Participant to choose a Healthcare Provider for Family Planning Services and must make such services available without regard to marital status, age, sex or parenthood. Participants may access, at a minimum, health education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures as described in Exhibit F, Family Planning Services Procedures. The CHC-MCO must pay for Out-of-Network Family Planning Services.

The CHC-MCO must permit Participants to select a Network Provider, including nurse midwives, to obtain maternity and gynecological care without prior approval from a PCP. This includes selecting a Network Provider to provide an annual well-woman gynecological visit, primary and preventive gynecology care, including a PAP smear and referrals for diagnostic testing related to maternity and gynecological care, and Medically Necessary follow-up care.

In situations where a newly enrolled Participant is pregnant and already receiving care from an Out-of-Network OB-GYN specialist at the time of Enrollment, the Participant may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery, pursuant to 28 PA Code §9.684.

7. Behavioral Health Services

All Participants who need behavioral health services will obtain these services from the Behavioral Health Managed Care Organizations (BH-MCOs). The CHC-MCO must coordinate with the BH-MCO as necessary to ensure that Participants receive all Medically Necessary Behavioral Health Services.

8. Pharmacy Services

Full Dual Eligible Participants are not eligible for Pharmacy services under Medicaid; they will receive their pharmacy services through their Medicare Part D coverage. The CHC-MCO must provide coverage of prescriptions and over-the-counter medicines for Full Dual Eligibles that are not otherwise covered by the dual eligible's Part D prescription drug plan. The CHC-MCO must provide pharmacy services for all other Participants. The CHC-MCO is responsible for coordinating pharmacy services across Medicare Part D, and other third-party pharmacy coverages to ensure that the Participant receives the pharmacy services outlined in the Participant's Person-Centered Service Plan.

The CHC-MCO must comply with the requirements described in Exhibit BBB, Pharmacy Services.

9. EPSDT Services

The CHC-MCO must comply with the requirements regarding EPSDT services as set forth in Exhibit J, EPSDT Guidelines.

The CHC-MCO must also adhere to specific Department regulations at 55 PA Code Chapters 3700 and 3800 as they relate to EPSDT examination for individuals under the age of 21 and entering substitute care or a child residential facility placement.

10. Emergency Services

The CHC-MCO must comply with the program standards regarding Emergency Services that are set forth in Exhibit K, Emergency Services.

The CHC-MCO must comply with the provisions of 42 U.S.C. §1396u-2(b)(2)(D), 28 PA Code §9.672, and Sections 2102 and 2116 of the Insurance Company Law of 1921 as amended, 40 P.S. §991.2102 and §991.2116, pertaining to coverage and payment of Medically Necessary Emergency Services.

The CHC-MCO must limit the amount to be paid to Non-participating Providers of Emergency Services to no more than the amount that would have been paid for such services under the Department's FFS Program. The Department will determine the amount of payment

after consideration of the payment proposed by the CHC-MCO, the amount sought by the Non-participating Provider, the payment rates established by the Department for equivalent services under the Department's FFS program, and the assumptions used to develop the Department's Actuarially Sound Rates paid to the CHC-MCO, along with supporting documentation submitted by the parties and information otherwise available to the Department.

Healthcare Providers may initiate the necessary intervention to stabilize an Emergency Medical Condition of a Participant without seeking or receiving prospective authorization by the CHC-MCO. The attending physician or the Provider treating the Participant is responsible for determining when the Participant is sufficiently stabilized for transfer or discharge, and that determination is binding on the CHC-MCO.

The CHC-MCO is responsible for all Emergency Services including those categorized as mental health or drug and alcohol except for emergency room evaluations for voluntary and involuntary commitments pursuant to 50 P.S. §§7101 et seq., which shall be the responsibility of the BH-MCO.

Nothing in the above section shall be construed to imply that the CHC-MCO may not:

- track, trend and profile emergency department utilization.
- retrospectively review and where appropriate, deny payment for inappropriate emergency room use.
- use all appropriate methods to encourage Participants to use PCPs rather than emergency rooms for symptoms that do not qualify as an Emergency Medical Condition.
- use a Participant lock-in methodology for Participants with a history of significant inappropriate emergency room usage.

11. Post-Stabilization Services

The CHC-MCO must cover Post-Stabilization Services, as defined in 42 CFR §438.114.

The CHC-MCO must limit charges to Participants for Post-Stabilization Services to an amount no greater than what the CHC-MCO would charge the Participant if he or she had obtained the services through the Provider Network.

The CHC-MCO must cover Post-Stabilization Services without authorization, and regardless of whether the Participant obtains the services within or outside its Provider Network if any of the following situations exist:

- a. The Post-Stabilization Services were administered to maintain the Participant's stabilized condition within one hour of Provider's request to the CHC-MCO for pre-approval of further Post-Stabilization Services.
- b. The Post-Stabilization Services were not pre-approved by the CHC-MCO because the CHC-MCO did not respond to the Provider's request for pre-approval of these Post-Stabilization Services within one (1) hour of the request.
- c. The Post-Stabilization Services were not pre-approved by the CHC-MCO because the Provider could not reach the CHC-MCO to request pre-approval for the Post-Stabilization Services.
- d. The CHC-MCO and the treating physician could not reach an agreement concerning the Participant's care and a CHC-MCO physician is not available for consultation. In this situation, the CHC-MCO must give the treating physician the opportunity to consult with a CHC-MCO physician and the treating physician may continue with the care of the patient until a CHC-MCO physician is reached or one of the criteria applicable to termination of a CHC-MCO's financial responsibility described below is met.

The CHC-MCO's financial responsibility for Post-Stabilization Services that the CHC-MCO has not pre-approved ends when:

- a. A Network physician with privileges at the treating hospital assumes responsibility for the Participant's care;
- b. A CHC-MCO physician assumes responsibility for the Participant's care through transfer;
- c. The CHC-MCO and the treating physician reach an agreement concerning the Participant's care; or
- d. The Participant is discharged.

12. Examinations to Determine Abuse or Neglect

- a. The CHC-MCO must provide Participants under evaluation as possible victims of abuse or neglect and who present for physical examinations for determination of abuse or neglect, with such services.
- b. The CHC-MCO must require all Providers to know the procedures for reporting suspected abuse and neglect in addition to the requirements for performing physical

examination of Participants. This requirement must be included in all applicable Provider Agreements.

- c. Should a PCP determine that a mental health assessment is needed, the PCP must inform the Participant or the APS or OAPS representative how to access mental health services and coordinate access to these services, when necessary.

13. Hospice Services

The CHC-MCO must provide hospice care and use certified hospice Providers in accordance with 42 C.F.R. §§418.1 et seq.

14. Organ Transplants

The CHC-MCO will pay for transplants to the extent that the Medical Assistance FFS Program pays for such transplants. When Medically Necessary, the Medical Assistance FFS program currently covers the following transplants: Kidney (cadaver and living donor), kidney/pancreas, cornea, heart, heart/lung, single lung, double lung, liver (cadaver and living donor), liver/pancreas, small bowel, pancreas/small bowel, bone marrow, stem cell, pancreas, liver/small bowel transplants, and multivisceral transplants.

15. Transportation

The CHC-MCO must provide all Medically Necessary emergency ambulance transportation, all Medically Necessary non-emergency ambulance transportation, and non-medical transportation. Non-Medical Transportation includes transportation to community activities, grocery shopping, religious services, and other activities as specified in the Participant's Person-Centered Service Plan.

All other medical transportation for Participants to and from Medicare and/or CHC Covered Services must be arranged through the MATP. The CHC-MCO must arrange and coordinate medical transportation with the MATP providers to ensure that Participants receive the medical transportation services outlined in their Person-Centered Service Plans.

A complete description of MATP responsibilities can be found in Exhibit L, Medical Assistance Transportation Program.

16. Healthy Beginnings Plus (HBP) Program

The CHC-MCO must provide services that meet or exceed HBP standards in effect as defined in current or future Medical Assistance Bulletins that govern the HBP Program. The CHC-MCO must also continue the coordinated prenatal activities of the HBP Program by

utilizing enrolled HBP Providers or developing comparable resources. Such comparable programs will be subject to review and approval by the Department. The CHC-MCO must provide a full description of its plan to provide prenatal care for pregnant women and infants in fulfillment of the HBP Program objectives for review and advance written approval by the Department. This plan must include comprehensive postpartum care.

Since the HBP program focuses on community-based services provided by licensed and non-licensed Providers who see recipients face-to-face in outpatient Provider offices or community settings, the CHC-MCO's prenatal program must have the majority of its pregnant Participants seen face-to-face in the community setting. Majority is defined as greater than fifty percent (50%) of unique pregnant women that have an initial care management assessment as reported. This will be accomplished by contractual relationships within the CHC-MCO's Provider Network, CHC-MCO employees, or delegated vendor relationship.

The HBP Programs also require that high risk pregnant women should be adequately treated for substance use disorder (SUD). The CHC-MCO will contract with high volume obstetrical hospitals and health systems that perform more than 900 Medicaid deliveries to establish highly coordinated health homes for pregnant Participants with SUD. These health homes will be focused on identifying, initiating treatment, and referring pregnant Participants for comprehensive drug and alcohol counseling services. If the CHC-MCO is unsuccessful in contracting with any of the high volume obstetrical hospitals or health systems, it must document its efforts to negotiate with these providers for review by the Department.

17. Nursing Facility Services

The CHC-MCO is responsible for payment for Medically Necessary nursing facility services (including bed hold days and up to fifteen (15) per hospitalization and up to thirty (30) Therapeutic Leave Days per year) if a Participant is admitted to a Nursing Facility or resides in a Nursing Facility at the time of Enrollment.

The CHC-MCO must abide by the decision of the Level of Care Determination Entity related to the need for Nursing Facility services for the Participant.

The CHC-MCO must allow newly enrolled Participants who are residing in a Nursing Facility on the Effective Date of Enrollment for CHC in the zone to continue to reside in the Nursing Facility on the date of their CHC-MCO Enrollment for the duration of the individuals' need for Nursing Facility services. Participants who do not reside in a Nursing Facility on their CHC Enrollment Effective Dates but require Nursing Facility Services after their Enrollment will remain in

the CHC program while residing in the Nursing Facility.

The CHC-MCO must, in coordination with the Department, ensure that all Nursing Facility related processes are completed and monitored. This includes but is not limited to: Preadmission Screening Resident Review (PASRR) process, specialized service delivery, Participant's rights, patient pay liability, personal care accounts or other identified processes.

18. Participant Self-Directed Services

In addition to the traditional agency model, CHC-MCOs must offer Participants who are eligible for HCBS the opportunity to self-direct Personal Assistance Services through one of two models.

- Participants may elect to receive personal assistance services through a Participant-Directed Employer Authority model, in which the Participant employs his or her own personal assistance provider, who can be a family member, a friend, a neighbor or any other qualified personal assistance worker; or
- Participants may elect the Budget Authority model called Services My Way, in which the Person-Centered Service Plan is converted to a budget and the Participant develops a spending plan to purchase needed goods and services. Participants in this model may elect to receive personal assistance through an agency and/or to employ their own personal assistance providers.

Personal assistance workers employed by Participants under either self-directed model become qualified and receive payment through a financial management services (FMS) vendor, which processes timesheets, makes payments, and manages all required tax withholdings, including FICA taxes. The CHC-MCO must contract with the Commonwealth-procured FMS entities, of which there are three that operate statewide.

19. Health and Wellness Education and Outreach for Participants and Caregivers

The CHC-MCO must provide health and wellness opportunities for Participants. This may include providing classes, support groups, and workshops, disseminating educational materials and resources, and providing website, email, or mobile application communications on topics including, but not limited to, heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This may also include annual preventive care reminders and caregiver resources. CHC-

MCOs are also encouraged to identify regional community health education opportunities, improve outreach and communication with Participants and community-based organizations, and actively promote healthy lifestyles as well as disease prevention and health promotion.

20. Settings for LTSS

The CHC-MCO must provide services in the least restrictive, most integrated setting. The CHC-MCO shall only provide LTSS in settings that comply with the HCBS Settings final rule at 79 F.R. 2948 (January 16, 2014).

21. Service Delivery Innovation

The CHC-MCO must promote innovation in the service delivery system. This includes innovation pursued by the CHC-MCO on its own initiative, as well as collaborative efforts involving the Department, CMS and local partners. Initial target areas for innovation are as follows.

- a. Housing innovation that includes, but is not limited to:
 - i. Pre-tenancy and tenancy supports that help Participants at risk of homelessness or institutionalization to obtain and maintain homes in the community. These may include but are not limited to: outreach to and engagement of Participants, housing search assistance, assistance and applying for housing and benefits, assistance with SSI eligibility processes, advocacy and negotiation with landlords and other tenants, moving assistance, eviction prevention, motivational interviewing, and incorporating social determinants of health into the person-centered planning process.
 - ii. Participation in local and statewide housing collaboratives, which may include local and state housing agencies and social services organizations.
- b. Employment innovation that supports Participants to seek, find and maintain employment.
- c. Workforce innovation that improves the recruitment, retention and skills of direct care workers, which may include but are not limited to incentives for education and training.
- d. Technology innovation that supports Participants to lead healthy and independent lives in the community, which may include but not be limited to home monitoring and telemedicine applications.

The CHC-MCO must participate in any initiatives in these target innovation areas when requested by the Department to participate. In addition, the CHC-MCO must submit a report to the Department annually that outlines the CHC-MCO's efforts in each of the four areas, lessons learned, and plans for the following

year. The first report must be submitted on June 1, 2017 and each report submitted annually thereafter.

B. Prior Authorization of Services

1. General Prior Authorization Requirements

The CHC-MCO is financially responsible for the provision of Emergency Services without regard to Prior Authorization or the emergency care Provider's contractual relationship with the CHC-MCO.

If the CHC-MCO wishes to require Prior Authorization of any services, the CHC-MCO must establish and maintain written policies and procedures which must have advance written approval by the Department. In addition, the CHC-MCO must include a list and scope of services for referral and Prior Authorization, which must be included in the CHC-MCO's Provider manual and Participant handbook. The CHC-MCO must receive advance written approval of the list and scope of services to be referred or prior authorized by the Department as outlined in Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the Community HealthChoices Program, and Exhibit M(1), Quality Management and Utilization Management Program Requirements. The Department will consider Prior Authorization policies and procedures approved under previous Community HealthChoices agreements approved under this agreement. The CHC-MCO's submission of new or revised policies and procedures for PARP review and approval shall not act to void any existing, previously approved policies and procedures. Unless otherwise required by law, the CHC-MCO must continue to operate under such existing policies and procedures until such time as the PARP approves the new or revised version.

The Department may subject Prior Authorization Denials issued under unapproved Prior Authorization policies to Retrospective Review and reversal and may impose sanctions and/or require corrective action plans in the event that the CHC-MCO improperly implements any Prior Authorization policy or procedure or implements such policy or procedure without Department approval.

When the CHC-MCO denies a request for services, the CHC-MCO must issue a written notice of denial using the appropriate notice outlined in templates N(1), N(2), (N)3, and N(7) found on the Intranet site supporting CHC. In addition, the CHC-MCO must make the notice available in accessible formats for individuals with visual impairments and for persons with limited English proficiency. If the CHC-MCO receives a request from the Participant, prior to the end of the required period of advance notice, for a translated and/or accessible version of the notice of denial, the required period of advance notice will begin anew as of the date that CHC-MCO mails the translated and/or accessible notice of denial to the Participant.

For Children in Substitute Care, the CHC-MCO must send notices to the County Children and Youth Agency with legal custody of the child or to the court-authorized juvenile probation office with primary supervision of a juvenile provided the CHC-MCO knows that the child is in substitute care and the address of the legal custodian of the child.

The Department will use its best efforts to review and provide feedback to the CHC-MCO (e.g., written approval, request for corrective action plan, denial, etc.) within sixty (60) days from the date the Department receives the request for review. For minor updates to existing approved Prior Authorization plans, the Department will use its best efforts to review updates within forty-five (45) days from the date the Department receives the request for review.

The CHC-MCO may not require prior authorization of Medicare services for Participants with Medicare. CHC-MCOs must conditionally approve Covered Services that are pending Medicare decisions in the event that these services are not covered by Medicare. Service Coordinators are required to work with the Participant's Medicare plan to ensure expeditious decision-making and communication of decisions made.

2. Time Frames for Notice of Decisions

- a. The CHC-MCO must process each request for Prior Authorization of a service and notify the Participant of the decision as expeditiously as the Participant's health condition requires, or at least orally, within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made. The CHC-MCO may make notification of coverage approvals via electronic notices as permitted under 28 PA Code §9.753(b). If additional information is needed to make a decision, the CHC-MCO must request such information from the appropriate Provider within forty-eight (48) hours of receiving the request and allow fourteen (14) days for the Provider to submit the additional information. If the CHC-MCO requests additional information, the CHC-MCO must notify the Participant on the date the additional information is requested, using the template, N(7) Request for Additional Information Letter on the Intranet supporting CHC.
- b. If the requested information is provided within fourteen (14) days, the CHC-MCO must make the decision to approve or deny the service, and notify the Participant orally, within two (2) business days of receipt of the additional information. The CHC-MCO must mail written notice of the decision to the Participant, the

Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made.

- c. If the requested information is not received within fourteen (14) days, the CHC-MCO must make the decision to approve or deny the service based upon the available information and notify the Participant orally within two (2) business days after the additional information was to have been received. The CHC-MCO must mail written notice of the decision to the Participant, the Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made.
- d. In all cases, the CHC-MCO must make the decision to approve or deny a covered service or item and the Participant must receive written notification of the decision no later than twenty-one (21) days from the date the CHC-MCO received the request, or the service or item is automatically approved. To satisfy the twenty-one (21) day time period, the CHC-MCO may mail written notice to the Participant, the Participant's PCP, and the prescribing Provider on or before the eighteenth (18th) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, the CHC-MCO must hand deliver the notice to the Participant, or the request is automatically approved.
- e. If the Participant is currently receiving a requested service and the CHC-MCO decides to deny the Prior Authorization request, the CHC-MCO must mail the written notice of denial at least (10) days prior to the effective date of the denial of authorization for continued services. If probable Participant fraud has been verified, the period of advance notice is shortened to five (5) days. The CHC-MCO is not required to provide advance notice when it has factual information on the following:
 - confirmation of the death of a Participant.
 - receipt of a clear written statement signed by a Participant that she or he no longer wishes services or gives information that requires termination or reduction of services and indicates that she or he understands that termination must be the result of supplying that information.
 - the Participant has been admitted to an institution where she or he is ineligible under the CHC-MCO for further services.
 - the Participant's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address.
 - the CHC-MCO established the fact that the Participant has been accepted for Medical Assistance by another State.

- a change in the level of medical care is prescribed by the Participant's physician.

3. Prior Authorization of Pharmacy Services

The CHC-MCO must comply with the requirements of Exhibit BBB specific to Prior Authorization of Pharmacy Services.

C. Continuity of Care

The CHC-MCO must provide continuity of care to Participants who are receiving LTSS as follows:

- For a Participant who is a NF resident on his/her Effective Date of Enrollment and the First Enrollment Effective Date of any Enrollment into the CHC program in the zone in which the Participant resides, the continuity of care period will run from the Participant's Effective Date of Enrollment into the CHC-MCO for the duration of the Participants' residency in the Nursing Facility. The CHC-MCO must enter into a contract or payment arrangement with the resident's NF to make payments for the Participant's Nursing Facility services, whether or not the Nursing Facilities is in the CHC-MCO network. The CHC-MCO must provide services and payment for all Participants who are in an NF on the date of Enrollment even if the NF does not enroll as a provider. Provider. The CHC-MCO is prohibited from interfering with a Participant's choice of NF. This continuity of care period shall continue so long as the Participant remains a resident of the same NF and shall apply to each enrollment into a CHC-MCO, whether at the first effective date of enrollment or at some time later in the operation of the CHC program if the Participant chooses to transfer to a CHC-MCO.
- For a Participant who is receiving LTSS through an HCBS Waiver program on his or her Effective Date of Enrollment, the continuity of care period for continuation of services provided under all existing PCSPs through all existing service Providers will run from the Effective Date of Enrollment into the CHC-MCO for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later. If a Participant chooses to transfer to a different CHC-MCO, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a PCSP been developed and implemented, whichever date is later.
- For a Participant who is receiving LTSS but whose LTSS Provider leaves the CHC-MCO Provider Network, the CHC-MCO must continue to allow the Participant to receive services for a 60 day period and must pay that Provider until such time as an alternative Network Provider can be identified and begins to deliver the same LTSS services as the former Provider.

- For all Participants, the Continuity of Care period for continuation of healthcare Providers, services, and any ongoing course of treatment is governed by the requirements outlined in 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 §9.684 and 31 PA Code §154.15. The CHC-MCO must comply with the procedures outlined in Medical Assistance Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations, to ensure continuity of Prior Authorized Services for individuals age twenty-one (21) and older and continuity of non-prior authorized services for all Participants.
- The CHC-MCO must transfer existing PCSPs to another CHC-MCO if the Participant chooses to transfer to another CHC-MCO. This must be done expeditiously, electronically if possible, in no more than five (5) business days after notification of the transfer.

D. Choice of Provider

Participants must be afforded choice of all Providers within the Provider Network, including Service Coordinators. CHC-MCOs may not attempt to steer Participants to CHC-MCOs Affiliates who are Providers or interfere with the Participants' choice of Provider.

E. Needs Screening

Upon Enrollment, the CHC-MCO will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination. Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.

F. Comprehensive Needs Assessments and Reassessments

The comprehensive needs assessment will be completed by a Service Coordinator and will be conducted in-person in accordance with the following time frames:

- For Participants that are NFCE but are not receiving LTSS at the time of Enrollment, the comprehensive needs assessment must be completed in accordance with the timelines outlined in **Services Prior to Effective Date of Enrollment**.
- For Participants that are Dual Eligible and identified by the IEE as having a need for immediate services, the comprehensive needs assessment must be completed in accordance with the timelines outlined in Prior to Effective Date of Enrollment.
- Participants without existing Person-Centered Service Plans who are

- identified through a needs screening as requiring a comprehensive needs assessment shall have a comprehensive needs assessment conducted within 15 days of the completion of the needs screening.
- Participants with existing PCSPs in place at the time of enrollment will have a comprehensive needs assessment conducted within 180 days of their enrollment.

The CHC-MCO must conduct a comprehensive needs reassessment no more than 12 months following the most recent prior comprehensive needs assessment or comprehensive needs reassessment unless a trigger event occurs. Reassessments must be completed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 14 days after the occurrence of any of the following trigger events:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge.
- A change in functional status.
- A change in caregiver or informal support status.
- A change in the home setting or environment.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.
- As requested by the Participant or designee, the caregiver, the provider, or the PCPT or PCPT Participant, or the Department.

The comprehensive needs assessment and reassessment must assess physical health, behavioral health, social, psychosocial, environmental, caregiver, LTSS, and other needs as well as preferences, goals, housing, and informal supports. The comprehensive needs assessment and reassessment processes developed by the CHC-MCO must also capture the following:

- Need for traditional comprehensive care management of chronic conditions and disease management.
- Functional limitations in performing ADL and IADLs and level of supports required by the Participant.
- Ability to manage and direct services and finances independently.
- Level of supervision required.
- Supports for unpaid caregivers.
- Identification of risks to the Participant's health and safety.
- Environmental challenges to independence and safety concerns.
- Availability of informal supports.
- Diagnoses and ongoing treatments.
- Medications.
- Use of adaptive devices.
- Preferences for community engagement.

The Department will designate a tool to be used for comprehensive needs assessments and reassessments. CHC-MCOs are permitted to gather additional information not included in the designated tool to supplement but not supplant the Department-designated tool.

G. Person-Centered Planning Team Approach Required

The CHC-MCO must develop a PCPT policy for Person-Centered Service Plan development and implementation. The PCPT approach must be part of the service planning and Service Coordination processes for Participants who require LTSS. The CHC-MCO PCPT approach must be person-centered and must take into account all goals and requirements of CHC. The CHC-MCO must annually submit and obtain Department approval of its PCPT policy to PCSP development and implementation.

H. Person-Centered Service Plans

PCSPs must be developed for all Participants who have had comprehensive needs assessments.

Each PCSP must address how the Participant's physical and behavioral health needs and conditions will be managed by the CHC-MCO and how services will be coordinated by the Service Coordinators. At a minimum, these PCSPs must identify:

- Active chronic problems, current non-chronic problems, and problems that were previously controlled or classified as maintenance care but have been exacerbated by disease progression or other intervening conditions.
- Current medications.
- All services authorized and the scope and duration of the services authorized, including any services that were authorized by the CHC-MCO since the last PCSP was finalized that need to be authorized moving forward.
- A schedule of preventive service needs or requirements.
- Disease management action steps.
- Known needed physical and behavioral healthcare and services.
- All designated points of contact and the Participant's authorizations of who may request and receive information about the Participant's services.
- How the Service Coordinator will assist the Participant in accessing Covered Services identified in the PCSP.

PCSPs for Participants needing or receiving LTSS must also address:

- All LTSS services necessary to support the Participant in living as independently as possible and remaining as engaged in their community as possible.
- For the needs identified in the comprehensive needs assessment, the interventions to address each need or preference, reasonable long-

term and short-term goals, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes.

- Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's maximum functioning level of well-being.
- Participant decisions around self-directed care and whether the Participant is participating in Participant-Direction.
- Communications plan.
- How frequently specific services will be provided.
- How technology and telehealth will be used.
- Participant choice of Providers.
- Individualized Back-Up Plans.
- The person(s)/Providers responsible for specific interventions/services.
- Participant's informal support network and services.
- Participant's need for and plan to access community resources and non-covered services, including any reasonable accommodations.
- How to accommodate preferences for leisure activities, hobbies, and community engagement.
- Any other needs or preferences of the Participant.
 - Participant's goals for the least restrictive setting possible, if they are being discharged or transitioned from an inpatient setting.

The Person-Centered Service Plan may specify the need for referrals and the need for assistance from the Service Coordinator in obtaining referrals. To the extent that the PCP is part of the PCSP development/PCTP process, the PCSP may also articulate referrals that the Service Coordinator will enter in the appropriate systems.

PCSPs must be completed no fewer than 30 days from the date the comprehensive needs assessment or reassessment is completed.

PCSPs for Participants who require LTSS will be developed by the Service Coordinator, the Participant, and the Participant's PCPT. Participants may appeal part or all of their Service Plan following the procedures outlined in Exhibit GG.

I. Department Review of Changes in Service Plans

The Department may review and revise any Person-Centered Service Plan. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes.

J. Service Coordination

Service Coordinators are responsible for assisting Participants in obtaining the services that they need. Service Coordinators lead the Person-Centered Service Planning process and oversee the implementation of

PCSPs. CHC-MCOs must annually submit and obtain Department approval of their Service Coordination staffing, Participant contact plan, caseloads, the required frequency of in-person contact with Participants, and how Service Coordinators share and receive real-time information about Participants and Participant encounters.

K. Service Coordinator and Service Coordinator Supervisor Requirements

The CHC-MCO must require that all employed or contracted Service Coordinators meet the minimum requirements of being a registered nurse or having a bachelor's degree in social work, psychology or other related field and at least three years of experience in the coordination of services. All Service Coordinator Supervisors must be employed by the CHC-MCO or a Service Coordination entity under contract with the CHC-MCO and must be a licensed social worker with at least 5 years of experience or a registered nurse with at least 5 years of experience. Service Coordinators and Service Coordinator Supervisors must also complete Department-approved training in required training topics.

L. Nursing Home Transition Services

CHC-MCOs must offer Nursing Home Transition (NHT) services as defined in Exhibit DDD(2), LTSS Covered Services Definitions, to Participants residing in Nursing Facilities who express a desire to move back to their homes or other community-based settings. Service Coordinators may coordinate NHT services.

M. Coordination of Services

The CHC-MCO must coordinate all necessary Covered Services and other services for its Participants. The CHC-MCO must provide for seamless and continuous coordination of services across a continuum of services for the Participant with a focus on improving healthcare outcomes and independent living. These activities should be done as part of Person-Centered Service Planning and the PCSP implementation process. The continuum of services may include the Covered Services, out-of-plan services, and non-MA Covered Services provided by other community resources.

1. CHC-MCO and BH-MCO Coordination

To facilitate the efficient administration of the Medical Assistance Program and to enhance the treatment of Participants who need both Covered Services and BH services, the CHC-MCO must develop and implement written agreements with each BH-MCO in the CHC-MCO's zone(s) regarding the interaction and coordination of services provided to Participants enrolled in the Community HealthChoices Program. These agreements must be submitted and approved by the Department. The CHC-MCOs and BH-MCOs are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services.

The Community HealthChoices Program requirements covering BH Services are outlined in Exhibit U, Behavioral Health Services. The CHC-MCO must work in collaboration with the BH-MCOs through participation in joint initiatives to improve overall health outcomes of its Participants and those activities that are required by the Department. These joint initiatives may include:

- a. Information exchange including the BH utilization data provided by the Department to control avoidable hospital admissions, readmissions and emergency department usage for Participants with SMI or substance use disorders or both.
- b. Development of specific coordination mechanisms to assess and, where appropriate, reduce the use of psychotropic medications prescribed for Participants.

The CHC-MCO will comply with the requirements regarding coordination of care, which are set forth in Coordination of Care, including those pertaining to BH.

- a. The CHC-MCO must, and the Department will require Health Choices Behavioral Health Managed Care contracts to submit to independent binding arbitration in the event of a dispute between the CHC-MCO and a BH-MCO concerning their respective obligations under this agreement and the Behavioral Health HealthChoices agreement. The mutual agreement of the CHC-MCO and a BH-MCO to such an arbitration process must be evidenced by and included in the written agreement between the CHC-MCO and the BH-MCO.
- b. The CHC-MCO must comply with the requirements specific to Pharmacy Services specified in Exhibit BBB.

2. Disability Advocacy Program

The CHC-MCO must cooperate with the Department's Disability Advocacy Program, which provides assistance to Participants in applying for SSI or Social Security Disability benefits by sharing Participant-specific information and performing coordination activities as requested by the Department, on a case-by-case basis.

N. CHC-MCO Responsibility for Reportable Conditions

The CHC-MCO must work with Department of Health (DOH) State and District Office Epidemiologists in partnership with the designated county/municipal health department staffs to ensure that reportable conditions are appropriately reported in accordance with 28 PA Code §§27.1 et seq. The CHC-MCO must designate a single contact person to facilitate the implementation of this requirement.

O. Participant Enrollment and Disenrollment

1. General

The CHC-MCO is prohibited from restricting its Participants from changing CHC-MCOs for any reason. The Participant has the right to initiate a change in CHC-MCO's plans at anytime.

The CHC-MCO is prohibited from offering or exchanging financial payments, incentives, commissions, etc., to any other CHC-MCO (not receiving an agreement to operate under the Community HealthChoices Program or not choosing to continue a relationship with the Department) for the exchange of information on the terminating CHC-MCO's Participants. This includes offering incentives to a terminating CHC-MCO to recommend that its Participants join the CHC-MCO offering the incentives. This section does not prohibit making a payment in connection with a transfer, which has received the Department's prior written approval, of the rights and obligations to another entity.

The Department will disenroll a Participant from a CHC-MCO when there is a change in residence which places the Participant outside the CHC zone(s) covered by this agreement, as indicated on the individual county file maintained by the Department's Office of Income Maintenance.

The Department will enroll Participants transferring from one CHC zone to another with the same CHC-MCO, provided that the CHC-MCO operates in both CHC zones, unless the Participant chooses to enroll in LIFE in the new zone.

2. CHC-MCO Outreach Materials

The CHC-MCO must develop outreach materials such as pamphlets and brochures which can be used by the IEE to assist Participants in choosing a CHC-MCO and PCP. The CHC-MCO must develop such materials for CHC in the form and context required by the Department. The Department must approve such materials in writing prior to their use. The Department's review will be conducted within thirty (30) calendar days and approval will not be unreasonably withheld.

The CHC-MCO is prohibited from distributing directly or through any agent or independent contractor, outreach materials without advance written approval of the Department. In addition, the CHC-MCO must comply with the following guidelines and/or restrictions.

- a. The CHC-MCO may not seek to influence an individual's Enrollment with the CHC-MCO in conjunction with the sale of

any other insurance.

- b. The CHC-MCO must comply with the Enrollment procedures established by the Department in order to ensure that, before the individual is enrolled with the CHC-MCO, the individual is provided accurate oral and written information sufficient to make an informed decision on whether to enroll.
- c. The CHC-MCO must not directly or indirectly conduct door-to-door, telephone or other cold-call marketing activities.
- d. The CHC-MCO must ensure that all outreach plans, procedures and materials are accurate and do not mislead, confuse or defraud either the Participant or the Department and must comply with Exhibit X, Community HealthChoices MCO Guidelines for Advertising, Sponsorships, and Outreach.

3. CHC-MCO Outreach Activities

- a. The CHC-MCO is prohibited from engaging in any marketing activities associated with Enrollment into a CHC-MCO in any CHC zone, with the exceptions listed in 3b through 3f below.

The CHC-MCO is also prohibited from subcontracting with an outside entity to engage in outreach activities associated with any form of Enrollment to eligible or Potential Participants. The CHC-MCO must not engage in outreach activities associated with Enrollments at the following locations and activities:

- CAOs
- Providers' offices
- Malls/Commercial or retail establishments
- Hospitals
- Nursing Facilities
- Adult Day Centers
- Senior Centers
- Check cashing establishments
- Door-to-door visitations
- Telemarketing

- Community Centers
 - Churches
 - Direct Mail
- b. The CHC-MCO may market its approved, companion D-SNP product to its Full Dual Eligible CHC-MCO Participants.
- c. The CHC-MCO, either individually or as a joint effort with other CHC-MCOs in the CHC zone, may use commonly accepted media methods for the advertisement of quality initiatives, educational outreach, and health-related materials and activities.

The CHC-MCO may not include, in administrative costs reported to the Department, the cost of advertisements in mass media, including but not limited to television, radio, billboards, the Internet and printed media for purposes other than noted above unless specific prior approval is provided by the Department. The CHC-MCO must obtain from the Department advance written approval of any advertising placed in mass media.

- d. The CHC-MCO may participate in or sponsor health fairs or community events. The Department may set limits on contributions and/or payments made to non-profit groups in connection with health fairs or community events and requires advance written approval for contributions and/or payments of \$2,000.00 or more. The Department will consider such participation or sponsorship when a written request is submitted thirty (30) calendar days in advance of the event, thus allowing the Department reasonable time to review the request and provide timely advance written approval. All contributions/payments are subject to financial audit by the Department.
- e. The CHC-MCO may offer items of little or no intrinsic value (i.e., trinkets with promotional CHC-MCO logos) at health fairs or other approved community events. Such items must be made available to the general public, not to exceed \$5.00 in retail value and must not be connected in any way to CHC-MCO Enrollment activity. All such items are subject to advance written approval by the Department.
- f. The CHC-MCO may offer Participants services in excess of those required by the Department, and is permitted to feature such expanded services in approved outreach materials. All such expanded benefits are subject to advance written approval by the Department and must meet the requirements of Section V.A.4., Expanded Services.

- g. The CHC-MCO may offer Participants consumer incentives only if they are directly related to improving health outcomes. The incentive cannot be used to influence a Participant to receive any item or service from a particular Provider, practitioner or supplier. In addition, the incentive cannot exceed the total cost of the service being provided. The CHC-MCO must receive advance written approval from the Department prior to offering a Participant incentive.
- h. Unless approved by the Department, CHC-MCOs are not permitted to directly provide products of value unless they are health-related and are prescribed by a licensed Provider. CHC-MCOs may not offer Participant coupons for products of value.
- i. The Department may review any and all outreach activities and advertising materials and procedures used by the CHC-MCO, including all outreach activities, advertising materials, and corporate initiatives that are likely to reach Medical Assistance Recipients. In addition to any other sanctions, the Department may impose monetary or restricted Enrollment sanctions should the CHC-MCO be found to be using unapproved outreach materials or engaging in unapproved outreach practices. The Department may suspend all outreach activities and the completion of applications for new Participants. Such suspensions may be imposed for a period of up to sixty (60) days from notification by the Department to the CHC-MCO citing the violation.
- j. The CHC-MCO is prohibited from distributing, directly or through any agent or independent contractor, outreach materials that contain false or misleading information.
- k. The CHC-MCO may not, under any conditions use the Department's eligibility system to identify and market to individuals participating in the LIFE Program or enrolled in another CHC-MCO. The CHC-MCO may not share or sell Participant lists with other organizations for any purpose, with the limited permissible exception of sharing Participant information with affiliated entities and/or subcontractors under Department- approved arrangements to fulfill the requirements of this agreement.
- l. The CHC-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with the guidelines outlined Community HealthChoices CHC-MCO Guidelines for Advertising, Sponsorships, and Outreach.
- m. The CHC-MCO must conduct and participate in Department

Provider and Participant outreach efforts.

4. Limited English Proficiency (LEP) Requirements

During the Enrollment Process, the CHC-MCO must seek to identify Participants who speak or read a language other than English as their first language. The CHC-MCO must identify spoken and written language preferences identified by the IEE and CHC-MCO during its first contact(s) with the Participant.

The CHC-MCO must provide, at no cost to Participants, oral interpretation services in the requested language or sign language interpreter services to meet the needs of Participants. The CHC-MCO must also provide specialized interpretive services to ensure access to services for Participants who are deaf and blind. These services must also include all services dictated by federal requirements for translation services designated to the CHC-MCO Providers if the Provider is unable or unwilling to provide these services.

The CHC-MCO must make all vital documents disseminated to English speaking Participants available in the prevalent languages designated by the Department. Documents may be deemed vital if related to the access to programs and services and include informational material. Vital documents include Provider Directories, Participant handbooks, appeal and grievance notices, and other notices that are critical to obtaining services. The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate language.

Vital documents must be posted on the CHC-MCO's website.

5. Alternate Format Requirements

The CHC-MCO must provide alternative methods of communication for Participants who are visually or hearing impaired or both, including Braille, audio tapes, large print, compact disc, DVD, computer diskette, special support services, and/or electronic communication. The CHC-MCO must, upon request from the Participant, make all written materials disseminated to Participants accessible to visually impaired Participants. The CHC-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Participants who are deaf or hearing impaired, upon request.

The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate format.

6. CHC-MCO Enrollment Procedures

The CHC-MCO must have in effect written administrative policies and procedures for newly enrolled Participants. The CHC-MCO must also provide written policies and procedures for coordinating Enrollment information with the Department's IEE. The CHC-MCO must receive advance written approval from the Department regarding these policies and procedures. The CHC-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 which have been prior approved by the Department for operation in a CHC zone. Unless otherwise required by law, the CHC-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

The CHC-MCO must enroll any Eligible Individual who selects or is assigned to the CHC-MCO in accordance with the Enrollment/Disenrollment dating rules that are determined and provided by the Department on the Intranet supporting CHC and the Automatic Assignment Exhibit, Exhibit ZZ regardless of the Eligible Individual's race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, gender identity, income status, program participation, Grievance status, Medical Assistance category status, health status, pre-existing condition, physical or mental disability or anticipated need for healthcare.

7. Enrollment of Newborns

Newborns will initially be enrolled in Medical Assistance FFS and not in the CHC-MCO.

8. Transitioning Participants Between CHC-MCOs

It may be necessary to transition a Participant between CHC-MCOs. Participants should be assisted by their Service Coordinators to facilitate a seamless transition. The CHC-MCO must follow the Department's established procedures as outlined in Exhibit BB of this agreement, CHC-MCO Participant Coverage Document.

9. Transitioning Participants Between CHC-MCOs and LIFE Programs

The Participant may voluntarily choose to transition between CHC-MCO and LIFE, where available, and if the Participant meets the eligibility criteria for LIFE. Eligible Participants must be assisted by their CHC-MCO Service Coordinators to facilitate a seamless transition. All transitions to the LIFE program will be effective on the date specified by the Department.

10. Change in Status

The CHC-MCO must report to the Department on a weekly

Enrollment/Alert file the following: pregnancy (not on CIS), death, and return mail alerts in accordance with Section VIII.B.5.

The CHC-MCO must report to the appropriate CAO using the CAO notification form any changes in the status of families or individual Participants within ten (10) business days of the change becoming known. These changes include phone number, address, pregnancy, death and family addition/deletion. A detailed explanation of how the information was verified must also be included on the form.

11. Participant Files

a. Monthly File

The Department will provide a Monthly Participant File for each CHC-MCO on the next to the last Saturday of each month. The file contains the Medical Assistance Eligibility Period, CHC-MCO coverage, BH-MCO coverage and other Participant demographic information. It will contain only one record for each Community HealthChoices Participant (the most current) where the Participant is both Medical Assistance and CHC eligible at some point in the following month. The CHC-MCO must reconcile this Participants file against its internal Participant information and notify the Department of any discrepancies found within the data on the file within thirty (30) business days.

Participants not included on this file with an indication of prospective coverage will not be the responsibility of the CHC-MCO unless a subsequent Daily Participant File indicates otherwise. Those with an indication of future month coverage will not be the responsibility of the CHC-MCO if an 834 Daily Participant File received by the CHC-MCO prior to the beginning of the future month indicates otherwise.

b. Daily File

The Department will provide to the CHC-MCO an Daily Participant File that contains record(s) for each Community HealthChoices Participant where data for that Participant has changed that day. The file will contain add, termination and change records, but will contain only one type of managed care coverage—either CHC, PH or BH. The file contains demographic changes, eligibility changes, Enrollment changes, Participants enrolled through the automatic assignment process, and TPL information. The CHC-MCO must process this file within 24 hours of receipt.

The CHC-MCO must reconcile this file against its internal Participant information and notify the Department of any discrepancies within thirty (30) business days.

12. Enrollment and Disenrollment Updates

a. Weekly Enrollment/Alert Reconciliation File

The Department will provide, every week by electronic file transmission, information on Participants enrolled or disenrolled. This file also provides dispositions on alerts submitted by the CHC-MCO. The CHC-MCO must use this file to reconcile alerts submitted to the Department.

b. Disenrollment Effective Dates

Participant disenrollments will become effective on the date specified by the Department. The CHC-MCO must have written policies and procedures for complying with disenrollment decisions made by the Department. Policies and procedures must be approved by the Department.

c. Discharge/Transition Planning

When any Participant is disenrolled from the CHC-MCO the CHC-MCO from which the Participant disenrolled remains responsible for participating in discharge/transition planning for up to six (6) months from the initial date of Disenrollment. The CHC-MCO must remain the Participant's CHC-MCO upon discharge (upon returning to the CHC zone covered by this agreement), unless the Participant chooses a different CHC-MCO or is determined to no longer be eligible for participation in CHC, provided that the Participant is discharged within six (6) months of the initial CHC-MCO Disenrollment date.

If the Participant chooses a different CHC-MCO, the receiving CHC-MCO must participate in the discharge/transition planning upon notification that the Participant has chosen its CHC-MCO.

13. Services for New Participants

The CHC-MCO must make available all Covered Services to any new Participant as of the Participant's Effective Date of Enrollment provided by the Department and must comply with the Continuity of Care requirements outlined in Section V.C. of this agreement. .

The CHC-MCO must ensure that existing Providers, existing service plans, and pertinent demographic information about the Participant collected through the IEE or directly indicated to the CHC-MCO by the Participant after Enrollment, will be used by the CHC-MCO upon the new Participant's effective Date of Enrollment in the CHC-MCO. The CHC-MCO must assure that the new Participants' needs

are adequately addressed.

The CHC-MCO must comply with access standards as required in Exhibit AAA Provider Network Composition/Service Access and follow the appointment standards described in Exhibit AAA when an appointment is requested by a Participant.

14. New Participant Orientation

The CHC-MCO must have written policies and procedures for new Participants or a written orientation plan or program that includes:

- Educational and preventative care programs that include an emphasis on health promotion, wellness and healthy lifestyles and practices,
- The proper use of the CHC-MCO identification card and the Department's ACCESS Card,
- The role of the PCP,
- The role of the Service Coordinator,
- The needs assessment process,
- The role of the PSPT,
- Person-Centered Service Plans and the service planning process,
- Access to behavioral health services, transportation, home modifications, etc.,
- Participant-Directed models,
- What to do in an emergency or urgent medical situation,
- How to utilize services in other circumstances,
- How to request information from the CHC-MCO
- How to register a Complaint, file a Grievance or request a DHS Fair Hearing.
- Service Coordination Unit and how to contact it directly, if necessary.

The CHC-MCO must obtain the Department's advance written approval of these policies and procedures.

The CHC-MCO is prohibited from contacting a potential Participant who is identified on the Daily Participant Enrollment File with an

automatic assignment indicator (either an "A" auto assigned or "M" Participant assigned) until five (5) business days before the effective date of the Participant's Enrollment otherwise at the request of the Department.

15. CHC-MCO Identification Cards

The CHC-MCO must issue its own identification card to Participants. The Department also issues an identification card, called an ACCESS Card, to each Participant, who is required to use when accessing services. Providers must use this card to access the Department's EVS and to verify the Participant's eligibility. The ACCESS Card will allow the Provider the capacity to access the most current eligibility information without contacting the CHC-MCO directly. The CHC-MCO must issue a single identification card to Participants enrolled in the aligned D-SNP for both the CHC-MCO and the D-SNP.

16. Participant Handbook

The CHC-MCO must provide a Participant handbook, or other written materials, with information on Participant rights and protections and how to access services, in the appropriate language or alternate format to Participants within five (5) business days of a Participant's effective date of Enrollment. The CHC-MCO may provide the Participant handbook in formats other than hard copy. If this option is exercised, the CHC-MCO must inform Participants what formats are available and how to access each format. The CHC-MCO must maintain documentation verifying that the Participant handbook is reviewed for accuracy at least once a year, and that all necessary modifications have been made. The CHC-MCO must notify all Participants on an annual basis of any changes made, and the formats and methods available to access the handbook. Upon request, the CHC-MCO must provide a hard copy version of the Participant handbook to the Member.

a. Participant Handbook Requirements

The CHC-MCO must provide that the Participant handbook is written at no higher than a sixth grade reading level and includes, at a minimum, the information outlined in Exhibit DD of this agreement, CHC-MCO Participant handbook.

The handbook must reference, and include a link to the handbook for the aligned D-SNP so that Participants enrolled in both plans may easily reference the D-SNP handbook.

Additionally, the CHC-MCO must ensure that (i) the font and format are readily accessible, (ii) the information is placed on its CHC-MCO website is prominent and readily accessible, (iii)

the information is provided in an electronic form which can be electronically retained and printed,

b. Department Approval

The CHC-MCO must submit the Participant handbook to the Department for advance written approval prior to distribution to Participants. The CHC-MCO must make any modifications in the language contained in the Participant handbook if required for Department approval.

The handbook must reference, and include a link to the handbook for the aligned D-SNP so that Participants enrolled in both plans may easily reference the D-SNP handbook.

17. Provider Directories

The CHC-MCO must make a single directory for all types of Network Providers.

The CHC-MCO must utilize a web-based Provider directory. The CHC-MCO must establish a process to ensure the accuracy of electronically posted content, including a method to monitor and update changes in Provider information. The CHC-MCO must perform at least monthly reviews and revisions of the web-based Provider directory, subject to random monitoring by the Department to ensure complete and accurate entries.

The CHC-MCO must provide the IEE with an updated electronic version of their Provider directory at a minimum on a weekly basis. This will include information regarding terminations, additions, PCPs and specialists not accepting new assignments, and other information determined by the Department to be necessary. The CHC-MCO must utilize the file layout and format specified by the Department. The format must include, but not be limited to the following:

- Correct Provider ID
- All Providers in the CHC-MCO's Network
- The location where the PCP will see Participants, as well as whether the PCP has evening and/or weekend hours
- Accessibility of the Provider site to persons with physical disabilities
- Language indicators including non-English language spoken by the Providers.

The CHC-MCO must notify its Participants annually of their right to request and obtain hard copy Provider Directories and where the online directories may be found. Upon request, the CHC-MCO must provide its Participants with its Provider Directories for all providers which include, at a minimum, the information listed in Exhibit FF of this agreement, PCP, Dentists, Specialists and Providers of Ancillary Services Directories. Upon request from the Participant, the CHC-MCO may print the most recent electronic version from their Provider file and mail it to the Participant.

The CHC-MCO must submit all Provider directories to the Department for advance written approval before distribution to its Participants if there are significant format changes to the directory.

The Directory must reference and include a link to the directory for the aligned D-SNP so that Participants enrolled in both plans may easily reference the D-SNP directory.

18. Participant Advisory Committee

The CHC-MCO must establish and maintain a Participant Advisory Committee (PAC) that includes CHO-MCO Member and Network Providers to advise on the experiences and needs of Participants. Representation on the PAC must include Participants who are representative of the population being served as well as family caregivers. Provider representation must include physical health, behavioral health, dental health and LTSS. The CHC-MCO must provide the Department annually with the membership (including designation) and meeting schedule of the PAC. The PAC membership must be composed of at least 60% of CHO-MCO Participants, with 25% of the total membership receiving LTSS. In addition to the individual diversity listed, geographic diversity should also be sought including both rural and urban representation.

The meeting schedule must be no less than quarterly with in-person meetings, and travel expenses for Participants or their family members need to be reimbursed. Any reasonable accommodations necessary must be made available to ensure in-person access to the PAC.

The CHC-MCO must also work with the Department to ensure that its PAC members are provided with an effective means to consult with each other and, when appropriate, coordinate efforts and resources for the benefit of the entire CHC population in the zone and/or populations with LTSS needs. The CHC-MCO must report out any updates or proposed changes, the number and nature of complaints, and any quality improvement strategies or implementations. PAC Members should be invited to raise questions and concerns about any topics affecting their quality of life and their experience of the plan. Minutes of the PAC must be provided to the Department by the CHC-MCO and made public on the CHC-MCO

website.

19. Voluntary Disenrollment

Participants may only voluntarily disenroll from the CHC program if

- They are eligible for and transition to LIFE or
- They are choosing to no longer receive any Medicaid-covered services.

20. Involuntary Disenrollment

The CHC-MCO may not request Disenrollment of a Participant because of an adverse change in the Participant's health status, or because of the Participant's utilization of Covered Services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her condition, disability, diagnosis, or needs. The CHC-MCO may not reassign or remove a Participant involuntarily from Network Providers who are willing and able to serve the Participant.

The Service Coordinator will provide assistance to the disenrolled Participant to access other resources in order to ensure continuity of care.

P. Participant Services

1. General

The CHC-MCO's Participant services functions must be operational at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday) and one (1) evening per week (5:00 p.m. to 8:00 p.m.) or one (1) weekend per month to address non-emergency problems encountered by Participants. The CHC-MCO must have arrangements to receive, identify, and resolve in a timely manner Emergency Participant Issues on a twenty-four (24) hour, seven (7) day-a-week basis. The CHC-MCO's Participant services functions must include, but are not limited to, the following:

- Explaining the operation of the CHC-MCO and assisting Participants in the selection of a PCP.
- Assisting Participants with making appointments and obtaining services, including interpreter services, as needed.
- Assisting with arranging transportation for Participants through the MATP. See Section V.A.15., Transportation and Exhibit L, Medical Assistance Transportation Program.
- Receiving, identifying and resolving Emergency Participant

Issues.

Under no circumstances will unlicensed Participant services staff provide health-related advice to Participants requesting clinical information. The CHC-MCO must require that all such inquiries are addressed by clinical personnel acting within the scope of their licensure to practice a health-related profession.

The CHC-MCO must forward all calls received by the Participant service area in which the caller requests their Service Coordinator. In the event the call is received beyond the hours of availability of the Service Coordinator, CHC-MCO staff must record a message, including the Participant's name, Participant identification number and call back number, which will be forwarded to the Service Coordinator staff for a return call to the Participant. The Service Coordinator must return the call as soon as possible but no longer than two (2) business days from the receipt of the call.

2. CHC-MCO Internal Participant Dedicated Hotline

The CHC-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated hotline to respond to Participants' inquiries, issues and problems regarding services. The CHC-MCO's internal Participant hotline staff is required to ask the callers whether or not they are satisfied with the response given to their call. The CHC-MCO must document all calls and if the caller is not satisfied, the CHC-MCO must refer the call to the appropriate individual within the CHC-MCO for follow-up and/or resolution. This referral must take place within forty-eight (48) hours of the call.

The CHC-MCO must provide the Department with the capability to monitor the CHC-MCO's Participant services and internal Participant dedicated hotline from each of the CHC-MCO's offices. The Department will only monitor calls from Participants or their representatives and will cease all monitoring activity as soon as it becomes apparent that the call is not related to a Participant.

The CHC-MCO is not permitted to utilize electronic call answering methods, as a substitute for staff persons, to perform this service. The CHC-MCO must ensure that its dedicated hotline meets the following Participant services performance standards:

- Provides for a dedicated toll-free phone line for its Participants.
- Provide for necessary translation and interpreter assistance for LEP Participants.
- Require representatives to document calls and forward call notes to the Participant's Service Coordinator.
- Be staffed by individuals trained in:

- Cultural, Linguistic, and Disability Competency.
 - addressing the needs of covered populations.
 - the availability of, contact information for, and the functions of the Service Coordination Unit.
 - the requirements for accessibility.
 - coordination with BH-MCOs.
 - how to identify and handle any emergency.
 - when to transfer callers to the nurse hotline.
 - Covered Services, the availability of protective and social services within the community. Medicare coverage and to address questions that relate to the CHC-MCO's companion D-SNP plan.
 - Medical and non-medical transportation.
- Be staffed with adequate service representatives so that the abandonment rate of less than or equal to five percent (5%) of the total calls.
 - Be staffed with adequate service representatives so that at least 85% of all calls are answered within thirty (30) seconds.
 - Provide for TTY and/or Pennsylvania Telecommunication Relay Service availability for Participants who are deaf or hard of hearing.

3. Nurse Hotline

The CHC-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated nurse hotline to respond to Participants' urgent health matters.

4. Education and Outreach/Health Education Advisory Committee

The CHC-MCO must establish and maintain a Health Education Advisory Committee that includes Participants and Providers in the community to advise on the health education needs of Participants. Provider representation includes physical health, LTSS, behavioral health, and dental health Providers. The CHC-MCO must provide the Department annually with the membership (including designation) and meeting schedule of the Health Education Advisory Committee.

The CHC-MCO must provide for and document coordination of health education materials, activities, and programs with public health entities, particularly as they relate to public health priorities and population-based interventions. Population-based interventions include those that are relevant to the populations being served and that take into consideration the ability of these populations to understand and act upon health information. The CHC-MCO must also work with the Department to ensure that its Health Education

Advisory Committees are provided with an effective means to consult with each other and, when appropriate, coordinate efforts and resources for the benefit of the entire Community HealthChoices population in the CHC zone and/or populations with Special Needs.

The CHC-MCO must provide the Department with a written description of all planned health education activities and targeted implementation dates on an annual basis.

5. Informational Materials

The CHC-MCO must distribute Participant newsletters at least three times each year to each Participant household. The CHC-MCO may provide the Participant newsletters in formats other than hard copy, but must provide a hard copy to every Participant who asks for one. The CHC-MCO must include information about common procedures in its Participant newsletter and information provided by the Department related to Departmental initiatives, and make the same information available on its website in an effort to increase Participant health literacy. The CHC-MCO should also provide information about its aligned D-SNP including the services covered, the enhanced Service Coordination available to those enrolled in both, and how to request enrollment. The CHC-MCO must obtain advance written approval from the Department of all Participant newsletters. The CHC-MCO must notify all Participants of the availability and methods to access each Participant newsletter.

The CHC-MCO must obtain advance written approval from the Department to use Participant or Community HealthChoices Program related information on electronic web sites and bulletin boards which are accessible to the public or to the CHC-MCO's Participants.

Q. Additional Addressee

The CHC-MCO must have administrative mechanisms for sending copies of information, notices and other written materials to a designated third party upon the request and signed consent of the Participant. The CHC-MCO must develop plans to process such individual requests and for obtaining the necessary releases signed by the Participant to ensure that the Participant's rights regarding confidentiality are maintained.

R. Participant Complaint, Grievance and DHS Fair Hearing Process

1. Participant Complaint, Grievance and DHS Fair Hearing Process

The CHC-MCO must develop, implement, and maintain a Complaint and Grievance process that provides for settlement of Participants' Complaints and Grievances and the processing of requests for DHS Fair Hearings as outlined in Exhibit GG, Complaint, Grievance, and DHS Fair Hearing Processes. The CHC-MCO must use the required

templates to inform Participants regarding decisions and the process. Templates GG(1) through GG(14) are available on the Intranet supporting CHC.

The CHC-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 which have been prior approved by the Department. Unless otherwise required by law, the CHC-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version.

The CHC-MCO must require each of its subcontractors to comply with the Participant Complaint, Grievance, and DHS Fair Hearing Process. This includes reporting requirements established by the CHC-MCO, which have received advance written approval by the Department. The CHC-MCO must provide to the Department for approval, its written procedures governing the resolution of Complaints and Grievances and the processing of DHS Fair Hearing requests. There must be no delegation of the Complaint, Grievance and Fair Hearing process to a subcontractor without prior written approval of the Department.

The CHC-MCO must abide by the final decision of DOH when a Participant has filed an external appeal of a second level Complaint decision.

When a Participant files an external appeal of a second level Grievance decision, the CHC-MCO must abide by the decision of the DOH's certified review entity (CRE), which was assigned to conduct the independent external review, unless appealed to the court of competent jurisdiction.

The CHC-MCO must abide by the final decision of BHA for those cases when a Participant has requested a DHS Fair Hearing and a stay of the BHA decision pending reconsideration and the stay is granted only the Participant may appeal to Commonwealth Court. The decisions of the Secretary and the Court are binding on the CHC-MCO.

2. DHS Fair Hearing Process for Participants

During all phases of the CHC-MCO Grievance process, and in some instances involving Complaints, the Participant has the right to request a Fair Hearing with the Department. The CHC-MCO must comply with the DHS Fair Hearing Process requirements defined in Exhibit GG of this agreement, Complaint, Grievance and DHS Fair Hearing Processes.

A request for a DHS Fair Hearing does not prevent a Participant from also utilizing the CHC-MCO's Complaint or Grievance process. If a

Participant requests both an external appeal/review and a DHS Fair Hearing, and if the decisions rendered are in conflict with one another, the CHC-MCO must abide by the decision most favorable to the Participant. In the event of a dispute or uncertainty regarding which decision is most favorable to the Participant, the CHC-MCO will submit the matter to DHS' Grievance and Appeals Coordinator for review and resolution.

S. OLTL and other DHS Hotlines

The CHC-MCO will cooperate with OLTL and other DHS Hotlines, which are intended to address clinically-related systems issues encountered by Participants and their advocates or Providers.

T. Provider Dispute Resolution Process

The CHC-MCO must develop, implement, and maintain a Provider Dispute Resolution Process, which provides for informal resolution of Provider Disputes at the lowest level and a formal process for Provider Appeals. The resolution of all issues regarding the interpretation of Department approved Provider Agreements must be handled between the two (2) entities and shall not involve the Department; therefore, Provider disputes and appeals are not within the jurisdiction of the Department's BHA.

Prior to implementation, the CHC-MCO must submit to the Department its policies and procedures for resolution of Provider Disputes/Provider Appeals for approval. Any changes made to the Provider Disputes/Provider Appeals policies and procedures must be submitted to the Department for approval prior to implementation of the changes.

The CHC-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 which have been prior approved by the Department. Unless otherwise required by law, the CHC-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

The CHC-MCO's Provider Disputes/Provider Appeals policies and procedures must include at a minimum:

- Informal and formal processes for settlement of Provider Disputes.
- Acceptance and usage of the Department's definition of Provider Appeals and Provider Disputes.
- Time frames for submission and resolution of Provider Disputes/Provider Appeals.
- Processes to ensure equitability for all Providers.
- Mechanisms and time-frames for reporting Provider Appeal decisions to

CHC-MCO administration, QM, Provider Relations and the Department.

- Establishment of a CHC-MCO Committee to process formal Provider Disputes/Provider Appeals which must provide:
 - At least one-fourth (1/4th) of the membership of the Committee must be composed of Providers/peers.
 - Committee members who have the authority, training, and expertise to address and resolve Provider Dispute/Provider Appeal issues.
 - Access to data necessary to assist committee members in making decisions.
 - Documentation of meetings and decisions of the Committee.

U. Certification of Authority and County Operational Authority

The CHC-MCO must maintain a Certificate of Authority to operate as an HMO in Pennsylvania. The CHC-MCO must provide to the Department a copy of its Certificate of Authority upon request.

The CHC-MCO must also maintain operating authority in each county within its zone. The CHC-MCO must provide to the Department a copy of the DOH correspondence granting operating authority in each such county upon request.

V. Executive Management

The CHC-MCO must include in its Executive Management structure:

- A full-time Administrator with authority over the entire operation of the CHC-MCO.
- A full-time CHC Program Manager to oversee the operation of the agreement, if different than the Administrator.
- A full-time Medical Director who is a current Pennsylvania-licensed physician. The Medical Director must be actively involved in all major clinical program components of the CHC-MCO and directly participates in the oversight of the QM Department and UM Department. The Medical Director and his/her staff/consultant physicians must devote sufficient time to the CHC-MCO to provide timely medical decisions, including after-hours consultation, as needed.
- A full-time Pharmacy Director who is a current Pennsylvania-licensed pharmacist. The Pharmacy Director oversees the pharmacy management and serves on the CHC-MCO P&T Committee.
- A full-time Director of Quality Management who is a Pennsylvania-licensed registered nurse, physician or physician's assistant or is a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Healthcare Quality (NAHQ) Certified in Healthcare Quality

and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The Director of Quality Management must be located in Pennsylvania and have experience in quality management and quality improvement. Sufficient local staffing under this position must be in place to meet quality management Requirements. The primary functions of the Director of Quality Management position are:

- Ensure individual and systemic quality of care
 - Integrate quality throughout the organization
 - Implement process improvement
 - Resolve, track, and trend quality of care complaints
 - Ensure a credentialed Provider network
-
- A full-time Director of LTSS who is responsible for and oversight of all LTSS in the program. The Director of LTSS must have at least five (5) years of experience administering managed long-term care programs. On a case-by-case basis, equivalent experience in administering long-term care programs and services, including HCBS, or in managed care may be substituted, subject to the prior approval of the Department.
 - A full-time CFO to oversee the budget and accounting systems implemented by the CHC-MCO. The CFO must ensure the timeliness and accuracy of all financial reports. The CFO shall devote sufficient time and resources to responsibilities under this agreement.
 - A full-time Information Systems (IS) Coordinator, who is responsible for the oversight of all information systems issues with the Department. The IS Coordinator must have a good working knowledge of the CHC-MCO's entire program and operation, as well as the technical expertise to answer questions related to the operation of the information system.

These full time positions must be solely dedicated to the PA Community HealthChoices Program.

W. Other Administrative Components

The CHC-MCO must provide for each of the administrative functions listed below. For those positions not indicated as full time, the CHC-MCO may combine or split the functions as long as the CHC-MCO can demonstrate that the duties of these functions conform to the agreement requirements.

- A Quality Management/Quality Improvement (QM/QI) Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant with past experience or education in QM systems. The Department may consider other advanced degrees relevant to QM in lieu of professional licensure. The QM/QI Coordinator is responsible for overseeing reporting and outcome measurement and HEDIS data collection, serving as point person between the Department and the

Department's EQR contractor.

- A Behavioral Health Coordinator who is a behavioral health professional and is located in Pennsylvania. The Behavioral Health Coordinator shall ensure that the CHC-MCO adhere to behavioral health requirements in this agreement. The primary functions of the Behavioral Health Coordinator are:
 - Coordinate Participant behavioral care needs with behavioral health Providers.
 - Develop processes to coordinate behavioral healthcare between PCPs and behavioral health Providers.
 - Participate in the identification of best practices for behavioral health in a primary care setting.
 - Coordinate behavioral care with medically necessary services.
- A Director of Network Management who coordinates all communications and contractual relationships between the CHC-MCO and its subcontractors and Providers. The Director of Network Management must be located in Pennsylvania and ensures that Providers receive prompt resolution to their problems or inquiries, appropriate education about participation in the CHC program and maintain a sufficient Provider Network. Individual Provider representatives are expected to report directly to the Director of Network Management.
- A UM Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant with past experience or education in UM systems. The Department may consider other advanced degrees relevant to UM in lieu of professional licensure.
- A full-time Director of Service Coordination oversees all Service Coordination functions of the CHC plan and who shall have the qualifications of a Service Coordinator and a minimum of five years of management/supervisory experience in the healthcare field. The Director of Service Coordination is responsible for all Service Coordination functions, whether the CHC-MCO provides all Service Coordinator functions in house or contracts with outside entities to meet Service Coordination requirements.
- A full-time Government Liaison who serves as the Department's primary point of contact with the CHC-MCO for day-to-day management of contractual and operational issues. The CHC-MCO must have a designated back-up trained to be able to handle urgent or time-sensitive issues when the Government Liaison is not available.
- A Participant Services Manager who oversees staff to coordinate communications with Participants and enables Participants to receive prompt resolution of their issues, problems or inquiries.
- A Provider Services Manager who oversees staff to coordinate

communications between the CHC-MCO and its Providers. There must be sufficient CHC-MCO Provider services, or equivalent department that addresses this function, staff to promptly resolve Provider Disputes, problems or inquiries. Staff must also be adequately trained to understand Cultural, Linguistic, and Disability competencies.

- A Provider Claims Educator who is located in Pennsylvania and facilitates the exchange of information between the Grievances, Claims processing, and Provider relations systems. The primary functions of the Provider Claims Educator are:
 - Educate contracted and non-contracted Providers (e.g. HCBS Providers and Participant-Directed Services Providers) regarding appropriate Claims submission requirements, coding updates, electronic Claims transactions and electronic fund transfer, and available CHC-MCO resources such as Provider manuals, website, fee schedules, etc.
 - Interface with the CHC-MCO's call center to compile, analyze, and disseminate information from Provider calls.
 - Identify trends and guide the development and implementation of strategies to improve Provider satisfaction.
 - Frequently communicate (i.e., telephonic and on-site) with Providers to assure the effective exchange of information and gain feedback regarding the extent to which Providers are informed about appropriate claims submission practices.
- A Complaint, Grievance and DHS Fair Hearing Coordinator whose qualifications demonstrate the ability to assist Participants throughout the Complaint, Grievance and DHS Fair Hearing processes.
- A Claims Administrator who oversees staff to ensure the timely and accurate processing of Claims, Encounter forms and other information necessary for meeting agreement requirements and the efficient management of the CHC-MCO.
- A Contract Compliance Officer who ensures that the CHC-MCO is in compliance with all the requirements of the agreement.

All CHC-MCO staff must have appropriate training, education, experience, and orientation to fulfill the requirements of the position. The CHC-MCO must update job descriptions for each of the positions if responsibilities for these positions change.

The CHC-MCO's staffing should represent the racial, ethnic, and cultural diversity of the Participants being served by CHC and comply with all requirements of Exhibit D, Standard Terms and Conditions for Services. Cultural Competency may be reflected by the CHC-MCO's pursuit to:

- Identify and value differences.
- Acknowledge the interactive dynamics of cultural differences.
- Continually expand cultural knowledge and resources with regard to the populations served.
- Recruit racial and ethnic minority staff in proportion to the populations served.
- Collaborate with the community regarding service provisions and delivery.
- Commit to cross-cultural training of staff and the development of policies to provide relevant, effective programs for the diversity of people served.

The CHC-MCO must have in place sufficient administrative staff and organizational components to comply with the requirements of this agreement. The CHC-MCO must include in its organizational structure, the components outlined in the agreement. The functions must be staffed by qualified persons in numbers appropriate to the CHC-MCO's size of Enrollment. The Department has the right to make the final determination regarding whether or not the CHC-MCO is in compliance.

The CHC-MCO may combine functions or split the responsibility for a function across multiple departments, unless otherwise indicated, as long as it can demonstrate that the duties of the function are being carried out. Similarly, the CHC-MCO may contract with a third party to perform one (1) or more of these functions, subject to the subcontractor conditions described in Section XIII, Subcontractual Relationships. The CHC-MCO is required to keep the Department informed at all times of the management individual(s) whose duties include each of the responsibilities outlined in this section.

X. Administration

The CHC-MCO must have an administrative office within each CHC zone covered by this agreement. The Department may grant exceptions to this requirement on an individual basis if the CHC-MCO has administrative offices elsewhere in Pennsylvania and the CHC-MCO is in compliance with all standards set forth by the DOH and PID.

The CHC-MCO must submit for review by the Department its organizational structure listing the function of each executive as well as administrative staff members. Staff positions outlined in this agreement must be approved and maintained in accordance with the Department's requirements. The Community HealthChoices key personnel must be available to the Department upon request.

1. Recipient Lock-in Program

A Centralized Recipient Lock-in Program is in place for the Medical Assistance FFS and the managed care delivery systems and is managed by the Department's Bureau of Program Integrity (BPI).

The CHC-MCO will maintain a Recipient Lock-in Program to interface with the Department's Recipient Lock-in Program, which will provide for appropriate professional resources to manage the program and to cooperate with the Department in all procedures necessary to restrict Participants. The Department has the sole authority to restrict Participants and has oversight responsibility of the CHC-MCO's Recipient Lock-in Program. The CHC-MCO must obtain approval from the Department prior to implementing a lock-in, including approval of written policies and procedures and correspondence to Participants. The CHC-MCO's process must include:

- Identifying Participants who are overutilizing and/or misutilizing medical services.
- Evaluating the degree of abuse including review of pharmacy and medical claims history, diagnoses and other documentation, as applicable.
- Proposing whether the Participant should be restricted to obtaining services from a single, designated Provider for a fixed period.
- Forwarding case information and supporting documentation to BPI at the address below, for review to determine appropriateness of lock-in and to approve the action.
- Upon BPI approval, sending notification via certified mail to Participant of proposed lock-in, including reason for lock-in, effective date and length of lock-in, name of designated Provider(s) and option to change Provider, with a copy to BPI.
- Sending notification of Participant's lock-in to the designated Provider(s) and the CAO.
- Enforcing the lock-ins through appropriate notifications and edits in the claims payment system.
- Preparing and presenting case at a DHS Fair Hearing to support lock-in action.
- Monitoring subsequent utilization to ensure compliance.
- Changing the selected Provider per the Participant's or Provider's request, within thirty (30) days from the date of the request, with prompt notification to BPI through the Intranet Provider change process.
- Continuing a Participant lock-in from the previous delivery system as a Participant enrolls in a MCO, with written notification to BPI.
- Reviewing the Participant's services prior to the end of the lock-in period to determine if the lock-in should be removed or maintained, with notification of the results of

the review to BPI, Participant, Provider(s) and CAO.

- Performing necessary administrative activities to maintain accurate records.
- Educating Participants and Providers to the lock-in program, including explanations in handbooks and printed materials.

MA Participants have the right to appeal a lock-in by requesting a DHS Fair Hearing. Participants may not file a Complaint or Grievance with the CHC-MCO regarding the lock-in action. A request for a DHS Fair Hearing must be in writing, signed by the Participant and sent to:

Department of Human Services
Office of Administration
Bureau of Program Integrity
Division of Program and Provider Compliance
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Phone number: (717) 772-4627

2. Contracts and Subcontracts

CHC-MCO may, as provided below, rely on subcontractors to perform and/or arrange for the performance of services to be provided to Participants on whose behalf the Department makes Capitation payments to CHC-MCO. Notwithstanding its use of subcontractor(s), CHC-MCO is responsible for compliance with the agreement, including:

- a. for the provision of and/or arrangement for the services to be provided under this agreement.
- b. for the evaluation of the prospective subcontractor's ability to perform the activities to be delegated.
- c. for the payment of any and all claims payment liabilities owed to Providers for services rendered to Participants under this agreement, for which a subcontractor is the primary obligor provided that the Provider has exhausted its remedies against the subcontractor; provided further that such Provider would not be required to continue to pursue its remedies against the subcontractor in the event the subcontractor becomes insolvent, in which case the Provider may seek payment of such Claims from the CHC-MCO. For the purposes of this section, the term "insolvent" shall mean:
 - i. The adjudication by a court of competent jurisdiction or administrative tribunal of a party as a bankrupt or

otherwise approving a petition seeking reorganization, readjustment, arrangement, composition, or similar relief under the applicable bankruptcy laws or any other similar, applicable Federal or State law or statute; or

i. The appointment by such a court or tribunal having competent jurisdiction of a receiver or receivers, or trustee, or liquidator or liquidators of a party or of all or any substantial part of its property upon the application of any creditor or other party entitled to so apply in any insolvency or bankruptcy proceeding or other creditor's suit; and

d. for the oversight and accountability for any functions and responsibilities delegated to any subcontractor.

The above notwithstanding, if the CHC-MCO makes payments to a subcontractor over the course of a year that exceed one-half of the amount of the Department's payments to the CHC-MCO, the CHC-MCO is responsible for any obligation by the subcontractor to a Provider that is overdue by at least sixty (60) days.

The CHC-MCO shall ensure that all subcontractors and Network Providers comply with all applicable CHC program requirements.

CHC-MCO shall indemnify and hold the Commonwealth of Pennsylvania, the Department and their officials, representatives, and employees harmless from any and all liabilities, losses, settlements, claims, demands, and expenses of any kind (including but not limited to attorneys' fees) which are related to any and all Claims payment liabilities owed to Providers for services rendered to Participants under this agreement for which a subcontractor is the primary obligor, except to the extent that the CHC-MCO and/or subcontractor has acted with respect to such Provider Claims in accordance with the terms of this agreement.

The CHC-MCO must make all Subcontracts available to the Department within five (5) days of a request by the Department. All Contracts and Subcontracts must be in writing and must include, at a minimum, the provisions contained in Exhibit II of this agreement, Required Contract Terms for Administrative Subcontractors.

In accordance with Exhibit D, the CHC-MCO must submit for prior approval subcontracts between the CHC-MCO and any individual, firm, corporation or any other entity to perform part or all of the selected CHC-MCO's responsibilities under this agreement. This provision includes, but is not limited to, contracts for vision services, dental services, Claims processing, Participant services, and pharmacy services.

Y. Records Retention

The CHC-MCO will comply with the program standards regarding records retention, which are set forth in federal and state law and regulations and in Exhibit D, Standard Grant Terms and Conditions for Services, of this agreement, except that, for purposes of this agreement, all records must be retained for a period of five (5) years beyond expiration or termination of the agreement, unless otherwise authorized by the Department. Upon thirty (30) days notice from the Department, the CHC-MCO must provide copies of all records to the Department at the CHC-MCO's site or other location determined by the Department, if requested. This thirty (30) days notice does not apply to records requested by the state or federal government for purposes of fiscal audits or Fraud and/or Abuse investigations. The retention requirements in this section do not apply to DHS-generated Remittance Advices.

Z. Fraud and Abuse

The CHC-MCO must develop and implement administrative and management arrangements or procedures and a mandatory written compliance plan to prevent, detect, and correct Fraud, waste, and Abuse that contains the following elements described in CMS publication "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" found at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf> and that includes the following:

- Written policies, procedures, and standards of conduct that articulate the CHC-MCO's commitment to comply with all Federal and State standards related to Medical Assistance MCOs.
- The designation of a compliance officer and a compliance committee that is accountable to CHC-MCO senior management.
- Effective training and education for the compliance officer and CHC-MCO employees.
- Effective lines of communication between the compliance officer and CHC-MCO employees.
- Enforcement of standards through well publicized disciplinary guidelines.
- Provisions for internal monitoring and auditing.
- Provisions for prompt response to detected offenses and the development of corrective action initiatives.
- Procedures for systematic confirmation of services actually provided.
- Policies and procedures for reporting all Fraud, waste and Abuse to the Department.
- Policies and procedures for fraud, waste, and abuse prevention, detection and investigation.
- A policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not

limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

- A policy and procedure for monitoring provider preclusion through data bases identified by the Department.

a. Fraud, Waste and Abuse Unit

The CHC-MCO must establish a Fraud, Waste and Abuse Unit comprised of experienced Fraud, Waste and Abuse reviewers. This Unit must have the primary purpose of preventing, detecting, investigating, referring, and reporting suspected Fraud, Waste and Abuse that may be committed by Network Providers, Participants, caregivers, employees, or other third parties with whom the CHC-MCO contracts. If the CHC-MCO has multiple lines of business, the Fraud, Waste and Abuse Unit must devote sufficient time and resources to the CHC Program's Fraud, Waste and Abuse activities. The Department will make the final determination regarding whether or not the CHC-MCO is in compliance with these requirements.

b. Written Policies

The CHC-MCO must create and maintain written policies and procedures for the prevention, detection, investigation, reporting and referral of suspected Fraud, Waste and Abuse, including any and all fraud and abuse policies delineated under state and or federal mandate.

c. Access to Provider Records

The CHC-MCO's Fraud, Waste and Abuse policies and procedures must provide that the CHC-MCO's Fraud, Waste and Abuse Unit has access to records of Network Providers.

d. Audit Protocol

The CHC-MCO must inform all Network Providers of the Pennsylvania Medical Assistance Provider Self Audit Protocol which allows Providers to voluntarily disclose overpayments or improper payments of Medical Assistance funds. This includes, but is not limited to inclusion in the Provider handbooks. The CHC-MCO must provide written documentation that this action has been completed.

The protocol is available on the Department's Web site at www.DHS.pa.gov/ under "Fraud and Abuse."

e. Procedure for Identifying Fraud, Waste and Abuse

The CHC-MCO's policies and procedures must also contain the following:

- i. A description of the methodology and standard operating procedures used to identify and investigate Fraud, Waste and Abuse, including a method for verifying with Participants whether services billed by Providers were received, and to recover overpayments or otherwise sanction Providers.
- ii. A description of specific controls in place for Fraud, Waste and Abuse detection, including an explanation of the technology used to identify aberrant billing patterns, Claims edits, post processing review of Claims, and record reviews.

f. Referral to the Department

The CHC-MCO must establish and implement a policy on referral of suspected Provider Fraud, Waste and Abuse to the Department. A standardized referral process is outlined in Exhibit KK of this agreement, Reporting Suspected Fraud, Waste and Abuse to the Department, to expedite information for appropriate disposition.

g. Education Plan

The CHC-MCO must create and disseminate written materials for the purpose of educating its employees, managers, Providers, subcontractors and subcontractors' employees about healthcare Fraud laws, the CHC-MCO's policies and procedures for preventing and detecting Fraud, Waste and Abuse and the rights of employees to act as whistleblowers.

h. Referral to Senior Management

The CHC-MCO must develop a certification process that demonstrates the policies and procedures were reviewed and approved by the CHC-MCO's senior management on an annual basis.

i. Prior Department Approval

The Fraud, Waste and Abuse policies and procedures must be submitted to the Department for prior approval, and the Department may, upon review of these policies and procedures, require that specified changes be made within a designated time in order for the CHC-MCO to remain in compliance with the terms of the agreement. To the extent that changes to the Fraud, Waste and Abuse unit are made,

or the policies or procedures are altered, updated policies and procedures must be submitted promptly to the Department. The Department may also require new or updated policies and procedures during the course of the agreement period.

j. Duty to Cooperate with Oversight Agencies

The CHC-MCO and its employees must cooperate fully with oversight agencies responsible for Fraud, Waste and Abuse detection, investigation, and prosecution activities. Such agencies include, but are not limited to, the Department, Governor's Office of the Budget, Office of Attorney General, the Pennsylvania State Inspector General, the DHHS Office of Inspector General, CMS, the United States Attorney's Office/ Justice Department and the Federal Bureau of Investigations.

Such cooperation must include providing access to all necessary case information, computer files, and appropriate staff. In addition, such cooperation will include participating in periodic Fraud, Waste and Abuse training sessions, meetings, and joint reviews of subcontracted Providers or Participants.

l. Hotline Information

The CHC-MCO must distribute the Department's toll-free Medical Assistance Provider Compliance Hotline number and accompanying explanatory statement to its Participants and Providers through its Participant and Provider handbooks. Notwithstanding this requirement, the CHC-MCO is not required to re-print handbooks for the sole purpose of revising them to include Medical Assistance Provider Compliance Hotline information. The CHC-MCO must, however, include such information in any new version of these documents to be distributed to Participants and Providers.

m. Duty to Notify

i. Department's Responsibility

The Department will provide the CHC-MCO with immediate notice via electronic transmission or access to Medichex listings or upon request if a Provider with whom the CHC-MCO has entered into a Provider Agreement is subsequently suspended or terminated from participation in the Medical Assistance or Medicare Programs. Upon notification from the Department that a Network Provider is suspended or terminated from participation in the Medical Assistance or Medicare Programs, the CHC-MCO must

immediately act to terminate the Provider from its Network. Terminations for loss of licensure and criminal convictions must coincide with the Medical Assistance effective date of the action.

ii. CHC-MCO's Responsibility

The CHC-MCO may not knowingly have a Relationship with the following:

- An individual who is barred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, 48 CFR Parts 1-51, or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

“Relationship”, for purposes of this section, is defined as follows:

- A director, officer, or partner of the CHC-MCO.
- A person with beneficial ownership of five percent (5%) or more of the CHC-MCO's equity.
- A person with an employment, consulting or other arrangement for the provision of items and services that are significant and material to the CHC-MCO's obligations under this agreement with the Department.

The CHC-MCO must immediately notify the Department, in writing, if a Network Provider or subcontractor is suspended, terminated or voluntarily withdraws from participation in the Medical Assistance program as a result of suspected or confirmed Fraud, Waste or Abuse. The CHC-MCO must also immediately notify the Department, in writing, if it terminates or suspends an employee as a result of suspected or confirmed Fraud or Abuse. The CHC-MCO must inform the Department, in writing, of the specific underlying conduct that led to the suspension, termination, or voluntary withdrawal. Provider Agreements must carry notification of the prohibition and sanctions for submission of false Claims and statements. CHC-MCOs who fail to report such information are subject to sanctions, penalties, or other actions. The Department's enforcement guidelines are

outlined in Exhibit LL, Guidelines for Sanctions Regarding Fraud, Waste and Abuse.

The CHC-MCO must also notify the Department if it recovers overpayments or improper payments related to Fraud, Abuse or Waste of Medical Assistance funds from non-administrative overpayments or improper payments made to Network Providers, or otherwise takes an adverse action against a Network Provider, e.g. restricting the Participants or services of a PCP.

n. Sanctions

The Department may impose sanctions, or take other actions if it determines that a CHC-MCO, Network Provider, employee, caregiver or subcontractor has committed “Fraud” or “Abuse” as defined in this agreement or has otherwise violated applicable law. Exhibit LL, Guidelines for Sanctions Regarding Fraud, Waste and Abuse, identifies the Fraud, Waste and Abuse issues that may result in sanctions, as well as the range of sanctions available to the Department.

o. Subcontracts

- i. The CHC-MCO must require that all Network Providers and all subcontractors take such actions as are necessary to permit the CHC-MCO to comply with the Fraud, Waste and Abuse requirements in this agreement.
- ii. To the extent that the CHC-MCO delegates oversight responsibilities to a third party (such as a Pharmacy Benefit Manager), the CHC-MCO must require that such third party complies with sections 6a. – 6h. above, of this agreement.
- iii. The CHC-MCO will require, via its Provider Agreement that Network Providers comply with Medical Assistance regulations and any enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions.

p. Overpayment Recovery

- The CHC-MCO shall audit, review and investigate Providers within its network. The CHC-MCO shall recover any overpayments directly from its Network Providers for audits, reviews or investigations

conducted solely by the CHC-MCO.

- The CHC-MCO will void encounters for those claims involving full recovery of the payment and adjust encounters for partial recoveries.
 - All voids and adjustments to encounters will be reported to the Department
- The Department has the right to audit, review and investigate Medical Assistance Providers within the CHC-MCO's network.
 - The Department will develop a process to coordinate audits, reviews or investigations of the CHC-MCO's Network Providers to avoid duplication of effort.
 - The CHC-MCO cannot initiate a review of a Network Provider after the Department advises the CHC-MCO of an open review/investigation by the Department, its representative, or another state or federal agency, without written Departmental authorization to proceed.
 - The Department will inform the CHC-MCO of its findings related to the CHC-MCOs Network Providers.
 - The CHC-MCO must recoup overpayments resulting from audits, reviews or investigations conducted solely by the Department.
 - The CHC-MCO must recover overpayments identified by the Department from its Network Provider after the CHC-MCO receives the final results of the Department review.
 - The CHC-MCO must remit the overpayment to the Department no later than 180 calendar days after the mailing date of the final result of the review.
- The Department may require the CHC-MCO to withhold payment to a Network Provider or to initiate a pre-payment review as a result of law enforcement reviews and activities or the

Department's audits, reviews or investigations.

- Joint reviews, audits or investigations between the CHC-MCO, the Department or the RAC may be conducted. Any recoveries as a result of a joint audit, review or investigation shall be shared equally between the CHC-MCO and Department after payment of contingency fee to the RAC.

7. Management Information Systems

The CHC-MCO must have a comprehensive, automated and integrated health MIS that is capable of meeting the requirements listed below and throughout this agreement. See the information provided on the DHS Internet at the following link: [\(added at a later time\)](#).

- a. The CHC-MCO must have at a minimum the following components to its MIS or the capability to link to other systems containing this information: Participants, Provider, Claims processing, Prior Authorization, Reference.
- b. The CHC-MCO must have an MIS sufficient to support data reporting requirements specified in this agreement.
- c. The Participant management system must have the capability to receive, update and maintain the CHC-MCO's Participant files consistent with information provided by the Department. The CHC-MCO must have the capability to provide daily updates of Participant information to subcontractors or Providers with responsibility for processing Claims or authorizing services based on Participant information.
- d. The CHC-MCO's Provider file must be maintained with detailed information on each Provider sufficient to support Provider payment and also meet the Department's reporting and Encounter Data requirements. The CHC-MCO must also be able to cross-reference its internal Provider identification number to the correct PROMISe™ Provider ID and/or the Provider's NPI number in PROMISe™ for each location in which the Provider renders services for the CHC-MCO. The CHC-MCO must ensure that each provider service location is enrolled and active with Medical Assistance. In addition, the CHC-MCO must maintain all service locations in their own system. The CHC-MCO must ensure that each Provider's license information is kept valid in PROMISe, and must outreach to their Providers to stress the importance of maintaining up to date information in PROMISe. Additionally, the CHC-MCO must ensure that Providers enrolled in their

network with a specific Provider type/specialty have the same Provider type/specialty in PROMISE for each service location.

- e. The CHC-MCO's Claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements identified in this agreement.
- f. The CHC-MCO's Prior Authorization system must be linked with the Claims processing component.
- g. The CHC-MCO's MIS must be able to maintain its Claims history with sufficient detail to meet all Department reporting and Encounter requirements.
- h. The CHC-MCO's credentialing system must have the capability to store and report on Provider specific data sufficient to meet the Provider credentialing requirements listed in Exhibit M(1), Quality Management and Utilization Management Program Requirements, of this agreement.
- i. The CHC-MCO must have sufficient telecommunication capabilities, including electronic mail, to meet the requirements of this agreement.
- j. The CHC-MCO must have the capability to electronically transfer data files with the Department and the IEE. The CHC-MCO must use a secure FTP product that is compatible with the Department's product.
- k. The CHC-MCO's MIS must be bidirectionally linked to the other operational systems listed in this agreement, in order that data captured in Encounter records accurately matches data in Participant, Provider, Claims and authorization files, and in order to enable Encounter Data to be utilized for Participant profiling, Provider profiling, Claims validation, Fraud and Abuse monitoring activities, rate setting and any other research and reporting purposes defined by the Department. The Encounter Data system must have a mechanism in place to receive and process the U277 and NCPDP response files; and to store the PROMISE™ ICN associated with each processed Encounter Data record returned on the files.
- l. The CHC-MCO must comply with all applicable business and technical standards available on the DHS Internet site at the following link:
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/p_031942.pdf. This includes compliance with the standards for connectivity to the Commonwealth's network. The CHC-MCO's MIS must be compatible with

the Department's MIS. The CHC-MCO must also comply with the Department's Se-Government Data Exchange Standards. In addition, the CHC-MCO must comply with any changes made to the Commonwealth's Business and Technical Standards. Whenever possible, the Department will provide advance notice of at least sixty (60) days prior to the implementation of changes. For more complex changes, every effort will be made to provide additional notice.

- m. The CHC-MCO must be prepared to document its ability to expand claims processing or MIS capacity should either or both be exceeded through the Enrollment of Participants.
- n. The CHC-MCO must designate appropriate staff to participate in DHS directed development and implementation activities.
- o. Subcontractors must meet the same MIS requirements as the CHC-MCO and the CHC-MCO will be held responsible for MIS errors or noncompliance resulting from the action of a subcontractor. The CHC-MCO must provide its subcontractors with the appropriate files and information to meet this requirement (i.e. the daily eligibility file, Provider files, etc.)
- p. The CHC-MCO's MIS shall be subject to review and approval during the Department's Community HealthChoices Readiness Review process as referenced in Section VI of this agreement, Program Outcomes and Deliverables.
- q. Prior to any major modifications to the CHC-MCO's information system, including upgrades and/or new purchases, the CHC-MCO must inform the Department in writing of the potential changes at least 60 days prior to the change. The CHC-MCO must include a work plan detailing recovery effort and use of parallel system testing.
- r. The CHC-MCO must be able to accept and generate HIPAA compliant transactions as required in the ASC X12 Implementation Guides.
- s. The Department will make reference files (Drug, Procedure Code, Diagnosis Code) available to the CHC-MCO on a routine basis that will allow it to effectively meet its obligation to provide services and record information consistent with requirements in this agreement. If the CHC-MCO chooses not to use these files, it must use comparable files to meet its obligation with this agreement. Exhibit CC, Data Support for CHC-MCOs, provides a listing of these files. Information about these files is available on the Intranet supporting CHC.

- t. The Department will make available Provider informational files on a routine basis that will allow the CHC-MCO to effectively meet its obligation consistent with requirements in this agreement. The CHC-MCO must use these files to record and provide Provider information, and to reconcile their Provider file with the Department's Provider file on a regular basis. These files include the List of Active and Closed Providers (PRV-414 and/or PRV-415) file to meet the obligation to maintain valid PROMISe Provider IDs; Managed Care Affiliations (PRV-640Q) file to meet the obligation to provide updates on the MCO Provider File (PRV-640); and NPI Crosswalk (PRV-430) file to provide all NPI records active with the Department. Exhibit CC, Data Support for CHC-MCOs, provides a listing of these files. Information about these files is available on the Intranet supporting CHC.
- u. The CHC-MCO must have a disaster recovery plan in place, and written policies and procedures documenting the disaster recovery plan including information on system backup and recovery in the event of a disaster.
- v. In addition to the CHC-MCO reconciling the 834 daily and monthly Participants files against its internal Participant information as referenced in Section V.F.10 of this agreement, the CHC-MCO must also reconcile the 820 capitation payment file against its internal Participant information, and report any discrepancies to the Department with thirty (30) days.

8. Department Access and Availability

The CHC-MCO must provide Department staff with access to appropriate on-site private office space and equipment.

The CHC-MCO must provide the Department with access to administrative policies and procedures pertaining to operations under this agreement, including, but not limited to:

- Personnel policies and procedures.
- Procurement policies and procedures.
- Public relations policies and procedures.
- Operations policies and procedures.
- Policies and procedures developed to ensure compliance with requirements under this agreement.

AA. Selection and Assignment of PCPs

The CHC-MCO must ensure that the PCP selection process includes, at a minimum, the following features:

- The CHC-MCO must honor a Participant's selection of a PCP through the IEE upon commencement of CHC-MCO coverage.
- The CHC-MCO may allow selection of a PCP group. Should the CHC-MCO permit selection of a PCP group and the Participant has selected a PCP group in the CHC-MCO's Network through the IEE, the CHC-MCO must honor upon commencement of the CHC-MCO coverage, the Participant's selection. In addition, the CHC-MCO is permitted to assign a PCP group to a Participant if the Participant has not selected a PCP or a PCP group at the time of Enrollment.
- If the Participant has not selected a PCP through the IEE for reasons other than cause, the CHC-MCO must make contact with the Participant within seven (7) business days of his or her Enrollment and provide information on options for selecting a PCP, unless the CHC-MCO has information that the Participant should be immediately contacted due to a medical condition requiring immediate care. To the extent practical, the CHC-MCO must offer freedom of choice to Participants in making a PCP selection.
- If a Participant does not select a PCP within fourteen (14) business days of Enrollment, the CHC-MCO must make an automatic assignment. If the Participant is enrolled in the D-SNP aligned with the CHC-MCO, the CHC-MCO must assign the PCP who the Participant uses in the D-SNP. The CHC-MCO must consider such factors (to the extent they are known), as current Provider relationships that may be identified through Encounters, existing Service Plans, or any CHC-MCO contacts with the Participant, specific medical needs, physical disabilities of the Participant, language needs, area of residence and access to transportation. The CHC-MCO must then notify the Participant by telephone or in writing of his/her PCP's name, location and office telephone number. The CHC-MCO must make every effort to determine PCP choice and confirm this with the Participant prior to the commencement of the CHC-MCO coverage in accordance with Participant Enrollment and Disenrollment, so that new Participants do not go without a PCP for a period of time after Enrollment begins.
- The CHC-MCO must take into consideration, language and cultural compatibility between the Participant and the PCP.
- The CHC-MCO must have written policies and procedures for allowing Participants to select or be assigned to a new PCP whenever requested by the Participant, when a PCP is terminated from the CHC-MCO's Network or when a PCP change is required as part of the resolution to a Grievance or Complaint proceeding. The policies and procedures must receive advance written approval by the Department.

- In cases where a PCP has been terminated from the network for reasons other than cause, the CHC-MCO must immediately inform Participants assigned to that PCP in order to allow them to select another PCP prior to the PCP's termination effective date. In cases where a Participant fails to select a new PCP, re-assignment must take place prior to the PCP's termination effective date.
- Participants can request a specialist as a PCP. If the CHC-MCO denies the request, that Denial is appealable.
- If a Participant uses a Pediatrician or Pediatric Specialist as a PCP, the CHC-MCO must, upon request from a family member, assist with the transition to a PCP who provides services for adults.

Should the CHC-MCO choose to implement a process for the assignment of a primary dentist, the CHC-MCO must submit the process for advance written approval from the Department prior to its implementation.

BB. Selection and Assignment of Service Coordinators

The CHC-MCO must ensure that the process of selection and assignment of Service Coordinators for participants who require Service Coordination includes, at a minimum, the following features:

- The CHC-MCO must offer the Participant the choice of at least two Service Coordinators.
- The CHC-MCO must make contact with the Participant within seven (7) business days of his or her Enrollment for a comprehensive needs assessment indicating the need for LTSS and provide information on options for selecting a Service Coordinator unless the CHC-MCO has information that the Participant should be immediately contacted due to a medical condition requiring immediate care.
- If a Participant does not select a Service Coordinator within fourteen (14) business days of Enrollment for a comprehensive needs assessment, the CHC-MCO must make an automatic assignment of Service Coordinator. The CHC-MCO must consider such factors (to the extent they are known), as current Provider relationships, the person assigned to the Participant for care management in the CHC-MCO's aligned D-SNP, specific medical needs, physical disabilities of the Participant, language needs, area of residence and access to transportation. The CHC-MCO must then notify the Participant by telephone or in writing of his/her Service Coordinator's name, location and office telephone number. The CHC-MCO must make every effort to determine Service Coordination choice and confirm this with the Participant

prior to the commencement of the CHC-MCO coverage in accordance with Participant Enrollment and Disenrollment, so that new Participants do not go without a Service Coordinator for a period of time after Enrollment begins or after assessment of needs for LTSS.

- The CHC-MCO must take into consideration, language and cultural compatibility between the Participant and the Service Coordinator.
- If a Participant requests a change in his or her Service Coordinator selection following the initial visit, the CHC-MCO must promptly grant the request and process the change in a timely manner.
- The CHC-MCO must have written policies and procedures for allowing Participants to select or be assigned to a new Service Coordinator whenever requested by the Participant, when a Service Coordinator is terminated from the CHC-MCO's Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding. The policies and procedures must receive advance written approval by the Department.

CC. Provider Services

The CHC-MCO must operate Provider services functions at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday). Provider services functions include, but are not limited to, the following:

- Assisting Providers with questions concerning Participant eligibility status.
- Assisting Providers with CHC-MCO Prior Authorization and referral procedures.
- Assisting Providers with Claims payment procedures and handling Provider Disputes and issues.
- Facilitating transfer of Participant medical records among Providers, as necessary.
- Providing to PCPs a monthly list of Participants who are under their care, including identification of new and deleted Participants. An explanation guide detailing use of the list must also be provided to PCPs.
- Developing a process to respond to Provider inquiries regarding current Enrollment.
- Coordinating the administration of Out-of-Plan Services.

1. Provider Manual

The CHC-MCO must keep its Network Providers informed and up-to-date with the latest policy and procedures changes as they affect the Medical Assistance Program. The key to maintaining this level of communication is the publication of a Provider Manual. The CHC-MCO must distribute copies of the Provider manual in a manner that makes them easily accessible to all Network Providers. The CHC-MCO may specifically delegate this responsibility to large Providers in its Provider Agreement. The Provider manual must be updated annually. The Department may grant an exception to this annual requirement upon written request from the CHC-MCO provided there are no major changes to the manual.

The CHC-MCO must submit its Provider manual to the Department for approval.

Information that must be included in the Provider manual is specified in Exhibit PP, Provider Manuals.

2. Provider Education

The CHC-MCO must demonstrate that its Provider Network is knowledgeable and experienced in treating and supporting Participants in the program. The CHC-MCO must submit an annual Provider education and training workplan to the Department that outlines its plans to educate and train Network Providers. The format for this workplan will be designated by the Department through its operations reporting requirements found on the intranet supporting CHC. This training plan must be developed in conjunction with the Department, and must cover all topic areas identified by the Department. The CHC-MCO must also include Participants, advocates and family members in designing and implementation of the training plan.

The CHC-MCO must submit in its annual plan its process for measuring training outcomes including the tracking of training schedules and Provider attendance.

At a minimum, the CHC-MCO must conduct the Provider training, as appropriate, in the following areas:

- a. A description of the needs screening, comprehensive needs assessment and reassessment, and service planning system and protocols and a description of the Provider's role in service planning and Service Coordination.
- b. A description of Service Coordination and how the Provider will fit into the Person-Centered Planning Team approach.

- c. A description of the population being served through CHC.
- d. A description of the accessibility requirements with which Providers are required to comply.
- e. Application of the definition of “Medically Necessary.”
- f. Information around Alzheimer’s Disease and related dementias, including information on assisting with and managing the symptoms and care needs of people with dementia throughout the course of their disease.
- g. EPSDT training for any Providers who serve Participants under age twenty-one (21).
- h. Identification and appropriate referral for mental health, drug, and alcohol, and substance abuse services.
- i. Sensitivity training on the diverse needs of persons with disabilities, such as persons who are deaf or hard of hearing how to obtain sign language interpreters and how to work effectively with sign language interpreters.
- j. Training on CHC-MCO policies against discrimination to ensure competency in treating Participants without discrimination on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, Medical Assistance status, health status, disease or pre-existing condition, anticipated need for healthcare or physical or mental handicap.
- k. Cultural, Linguistic and Disability Competency, including: the right of Participants with LEP to engage in effective communication in their language; how to obtain interpreters; and how to work effectively with interpreters.
- l. Treating the populations served by the CHC-MCO, including the right to treatment for Participants with disabilities.
- m. Administrative processes that include, but are not limited to: coordination of benefits, Participant Restriction Program, and Encounter Data reporting.
- n. Issues identified by Provider relations or Provider hotline staff in response to calls or complaints by Providers.
- o. Issues identified through the QM process.
- p. The process to submit materials to the CHC-MCO for

utilization review and Prior Authorization review decisions. Submitted materials must include but are not limited to letters of medical necessity.

- q. Information on the Complaint, Grievance and Fair Hearing and Appeals process including but not limited to expectations a Provider representing a Participant at a Grievance hearing.
- r. Information on PIP and how Providers may benefit from participation in these programs.

The CHC-MCO may submit an alternate Provider training and education workplan should the CHC-MCO wish to combine its activities with other CHC-MCOs operating in the CHC zones covered by this agreement or wish to develop and implement new and innovative methods for Provider training and education. However, this alternative workplan must have advance written approval by the Department. Should the Department approve an alternative workplan, the CHC-MCO must have the ability to track and report on the components included in the CHC-MCO's alternative Provider training and education workplan.

3. Panel Listing Requirements

The CHC-MCO is required to give its Network Providers panel listings of Participants who receive EPSDT services. The CHC-MCO must provide electronic panel listings at the request of a Provider, in a format determined by the CHC-MCO. Panel listings supplied to Providers must include, at least, the following data elements:

Participant identification (Last, First and Middle Name)

- Date of birth
- Age
- Telephone number
- Address
- Identification of new patients
- Date of last EPSDT Screen
- Screen Due or Overdue

DD. Provider Network

To minimize the disruption of services to Participants, the CHC-MCO must

enroll in its Provider network all willing and qualified LTSS Providers that provide HCBS through the OLTL waivers in effect prior to CHC implementation date and through all Nursing Facilities in the assigned zone. This will allow participants who are receiving LTSS as of the date of their enrollment in the CHC to maintain their current services with their current service provider.

A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO. A qualified Provider is a Provider that meets applicable MA program participation or waiver requirements for the Provider's provider type.

This requirement will remain in effect for HCBS Providers for the first 180 days that CHC is operational in each zone. Following the 180 day period, the CHC-MCO may adjust its Provider Network in accordance with the Network access and adequacy standards outlined in this agreement.

For NF, the CHC-MCO must ensure payment for all participants who are in a NF on the day that they become CHC eligible until the time that they leave the NF on their own accord. This includes payment to NFs that are either enrolled or not enrolled as a Provider with the CHC-MCO. Notwithstanding the above, as outlined in Section V.Cof this agreement and regardless of whether a given nursing facility is a Network Provider, CHC-MCOs must pay nursing facilities for any residents who are residing in the nursing facility on the first effective date of Enrollment into CHC for the zone for as long as the residents reside in the nursing facility.

The CHC-MCO must establish and maintain adequate Provider Networks to serve all of the eligible CHC population in each CHC zone covered by this greement. Provider Networks must include all Covered Services. Detailed requirements related to the composition of Provider Networks and Participants' access to services from the Providers in those Networks are located in Exhibit AAA, Provider Network Composition/Service Access.

If the CHC-MCO's Provider Network is unable to provide necessary Covered Services covered under the agreement, to a Participant, the CHC-MCO must adequately and timely cover these services out-of-network, for the Participant for as long as the CHC-MCO is unable to provide them and must coordinate with the Out-of-Network Provider with respect to payment.

1. Provider Qualifications

All Providers must meet the minimum qualification requirements established by the Department and must be credentialed by the Department.

2. Provider Agreements

The CHC-MCO must have written Provider Agreements with a sufficient number of Providers to ensure Participant access to all

Covered Services Minimum standards for sufficiency can be found in Exhibit AAA.

The requirements for these Provider Agreements are set forth in Exhibit CCC, CHC-MCO Provider Agreements.

3. Cultural Competency, Linguistic Competency, and Disability Competency

Both the CHC-MCO and Network Providers must demonstrate Cultural Competency, Linguistic Competency, and Disability Competency.

CHC-MCOs and Network Providers must understand that racial, ethnic, linguistic, and cultural differences between Provider and Participant cannot be permitted to present barriers to accessing and receiving quality services; must demonstrate the willingness and ability to make the necessary distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the Participant's racial, ethnic, linguistic or cultural background and which may be equally or more effective and appropriate for the particular Participant; and must demonstrate consistency in providing quality care across a variety of races, ethnicities and cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, etc., may make one treatment method more palatable to a Participant of a particular culture than to another of a differing culture.

4. Primary Care Practitioner Responsibilities

The CHC-MCO must have written policies and procedures for ensuring that every Participant chooses or is assigned to a PCP. The PCP must serve as the Participant's initial and most important point of contact regarding healthcare needs. At a minimum, the CHC-MCO Network PCP is responsible for:

- a. Providing primary and preventive care and acting as the Participant's advocate, providing, recommending, and arranging for care.
- b. Documenting all care rendered in a complete and accurate Encounter record that meets or exceeds the DHS data specifications.
- c. Maintaining continuity of each Participant's healthcare.
- d. Communicating effectively with the Participant by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with LEP

when needed by the Participant. Interpreter services must be free of charge to the Participant.

- e. Making referrals for specialty care and other Medically Necessary services, both in and out-of-plan.
- f. Maintaining a current medical and other service record for the Participant, including documentation of all services provided to the Participant by the PCP, as well as any specialty or referral services.
- g. Coordinating Behavioral Health Services by working with BH-MCOs as specified in Exhibit U: "Behavioral Health Services."
- h. The CHC-MCO will retain responsibility for monitoring PCP actions to ensure they comply with the provisions of this agreement.

5. Specialists as PCPs

A Participant may select a specialist to act as PCP.

The CHC-MCO must adopt and maintain procedures by which a Participant CHC:

- A standing referral to a specialist with clinical expertise in treating the disease or condition; or
- The designation of a specialist to provide and coordinate the Participant's primary and specialty care.

When possible, the specialist must be a healthcare Provider participating in the CHC-MCO's Network. If the specialist is not a Network Provider, the CHC-MCO may require the specialist to meet the requirements of the CHC-MCO's Network Providers, including the CHC-MCO's credentialing criteria as developed in conjunction with the Department and QM/UM Program policies and procedures.

Information for Participants must include a description of the procedures that a Participant shall follow to request and receive:

- A standing referral to a specialist with clinical expertise in treating the disease or condition; or
- The designation of a specialist to provide and coordinate the Participant's primary and specialty care.

The CHC-MCO must have adequate Network capacity of qualified specialists to act as PCPs. These physicians may be predetermined and listed in the directory but may also be determined on an as needed basis. The CHC-MCO must establish in conjunction with

the Department and maintain its own credentialing and recredentialing policies and procedures to ensure compliance with these specifications.

The CHC-MCO must require that Providers credentialed as specialists and as PCPs agree to meet all of the CHC-MCO's standards for credentialing PCPs and specialists, including compliance with record keeping standards, the Department's access and availability standards and other QM/UM Program standards. The specialist as a PCP must agree to provide or arrange for all primary care, consistent with CHC-MCO preventive care guidelines, including routine preventive care, and to provide those specialty medical services consistent with the Participant's assessed needs in accordance with the CHC-MCO's standards and within the scope of their specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist as a PCP also must have admitting privileges at a hospital in the CHC-MCO's Network.

6. Related Party

A hospital, Nursing Facility, or home health agency that is a Related Party to a CHC-MCO must be willing to negotiate in good faith with other CHC-MCOs regarding the provision of services to Participants. The Department reserves the right to terminate this agreement with the CHC-MCO if it determines that a Provider related to the CHC-MCO has refused to negotiate in good faith with other CHC-MCOs.

A CHC-MCO must negotiate with and make referrals in good faith to providers that are not Related Parties to the MCOs.

7. Integration

The CHC-MCO must prohibit Network Providers from intentionally segregating their Participants in any way from other persons receiving services.

The CHC-MCO must investigate Complaints and take affirmative action so that Participants are provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, Medical Assistance status, health status, disease or pre-existing condition, anticipated need for healthcare or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

- Denying or not providing a Participant any Medical Assistance Covered Service or availability of a facility within the CHC-MCO's Network. The CHC-MCO must have explicit policies to provide access to complex interventions such as cardiopulmonary

resuscitations, intensive care, transplantation and rehabilitation when medically indicated and must educate its Providers on these policies. Healthcare and treatment necessary to preserve life must be provided to all persons who are not terminally ill or permanently unconscious, except where a competent Participant objects to such care on his/her own behalf or an Advanced Healthcare Directive has been executed.

- Subjecting a Participant to segregated, separate, or different treatment, including a different place or time from that provided to other Participants, public or private patients, in any manner related to the receipt of any Medical Assistance Covered Service, except where Medically Necessary.
- The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, gender identity, income status, program participation, language, Medical Assistance status, health status, disease or pre-existing condition, anticipated need for healthcare or physical or mental disability of the participants to be served.

If the CHC-MCO knowingly executes an agreement with a Provider with the intent of allowing or permitting the Provider to implement barriers to care (i.e. the terms of the Provider Agreement are more restrictive than this agreement), the CHC-MCO shall be in breach of this agreement.

8. Network Changes/Provider Terminations

a. Network Changes

i) Notification to the Department

Other than terminations outlined below in Section 7.b (Provider Terminations), the CHC-MCO must notify the Department within 10 days of any changes to its Provider Network (closed panels, relocations, death of a Provider, etc.) which would negatively impact the ability of Participants to receive services.

ii) Procedures and Work Plans

The CHC-MCO must have procedures to address changes in its Network that impact Participant access to services, in accordance with the requirements of Exhibit AAA Network Composition. Failure of the CHC-MCO to address changes in Network composition that negatively affect Participant access to services is grounds for termination of this agreement.

iii) Time frames for Notification to Participants

The CHC-MCO must update web-based Provider directories to reflect any changes in the Provider Network as required in

Provider Directories.

- b. **Provider Terminations**
The CHC-MCO must comply with the Department's requirements for Provider terminations as outlined in Exhibit C, CHC-MCO Requirements for Provider Terminations.

9. Other Provider Enrollment Standards

The CHC-MCO must comply with the program standards regarding Provider enrollment that are set forth in this agreement.

The CHC-MCO must require all Network Providers to be enrolled in the Commonwealth's MA program and possess an active PROMISe™ Provider ID for each location in which they provide services for the CHC-MCO. In addition, the CHC-MCO must be able to store and utilize the PROMISe™ Provider ID and NPI stored in PROMISe™ for each location.

The CHC-MCO must enroll a sufficient number of Providers qualified to conduct the specialty evaluations necessary for investigating alleged physical and/or sexual abuse.

10. Twenty-Four Hour Coverage

It is the responsibility of the CHC-MCO to have coverage available directly or through its PCPs, who may have on-call arrangements with other qualified Providers, for urgent or emergency care on a twenty-four (24) hour, seven (7) day-a-week basis. The CHC-MCO must not use answering services in lieu of the above PCP emergency coverage requirements without the knowledge of the Participant. For Emergency or Urgent Medical Conditions, the CHC-MCO must have written policies and procedures on how Participants and Providers can make contact to receive instruction for treatment. If the PCP determines that emergency care is not required, 1) the PCP must see the Participant in accordance with the time frame specified in Exhibit AAA under Appointment Standards, or 2) the Participant must be referred to an urgent care clinic which can see the Participant in accordance with the time frame specified in Exhibit AAA under appointment standards.

EE. QM and UM Program Requirements

1. Overview

The CHC-MCO shall provide a Quality Assessment and

Performance Improvement Program consistent with federal guidelines under Title XIX of the Social Security Act, 42 CFR Part 438, Subpart D and must comply with the Department's Quality Management (QM) and Utilization Management (UM) Program standards and requirements set forth in Exhibit M(1) Quality Management and Utilization Management Program Requirements, Exhibit M(2) External Quality Review, and Exhibit M(4) Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CHC-MCO must comply with the Quality Management/Utilization Management Reporting Requirements found on the intranet supporting CHC. The Department retains the right of advance written approval and to review on an ongoing basis all aspects of the CHC-MCO QM and UM programs, including subsequent changes. The CHC-MCO must comply with all QM and UM program reporting requirements and must submit data in formats to be determined by the Department.

The Department, in collaboration with the CHC-MCO, retains the right to determine and prioritize QM and UM activities and initiatives based on areas of importance to the Department and CMS.

2. Quality Management/Performance Improvement

The goal is to deliver quality care that enables participants to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. The CHC-MCO shall provide quality LTSS to participants and promote improvement in the quality of care provided to enrolled Participants through established quality management and performance improvement processes. The CHC-MCO shall have a written Quality Management/Quality Improvement (QM/QI) program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. The CHC-MCO shall have a QM/QI committee which shall include medical and long-term care staff and contract providers. The role of the committee is to analyze and evaluate the results of QM/QI activities and to develop appropriate policies, actions and follow-up to ensure appropriate service provision for participants. The QM/QI committee should be a distinct unit within the organizational structure and remain separate from other units in the organization.

The quality management program should include the following:

- A written Quality Assessment and Performance Improvement (QAPI) plan completed on an annual basis with quarterly updates.
- Monitoring and evaluating activities which include peer review and Quality Management Committees.
- Protection of Participant records.

- Participant rights and responsibilities.
- Tracking and trending participant and provider issues.
- Mechanism to assess the quality and appropriateness of care furnished to participants.
- Performance Improvement programs.
- Submission of Participant's specific data.
- Reporting on designated quality measures to identify outcomes and trends and how trends will be addressed.
- Procedures outline how and when information will be entered into the Department's quality data reporting system.

3. Utilization Management

The CHC-MCO shall establish a Utilization Management structure consistent with guidance from the Department.

4. Healthcare Effectiveness Data and Information Set (HEDIS)

The CHC-MCO must submit HEDIS data to the Department by June 15th of the current year as outlined in Exhibit M(4) Healthcare Effectiveness Data and Information Set (HEDIS). The previous calendar year is the standard measurement year for HEDIS data.

5. External Quality Review (EQR)

On at least an annual basis, the CHC-MCO will cooperate fully with any external evaluations and assessments of its performance authorized by the Department under this agreement and conducted by the Department's contracted External Quality Review Organization (EQRO) or other designee. Independent assessments will include, but not be limited to, any independent evaluation required or allowed by federal or state statute or regulation. See Exhibit M(2) External Quality Review. The Department may use the term PA Performance Measures in place of External Quality Review performance measures throughout this agreement.

6. Pay for Performance Programs

The Department may establish a Pay for Performance (P4P) Program to provide financial incentives for CHC-MCOs that meet quality goals. An initial P4P program may be established for CHC-MCOs that assist Participants to remain financially eligible through redetermination.

7. QM/UM Program Reporting Requirements

The CHC-MCO must comply with all QM and UM program reporting

requirements and time frames outlined in Exhibit M(1) Quality Management and Utilization Management Program Requirements and Quality Management/Utilization Management Deliverables, available on the intranet supporting CHC. The Department will, on a periodic basis, review the required reports and make changes to the information/data and/or formats requested based on the changing needs of CHC. The CHC-MCO must comply with all requested changes to the report information and formats as deemed necessary by the Department. The Department will provide the CHC-MCO with at least sixty (60) days notice of changes to the QM/UM reporting requirements. Information regarding QM and UM reporting requirements may be found on the intranet supporting CHC. at: (Link will be added at a later time).

8. Delegated Quality Management and Utilization Management Functions

The CHC-MCO may not structure compensation or payments to individuals or entities that conduct Utilization Management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Participant.

9. Participant Involvement in the Quality Management and Utilization Management Programs

The CHC-MCO will participate and cooperate in the work and review of the Department's formal advisory body through participation in the Medical Assistance Advisory Committee (MAAC) and its subcommittees. Additionally, the CHC-MCO's Participant Advisory Committee shall provide input into the QM and UM programs.

10. Confidentiality

The CHC-MCO must have written policies and procedures for maintaining the confidentiality of data that addresses medical records, Participant information and Provider information and is in compliance with the provisions set forth in Section 2131 of the Insurance Company Law of 1921, as amended, 40 P.S. §991.2131; 55 PA Code Chapter 105; and 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information).

The CHC-MCO must require its Network Provider offices and sites to have mechanisms that guard against unauthorized or inadvertent disclosure of confidential information to persons outside the CHC-MCO.

Release of data by the CHC-MCO to third parties requires the Department's advance written approval, except for releases for the purpose of individual care and coordination among Providers, releases authorized by the Participant or those releases required by court order, subpoena or law.

11. Department Oversight

The CHC-MCO and its subcontractor(s), including Network Providers, will make available to the Department upon request, data, clinical and other records and reports for review of quality of care, access and utilization issues including but not limited to activities related to External Quality Review, HEDIS, Encounter Data validation, and other related activities.

The CHC-MCO must submit a plan, in accordance with the time frames established by the Department, to resolve any performance or quality of care deficiencies identified through ongoing monitoring activities and any independent assessments or evaluations requested by the Department.

The CHC-MCO must obtain advance written approval from the Department before releasing or sharing data, correspondence and/or improvements from the Department regarding the CHC-MCO's internal QM and UM programs with any of the other CHC-MCOs or any external entity.

The CHC-MCO must obtain advance written approval from the Department before participating in or providing letters of support for QM or UM data studies and/or any data related external research projects related to CHC with any entity.

12. CHC-MCO Cooperation with Research and Evaluation

The CHC-MCO must cooperate fully with research and evaluation activities as requested by the Department.

FF. Mergers, Acquisitions, Mark, Insignia, Logo and Product Name

1. Mergers and Acquisitions

The Department must be notified at least thirty (30) calendar days in advance of a merger or acquisition of the CHC-MCO. The CHC-MCO must bear the cost of reprinting CHC outreach material, if a change involving content is made prior to the IEE's annual revision of materials.

2. Mark, Insignia, Logo, and Product Name Changes

The CHC-MCO must submit mark, insignia, logo, and product name changes within thirty (30) calendar days of projected implementation for the Department's review. The CHC-MCO must be responsible for bearing the cost of reprinting CHC outreach materials, if a change is made prior to the IEE's annual revision of materials. These changes, made by the CHC-MCO include, but are not limited to, change in

mark, insignia, logo, and/or product name of the CHC-MCO.

GG. Cooperation with IEE

The CHC-MCO must cooperate with the IEE, as instructed by the Department.

EXHIBIT C

CHC-MCO REQUIREMENTS FOR PROVIDER TERMINATIONS

The CHC-MCO must comply with the requirements outlined in this Exhibit when they terminate a Provider from the Network. The requirements have been delineated to identify the requirements for terminations that are initiated by the CHC-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 Participants to access services.

1. Termination by the CHC-MCO

A. Notification to Department

The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, hospital, specialty unit within a facility, and/or a large Provider group) sixty (60) days prior to the effective date of the termination.

The CHC-MCO must submit a Provider termination work plan and supporting documentation within ten (10) business days of the CHC-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 CHC-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 CHC-MCO must allow a Participant to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Participant is notified by the CHC-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 Participant is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve (12) months the Participant 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 Participant 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. Per Department of Health regulation Title 28, §9.684(d), the transitional period may be extended by the CHC-MCO if the extension is determined to be clinically appropriate. The CHC-MCO shall consult with the Participant and the healthcare Provider in making the determination. The CHC-MCO must also allow a Participant who is pregnant to continue to receive care from the Provider that is being terminated through the completion of the Participant's postpartum care.

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

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

C. Notification to Participants

If the Provider that is being terminated from the Network is a PCP, the CHC-MCO, using the template notice titled C(1) Provider Termination Template For PCPs found on the intranet supporting CHC, must notify all Participants who receive primary care services from the Provider thirty (30) days prior to the effective date of the Provider's termination. Participants 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 Participant 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 CHC-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the intranet supporting CHC, must notify all Participants who have received services from the Provider during the previous twelve (12) months, as identified through referral and claims data; all Participants who are scheduled to receive services from the Provider; and all Participants 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. Participants 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 Participant 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 CHC-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination found on the Intranet supporting CHC, must notify all Participants assigned to a PCP with admitting privileges at the hospital, all Participants assigned to a PCP that is owned by the hospital, and all Participants 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 Participants.

If the CHC-MCO is terminating a specialty unit within a facility or hospital, the Department may require the CHC-MCO to provide thirty (30) day advance written notice to a specific Participant population or to all of its Participants, 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 CHC-MCO and Provider.

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

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

The CHC-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.

2. Termination by the Provider

A. Notification to Department

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

The CHC-MCO must submit a Provider termination work plan within ten (10) business days of the CHC-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 CHC-MCO must comply with both this section and the PA Department of Health (DOH) requirements found in 28 Pa. Code § 9.684.

B. Notification to Participants

If the Provider that is terminating its participation in the Network is a PCP, the CHC-MCO, using the template notice titled C(1) Provider Termination Template For PCPs, found on the intranet supporting CHC, must notify all Participants 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 CHC-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the intranet supporting CHC, must notify all Participants, who have received services from the Provider during the previous twelve (12) months, all Participants who

were scheduled to receive services from the terminating Provider, and all Participants 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 CHC-MCO must use referral and claims data to identify these Participants.

If the Provider that is terminating its participation in the Network is a hospital or specialty unit within a facility, the CHC-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination, found on the intranet supporting CHC, must, thirty (30) days prior to the effective date of the hospital's termination, notify all Participants assigned to a PCP with admitting privileges at the hospital, all Participants 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.;The MCO must use referral and claims data to identify these Participants.

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 CHC-MCO to provide thirty (30) days advance written notice to a specific Participant population or to all of its Participants, 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 Participants.

The CHC-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.

3. Workplans and Supporting Documentation

A. Workplan Submission

The CHC-MCO must submit a Provider termination work plan within ten (10) business days of the CHC-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 dates, and status. The workplan should define the steps within each of the tasks. The tasks may include, but are not limited to:

- Commonwealth Notifications (DHS and DOH).
- Provider Impact and Analysis.
- Provider Notification of the Termination.
- Participant Impact and Analysis.
- Participant Notification of the Termination.
- Participant Transition.
- Participant Continuity of Care.
- Systems Changes.
- Provider Directory Updates for IEE (include date when all updates will appear on Provider files sent to enrollment broker).
- CHC-MCO Online Directory Updates.

- Participant Service and Provider Service Script Updates.
- Submission of Required Documents to the Department (Participant notices and scripts for prior approval).
- Submission of Final Participant 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 that the CHC-MCO submit the following supporting documentation, in addition to the workplan, within ten (10) business days of the CHC-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, but electronic means is preferable.

1) Background Information

- a) Submit a summary of issues/reasons for termination.
- b) Submit information on negotiations or outreach that has occurred between the CHC-MCO and the Provider including dates, parties present, and outcomes.

2) Participant 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 Participants currently accessing terminating Providers can access services being provided by the terminating Provider from remaining Network Providers who are accepting new Participants. 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 CHC-MCO's Participants at another hospital or facility.
- e) Submit a copy of the final Provider notices to the Department.

3) Participant Identification and Notification Process

- a) Submit information that identifies the total number of Participants 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 Participant notices, utilizing the templates included as C(1) – C(4), Provider and Hospital Termination Templates and Continuity of Care Denial Notice, found on the intranet supporting CHC, as appropriate, for Department review and prior approval.

4) Participant Services

- a) Submit for Department prior approval, the call center script to be used to respond to inquiries regarding the termination.
- b) Identify a 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 Participant services calls (broken out by PCP, Specialist, and Hospital).
 - Termination call reasons (broken out by Inquiries, PCP Change, Opt Out/Plan Change).

5) Affected Participants in Service Coordination

- a) Submit the total number of Participants in Service Coordination affected by the termination.
- b) Submit the criteria to the Department that the CHC-MCO will utilize for continuity of care for Participants 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 Participants in care management about the termination.

6) Enrollment Services

- a) Submit final, approved Participant notices to the Department, the Participant notices should be on CHC-MCO letterhead.

7) News Releases

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

8) Website Update

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

EXHIBIT E(1)

OTHER FEDERAL REQUIREMENTS

1. The contract shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contract involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.
2. Contracts, subcontracts, and subgrants of amounts in excess of \$100,000 shall contain a provision, which requires compliance with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 1178, and Environmental Protection Agency regulations (40 CFR part 15).
3. Contracts shall recognize mandatory standards and policies relating to energy efficiency, which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).
4. All contracts shall be in compliance with Equal Employment Opportunity (EEO) provisions.
5. All contracts in excess of \$2,000 shall be in compliance with the Copeland Anti-Kickback Act and the Davis-Bacon Act.
6. All contracts in excess of \$2,000 for construction and \$2,500 employing mechanics or laborers, shall abide by and be in compliance with the Contract Work Hours and Safety Standards.
7. The CHC-MCO must be in compliance with the Byrd Anti-Lobbying Amendment.

Specific Federal Regulatory Cites for Managed Care Agreements

Citation	Requirement
1903(m)(4)(B)	The CHC-MCO will make reports of any transactions between the CHC-MCO and parties in interest that are provided to the State or other agencies pursuant to Section 1903(m)(4)(A) of the Act available to CHC-MCO Participants upon reasonable request.

Citation	Requirement
42 CFR 438.6(f)(2)(ii)	The CHC-MCO will report all identified provider-preventable conditions in a form or frequency, which may be specified by the State.
ARRA 5006(a) State Medicaid Director Letter SMD #10-001 01/22/2010	The CHC-MCO is prohibited from imposing enrollment fees, premiums, or similar charges on Indians served by an Indian healthcare provider; Indian Health Service (IHS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services (CHS).
ARRA 5006(d) SMD 10-001	The CHC-MCO must 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.
ARRA 5006(d) SMD 10-001	The CHC-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 Participants who are eligible to receive services from such providers.
ARRA 5006(d) SMD 10-001	The CHC-MCO must pay I/T/U providers, whether participating in the network or not, for covered Medicaid or CHIP managed care services provided to Indian Participants who are eligible to receive services from such providers either at a rate negotiated between the CHC-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

Citation	Requirement
<p>42 CFR 438.6(f)(2)(i) 42 CFR 434.6(a)(12)(i) 42 CFR 447.26(b)</p>	<p>The CHC-MCO is prohibited from making payment to a Provider for provider- preventable conditions that meet the following criteria:</p> <ul style="list-style-type: none"> (i) Is identified in the State Plan (ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by the evidence-based guidelines (iii) Has a negative consequence for the beneficiary (iv) Is auditable (v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
<p>42 CFR 438.6(f)(2)(ii) 42 CFR 434.6(a)(12)(ii)</p>	<p>The CHC-MCO must require all Providers to report provider-preventable conditions associated with claims for payments or Participant treatments for which payment would otherwise be made.</p>
<p>1916(a)(2)(D) 1916(b)(2)(D) 42 CFR 438.108 42 CFR 447.50-57 State Medicaid Director Letter SMDL #06-015 6/16/2006</p>	<p>Any cost sharing imposed by the CHC-MCO on Participants is in accordance with Medicaid Fee for Service requirements at 42 CFR 447.50 through 42 CFR 447.57</p>
<p>1903(i) final sentence 1903(i)(2)(A)</p>	<p>The CHC-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2).</p>

Citation	Requirement
<p>1903(i) final sentence 1903(i)(2)(B)</p>	<p>The CHC-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).</p>
<p>1903(i) final sentence 1903(i)(2)(C)</p>	<p>The CHC-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the State has failed to suspend payments under the plan during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of Section 1862(o) of the Act and this subparagraph unless the State determines in accordance with such regulations that there is good cause not to suspend payments.</p>
<p>1903(i) final sentence 1903(i)(16)</p>	<p>The CHC-MCO shall not make payment with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of</p>
<p>1903(i) final sentence 1903(i)(17)</p>	<p>The CHC-MCO shall not make payment with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.</p>

Citation	Requirement
<u>1903(i) final sentence</u> <u>1903(i)(18)</u>	The CHC-MCO shall not make payment with respect to any amount expended for home healthcare services provided by any agency or organization, unless the agency or organization provides the State with a surety bond as specified in Section 1861(o)(7) of the Act.
<u>1903(t)</u> <u>42 CFR 495.332 (d)(2)</u> <u>42 CFR 438.6(c)(5)(iii)</u> <u>42 CFR 495.332 (d)(2)</u> <u>42 CFR 438.6(c)(5)(iii)</u> <u>42 CFR 495.304</u> <u>42 CFR 495.310(c)</u> <u>42 CFR 447.253(e)</u> <u>42 CFR 495.370(a)</u> <u>SMD# 09-006, Attachment A</u> <u>1903(t)(6)(A)(ii)</u>	If the CHC-MCO is required by the State to disburse electronic health records (EHR) incentive payments to eligible professionals, the agreement establishes a methodology for verifying that this process does not result in payments that exceed 105 percent of the capitation payment, in accordance with 42 CFR 438.6(c)(5)(iii).
<u>1903(t)(6)(A)(ii)</u> <u>495.310(k)</u> <u>495.332(c)(9)</u>	If the CHC-MCO is required by the State to disburse EHR incentive payments to eligible professionals, the agreement between the CHC-MCO and the State includes a description of the process and methodology for ensuring and verifying that incentive payments are paid directly to the eligible professional (or to an employer or facility to which such Provider has assigned payments) without any deduction or rebate.

Citation	Requirement
<p> 1124(a)(2)(A) 1903(m)(2)(A)(viii) 1903(t)(6)(A)(ii) 42 CFR 455.100-103 42 CFR 455.104(b) </p>	<p>In accordance with Section 1903(t)(6)(A)(ii) of the Act and the regulations implementing such section, the CHC-MCO must disclose the following information to the state for any person or corporation with ownership or control interest in the CHC-MCO:</p> <ul style="list-style-type: none"> • Name and address (the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.) • Date of birth and Social Security Number (in the case of an individual) • Other tax identification number (in the case of a corporation) • Whether the person (individual or corporation) with an ownership or control interest in the CHC-MCO or a CHC-MCO subcontractor is related to another person with ownership or control interest in the CHC-MCO as a spouse, parent, child, or sibling. • The name of any other Medicaid Provider or fiscal agent in which the person or corporation has an ownership or control interest. • The name, address, date of birth and Social Security Number of any managing employee of the CHC-

**DEPARTMENT OF HUMAN
SERVICES ADDENDUM TO STANDARD
CONTRACT TERMS AND CONDITIONS**

A. **APPLICABILITY**

This Addendum is intended to supplement the Standard Terms and Conditions. To the extent any of the terms contained herein conflict with terms contained in the Standard Contract Terms and Conditions, the terms in the Standard Contract Terms and Conditions shall take precedence. Further, it is recognized that certain terms contained herein may not be applicable to all the services which may be provided through Department contracts.

B. **CONFIDENTIALITY**

The parties shall not use or disclose any information about a Participant or the services to be provided under this agreement for any purpose not connected with the parties' agreement responsibilities except with written consent of such Participant, Participant's attorney, or Participant's parent or legal guardian.

C. **INFORMATION**

During the period of this agreement, all information obtained by the CHC-MCO through work on the project will be made available to the Department immediately upon demand. If requested, the CHC-MCO shall deliver to the Department background material prepared or obtained by the CHC-MCO incident to the performance of this agreement. Background material is defined as original work, papers, notes and drafts prepared by the CHC-MCO 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**

CHC-MCO agrees to obtain all licenses, certifications and permits from Federal, State, and Local authorities permitting it to carry on its activities under this agreement.

E. **PROGRAM SERVICES**

Definitions of service, eligibility of recipients of service, and other limitations in this agreement are subject to modification by amendments to Federal, State and local laws, regulations, and program requirements without further notice to the CHC-MCO hereunder.

F. **CHILD PROTECTIVE SERVICE LAWS**

In the event that the agreement calls for services to minors, the CHC-MCO 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 (55 PA Code, chapter 3490).

G. PRO-CHILDREN ACT OF 1994

The CHC-MCO 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 healthcare 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 CHC-MCO and such services may in whole or in part be claimed by the Commonwealth for Medicare/Medicaid reimbursements, CHC-MCO 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 agreement.
 - 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 agreement period.

I. TRAVEL AND PER DIEM EXPENSES

The CHC-MCO shall not be allowed or paid travel or per diem expenses except as provided for in CHC-MCO's Budget and included in the agreement amount. Any reimbursement to the CHC-MCO for travel, lodging, or meals under this agreement shall be at or below state rates as provided in Management Directive 230.10, Commonwealth Travel Policy, as may be amended, unless the CHC-MCO has higher rates which have been established by its offices/officials, and published prior to entering into this agreement. 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 CHC-MCO 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 agreement. As required by law, an independent contractor is responsible for malpractice insurance for healthcare personnel. CHC-MCO shall provide insurance policy number and provider' name, or a copy of the policy with all renewals for the entire agreement period.
2. The CHC-MCO shall, at its expense, procure and maintain during the term of the agreement, 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 CHC-MCO'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 CHC-MCO, 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 agreement or the failure to perform under this agreement whether such performance or nonperformance be by the CHC-MCO, 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 agreement and during the term of the agreement, the CHC-MCO 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. The CHC-MCO agrees to obtain all supplies and equipment for use in the performance of this agreement 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. The CHC-MCO has title to all personal property acquired by the CHC-MCO, including purchase by lease/purchase agreement, for which the CHC-MCO is to be reimbursed under this agreement. Upon cancellation or termination of this agreement, disposition of such purchased personal property which has a remaining useful life shall be made in accordance with the following provisions.
 - a. The CHC-MCO 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 borne by the CHC-MCO receiving the property and will be reimbursed by the Department. Title to all transferred property shall vest in the designated CHC-MCO. The Department will reimburse the CHC-MCO for its share, if any, of the value of the remaining life of the property in the same manner as provided under sub clause b of this paragraph.
 - b. If the CHC-MCO 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 CHC-MCO shall reimburse the Department in the amount determined from the tables.
 - c. When authorized by the Department in writing, the CHC-MCO 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 CHC-MCO, including purchase by lease-purchase contract, for which the CHC-MCO is to be reimbursed under this agreement shall be deemed "Department Property" for the purposes of subsection 5, 6, and 7 of this section.
5. The CHC-MCO 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 agreement.
7. In the event that the CHC-MCO 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 agreement, or shall reimburse the Department, at the Department's direction.

L. DISASTERS

If, during the terms of this agreement, 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 CHC-MCO hereunder during the period of time there is no need for the services provided by the CHC-MCO except to render compensation which the CHC-MCO 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 CHC-MCO warrants that no person or selling agency has been employed or retained to solicit or secure this agreement 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 CHC-MCO for the purpose of securing business). For breach or violation of this warranty, the Department shall have the right to annul this agreement without liability or, in its discretion, to deduct from the consideration otherwise due under the agreement, or otherwise recover, the full amount of such commission, percentage, and brokerage, or contingent fee.

O. CHC-MCO'S CONFLICT OF INTEREST

The CHC-MCO hereby assures that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The CHC-MCO further assures that in the performance of this agreement, it will not knowingly employ any person having such interest. CHC-MCO hereby certifies that no member of the board of the CHC-MCO 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 agreement, shall participate in any decision relating to this agreement 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 agreement or the proceeds thereof.

**Q. CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS
(Applicable to contracts \$25,000 or more)**

1. The CHC-MCO, within 10 days of receiving the notice to proceed, must contact the Department of Human Services' Contractor Partnership Program (CPP) to present, for review and approval, the CHC-MCO'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 agreement. If no employment opportunities arise as a result of this agreement, the CHC-MCO must identify other employment opportunities available within the organization that are not a result of this agreement. 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 agreement.

2. The CHC-MCO's CPP approved recruiting and hiring plan shall be maintained throughout the term of the agreement and through any renewal or extension of the agreement. Any proposed change must be submitted to the CPP Division which will make a recommendation to the Contracting Officer regarding course of action. If an agreement is assigned to another CHC-MCO, the new CHC-MCO must maintain the CPP recruiting and hiring plan of the original agreement.
3. The CHC-MCO, within 10 days of receiving the notice to proceed, must register in the Commonwealth Workforce Development System (CWDS). In order to register the selected CHC-MCO 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 CHC-MCO will receive written notice (via the pink CHC-MCO'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 CHC-MCO to the Central Office of Employment and Training – CPP Division. A copy of the submitted Form PA-1540 must also be submitted (by the CHC-MCO) 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 CHC-MCO is non-compliant, CPP Division will contact the Contract Monitor to request corrective action. The Department may cancel this agreement upon thirty (30) days written notice in the event of the CHC-MCO's failure to implement or abide by the approved plan.

R. TUBERCULOSIS CONTROL

As recommended by the Centers for Disease Control and the Occupational Safety and Health Administration, effective August 9, 1996, in all State Mental Health and Mental Retardation Facilities, all full-time and part-time employees (temporary and permanent), including contract service providers, having direct patient contact or providing service in patient care areas, are to be tested serially with PPD by Mantoux skin tests. PPD testing will be provided free of charge from the state MH/MR facility. If the contract service provider has written proof of a PPD by Mantoux method within the last six months, the MH/MR facility will accept this documentation in lieu of administration of a repeat test. In addition,

documented results of a PPD by Mantoux method will be accepted by the MH/MR facility. In the event that a CHC-MCO 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 CHC-MCO refuses to be tested in accordance with this 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 CHC-MCO

CHC-MCOs 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 confidentiality 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 CHC-MCO 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 agreement.

T. LOBBYING CERTIFICATION AND DISCLOSURE
(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 CHC-MCO will be required to complete and return a "Lobbying Certification Form" and a "Disclosure of Lobbying Activities form" with their signed agreement, which forms will be made attachments to the agreement.

U. **AUDIT CLAUSE**
(Applicable to
agreements \$100,000 or more)

This agreement is subject to audit in accordance with the Audit Clause attached hereto and incorporated herein.

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 (vaginocopy); separate procedure (females only).^A
- Colposcopy (vaginocopy); with biopsy(s) of the cervix and/or endocervical curettage.^A
- Colposcopy (vaginocopy); 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(s), with or without fulguration (separate procedure) (females only).
- Cauterization of cervix; electro or thermal (females only).
- Cauterization of cervix; cryocautery, 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 county.
- 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 J

EPSDT GUIDELINES

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

The CHC-MCO must have written policies and procedures for enrolling Participants into an EPSDT program and 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 CHC-MCO must assist individuals in gaining access to necessary medical, social, education, and other services in accordance with Medical Assistance Bulletin #1239-94-01 "Medical Assistance Case Management Services for Recipients Under the Age of 21".

1. Screening

The CHC-MCO must ensure that periodic EPSDT screens are conducted by a process, including data collection format, approved by the Department, on all Participants under age 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, she/he is required to refer the child (not over five years of age) through CONNECT, 1-800-692- 7288, for referral for local Early Intervention Program services. The CHC-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 21 to receive all Medically Necessary healthcare 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 Healthcare Provider practicing

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

The CHC-MCO must have a system in place to actively identify the need for and furnish "expanded services". Such policies will be clearly communicated to Providers and Participants through the Provider Manual and the Participant handbook. If a Healthcare Provider prescribes services or equipment for an individual under the age of 21, which is not normally covered by the MA Program, or for which the CHC-MCO requires Prior Authorization, the CHC-MCO must follow the Prior Authorization requirements outlined in Section V.B and Exhibit H of the contract.

With respect to SSI and SSI-related Participants under the age of 21, at the first appointment following enrollment, the PCP must make an initial assessment of the health needs of the child over an appropriate period (not to exceed one year), including the child's need for primary and specialty care. The results of that assessment shall be discussed with the family or custodial agency (and, if appropriate, the child) and shall be listed in the child's medical records. The family shall be informed in writing of the plan, and the right to use complaint procedures if they disagree. As part of the initial assessment, the PCP shall make a recommendation regarding whether case management services should be provided to the child, based on medical necessity, and with the families or custodial agency's consent, this recommendation shall be binding on the CHC-MCO.

3. Tracking

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

- 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 Participants under the age of 21 with elevated blood lead levels to early intervention; routine evaluation for iron deficiencies; and timely identification and treatment of asthma.

4. Follow-ups and Outreach

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

- Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Participants.
- Telephone protocols to remind Participants 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 Participants, including home visits, as appropriate.
- A process for outreach and follow-up to Participants 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 Participants under the age of 21 who are under their supervision and who are due to receive EPSDT screens and follow-up treatment.
- The CHC-MCO may develop alternate processes for follow-up and outreach subject to prior written approval from the Department.

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

Arranging for Medically Necessary follow-up care for healthcare services is an integral part of the Provider's continuing care responsibility after a screen or any other healthcare contact. In cases involving a Participant under the age of 21 with complex medical needs or serious or multiple disabilities or illnesses, case management services must be offered, consistent with MA Bulletin #1239-94-01 regarding "Medical Assistance Case Management Services for Recipients Under the Age of 21".

To assist the CHC-MCO in provision of the above four required services (Screening, Diagnosis and Treatment, Tracking, and Follow-ups and Outreach) to children in substitute care, the CHC-MCO will be required to develop master lists of all enrolled children who are coded as such on the monthly Participant files. The CHC-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 Participants 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 CHC-MCO must submit to the Department, reports 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 Participants under the age of 21 identified with Special Needs, the CHC-MCO must appoint a CHC-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 healthcare. To achieve this goal, The CHC-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 Participants and a CHC-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 CHC-MCO Provider Networks.
- Applicable training for PCPs and Providers including the identification of CHC-MCO contact persons.

EXHIBIT K

EMERGENCY SERVICES

The CHC-MCO must agree to accept the Department's definition of Emergency Services. Case management protocols will not apply in cases where they would interfere with treatment of emergencies. In the case of a pregnant woman who is having contractions, if the CHC-MCO attempts to utilize its case management protocols to direct its Participant from an Out-of-Network Provider to a Network Provider, it must collect and maintain data to demonstrate that there was adequate time to effect a safe transfer to another hospital before delivery or that the transfer would not pose a threat to the health and safety of the Participant or the unborn child. Where a transfer is enacted, the CHC-MCO must be able to demonstrate that its case management protocols did not interfere with the transferring hospital's obligation to:

- Restrict transfer until the Participant is stabilized.
- Effect an appropriate transfer or provide medical treatment within its capacity to minimize the risk of transfer to the Participant's health.
- Require a supervised transfer.
- Offer the Participant informed refusal to consent to transfer along with documentation of the associated risks and benefits.
- Not divert a Participant being transported by emergency vehicle from its Emergency Service on the basis of his/her insurance.

Emergency Providers may initiate the necessary intervention to stabilize the condition of the Participant without seeking or receiving prospective authorization by the CHC-MCO.

The CHC-MCO must develop a process for paying for Emergency Services (including their plans, if any, to pay for triage). The CHC-MCO shall pay for Emergency Services in or outside of the CHC zone (including outside of Pennsylvania). Payment for Emergency Services shall be made in accordance with applicable law.

The CHC-MCO may not deny payment for treatment obtained under either of the following circumstances:

- A Participant has an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- A representative of the CHC-MCO instructs the Participant to seek Emergency Services.

The CHC-MCO may not:

- Limit what constitutes an Emergency Medical Condition with reference to the definition of “Emergency Medical Condition, Emergency Services, and Post-Stabilization Services” on the basis of lists of diagnoses or symptoms.
- Refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Participant’s Primary Care Practitioner, CHC-MCO, or applicable state entity of the Participant’s screening and treatment within ten (10) calendar days of presentation for Emergency Services.
- Hold a Participant who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Participant.

The CHC-MCO must also develop a process to ensure that PCPs promptly see Participants who did not require or receive hospital Emergency Services for the symptoms prompting the attempted emergency room visit.

The CHC-MCO is responsible for all Emergency Services including those categorized as mental health or drug and alcohol. Exception: Emergency room evaluations for voluntary and involuntary commitments pursuant to the 1976 Mental Health Procedures Act will be the responsibility of the BH-MCO.

EXHIBIT L

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM

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

- Non-emergency transportation to a medical service that is covered by the Medicare or the MA Medical Assistance Program. This includes transportation for urgent care appointments.
- Transportation to another county, as Medically Necessary, to get medical care as well as advice on locating a train, bus, and route information.
- Reimbursement for mileage, parking, and tolls with valid receipts, if the consumer used their own car or someone else's to get to the medical care Provider.

When requested, the CHC-MCO must arrange non-emergency transportation for urgent appointments for their Participants through the MATP. MATP agencies have been instructed to contact the CHC-MCO for verification that a Medical Assistance Participant's services request is for transportation to a Medical Assistance compensable service. The Department strongly encourages the CHC-MCO to jointly undertake activities with MATP agencies such as sharing Provider Network information, developing informational brochures, and establishing procedures which enhance transportation services for Participants.

EXHIBIT U

BEHAVIORAL HEALTH SERVICES

No mental health or drug and alcohol services, except ambulance, pharmacy and emergency room services, will be covered by the CHC-MCOs.

Behavioral Health Services Excluded from CHC-MCO Covered Services

The following services are not the responsibility of the CHC-MCO, under CHC.

The BH-MCO will provide timely access to diagnostic, assessment, referral, and treatment services for Participants 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.
- 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.
- Pharmacy 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:

- Non-hospital residential detoxification, rehabilitation and halfway houses services for drug/alcohol dependence.
- 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.

- Drug and alcohol drop-in centers.

EXHIBIT X

COMMUNITY HEALTHCHOICES CHC-MCO GUIDELINES FOR ADVERTISING, SPONSORSHIPS, AND OUTREACH

I. Overview

The CHC-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. This plan must address how the CHC-MCO will market its D-SNP product to CHC-MCO Participants.

II. Community HealthChoices Outreach Procedures

CHC-MCOs must adhere to the following guidelines and all the requirements specified in Section V.F.2, CHC-MCO Outreach Materials, and V.F.3, CHC-MCO Outreach Activities, of the agreement when submitting outreach materials, policies and procedures to the Department.

A. Submission of CHC-MCO Outreach Materials

Purpose: To obtain Department approval of new or revised outreach materials, plans or procedures.

Objectives:

1. To assure that CHC-MCO outreach materials are accurate.
2. To prevent the CHC-MCO from distributing outreach materials that mislead, confuse or defraud either the Participant or the Department.

Process:

1. The CHC-MCO submits outreach materials to the Department for prior approval using the CHC Educational Materials Approval Form (form attached).
2. The Department's contract monitoring Core Team will review and forward to the CHC-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 CHC-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 CHC-MCO within ten (10) business days.
5. Outreach material usage:
 - a. Direct outreach materials will be used only by the IEE personnel after final written approval is received by the CHC-MCO from the Department.
 - b. Indirect outreach materials (i.e., advertisements) may be utilized immediately after final written approval is received by the CHC-MCO from the Department.

B. Criteria for Review of CHC-MCO Outreach Materials

Purpose: To assure that printed materials, advertising, promotional activities and new Participant orientations coordinated through the IEE are designed to enable Participants 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 Participant or the Department with the assertion or statement that the Participant must enroll in the CHC-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 CHC-MCO is endorsed by CMS, the federal or state government, or similar entity.

Process:

1. Receive a written overall outreach plan annually if the CHC-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 CHC-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 (i.e., 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?
 - g. Does the information create a negative image of the traditional FFS system?
4. The Department will forward a final written response to the CHC-MCO within ten (10) business days.

C. CHC-MCO Participating In or Hosting an Event

The CHC-MCO may submit requests to sponsor or participate in health fairs or community events; the request should demonstrate that the CHC-MCO will participate in such fairs or events through activities, including approved outreach activities that are primarily health-care related. The CHC-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 CHC-MCOs that Pennsylvania laws and regulations prohibit certain kinds of offers or payments to Participants as inducements or incentives for Participants to use the CHC-MCO's services.

Objectives:

1. To provide amenities that create an environment that is comfortable and convenient for Participants 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 CHC-MCO.

Process:

1. The CHC-MCO must submit a request, using the applicable Community HealthChoices CHC-MCO Outreach Approval Form or the Community HealthChoices Educational Materials Approval Form, to the appropriate Department review agency 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 as confidential.

D. Community HealthChoices CHC-MCO Outreach Approval Form

**E.
Community HealthChoices Educational Materials Approval Form**

- 1.

COMMUNITY HEALTHCHOICES EDUCATIONAL MATERIALS APPROVAL FORM

CHC-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: _____

**COMMUNITY HEALTHCHOICES CHC-MCO OUTREACH APPROVAL
FORM**

CHC-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 CC

DATA SUPPORT FOR CHC-MCOs

Each CHC-MCO will be required to connect to the Department's Network for the purpose of on-line inquiries, intranet access and file transfers. Specifications and limited technical assistance will be made available. No information made available to the CHC-MCO is to be used for any purpose other than supporting their program under CHC. Access to the Department's Network will continue for the functions not included under PROMISE™.

The CHC-MCOs will be required to adhere to Department requirements and HIPAA transactions. Each CHC-MCO will need to be certified through PROMISE™ prior to implementing any data exchange. The Department will provide training on the use and interpretation of information found on the system.

DHS INQUIRY ACCESS:

1. Client Information System (CIS)

The Department will make available to each CHC-MCO access to the Department's CIS database. This database provides eligibility history, demographic information, and TPL information to support the CHC-MCO in meeting their obligations.

2. Intranet

The Department will make available to each CHC-MCO access to the Department's intranet supporting CHC.

3. DHS Internet

Each CHC-MCO will have access to the Department's internet at www.dhs.pa.gov.

PROMISE™ INQUIRY ACCESS:

1. Eligibility Verification System (EVS)

All CHC-MCOs will be provided access to EVS. EVS can be used to verify eligibility, MCO coverage and TPL information. Access will be via the following methods:

- Toll-free via an Automated Voice Response System (AVRS).
- Web access to a Bulletin Board System (BBS).
- Toll free via Provider Electronic Solutions software or point of service (POS) device.
- Internet.
- Provider Portal.
- Direct line/VAN.

2. On-Line Inquiry

Access to the following on-line screens will be made available to the CHC-MCOs:

- Provider.
- Reference.
- Participant Eligibility Verification.
- Claims.
- Prior Authorization.

DATA FILES:

Following are the descriptions of the data files that will be provided to the CHC-MCO by the IEE, or by the Department; the data files that the CHC-MCO will be required to submit to the IEE or the Department; and the files that the IEE will be required to provide to the Department. Additional files may be made available upon request. File layouts and schedules can be found on the Intranet supporting CHC.

FILES AND REPORTS PROVIDED TO THE CHC-MCO:

NAME	PURPOSE	FREQUENCY
834 Daily Participant File	HIPAA compliant file of any change affecting a Participant's demographic, eligibility and enrollment data and TPL information for that day.	Daily
834 Monthly Participant File	HIPAA compliant file containing one record for each Participant who is both Medical Assistance and CHC eligible at some point in the following month as of the date that the file is generated.	Monthly
Weekly Enrollment/Alert Reconciliation File	File of the disposition of each record submitted on the Weekly Enrollment/Alert Reconciliation File of enrollments and alerts.	Weekly
Pending Enrollment File	File from the IEE that provides the CHC-MCOs with pre-enrollment data.	Weekly
Response to the Automated Provider Directory	A response file (from the IEE) to the Automated Provider Directory that is posted each time a file has been processed.	Weekly
ARM 568 Report File	Report file of CIS eligibility statistics by county/district.	Monthly - Optional
DHS Casualty and Estate Encounter Data File Request	TPL file of Participants for every CHC-MCO where TPL needs adjudicated encounter claims information.	Daily - Urgent

CC-

NAME	PURPOSE	FREQUENCY
CHC-MCO Electronic Resource Error File	TPL file of records returned by DHS due to errors.	Weekly
CMS Drug Product Data File	Listing of CMS approved drugs covered by Medicaid.	Quarterly
Response to PCP File	Report of records returned by PROMISe due to error.	Weekly
Procedure Code Extract	The Procedure Code File contains five files within the zip file: Modifier Max Fee, Procedure Code, Provider Type, Restricted, and Related.	Monthly
Diagnosis Code File	Diagnosis Code File to assist in the coding of Claims and Encounter Data.	Monthly
820 Capitation Payment File	HIPAA compliant file reflecting Capitation payments and adjustments processed for eligible Participants.	Monthly
835 Remittance Advice File	HIPAA compliant file of all gross adjustments that processed.	Weekly
MCO Payment Summary File	Summary file of capitation payments by county group, rate cell and date of service up to 36 months.	Monthly
List of Active and Closed Providers (PRV-415)	File of enrolled Medical Assistance Providers in Pennsylvania and the surrounding states and Providers closed within the last 90 days.	Monthly
List of Active and Closed Providers (PRV-414)	File of enrolled Medical Assistance Providers in Pennsylvania and the surrounding states and Providers closed within the last 90 days.	Weekly
NPI Crosswalk File (PRV-430)	File of Providers that registered their NPI number with the Department.	Weekly
Special Indicator File (PRV-435)	File of Provider/service locations and special indicators to identify those Providers eligible for the enhanced payments.	Weekly
CHC-MCO Provider Error Report	Report of CHC-MCO Provider records returned by DHS due to error.	Monthly
The Annual Refresh File	The file contains TPL data for anyone who has been in managed care any time in the last two years.	Annual

TPL Service Class and Matrix	This file contains HCPCS procedure service class and coverage codes. It is used to determine coverage, cost avoidance, and benefit recovery for a particular service on a claim.	Monthly
Daily EDI Claims Submission Statistics	Summary report providing EDI encounter totals sent to the PROMISE™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the day.	Daily
Weekly EDI Claims Submission Statistics	Summary report providing EDI encounter totals sent to the PROMISE™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the week.	Weekly
Monthly EDI Claims Submission Statistics	Summary report providing EDI encounter totals sent to the PROMISE™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the month.	Monthly
Record Accept/Reject Report	Report sent from the translator in response to incoming HIPAA transaction files from the CHC-MCOs.	Daily/After Each Submission
U277	HIPAA transaction generated from PROMISE™ at the end of each processing day, providing a limited data set of all accepted, suspended, and rejected encounters during that Business Day's processing.	Daily
NCPDP Response	HIPAA transaction generated from PROMISE™ providing a limited data set of all accepted and rejected drug encounters per file submission.	Daily
Record Accept/Reject File	Flat file sent from the translator in response to incoming HIPAA transaction files from the CHC-MCOs.	Daily
Monthly Rejected Encounter Activity Report	Report sent to the CHC-MCOs providing a summary/counts of all encounters remaining uncorrected in the suspense database at a given month's end.	Monthly
997 BES Report	Provided by the BES Translator. Sent to the Submitter when the entire file is rejected for invalid HIPAA formats.	Daily
FFS Pharmacy Files	Pharmacy data from FFS to the CHC, PH, and BH plans.	Weekly

Reapplication File	File of Participants who have Medical Assistance reapplication and SAR (Semi Annual Reporting) due dates that are 90 days in advance of the run date.	Monthly
Quarterly Network Provider File	File of Network Providers returned to the MCO.	Quarterly
TPL Monthly File	This file provides the MCOs with TPL information from DHS's TPL database specific to their Participants.	Monthly
Service History Data Files	Files containing service history data (FFS and encounters) for enrolled Participants from the DHS data warehouse.	Weekly

FILES PROVIDED BY THE CHC-MCO:

NAME	PURPOSE	FREQUENCY
CHC-MCO Network Provider File (PRV640)	File provided listing all Providers within the Network to serve Participants.	Monthly
PCP File	File provides the PCP assignments for all Participants.	Weekly
CHC-MCO Casualty /Estate Claims File	TPL file of adjudicated claims for Participants on DHS for use in casualty/estate recoveries.	Weekly, sometimes daily
CHC-MCO Recovery Flagging File	TPL file provides DHS with a list of encounters on which the CHC-MCO intends to pursue recovery.	Monthly/Weekly
CHC-MCO Reconciliation File	TPL file provides DHS with a list of encounters on which the CHC-MCO has realized a recovery, been denied by the third party, or has abandoned recovery activity.	Monthly/Weekly

CHC-MCO Electronic Resource File	TPL file provides the CHC-MCOs with a process to send both new and updated resource referrals electronically in batch format to DHS for update to the TPL file.	Weekly
NAME	PURPOSE	FREQUENCY
837P, 837I, 837D, NCPDP	HIPAA compliant file submitted by the CHC-MCO providing the Department with Encounter Data for all CHC-MCO Participants.	As Scheduled
NCPDP Supplemental File	A file containing supplemental data for NCPDP transactions used for the purpose of drug rebate dispute resolution.	Monthly
Weekly Enrollment/ Alert File	File provided to notify the Department of return mail, newborns not in CIS, a Participant's pregnancy not reflected in CIS, or a deceased Participant with no Date of Death reflected in CIS.	Weekly
Automated Provider Directory File	File contains information on all Providers in the Network for the CHC-MCO. The information will be used by the IEE for their Electronic (On-line) Provider Directory.	Weekly
CHC/PH/BH Pharmacy File	Pharmacy data from the physical health plans to the behavioral health plans.	Submission based on schedule developed by the CHC-MCO (at least twice per month).
Insure Kids Now—Dental Provider Data File	A quarterly file provided by the MCOs to DHS containing select information about their Dental Providers.	Quarterly

EXHIBIT DD

CHC-MCO PARTICIPANT HANDBOOK

The CHC-MCO must ensure that the Participant handbook contains written information regarding Participant rights and protections and is written at no higher than a sixth grade reading level. The CHC-MCO must provide a Participant handbook in the appropriate prevalent language, or alternate format, to all Participants within five (5) business days of being notified of a Participant's Enrollment, but no sooner than five (5) business days before the Participant's effective date of Enrollment. The CHC-MCO may provide the Participant handbook in formats other than hard copy. If this option is exercised, the CHC-MCO must inform Participants what formats are available and how to access each. Upon request, the CHC-MCO must provide a hard copy version of the Participant handbook to the Participant.

At a minimum, the Participant handbook shall include:

1. Information about the CHC-MCO, its services, the practitioners providing care, and the Participant's rights and responsibilities.
2. Role of the PCP in directing and managing care and as a Participant advocate.
3. Information on the role of the IEE and how to access services, including but not limited to, what services they provide to the Participant and contact information.
4. Description of services which should include assistance with changing CHC-MCOs, PCPs, and the right to request an updated Provider directory.
5. How to access after-hour, non-emergency care.
6. Description of the CHC-MCO ID card and the ACCESS card and their uses.
7. Statement that no balanced billing is allowed.
8. Information about co-payments, Prior Authorization, service limits, and the Covered Services exception process.
9. An explanation of the Participant's financial responsibilities for payment of services provided by a Non-participating Provider, when an item or service that requires Prior Authorization is provided by a Provider without Prior Authorization being obtained, or when an item or service is provided that is not covered by the CHC-MCO.
 - An explanation that prescriptions for medications that are written by Non-participating Providers (whether or not they are presented at a participating or non-participating pharmacy) will be the Participant's

responsibility with the following exceptions:

- The Non-participating/non-network Provider arrangements were approved in advance by the CHC-MCO and any prior authorization requirements (if applicable) were met;
 - The Non-participating/non-network prescriber and the pharmacy are the Participant's Medicare Providers; or
 - The Participant is covered by a third party carrier and the Non-participating/non-network prescriber and the pharmacy are the Participant's third party Providers.
10. Information that the Participant is not liable for payment of Covered Services provided when a Pennsylvania Medical Assistance participating healthcare Provider does not receive payment from the CHC-MCO.
 11. Rights of the Participant regarding confidentiality of their medical records.
 12. Rights of the Participant to request and receive a copy of his or her medical records and to request that they be corrected or amended as specified in 45 CFR Parts 164.524 and 164.526.
 13. Rights of Participants to receive information regarding the patient payment responsibilities related to Nursing Facility services.
 14. Information on the availability of and how to access or receive assistance in accessing, at no cost to the Participant, oral interpretation services for all services provided by the CHC-MCO for all non-English languages. The CHC-MCO must make vital documents disseminated to English-speaking Participants available in alternative languages, upon request of the Participant. Documents may be deemed vital if related to the access of LEP persons to programs and services.
 15. Availability of and information on how to access or receive assistance in accessing, at no cost to the Participant, communication methods including TTY and relay services and materials in an alternate format such as Braille, audio tape, large print, compact disc (CD), DVD, computer diskette, and/or electronic communication including how the CHC-MCO will arrange for providing these alternate format Participant materials.
 16. Table of contents.
 17. Information about choosing and changing PCPs.
 18. Information about choosing a primary dentist, if applicable.
 19. Information on how to request a specialist as a PCP or a standing referral to a specialist.
 20. Information on availability of specialists.

21. Information about what to do when family size, address or phone number changes.
22. Information regarding appointment standards.
23. Information regarding Medical Assistance Participants' rights and CHC-MCOs' responsibilities per Section 1867 of the Social Security Act.
24. A description of all available contract services, including how to access those services, which services require Prior Authorization, and an explanation of any service limitations or exclusions from coverage, including an explanation that limitations and most exclusions do not apply to Participants under the age of 21, specific instructions on how transportation is provided, and a notice stating that the CHC-MCO will be liable only for those services that are the responsibility of the CHC-MCO.
25. A description of the services not covered if the CHC-MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds.
26. Information on how to request guidelines, including utilization review and clinical practice guidelines.
27. An explanation of the procedures for obtaining benefits, including self-referred services, services requiring Prior Authorization, services requiring a Covered Service Limit Exception request, if applicable, and services requiring a referral.
28. How to contact Participant Services, the Nurse Hotline, the Service Coordinator Unit and a description of their functions.
29. Information regarding the Complaint, Grievance and DHS Fair Hearing processes, as set forth in the CHC Participant handbook Template for Complaints, Grievances and Fair Hearings, and the right to interim relief within the relevant time frames of the process (55 PA Code Section 275.4(d)).
30. An explanation of how to obtain a list of all available PCPs, specialists, pharmacies, and Providers of ancillary services, upon request, in the appropriate alternate format or language.
31. What to do in case of an Emergency Medical Condition and instructions for receiving advice on care in case of an emergency. The Participant handbook should instruct Participants to use the emergency medical services (EMS) available and/or activate EMS by dialing 9-1-1 in a life-threatening situation.
32. How to obtain emergency transportation and Medically Necessary transportation. Provide the names and telephone numbers for county MATP Providers.

33. EPSDT standard services and information regarding Early Intervention services, including dental services that fall under EPSDT. CHC-MCOs must update their handbooks to reflect increased access for application of topical fluoride varnish by CRNPs and physicians.
34. How and where to access Behavioral Health, Family Planning and vision services.
35. Information on how to obtain prescription drugs, including information on the CHC-MCO's formulary and how to request a copy.
36. Information on what to do regarding out of county/out of state moves.
37. Wellness behaviors and activities the Participant can engage in to improve his/her own health such as diet, exercise, and age-appropriate vaccinations and screenings.
38. Information regarding pregnancies which conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant. The concept of remaining with the same CHC-MCO for the entire pregnancy will be advocated.
39. Notification that the selection of certain PCP sites may result in medical residents, nurse practitioners and physicians assistants providing care to Participants.
40. Information regarding the availability of second opinions and when and how to access them.
41. Information regarding the right to receive services from an Out-of-Network Provider when the CHC-MCO cannot offer a choice of two qualified specialists, and an explanation of how to request authorization for out-of-network services and how to appeal an Adverse Action such as a denial of Covered Services.
42. Information on the availability and process for accessing Medical Assistance Out-of-Plan Services which are not the responsibility of the CHC-MCO, but are available to Participants.
43. Information regarding the Women's, Infants' and Children (WIC) Program and how to access the program.
44. Information regarding HIV/AIDS Programs and how to access them.
45. Information on Tobacco Cessation Programs and how to access them.
46. Information about Estate Recovery.

47. Information about LTSS.
48. Information about Assessment, Reassessment, and PSCP processes.
49. Information about Service Coordination.
50. Information on advance directives (durable healthcare power of attorney and living wills) for adult Participants including:
 - a. The description of State law, if applicable.
 - b. The process for notifying the Participant of any changes in applicable state law as soon as possible, but no later than ninety (90) days after the effective date of the change.
 - c. Any limitation the CHC-MCO has regarding implementation of advanced directives as a matter of conscience.
 - d. The process for Participants to file a Complaint concerning noncompliance with the advanced directive requirements with the CHC-MCO and the State survey and certification agency.
 - e. How to request written information on advance directive policies.
51. A statement that all Participants will be treated with respect and due consideration for their dignity and privacy.
52. A statement that Participants may receive, from a Provider, information on available treatment options and alternatives, presented in a manner appropriate to the Participant's condition and ability to understand.
53. A statement that Participants have the right to participate in decisions regarding their healthcare, including the right to refuse treatment.
54. A statement that Participants are guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
55. A statement that each Participant is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the CHC-MCO and its Providers or the state agency treat the Participant.
56. Explanation of CHC-MCO's and Participant Restriction Program including how to request a DHS Fair Hearing regarding a restriction action and how to request a change of pharmacy or Provider.
57. The Department's Medical Assistance Provider Compliance Hotline number and explanatory statement.

EXHIBIT FF

PROVIDER DIRECTORIES

A) PCP and Dentist Directories

The CHC-MCO shall be required to provide its Participants 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.
- 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 dentist possess anesthesia certificates.
- Identification of whether the dentist is able to serve adults with developmental disabilities.
- Identification of languages spoken and communication competencies by healthcare 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 Participants.

The CHC-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 CHC-MCO shall be required to provide its Participants with specialists and Providers of ancillary services directories which 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.
- Identification of special services, languages spoken and communication competencies, etc.

C) LTSS Providers

The CHC-MCO shall be required to provide its Participants with LTSS Provider directories upon request, which include, at a minimum, the following information:

- The names, addresses and telephone numbers of LTSS Providers.
- Identification of the services provided by each LTSS Provider listed.
- Identification of special services, languages spoken and communication competencies, etc.
- Experience or expertise in serving individuals with particular conditions.

EXHIBIT GG

COMPLAINT, GRIEVANCE AND DHS FAIR HEARING PROCESSES

A. General Requirements

1. The CHC-MCO must obtain the Department's prior written approval of all Complaint, Grievance and DHS Fair Hearing policies and procedures.
2. The CHC-MCO may not charge Participants a fee for filing a Complaint or Grievance at any level of the process.
3. The CHC-MCO must have written policies and procedures for registering, responding to and resolving Complaints and Grievances (at all levels) as they relate to the Medical Assistance population and must make these policies and procedures available upon request.
4. The CHC-MCO must maintain written documentation of each Complaint and Grievance and the actions taken by the CHC-MCO.
5. The CHC-MCO must provide Participants with access to all relevant documentation pertaining to the subject of the Complaint or Grievance.
6. The CHC-MCO must have a data system to process, track and trend all Complaints and Grievances, and submit data to the Department.
7. The CHC-MCO must have a link between the Complaint and Grievance processes and the Quality Management and Utilization Management Programs.
8. The CHC-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to Participant Complaints and Grievances in accordance with the requirements in this Exhibit.
9. CHC-MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training and experience to make an informed and impartial determination regarding issues assigned to them.
10. The CHC-MCO may not use the timeframes or procedures of the Complaint and Grievance process to avoid the decision process or to discourage or prevent the Participant from receiving Covered Services in a timely manner.
11. The CHC-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 Participants who are hearing impaired; Braille; tape; or computer disk; and other commonly accepted alternative forms of communication. The CHC-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitation of Participants with disabilities so they can treat these individuals with

patience, understanding, and respect.

12. The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant. This includes:
 - Providing qualified sign language interpreters for Participants who are severely hearing impaired.
 - Providing information submitted on behalf of the CHC-MCO at the Complaint or Grievance review in an alternative format accessible to the Participant filing the Complaint or Grievance. The alternative format version should be supplied to the Participant at or before the review, so the Participant can discuss and/or refute the content during the review. Providing personal assistance to Participants with other physical limitations in copying and presenting documents and other evidence.
13. The CHC-MCO must provide language interpreter services when requested by a Participant, at no cost to the Participant.
14. The CHC-MCO must offer Participants the assistance of a CHC-MCO staff member throughout the Complaint and Grievance processes at no cost to the Participant.
15. The CHC-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in any previous level of review or decision-making.
16. The CHC-MCO must notify the Participant when the CHC-MCO fails to decide a first level Complaint or first level Grievance within the time frames specified in this Exhibit, using the required template. The CHC-MCO must mail this notice one day following the date the decision was to be made.
17. The CHC-MCO must notify the Participant when it denies payment after a service has been delivered because the service or item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program using the required template (template GG(11)). Templates located on the CHC Intranet site. The CHC-MCO must mail this notice to the Participant on the day the decision was made to deny payment.
18. The CHC-MCO must notify the Participant when it denies payment after a service has been delivered because the service or item provided is not a Covered Service for the Participant, using the required template (template GG(12)). The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.
19. The CHC-MCO must notify the Participant when it denies payment after a service has been delivered because the CHC-MCO determined that the service was not Medically Necessary, using the required template. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

20. The CHC-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances (at all levels) at one location within each of its zones of operation. If a Participant requests an in-person review, the CHC-MCO must notify the Participant of the location of the review and who will be present at the review using the required template (template GG(14)).
21. The CHC-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.
22. The CHC-MCO must use the templates (template GG(1) through GG(14) which are available on the intranet supporting CHC).

B. Complaint Requirements

1. First Level Complaint Process

- a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Complaint either in writing or orally. The CHC-MCO must commit oral requests to writing if not confirmed in writing by the Participant. The CHC-MCO must provide the written confirmation to the Participant or the Participant'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. If the Complaint disputes the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames; challenges the failure to meet the required time frames for providing a service/item; disputes a denial made for the reason that a service/item is not a covered benefit; disputes a denial of payment after the service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Participant, the Participant must file a Complaint within forty-five (45) days from the date of the incident complained of or the date the Participant receives written notice of the decision. For all other Complaints, there is no time limit for filing a Complaint.
- b. The CHC-MCO must provide Participants with a toll free number to file a Complaint, request information about the Complaint process, and ask any questions the Participant may have about the status of a Complaint.
- c. If a Participant files a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit, the Participant must continue to receive the disputed service/item at the previously authorized level pending resolution of the Complaint, if the Complaint is 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 CHC-MCO shall send the Participant and Participant's representative, if any, an acknowledgment letter using the template (templates GG(2a) and GG(2b)).
- e. The first level Complaint review for Complaints **not involving** a clinical issue shall be performed by a first level Complaint review committee, which shall include one or more employees of the CHC-MCO who were not 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 shall be performed by a first level Complaint review committee, which shall include one or more employees of the CHC-MCO who were not involved in any previous level of review or decision making on the issue that is the subject of the Complaint. The Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint.
- g. The Participant must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CHC-MCO shall be flexible when scheduling the review to facilitate the Participant's attendance. The Participant shall be given at least seven (7) days advance written notice of the review date. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity to communicate with the first level Complaint review committee by telephone or video conference. The Participant may elect not to attend the first level Complaint meeting but the meeting must be conducted with the same protocols as if the Participant was present.
- h. If a Participant 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 will be held and the other members of the first level Complaint review committee must participate in the review through the use of video conferencing.
- i. The first level Complaint review committee shall complete its review of the Complaint as expeditiously as the Participant's health condition requires, but no more than thirty (30) days from receipt of the Complaint, which may be extended by fourteen (14) days at the request of the Participant.
- j. 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.
- k. The CHC-MCO must send a written notice of the first level Complaint decision, using the required template, to the Participant, Participant's representative, if any, service Provider and prescribing PCP, if applicable, within five (5) business days from the first level Complaint review committee's decision.

- i. The Participant or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for a second level Complaint review ("second level Complaint") within forty-five (45) days from the date the Participant receives written notice of the CHC-MCO's first level Complaint decision.
- m. If the Complaint disputes the failure of the CHC-MCO to provide a service/item or to decide a Complaint or Grievance within specified time frames or disputes a denial made for the reason that a service/item is not a covered benefit, or disputes a denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania MA Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Participant, the Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision.

2. **Second Level Complaint Process**

- a. Upon receipt of the second level Complaint, the CHC-MCO shall send the Participant and Participant's representative, if any, an acknowledgment letter using the required template (template GG(4)).
- b. If a Participant files a second level Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit, the Participant must continue to receive the disputed service/item at the previously authorized level pending resolution of the second level Complaint, if the second level Complaint is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision.
- c. The second level Complaint review shall be performed by a second level Complaint review committee made up of three (3) or more individuals who were not involved in any previous level of review or decision-making on the matter under review.
- d. At least one-third of the second level Complaint review committee may not be employees of the CHC-MCO or a related subsidiary or Affiliate.
- e. A committee member who does not personally attend the second level Complaint review may not be part of the decision-making process unless that member actively participates in the review by telephone or video conference and has the opportunity to review all information introduced during the review.
- f. The Participant must be provided the opportunity to appear before the second level Complaint review committee. The CHC-MCO shall be flexible when scheduling the second level Complaint review to facilitate the Participant's

attendance. The Participant shall be given at least fifteen (15) days advance written notice of the review date. If the Participant cannot appear in person at the second level Complaint review, the CHC-MCO must provide the opportunity to communicate with the second level Complaint review committee by telephone or video conference. The Participant may elect not to attend the second level Complaint meeting but the meeting must be conducted with the same protocols as if the Participant was present.

- g. If a Participant 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 will be held and the other members of the second level Complaint review committee must participate in the review through the use of video conferencing.
- h. The decision of the second level Complaint review committee must be based solely on the information presented at the review.
- i. The second level Complaint review committee shall complete the second level Complaint review within forty-five (45) days from the CHC-MCO's receipt of the Participant's second level Complaint.
- j. Testimony taken by the second level Complaint review committee (including the Participant's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.
- k. The CHC-MCO must send a written notice of the second level Complaint decision, using the required template (template GG(5)) to the Participant, Participant's representative, if any, service Provider and prescribing Provider, if applicable within five (5) business days from the second level Complaint review committee's decision.
- l. The Participant or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an external review of the second level Complaint decision with either the DOH or the PID within fifteen (15) days from the date the Participant receives the written notice of the CHC-MCO's second level Complaint decision.
- m. If the second level Complaint disputes the failure of the CHC-MCO to provide a service/item or to decide a Complaint or Grievance within specified timeframes or disputes a denial made for the reason that a service/item is not a covered benefit, or disputes a denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Participant, the Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's second level

Complaint decision.

3. External Review of Second Level Complaint Review Decision

- a. If a Participant files a request for an external review of a second level Complaint decision to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit, the Participant must continue to receive the disputed service/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 on the CHC-MCO's second level Complaint decision.
- b. Upon the request of either the DOH or PID, the CHC-MCO must transmit all records from the first level review and second level review to the requesting department within thirty (30) days from the request in the manner prescribed by that department. The Participant, the Healthcare Provider or the CHC-MCO may submit additional materials related to the Complaint.
- c. The DOH and PID will determine the appropriate agency for the review.

4. Expedited Complaint Process

- a. The CHC-MCO must conduct expedited review of a Complaint at any point prior to the second level Complaint decision, if a Participant or Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from the Participant's Provider that the Participant's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular Complaint process. This certification is necessary even when the Participant's request for the expedited review is made orally. The certification must include the Provider's signature.
- b. A request for an expedited review of a Complaint may be filed either in writing, by fax or orally. Oral requests must be committed to writing by the CHC-MCO. The Participant's signature is not required.
- c. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant of the right to present evidence and allegations of fact or of law 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, the CHC-MCO, must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three (3) business days of the Participant's request for expedited review, the CHC-MCO shall decide the Complaint within the standard time frames as set forth

in this Exhibit. The CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within two (2) days of the decision to deny expedited review, using the required template (template GG(6b)).

- e. If a Participant files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit, the Participant must continue to receive the disputed service/item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
- f. Complaints requiring expedited review must be reviewed by a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review. The members of the Complaint review committee may not have been involved in any previous level of review or decision-making on the issue under review. The licensed physician must decide the Complaint.
- g. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Healthcare Provider within either forty-eight (48) hours of receiving the Provider certification or three (3) business days of receiving the Participant's request for an expedited review, whichever is shorter. In addition, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Healthcare Provider within two (2) days of the decision using the required template (template GG(6a)).
- h. The CHC-MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.
- i. The Participant, or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Complaint review with the CHC-MCO within two (2) business days from the date the Participant receives the CHC-MCO's expedited Complaint decision.
- j. The CHC-MCO shall follow DOH guidelines relating to submission of requests for expedited external reviews.
- k. The CHC-MCO may not take punitive action against a Provider who either requests expedited resolution of a Complaint or supports a Participant's request for expedited review of a Complaint.
- l. The Participant may file a request for a DHS Fair Hearing within thirty (30)

days from the mail date on the written notice of the CHC-MCO's expedited Complaint decision.

C. Grievance Requirements

1. First Level Grievance Process

- a. A CHC-MCO shall permit a Participant or the Participant representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Grievance either in writing or orally. The CHC-MCO must commit oral requests to writing if not confirmed in writing by the Participant and must provide the written confirmation to the Participant for signature. The Participant's signature may be obtained at any point in the process, and failure to obtain a signed Grievance may not delay the Grievance process. Participants will be given forty-five (45) days from the date the Participant receives the written notice to file a Grievance.
- b. The CHC-MCO must provide Participants with a toll free number to file a Grievance, request information about the Grievance process, and ask questions the Participant may have about the status of a Grievance.
- c. A Participant who files a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the Grievance, if the Grievance is 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 CHC-MCO shall send the Participant and Participant's representative, if the Participant has designated one, an acknowledgment letter using the required template (template GG(7)).
- e. A Participant who consents to the filing of a Grievance by a Healthcare Provider may not file a separate Grievance. The Participant may rescind consent throughout the Grievance process upon written notice to the CHC-MCO and the Provider.
- f. In order for the Provider to represent the Participant in the conduct of a Grievance, the Provider must obtain the written consent of the Participant. A Provider may obtain the Participant's written permission at the time of treatment. A Provider may not require a Participant 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 Participant, the Participant's date of birth and identification number.
 - ii. If the Participant is a minor, or is legally incompetent, the name, address and relationship to the Participant of the person who signed the consent.

- iii. The name, address and CHC-MCO identification number of the Provider to whom the Participant is providing consent.
 - iv. The name and address of the CHC-MCO to which the Grievance will be submitted.
 - v. An explanation of the specific service/item for which coverage was provided or denied to the Participant to which the consent will apply.
 - vi. The following statement: “The Participant or the Participant’s representative may not submit a Grievance concerning the services/items listed in this consent form unless the Participant or the Participant’s representative rescinds consent in writing. The Participant or the Participant’s representative has the right to rescind consent at any time during the Grievance process.”
 - vii. The following statement: “The consent of the Participant or the Participant’s representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the second level review process.”
 - viii. The following statement: “The Participant or the Participant’s representative, if the Participant 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 Participant or the Participant’s representative understands the information in the Participant’s consent form.”
 - ix. The dated signature of the Participant, or the Participant’s representative, and the dated signature of a witness.
- g. The first level Grievance review shall be performed by the first level Grievance review committee, which shall include one or more employees of the CHC-MCO who was not involved in any previous level of review or decision making on the subject of the Grievance.
 - h. The first level Grievance review committee shall include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.
 - i. The Participant must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CHC-MCO shall be flexible when scheduling the review to facilitate the Participant’s attendance. The Participant shall be given at least seven (7) days advance written notice of the review date. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity to communicate with the first level Grievance review committee by telephone or video conference. The Participant may elect not to attend the first level

Grievance meeting but the meeting must be conducted with the same protocols as if the Participant was present.

- j. If a Participant requests an in-person first level Grievance review, at a minimum, a member of the first level Grievance review committee must be physically present at the location where the first level Grievance review will be held and the other members of the first level Grievance review committee must participate in the review through the use of video conferencing.
- k. The first level Grievance review committee shall complete its review of the Grievance as expeditiously as the Participant's health condition requires, but no more than thirty (30) days from receipt of the Grievance, which may be extended by fourteen (14) days at the request of the Participant.
- l. The first level Grievance review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Grievance record.
- m. The CHC-MCO must send a written notice of the first level Grievance decision, using the required template (template GG(3b)), to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing PCP, if applicable, within five (5) business days from the first level Grievance review committee's decision.
- n. The Participant or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for a second level Grievance review ("second level Grievance") within forty-five (45) days from the date the Participant receives the written notice of the CHC-MCO's first level Grievance decision.
- o. The Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's first level Grievance decision.

2. Second Level Grievance Process

- a. Upon receipt of the second level Grievance, the CHC-MCO shall send the Participant and the Participant's representative, if the Participant has designated one, an acknowledgment letter using the required template (template GG(8)).
- b. A Participant who files a second level Grievance to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the second level Grievance, if the second level Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the CHC-MCO's first level Grievance decision.

- c. The second level Grievance review shall be performed by a second level Grievance review committee made up of three (3) or more individuals who were not involved in any previous level of review or decision making to deny coverage or payment for the requested service/item. At least one-third of the second level Grievance review committee may not be employees of the CHC-MCO or a related subsidiary or affiliate.
- d. The second level Grievance review committee shall include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review.
- e. The Participant must be provided the opportunity to appear before the second level Grievance review committee. The CHC-MCO shall be flexible when scheduling the second level review to facilitate the Participant's attendance. The Participant shall be given at least fifteen (15) days advance written notice of the review date. If the Participant cannot appear in person at the second level review, the CHC-MCO must provide an opportunity to communicate with the second level Grievance review committee by telephone or video conference. The Participant may elect not to attend the second level Grievance meeting but the meeting must be conducted with the same protocols as if the Participant was present.
- f. If a Participant requests an in-person second level Grievance review, at a minimum, a member of the second level Grievance review committee must be physically present at the location where the second level Grievance review will be held and the other members of the second level Grievance review committee must participate in the review through the use of video conferencing.
- g. The decision of the second level Grievance review committee must be based solely on the information presented at the review.
- h. The second level Grievance review committee shall complete the second level Grievance review within forty-five (45) days from receipt of the Participant's second level Grievance.
- i. Testimony taken by the second level Grievance review committee (including the Participant's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Grievance record.
- j. The CHC-MCO must send a written notice of the second level Grievance decision, using the required template (template GG(9)), to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing Provider, if applicable, within five (5) business days of the second level Grievance review committee's decision.
- k. The Participant or Participant representative, which may include the

Participant's Provider, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, may file a request with the CHC-MCO for an external review ("external Grievance review") of the second level Grievance decision by a certified review entity appointed by the DOH. The request must be filed within fifteen (15) days from the date the Participant receives the written notice of the CHC-MCO's second level Grievance decision.

- l. The Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's second level Grievance decision.

3. **External Review of Second Level Grievance Decision:**

- a. The CHC-MCO must process all requests for external Grievance review. The CHC-MCO must follow the protocols established by the DOH in meeting all timeframes and requirements necessary in coordinating the request and notification of the decision to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing Provider.
- b. A Participant who files a request for an external Grievance review to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is hand delivered or post-marked within ten (10) days of the mail date on the written notice of the CHC-MCO's second level Grievance decision.
- c. Within five (5) business days of receipt of the request for an external Grievance review, the CHC-MCO shall notify the Participant, the Participant's representative, if the Participant has designated one, or the Healthcare Provider, and the DOH that the request for external Grievance review has been filed.
- d. The external Grievance review shall be conducted by a certified review entity (CRE) not directly affiliated with the CHC-MCO.
- e. Within two (2) business days from receipt of the request for an external Grievance review, the DOH randomly assigns a CRE to conduct the review. The CHC-MCO and assigned CRE entity will be notified of this decision.
- f. If the DOH fails to select a CRE within two (2) business days from receipt of a request for an external Grievance review, the CHC-MCO may designate a CRE to conduct a review from the list of CREs approved by the DOH. The CHC-MCO may not select a CRE that has a current contract or is negotiating a contract with the CHC-MCO or its Affiliates or is otherwise affiliated with the CHC-MCO or its Affiliates.
- g. The CHC-MCO must forward all documentation regarding the decision,

including all supporting information, a summary of applicable issues and the basis and clinical rationale for the decision, to the CRE conducting the external Grievance review. The CHC-MCO must transmit this information within fifteen (15) days from receipt of the Participant's request for an external Grievance review.

- h. Within fifteen (15) days from receipt of the request for an external Grievance review by the CHC-MCO, the Participant or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, 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 CHC-MCO so that the CHC-MCO has an opportunity to consider the additional information.
- i. Within sixty (60) days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review shall issue a written decision to the CHC-MCO, the Participant, the Participant's representative and the Provider (if the Provider filed the Grievance with the Participant's consent), that includes the basis and clinical rationale for the decision. The standard of review shall be whether the service/item was Medically Necessary and appropriate under the terms of the CHC-MCO's contract.
- j. The external Grievance decision may be appealed by the Participant, the Participant's representative, or the Healthcare Provider to a court of competent jurisdiction within sixty (60) days from the date the Participant receives notice of the external Grievance decision.

4. Expedited Grievance Process

- a. The CHC-MCO must conduct expedited review of a Grievance at any point prior to the second level Grievance decision, if a Participant or Participant representative, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from his or her Provider that the Participant's life, health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. This certification is necessary even when the Participant's request for the expedited review is made orally. The certification must include the Provider's signature.
- b. A request for expedited review of a Grievance may be filed either in writing, by fax or orally. Oral requests must be committed to writing by the CHC-MCO. The Participant's signature is not required.
- c. The expedited review process is bound by the same rules and procedures as the second level Grievance review process with the exception of timeframes, which are modified as specified in this section.

- d. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.
- e. If the Provider certification is not included with the request for an expedited review, the CHC-MCO, must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three (3) business days of the Participant's request for expedited review, the CHC-MCO shall decide the Grievance within the standard time frames as set forth in this Exhibit. The CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within two (2) days of the decision to deny expedited review, using the required template (template GG(6b)).
- f. A Participant who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
- g. Review of Grievances must be performed by a Grievance review committee that includes a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review. The members of the Grievance review committee may not have been involved in any previous level of review or decision-making on the subject of the Grievance. The licensed physician must decide the Grievance.
- h. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Provider within either forty-eight (48) hours of receiving the Provider certification, or three (3) business days of receiving the Participant's request for an expedited review, whichever is shorter. In addition, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Healthcare Provider within two (2) days of the decision using the required template (template GG(10)).
- i. The Participant, or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Grievance review with the CHC-MCO; within two (2) business days from the date the Participant receives the CHC-MCO's expedited Grievance decision.

- j. The CHC-MCO shall follow DOH guidelines relating to submission of requests for expedited external reviews.
- k. The CHC-MCO may not take punitive action against a Provider who either requests expedited resolution of a Grievance or supports a Participant's request for expedited review of a Grievance.
- l. The Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's expedited Grievance decision.

D. Department's Fair Hearing Requirements

1. Department's Fair Hearing Process

- a. Participants do not have to exhaust the Complaint or Grievance process prior to filing a request for a DHS Fair Hearing.
- b. The Participant or the Participant's representative may request a DHS Fair Hearing within thirty (30) days from the mail date on the initial written notice of decision and within thirty (30) days from the mail date on the written notice of the CHC-MCO's first or second level Complaint or Grievance notice of decision for any of the following:
 - i) The denial, in whole or part, of payment for a requested service/item if based on lack of Medical Necessity.
 - ii) The denial of a requested service/item on the basis that the service/item is not a Covered Service.
 - iii) The denial or issuance of a limited authorization of a requested service/item, including the type or level of service/item.
 - iv) The reduction, suspension, or termination of a previously authorized service/item.
 - v) The denial of a requested service/item but approval of an alternative service/item.
 - vi) The failure of the CHC-MCO to provide services/items in a timely manner, as defined by the Department.
 - vii) The failure of the CHC-MCO to decide a Complaint or Grievance within the time frames specified in this Exhibit.
 - viii) the denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program.

- ix) The denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Participant.
- c. The request for a DHS Fair Hearing must include a copy of the written notice of decision that is the subject of the request. Requests must be sent to:

Pennsylvania Department of
Human Services
Bureau of Hearings and Appeals
2330 Vartan Way
Second Floor
Harrisburg, PA 17110-9721
Telephone: (717) 783-3950
Fax: (717) 772-2769 or (717) 346-1959

- d. A Participant who files a request for a DHS Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for a DHS Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
- e. Upon receipt of the request for a DHS Fair Hearing, the Department's BHA or a designee will schedule a hearing. The Participant and the CHC-MCO will receive notification of the hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the Participant. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.
- f. The CHC-MCO is a party to the hearing and must be present. The CHC-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Department's decision is based solely on the evidence presented at the hearing. The failure of the CHC-MCO to participate in the hearing will not be reason to postpone the hearing.
- g. The CHC-MCO must provide Participants, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.
- h. If BHA has not issued a final administrative action within ninety (90) days of the receipt of the request for a DHS Fair Hearing, the CHC-MCO shall follow the requirements at 55 PA Code § 275.4 regarding the provision of interim assistance upon the request for such by the Participant. When the Participant is responsible for delaying the hearing process, the time limit for final administrative action will be extended by the length of the delay attributed to the Participant.
- i. BHA adjudication is binding on the CHC-MCO unless reversed by the Secretary of DHS. Either party may request reconsideration from the

Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of final administrative action or from the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the CHC-MCO.

2. Expedited Fair Hearing Process

- a. A request for an expedited DHS Fair Hearing may be filed by the Participant or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, with the Department either in writing or orally.
- b. Participants do not have to exhaust the Complaint or Grievance process prior to filing a request for an expedited DHS Fair Hearing.
- c. An expedited DHS Fair Hearing will be conducted if a Participant or a Participant's representative provides the Department with written certification from the Participant's Provider that the Participant's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular DHS Fair Hearing process. This certification is necessary even when the Participant's request for the expedited Fair Hearing is made orally. The certification must include the Provider's signature. The Provider may also testify at the DHS Fair Hearing to explain why using the usual time frames would place the Participant's health in jeopardy.
- d. A Participant who files a request for an expedited Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for an expedited Fair Hearing is 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, the Department's BHA or a designee will schedule a hearing.
- f. The CHC-MCO is a party to the hearing and must participate in the hearing. The CHC-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The failure of the CHC-MCO to participate in the hearing will not be reason to postpone the hearing.
- g. The CHC-MCO must provide the Participant, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.
- h. BHA has three (3) business days from the receipt of the Participant's oral or written request for an expedited review to process final administrative action.
- i. BHA adjudication is binding on the CHC-MCO unless reversed by the Secretary of DHS. Either party may request reconsideration from the

Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of adjudication or from the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the CHC-MCO.

E. Provision of and Payment for Services/Items following Decision

1. If the CHC-MCO or BHA reverses a decision to deny, limit, or delay services/items that were not furnished during the Complaint, Grievance or DHS Fair Hearing process, the CHC-MCO must authorize or provide the disputed services/items promptly and as expeditiously as the Participant's health condition requires. If the CHC-MCO requests reconsideration, the CHC-MCO must authorize or provide the disputed services/items pending reconsideration unless the CHC-MCO requests a stay of the BHA decision and the stay is granted.
2. If the CHC-MCO or BHA reverses a decision to deny authorization of services/items, and the Participant received the disputed services/items during the Complaint, Grievance or DHS Fair Hearing process, the CHC-MCO must pay for those services/items.

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 CHC-MCO and the Department concerning the Community HealthChoices Program.
- Meet the applicable requirements of 42 CFR 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 CHC-MCO either directly or indirectly through capitation, that data for all services provided will be reported timely to the CHC-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 CHC Participants, that the subcontractor will report all new third party resources to the CHC-MCO identified through the provision of medical services, which previously did not appear on the Department's Participant information files provided to the CHC-MCO.
- Contain a hold harmless clause that stipulates that the CHC-MCO subcontractor agrees to hold harmless the Commonwealth, all Commonwealth officers and employees and all CHC-MCO Participants in the event of nonpayment by the CHC-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 CHC-MCO.
- Contain a provision in all subcontracts of compliance with all applicable federal and state laws.

- Contain provisions in all subcontracts with any individual firm, corporation or any other entity which provides medical services to Community HealthChoices Participants, that prohibits gag clauses which limit the subcontractor from disclosure of medical necessary or appropriate healthcare information or alternate therapies to Participants, other healthcare 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 Community HealthChoices Program.
- Contain provisions in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to Community HealthChoices Participants, that limits incentives to those permissible under the applicable federal regulation.

The CHC-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 Participants.

The CHC-MCO and its subcontractor(s) must agree to maintain books and records relating CHC 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 CHC-MCO and its subcontractor(s) also must agree to comply with all standards for practice and medical records keeping specified by the Commonwealth.

The CHC-MCO and its subcontractor(s) 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 contract and record retention period, these records shall be available at the CHC-MCO's chosen location, subject to approval of the Commonwealth. The CHC-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 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 CHC-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 five 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 CHC-MCO and its subcontractor(s) must agree to retain the source records for its data reports for a minimum of seven years and must have written policies and procedures for storing this information.

The CHC-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 CHC-MCO shall require, as a written provision in all contracts for services rendered to the Participant, that the subcontractor shall be held civilly and/or criminally liable to both the CHC-MCO and the Department, in the event of nonperformance, misrepresentation, fraud, or abuse. The CHC-MCO shall notify its PCPs and all subcontractors of the prohibition and sanctions for the submission of false claims and statements.

The CHC-MCO shall require, as a written provision in all subcontracts that the subcontractor cooperate with Quality Management/Utilization Management Program requirements.

The CHC-MCO shall require Providers to comply with all Service Coordination program requirements, including, where applicable, cooperation with the PCPT approach for PCSP and Service Coordination.

The CHC-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 CHC-MCO identifies deficiencies or areas needing improvement, the CHC-MCO and the subcontractor must take corrective action.

EXHIBIT KK

REPORTING SUSPECTED FRAUD AND ABUSE TO THE DEPARTMENT

The following requirements are adapted from 55 PA Code Chapter 1101, General Regulations for the Medical Assistance Program, specifically 55 PA Code § 1101.75(a) and (b), Provider Prohibited Acts, which are directly adapted from the 62 P.S. § 1407, (also referred to as Act 105 of 1980, Fraud and Abuse Control Act). The basis for Recipient referrals is 55 PA Code § 1101.91 and § 1101.92, Recipient Mis-utilization and Abuse and Recipient Prohibited Acts. For information on these regulations, go to <http://www.pacode.com>.

Reporting Requirements:

CHC-MCOs must report to the Department any act by Providers, Participants, caregivers and employees that may affect the integrity of the CHC Program under the Medical Assistance Program. Specifically, if the CHC-MCO suspects that Fraud, Abuse or Waste, as discussed in the Fraud and Abuse section of the agreement, may have occurred, the CHC-MCO must report the issue to the OLTL. The CHC-MCO must have a process to notify OLTL of any adverse actions and/or Provider disclosures received 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.

CHC-MCOs are required to report quality issues to the Department for further investigation. Quality issues are those which, on an individual basis, affect the Participant's health (e.g., poor quality services, inappropriate treatment, aberrant and/or abusive prescribing patterns, and withholding of Medically Necessary services from the Participant).

The CHC-MCO must make all Fraud, Abuse, Waste, or quality referrals within thirty (30) days of the identification of the problem/issue. The CHC-MCO must send to OLTL 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 indicating the supporting documentation information 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 Participant or significant financial loss to the Department) must be referred immediately to the Department's OLTL for further investigation.

The CHC-MCO must train or educate its Network Providers on the reporting requirements of incidents of abuse and of the Older Adult Protective Services Act and the Adult Protective Services Act. To the extent a Participant is an alleged victim of abuse, neglect, exploitation or abandonment the CHC-MCO shall fully cooperate in the investigation of the case and the coordination of any services provided by the CHC-MCO. As part of its quality management plan, the CHC-MCO shall have a means to identify Participants who may be at risk of abuse or neglect and take steps to minimize those risks while balancing the right

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of the Participant to live in their community or place of choice.

The CHC-MCO must follow the processes unless prior approval is received from OLTL. Reports must be submitted online using the CHC-MCO Referral Form. The instructions and form templates are located at [\(Will add link at a later time\)](#) .

Once completed, the CHC-MCO must electronically submit the form to BPI and must submit the following information by fax or mail to OLTL:

- Checklist of Supporting Documentation for Referrals, accessible on the CHC-MCO Referral Form.
- A copy of the confirmation page which will appear after “Submit” button is clicked, submitting the CHC-MCO Referral Form.
- All supporting documentation.

OLTLBPI FAX Number 717-772-4638, Attn: BPI DPPC

DHS Bureau of Program Integrity
Managed Care Unit
P.O. Box 2675
Harrisburg, PA 17105-2675

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 or staff person referrals [*The below list is provided as examples of materials that could be relevant to an investigation of the referral. The list is not all inclusive.*]-

- confirmation page from online referral
- encounter forms (lacking signatures or forged signatures)
- timesheets
- attendance records of Participant
- written statement from parent, Provider, school officials or client that services were not rendered or a forged signature
- 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)
- copies of complaints filed by members
- admission of guilty 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(s)
- 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

GUIDELINES FOR SANCTIONS REGARDING FRAUD, WASTE AND ABUSE

The Department recognizes its responsibility to administer the Community HealthChoices Program and ensure that the public funds which pay for this program are properly spent.

To maintain the integrity of the Community HealthChoices Program and to ensure that CHC-MCOs comply with pertinent provisions and related state and federal policies, rules and regulations involving Fraud, Waste and Abuse issues, the Department will impose sanctions on the CHC-MCOs as deemed appropriate where there is evidence of violations involving Fraud, Waste and Abuse issues in the Community HealthChoices Program. To that end, program compliance and improvement assessments, including financial assessments payable to BPI, will be applied by BPI for the CHC-MCO's identified program integrity compliance deficiencies. The Department may impose sanctions available to it 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.
- B. Failure to cooperate with reviews by oversight agencies or their representative, including the Department, Office of Attorney General, Office of Inspector General of the U.S. DHHS, and other state or federal agencies and auditors.
- C. Failure to adhere to applicable state and federal laws and regulations.
- D. Failure to adhere to the terms of the Community HealthChoices agreement, and the relevant exhibits which relate to Fraud, Waste and Abuse issues.

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 CHC-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 intends to maintain an effective, reasonable and consistent sanctioning process as deemed necessary to protect the integrity of the Community HealthChoices Program.

EXHIBIT PP PROVIDER MANUALS

The CHC-MCO shall work with the Department to develop, distribute prior to implementation, and maintain a Provider manual. In addition, the CHC-MCO and/or CHC-MCO Subcontractors will be expected to distribute copies of all manuals and subsequent policy clarifications and procedural changes to Network 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 Medical Assistance bulletin within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the Medical Assistance bulletin, whichever is later, when such change(s) affect(s) information that the CHC-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 needs screening, comprehensive needs assessment and reassessment, and service planning system and protocols and a description of the Provider's role in Service Planning and Service Coordination.
- B. A description of Service Coordination and how the Provider will fit into the Person-Centered Planning Team approach.
- C. A description of the population being served through CHC.
- D. A description of the accessibility requirements with which Providers are required to comply.
- E. 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.
- F. Information on how Participants may access specialists, including standing referrals and specialists as PCPs.
- G. 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.
- H. Contact information to access the CHC-MCO, DHS, advocates, other related organizations, etc.
- I. A copy of the CHC-MCO's Formulary, Prior Authorization, and program exception process.
- J. Contact follow-up responsibilities for missed appointments.
- K. Description of role of the Service Coordinator and how to contact them.
- L. Description of drug and alcohol treatment available and how to make referrals.
- M. Complaint, Grievance and DHS Fair Hearing information.

- N. Information on Provider Disputes.
- O. CHC-MCO policies, procedures, available services, sample forms, and fee schedule applicable to the Provider type.
- P. A full description of Covered Services, listing all Covered Services outlined in Exhibit DDD(1) and DDD(2).
- Q. Billing instructions.
- R. Information regarding applicable portions of 55 PA Code, Chapter 1101, General Provisions.
- S. Information on self-referred services and services which are not the responsibility of the CHC-MCO but are available to Participants on a Fee-for-Service basis.
- T. Provider performance expectations, including disclosure of Quality Management and Utilization Management criteria and processes.
- U. Information on procedures for sterilizations, hysterectomies and abortions (if applicable).
- V. Information about EPSDT screening requirements and EPSDT services, (including information on the dental referral process).
- W. A description of certain Providers' obligations, under law, to follow applicable procedures in dealing with Participants on "Advanced Directives" (durable healthcare power of attorney and living wills). This includes notification and record keeping requirements.
- X. Information on ADA and Section 504 of the Rehabilitation Act of 1973, other applicable laws, and available resources related to the same.
- Y. A definition of "Medically Necessary" consistent with the language in the agreement.
- Z. Information on Participant confidentiality requirements.

Information regarding school-based/school-linked services in this CHCzone;

- AA. The Department's Medical Assistance Provider Compliance Hotline (formerly the Fraud and Abuse Hotline) number and explanatory statement.
- BB. Explanation of CHC-MCO's and DHS's Recipient Restriction Program.
- AA. Information regarding written translation and oral interpretation services for Participants 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.

and to Subcontractors, regarding the contents and requirements of the Provider manuals.

EXHIBIT WW

COMMUNITY HEALTHCHOICES AUDIT CLAUSE

AUDITS

Annual Contract Audits

The CHC-MCO shall cause, and bear the costs of, an annual contract audit to be performed by an independent, licensed Certified Public Accountant. The contract audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The contract audit shall be digitally submitted to OLTL, OMAP, BMCO, Division of Financial Analysis via the E-FRM system no later than June 30 after the contract year is ended.

If circumstances arise in which the Commonwealth or the CHC-MCO invoke the contractual termination clause or determine the contract will cease, the contract audit for the period ending with the termination date or the last date the CHC-MCO is responsible to provide Medical Assistance benefits to Community HealthChoices recipients shall be submitted to the Commonwealth within 180 days after the contract termination date or the last date the CHC-MCO is responsible to provide Medical Assistance benefits.

The CHC-MCO shall ensure that audit working papers and audit reports are retained by the CHC-MCO's auditor for a minimum of five (5) years from the date of final payment under the contract, unless the CHC-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 CHC-MCO's auditor.

Annual Entity-Wide Financial Audits

The CHC-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 OLTL, OMAP, BMCO via E-FRM within t h i r t y (30) days from the date it is made available to the CHC-MCO.

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 CHC-MCO, its subcontractors or Providers. Any such additional audit work will rely on work already performed by the CHC-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 CHC-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 contract.
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 contract terms and conditions.
3. Program audits and reviews to measure the economy, efficiency, and effectiveness of program operations under this contract.

Audits performed by the Commonwealth shall be in addition to any federally-required audits or any monitoring or review efforts. Commonwealth audits of the CHC-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 CHC-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 CHC-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, contracts 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 CHC-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 contract and record retention period, these records shall be available at the CHC-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 CHC-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 contract period and five (5) 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 CHC-MCO shall include in all risk sharing CHC-MCO subcontract agreements clauses, which reflect the above provisions relative to "Annual Contract Audits", "Annual Entity-Wide Financial Audits", "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

The CHC-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
ENCOUNTER DATA SUBMISSION REQUIREMENTS
And
PENALTY APPLICATIONS

The submission of timely and accurate Encounter Data is critical to the Commonwealth'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 REQUIREMENT**

All MCOs must be certified through PROMISE prior to the submission of live Encounter Data. The certification process is detailed at: (Will add link at a later time)

- **SUBMISSION REQUIREMENTS**

Timeliness:

With the exception of pharmacy Encounters, all CHC-MCO approved Encounters and those specified CHC-MCO denied Encounters must be approved in PROMISE by the last day of the third month following the month of initial CHC-MCO adjudication.

Pharmacy Encounters must be submitted and approved in PROMISE within thirty (30) days following the CHC-MCO adjudication.

Metric: During the sixth month following the month of the initial PROMISE adjudication, the Encounters will be analyzed for timely submission of Encounters.

- Failure to achieve PROMISE approved/paid status for ninety-eight percent (98%) of all CHC-MCO paid/approved and specified CHC-MCO denied Encounters by the last day of the third month following initial CHC-MCO adjudication may result in a penalty.
- Any Encounter corrected or initially submitted after the last day of the third month following initial CHC-MCO adjudication may be subject to a penalty.

Accuracy and Completeness:

Accuracy and completeness are based on the consistency between Encounter information submitted to the Commonwealth and information for the same service maintained by the CHC-MCO in their claims/service history data base.

Metric: Accuracy and completeness will be determined through a series of analyses applied to CHC-MCO claims history data and Encounters received and processed through PROMISE. This analysis will be done at least yearly but no more than twice a year and consist of making a comparison between an Encounter sample and what is found in CHC-MCO claims history. A sample may also be drawn from the CHC-MCO service history and compared against Encounters processed through PROMISE.

Samples will be drawn proportionally based on the CHC-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 two hundred (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	\$28,000
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

Rev. 08-11-09

EXHIBIT AAA

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

The CHC-MCO must consider the following in establishing and maintaining its Provider Network:

- The anticipated Medical Assistance Enrollment.
- The expected utilization of services, taking into consideration the characteristics and needs of specific Medical Assistance populations represented in the CHC-MCO.
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted Medical Assistance services.
- All Providers operating within the Provider Network who provide services to Recipients must be enrolled in the Commonwealth's Medical Assistance program and possess an active PROMISE™ Provider ID.
- The number of Network Providers who are not accepting new Medical Assistance Participants.
- The geographic location of Providers and Participants, considering distance, travel time, the means of transportation ordinarily used by Participants, and whether the location provides physical access for Participants with disabilities.

The CHC-MCO must ensure that its Provider Network is adequate to provide its Participants in this CHC zone with access to quality Participant care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the CHC-MCO must supply geographic access maps using Participant 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 Participants. The Department may require additional numbers of specialists, ancillary, and LTSS Providers should it be determined that geographic access is not adequate. The CHC-MCO must also have a process in place which ensures that the CHC-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The CHC-MCO must make all reasonable efforts to honor a Participant's choice of Providers who are credentialed in the Network. If the CHC-MCO is unable to ensure a Participant's access to Provider or specialty Provider services within the Provider Network, within the travel times set forth in this exhibit, the CHC-MCO must make all reasonable efforts to ensure the Participant's access to these services within the travel times herein through Out-of-Network providers. In locations where the CHC-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 Participant's access to these services within the travel times set forth in this exhibit, the CHC-MCO must

work with Participants to offer reasonable Provider alternatives. Additionally, the CHC-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire CHC zone in which the CHC-MCO operates if Providers exist:

a. PCPs

Make available to every Participant 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.

Participants 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 Participants who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).

c. Specialists

i. For all specialty Provider types, the CHC-MCO must ensure a choice of two (2) Providers who are accepting new patients within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).

d. Hospitals

Ensure at least one (1) hospital within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural) and a second choice within the CHC zone.

e. LTSS Providers

Ensure at least two (2) Providers for each LTSS Covered Service within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).

f. Out-of-Network Access

Ensure the provision of Covered Services to all Participants such that if the CHC-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the CHC-MCO must allow Participants to pick an Out-of-Network Provider if not satisfied with the Network Provider. The CHC-MCO must develop a system to determine Prior Authorization for Out-of-Network Services through the

Community HealthChoices Agreement:

Person-Centered Planning Team and UM, depending on the service for which the Out-of-Network Provider is being authorized, including provisions for informing the Participant of how to request this authorization for Out-of-Plan Services.

If the CHC-MCO is unable to ensure a Participant's access to Provider or specialty Provider services within the Provider Network, within the travel times set forth in this exhibit, the CHC-MCO must make all reasonable efforts to ensure the Participant's access to these services within the travel times herein through Out-of-Network Providers. In locations where the CHC-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 Participant's access to these services within the travel times set forth in this exhibit, the CHC-MCO must work with Participants to offer reasonable Provider alternatives.

g. Medicare Network Compliance

If the Medicare Network standards would require more Providers for any Provider type or Service Area, the CHC-MCO must meet the Medicare standards in its CHC-MCO.

h. Anesthesia for Dental Care

For Participants needing anesthesia for dental care, the CHC-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.

i. 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 CHC zone.

j. CNMs / CRNPs, Other Healthcare Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Healthcare Providers. The CHC-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Healthcare Providers and maintain payment policies that reimburse CNMs and CRNPs and other Healthcare 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.

k. Qualified Providers

The CHC-MCO must limit its PCP Network to appropriately qualified Community HealthChoices Agreement:

Providers. The CHC-MCO's PCP Network must meet the following:

- Seventy-five to one hundred percent (75-100%) of the Network consists of PCPs who have completed an approved Primary Care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics.
- 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. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

I. Participants Freedom of Choice

The CHC-MCO must demonstrate its ability to offer its Participants freedom of choice in selecting a PCP. At a minimum, the CHC-MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Participants. 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) Participants to the panel. The number of Participants assigned to a PCP may be decreased by the CHC-MCO if necessary to maintain the appointment availability standards.

m. PCP Composition and Location

The CHC-MCO and the Department will work together to avoid the PCP having a caseload or medical practice composed predominantly of Participants. In addition, the CHC-MCO must organize its PCP Sites so as to ensure continuity of care to Participants and must identify a specific PCP within the PCP site for each Participant. The CHC-MCO may apply to the Department for a waiver of these requirements on a PCP Site-specific basis. The Department may waive these requirements for good cause demonstrated by the CHC-MCO.

n. FQHCs / RHCs

The CHC-MCO must contract with a sufficient number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access to FQHC and RHC services, provided FQHC and RHC services are

available, within a travel time of thirty (30) minutes (Urban) and sixty (60) minutes (Rural). If the CHC-MCO's Primary care Network includes FQHCs and RHCs, these sites may be designated as PCP Sites. If a CHC-MCO cannot contract with a sufficient number of FQHCs and RHCs, the CHC-MCO must demonstrate in writing it has attempted to reasonably contract in good faith.

o. Medically Necessary Emergency Service

The CHC-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 Healthcare 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.

p. ADA Accessibility Guidelines

The CHC-MCO must inspect the office of any PCP or dentist who seeks to participate in the 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 CHC-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 Provider Network provided that the PCP or dentist: 1) requests and is determined by the CHC-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 one hundred-eighty (180) days after the CHC-MCO identified the barrier.

The CHC-MCO must document its efforts to determine architectural accessibility. The CHC-MCO must submit this documentation to the Department upon request.

q. Laboratory Testing Sites

The CHC-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.

r. CHC-MCO Discrimination

The CHC-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 CHC-MCO from including Providers only to the extent necessary to meet the needs of the organization's Participants or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the CHC-MCO.

s. Declined Providers

If the CHC-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.

t. Second Opinions

The CHC-MCO must provide for a second opinion from a qualified Provider within the Network, at no cost to the Participant. If a qualified Provider is not available within the Network, the CHC-MCO must assist the Participant in obtaining a second opinion from a qualified Provider outside the Network, at no cost to the Participant, unless co-payments apply.

2. Appointment Standards

The CHC-MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever a Participant 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 Participant. 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
Community HealthChoices Agreement:

referred to an emergency facility.

- ii. Urgent Medical Condition cases must be scheduled within twenty-four (24) hours.
- iii. Non-Urgent Sick Visits with a PCP within seventy-two (72) hours of request, as clinically indicated.
- iv. Routine appointments must be scheduled within ten (10) business days. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.
- v. The CHC-MCO must provide the Department with its protocol for ensuring that a Participant'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 Participant with a difficult medical need. The Participant must be informed of scheduling time frames through educational outreach efforts.
- vi. The CHC-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room visits.

b. Specialty Referrals

For specialty referrals, the CHC-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 shall be scheduled to occur within thirty (30) days for all specialty Provider types.

c. Pregnant Women

Should the IEE or Participant notify the CHC-MCO that a new Participant is pregnant or there is a pregnancy indication on the files transmitted to the CHC-MCO by the Department, the CHC-MCO must contact the Participant 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 CHC-MCO must arrange initial prenatal care

appointments for enrolled pregnant Participants as follows:

- i. First trimester — within ten (10) business days of the Participant being identified as being pregnant.
- ii. Second trimester — within five (5) business days of the Participant being identified as being pregnant.
- iii. Third trimester — within four (4) business days of the Participant being identified as being pregnant.
- iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the CHC-MCO or maternity care Provider, or immediately if an emergency exists.

d. EPSDT

The CHC-MCO must distribute quarterly lists to each PCP in its Provider Networks which identify Participants who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in this exhibit, or Participants who have not complied with EPSDT periodicity and immunization schedules for children. The CHC-MCO must contact such Participants, documenting the reasons for noncompliance and documenting its efforts for bringing the Participants' care into compliance. EPSDT screens for any new Participant 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.

3. Policies and Procedures for Appointment Standards

The CHC-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 CHC-MCO must have written policies and procedures for disseminating its appointment standards to all Participants through its Participant handbook and through other means. In addition, the CHC-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The CHC-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

Community HealthChoices Agreement:

The CHC-MCO must comply with the access standards in accordance with this exhibit and Section V.S of the agreement, Provider Agreements. If the CHC-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 CHC-MCO must make reasonable efforts to honor a Participant's choice of Providers among Network Providers as long as:

- i. The CHC-MCO's agreement with the Network Provider covers the services required by the Participant.
- ii. The CHC-MCO has not determined that the Participant's choice is clinically inappropriate.

The CHC-MCO must provide the Department adequate assurances that the CHC-MCO, with respect to this CHC zone, has the capacity to serve the expected Enrollment in this CHC zone. The CHC-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 CHC-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. CHC-MCO's Corrective Action

The CHC-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 CHC-MCO will be given the opportunity to institute a corrective action plan. The CHC-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 CHC-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the CHC-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the CHC-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the CHC-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 CHC-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

PHARMACY SERVICES

1. General Requirements

- a. The CHC-MCO must cover all Covered Pharmacies 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. (Sec. 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 Medical Assistance program, and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.
- b. The CHC-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.
- c. Unless financial responsibility is otherwise assigned, all Covered Pharmacies are the payment responsibility of the Participant's CHC-MCO. The only exception is that the 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.
- d. All Covered Pharmacies must be dispensed through CHC-MCO Network Providers. This includes Covered Pharmacies prescribed by both the CHC-MCO and the BH-MCO Providers.
- e. Under no circumstances will the CHC-MCO permit the therapeutic substitution of a pharmacy by a pharmacist without explicit authorization from the licensed prescriber.
- f. All proposed pharmacy programs and drug Utilization Management programs, such as Prior Authorization, Step Therapy, partial fills, specialty pharmacy, pill-splitting, etc. must be submitted to the Department for review and approval prior to implementation.
- g. The CHC-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Pharmacies, 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 Pharmacy is provided as a pharmacy 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, and FFS guidelines to determine medical necessity of drugs that require Prior Authorization in the Medical Assistance FFS Program, when designated by the Department.
- h. The CHC-MCO must agree to adopt the same guidelines to determine medical necessity of selected drugs or classes of drugs as those adopted by the Medical Assistance FFS Program when designated by the Department by publication of Managed Care Operations Memoranda (MC OPS Memos).
- i. The CHC-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 CHC-MCO must also comply with the procedures outlined in Medical Assistance Bulletin 99-03-13 and Medical Assistance Bulletin #99-96-01. The CHC-MCO policy and procedures for continuity of care for pharmacies, 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 CHC-MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to pharmacies that the Participant was prescribed before enrolling in the CHC-MCO.

2. Coverage Exclusions

- a. In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. 1396r-8, the CHC-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 CHC-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 CHC-MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

- c. The CHC-MCO must exclude coverage of noncompensable drugs in accordance with 55 PA Code §1121.54.

3. Formularies and Preferred Drug Lists (PDLs)

- a. The CHC-MCO may use a Formulary or a PDL. All drugs must be Covered Pharmacies.
- b. The Formulary or PDL must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee.
- c. The Formulary or PDL must meet the clinical needs of the Medical Assistance population. The Formulary or PDL must include a range of drugs in each therapeutic drug class represented. The Department reserves the right to determine if the Formulary or PDL meets the clinical needs of the Medical Assistance population.
- d. The Formulary or PDL must be clinically based. Only those drugs that do not have a significant, clinically meaningful therapeutic advantage, in terms of safety, effectiveness, or clinical outcomes, over other drugs included in the Formulary or PDL, may be designated as non-formulary or non-preferred.
- e. The CHC-MCO must make a satisfactory written explanation of the reason(s) for designating a drug as non-formulary or non-preferred available to the Department upon request.
- f. The CHC-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 Community HealthChoices Program.
- g. The CHC-MCO must receive written approval from the Department of the Formulary or PDL, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs 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 and the requirements.
- h. The CHC-MCO must submit all Formulary or PDL changes (other than additions) and deletions to the Department for review and written approval prior to implementation.
- i. The CHC-MCO must submit written notification of any Formulary or PDL additions to the Department within fifteen (15) days of implementation.

- j. The Formulary or PDL must be re-submitted for Department review and approval annually.
- k. The CHC-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Pharmacy either by addition to the Formulary or PDL, or through Prior Authorization, within ten (10) days from their availability in the marketplace.

4. Prior Authorization of Pharmacies

- a. The CHC-MCO may require Prior Authorization (includes Step Therapy) as a condition of coverage or payment for a Covered Pharmacy provided that:
 - i. The CHC-MCO provides 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.
 - ii. If a Participant's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the CHC-MCO instructs the pharmacist to dispense either a:
 - 1) Fifteen (15) day supply if the prescription qualifies as an Ongoing Medication, unless the CHC-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
 - 2) A seventy-two (72) hour supply of a new medication.
- b. For drugs not able to be divided and dispensed into individual doses, the CHC-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 Participant 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 Participant may be taking, would jeopardize the health or safety of the Participant.

- d. If Prior Authorization of a drug is required, the CHC-MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber. If the CHC-MCO denies the request for Prior Authorization, the CHC-MCO must issue a written denial notice, using the appropriate Pharmacy Denial Notice template listed on the Department's Intranet supporting CHC within twenty-four (24) hours of receiving the request for Prior Authorization.
- e. If the Participant files a Grievance or DHS Fair Hearing request from a denial of an Ongoing Medication, the CHC-MCO must authorize the medication until the Grievance or DHS Fair Hearing request is resolved.
- f. When medication is authorized due to the CHC-MCO's obligation to continue services while a Participant's Grievance or Fair Hearing is pending, and the final binding decision is in favor of the CHC-MCO, a request for subsequent refill of the prescribed medication does not constitute an Ongoing Medication.
- g. The CHC-MCO must establish and maintain written Prior Authorization policies, procedures, and guidelines to determine medical necessity of Covered Pharmacies that require Prior Authorization, including drugs that require Step Therapy and drugs that are designated as non-formulary or non-preferred.
- h. The CHC-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 Community HealthChoices Program, and receive written approval from the Department prior to implementation.
- i. The CHC-MCO must submit additions, changes and deletions to Prior Authorization (including Step Therapy) policies, procedures and any associated medical necessity guidelines for Department review and written approval prior to implementation.

5. Provider and Participant Notification

The CHC-MCO must have policies and procedures for notification to Providers and Participants of changes to the Formulary or PDL and Prior Authorization requirements.

- a. Written notification for changes to the Formulary or PDL and Prior Authorization requirements must be provided to all affected Providers and Participants at least thirty (30) days prior to the effective date of the change.
- b. The CHC-MCO must provide all other Providers and Participants written notification of changes to the Formulary or PDL and Prior Authorization requirements upon request.

c. The CHC-MCO also must generally notify Providers and Participants of

Formulary or PDL and Prior Authorization changes through Participant and Provider newsletters, its web site, or other regularly published media of general distribution.

6. CHC-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, Medical Assistance program Participants and other appropriate clinicians. Medical Assistance program Participant representative membership must include the following:
 - i. One (1) physical health Participant representative. The physical health Participant representative must be a Participant enrolled in the CHC-MCO, or a physician, a pharmacist, or a physical health Participant advocate designated by Participants enrolled in the CHC-MCO to represent them.
 - ii. One (1) behavioral health Participant representative. The behavioral health Participant representative must be a Participant enrolled in the CHC-MCO, or a physician, a pharmacist, a behavioral health Participant advocate, or a family member designated by Participants enrolled in the CHC-MCO to represent them.
- b. The CHC-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 CHC-MCO P&T Committee meeting must be posted for public view on the CHC-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 - Any Willing Pharmacy

The CHC-MCO must contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance program that is willing to comply with the CHC-MCO's payment rates and terms and to adhere to quality standards established by the CHC-MCO as required by 62 P.S. 449.

The provisions for any willing pharmacy apply if the CHC-MCO Subcontracts with specialty pharmacies, or designates specific Network pharmacies as the preferred Provider(s) of specialty drugs(s). CHC-MCOs are required to contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance program that is willing to accept the same payment rate(s) as the preferred Provider(s) of specialty drugs and comply with the same terms and conditions for quality standards and reporting as the preferred Provider(s) of specialty drugs.

Subcontracts and agreements with specialty pharmacies and Network pharmacies designated to serve as preferred Providers of specialty drugs must be submitted to the Department for advance written approval.

8. Pharmacy 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 Medical Assistance 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 CHC-MCOs.

- a. In order to ensure full compliance with the provisions of the ACA, CHC-MCOs must report the necessary Encounter Data in order for the Department to invoice drug manufacturers for rebates for all Covered Pharmacies. This includes physician-administered drugs, drugs dispensed by 340B covered entities or contract pharmacies, and drugs dispensed to CHC-MCO participants with private or public pharmacy coverage and the CHC-MCO provided secondary coverage.
- b. The CHC-MCO must report all pharmacy 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.

The CHC-MCO may negotiate its own market share rebates for pharmaceutical products with drug companies.

9. Pharmacy Encounters

- a. The CHC-MCO shall submit all pharmacy Encounters to the Department within thirty (30) days of the adjudication date of the claim to the CHC-MCO for payment.
- b. The CHC-MCO shall provide all pharmacy Encounter Data and supporting information as specified below for the Department to collect rebates through the Medicaid Drug Rebate Program. For all pharmacy Encounter Data including pharmacy point-of-sale (NCPDP), physician-administered drugs (837P), outpatient 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.
 1. The CHC-MCO shall also include the HCPCS code associated with the NDC for all 837P and 837I Encounters where payment was made by the CHC-MCO based on the HCPCS code and HCPCS code units.

2. The CHC-MCO shall also include the diagnosis codes associated with the NDC for all 837P and 837I Encounters where payment was made by the CHC-MCO based on the HCPCS code and HCPCS code units.
- ii. Valid NDC units for the drug dispensed.
 1. The CHC-MCO shall also include the HCPCS units associated with the NDC for all 837P and 837I Encounters where payment was made by the CHC-MCO based on the HCPCS code and HCPCS code units.
 - iii. Actual paid amount by the CHC-MCO to the Provider for the drug dispensed.
 - iv. Actual TPL amount paid by the Participant's primary pharmacy coverage to the Provider for the drug dispensed.
 - v. Actual copayment paid by the Participant to the Provider for the drug dispensed.
 - vi. Actual dispensing fee paid by the CHC-MCO to the Provider for the drug dispensed.
 - vii. The billing Provider's:
 1. NPI and/or Medical Assistance Identification Number.
 2. Full address and phone number associated with the NPI.
 - viii. The prescribing Provider's:
 1. NPI and/or Medical Assistance Identification Number.
 2. 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 CHC-MCO to the Provider for the drug.
 - xi. Any other data elements identified by the Department to invoice for drug rebates.
- c. The CHC-MCO shall edit and validate claim transaction submissions and pharmacy Encounter Data for completeness and accuracy in accordance with claim standards such as NCPDP. The actual paid amount by the CHC-MCO to the dispensing Provider must be accurately submitted on each pharmacy Encounter to the Department.

- d. The CHC-MCO shall ensure that the NDC on all pharmacy Encounters is appropriate for the HCPCS code based on the NDC and units billed. The NDC must represent a drug that was available to the physician in an outpatient setting for administration.
- e. The Department will review the pharmacy Encounters and remove applicable 340B covered entity Encounters from the drug rebate invoicing process.
 - i. The Department does not recognize 340B contracted pharmacies as 340B Providers and will not remove Encounters billed by contract pharmacies from the rebate invoicing process.
- f. The CHC-MCO shall meet pharmacy Encounter Data accuracy requirements by submitting CHC-MCO paid pharmacy Encounters with no more than a (three percent (3%) error rate, calculated for a month's worth of Encounter submissions. The Department will monitor the CHC-MCO's corrections to denied Encounters by random sampling performed quarterly and over the term of this agreement. The CHC-MCO shall have corrected and resubmitted seventy-five percent (75%) of the denied Encounters for services covered under this agreement included in the random sample within thirty (30) calendar days of denial.
- g. If the CHC-MCO fails to submit pharmacy Encounter data within time frames specified, the Department shall assess civil monetary penalties upon the CHC-MCO. These penalties shall be \$2,000 for each calendar day that the pharmacy Encounter Data is not submitted. The Department may waive these sanctions if it is determined that the CHC-MCO was not at fault for the late submission of the data.

10. Denied or Disputed Pharmacy Encounters

- a. The Department will review the CHC-MCO's pharmacy Encounter Data and will notify the CHC-MCO of the following:
 - i. Disputed pharmacy Encounters identified through the drug rebate invoicing process.
 - ii. CMS Terminated and miscoded/invalid NDCs in the pharmacy Encounter Data.
 - iii. Invalid NDC units for the NDC on the Encounter.
 - iv. Pharmacy Encounters that were denied by the Department's MMIS upon submission by the CHC-MCO.
- b. Within (thirty) 30 calendar days of receipt of the denied or disputed

pharmacy Encounter notification, the CHC-MCO shall, if needed, correct and resubmit any disputed pharmacy Encounters and send a response file that includes:

- i. Corrected and resubmitted pharmacy Encounters or,
 - ii. Detailed explanation of reasons why the disputed pharmacy Encounters could not be corrected. This will include documentation of all attempts to correct the disputed Encounters at the claim level detail.
- c. Failure to submit accurate and complete outpatient Encounter Data will result in the Department assessing civil monetary penalties. If the CHC-MCO fails to correct and resubmit a deficiency in submitted pharmacy Encounter Data upon notification and within the time frames specified in a corrective action plan approved by the Department, the Department will assess civil monetary penalties. These penalties shall be \$2,000 for each calendar day that exceeds the time frames specified in the corrective action plan. The Department may waive these sanctions if it is determined that the CHC-MCO was not at fault for the failure to correct the deficiency within the time period specified in the approved corrective action plan.

11. General Reporting Requirements

The CHC-MCO must maintain an information system that collects, analyzes, integrates and reports pharmacy claims data; including but not limited to pharmacy utilization, amounts paid to Providers and subcontractors—including Pharmacy Benefits Managers.

- a. The CHC-MCO must take the following steps to ensure that data is accurate and complete:
 - i. Verify the accuracy and timeliness of reported data.
 - ii. Screen the data for completeness and consistency.
 - iii. Collect utilization data in standardized formats as requested by the Department.
- b. The CHC-MCO will truthfully certify that the data submitted is in the manner and format established by the Department and must attest, based on the best knowledge, information and belief to the accuracy and completeness of the data being submitted.
- c. The CHC-MCO shall conduct and submit to the Commonwealth a monthly audit of pharmacy claims accuracy. The audit shall be conducted by an entity or CHC-MCO staff independent of pharmacy claims management.

- d. The audit shall utilize a statistically valid, random sample of all processed or paid pharmacy claims upon initial submission in each month. The minimum attributes to be tested for each claim selected shall include:
 - i. Claim data entered into the claims processing system.
 - ii. Claim is associated to the correct Provider.
 - iii. Prescription obtained the proper authorization.
 - iv. Participant eligibility at processing date correctly applied.
 - v. Allowed payment amount agrees with contracted rate and the terms of the Provider participation agreement.
 - vi. Duplicate payment of the same claim has not occurred.
 - vii. Denial reason applied appropriately.
 - viii. Copayment considered and applied.
 - ix. Patient liability correctly identified and applied.
 - x. Effect of modifier codes correctly applied.
 - xi. Other insurance properly considered and applied.
- e. The results of testing at a minimum should be documented to include:
 - i. Results of each attribute tested for each claim selected.
 - ii. Amount of overpayment or underpayment for claims processed or paid in error.
 - iii. Explanation of the erroneous processing for each claim processed or paid in error.
 - iv. Determination of the source of the error.
 - v. Claims processed or paid in error have been corrected.
- f. The CHC-MCO shall submit a claims payment accuracy percentage report for the claims processed by the Pharmacy Benefits Manager.
- g. CHC-MCO shall report the amount paid for pharmacy services, where such services are paid on a Fee-for-Service basis. Where the CHC-MCO pays a derived sub-capitated amount for pharmacy services, the CHC-MCO shall enter the required code and derived amount in the Encounter.

12. Drug Utilization Review (DUR) Program

The CHC-MCO must provide a DUR Program to assure that prescriptions are appropriate, Medically Necessary and not likely to result in Adverse medical outcomes, and to enhance the quality of patient care by educating prescribers, pharmacists and Participants.

a. Prospective Drug Utilization Review (Pro-DUR)

- i.** The CHC-MCO must provide for a review of drug therapy before each prescription is filled or delivered to a Participant 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.
- i.** The CHC-MCO must provide for counseling of Participants receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

b. Retrospective Drug Utilization Review (Retro-DUR)

- i.** The CHC-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.
- i.** The CHC-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.
- i.** The CHC-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.

c. Annual DUR Report

The CHC-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.

d. Drug Utilization Review Board (DUR Board)

The Department maintains a DUR Board that reflects the structure of the healthcare delivery model that includes both a managed care and a Fee-for-Service delivery system. Each CHC-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 Medical Assistance program Participants. 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.

13. Pharmacy Benefit Manager (PBM)

The CHC-MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions in Section XIII: Subcontractual Relationships, and has received advance written approval by the Department. The standards for Network composition and adequacy for pharmacy services includes the requirements for any willing pharmacy as described above. The CHC-MCO must indicate the intent to use a PBM, identify the proposed PBM Subcontract and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly or in part by a CHC-MCO, retail pharmacy Provider, chain drug store or pharmaceutical manufacturer, the CHC-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.

14. Requirements for CHC-MCO and BH-MCO Interaction and Coordination of Pharmacy Services

- a. BH-MCO prescribing Providers must comply with the CHC-MCO requirements for Utilization Management of outpatient behavioral health drugs.
- b. The BH-MCO will be required to issue an initial list of BH-MCO Providers to the CHC-MCO, and quarterly updates that include additions and terminations.

Should the CHC-MCO receive a request to dispense medication prescribed by a BH Provider not listed on the BH-MCO's Provider file, the CHC-MCO must work through the appropriate BH-MCO to identify the Provider. The CHC-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 CHC-MCO may deny payment of a Claim for a Covered Pharmacy 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 CHC-MCO's PCP or specialists in the Participant's CHC-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 Participant may be taking, would jeopardize the health and safety of the Participant.
- e. The CHC-MCO must receive written approval from the Department of the policies and procedures for the CHC-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. Comply with any CHC-BH MCO pharmacy data exchange procedures specified by the Department.
 - iii. Timely resolve disputes which arise from the payment for or use of drugs, including a mechanism for timely, impartial mediation when resolution between the CHC-MCO and BH-MCO does not occur.
 - iv. Share independently developed Quality Management/Utilization Management information related to pharmacy services, as applicable.
 - v. 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 Participants associated with specific drugs.
- f. The CHC-MCO must send data files, via the Department's file transfer protocol (FTP), containing records of detailed pharmacy services as provided to individual Participants of the BH-MCOs contracted with the

Department. The CHC-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 CCC

CHC MCO PROVIDER AGREEMENTS

The CHC-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Participant access to all Medically Necessary services covered by the Community HealthChoices Program.

The CHC-MCO's Provider Agreements must include the following provisions:

- a. A requirement that the Provider participate, as needed, in the needs screening, comprehensive needs assessment and reassessment, service planning, and Service Coordination processes;
- b. A requirement that the Provider comply with any accessibility, Cultural Competency, Linguistic Competency, or Disability Competency requirements the Department issues for meeting the needs of the CHC population.
- c. A requirement that the CHC-MCO must not exclude or terminate a Provider from participation in the CHC-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.
- d. A requirement that the CHC-MCO must not exclude a Provider from the CHC-MCO's Provider Network because the Provider advocated on behalf of a Participant for Medically Necessary and appropriate healthcare consistent with the degree of learning and skill ordinarily possessed by a reputable Healthcare Provider practicing according to the applicable legal standard of care.
- e. A provision that prohibits the Provider from denying services to a Participant during the Medical Assistance FFS eligibility window prior to the effective date of the CHC-MCO Enrollment.
- f. Notification of the prohibition and sanctions for submission of false Claims and statements.
- g. The definition of Medically Necessary as defined in Section II of this agreement, Definitions.
- h. A requirement that the CHC-MCO cannot prohibit or restrict a Healthcare 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 Participant 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.
- i. A requirement that the CHC-MCO cannot prohibit or restrict a Healthcare Provider

acting within the lawful scope of practice from providing information the Participant needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or nontreatment.

- j. A requirement that the CHC-MCO cannot terminate a contract or employment with a Healthcare Provider for filing a Grievance on a Participant's behalf.
- k. A clause which specifies that the agreement will not be construed as requiring the CHC-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.
- l. 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.
- m. 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 CHC-MCO either directly or indirectly through capitation.
- n. A continuation of benefits provision which states that the Provider agrees that in the event of the CHC-MCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the CHC-MCO's Participants, including Participants in an inpatient setting, through the period for which the capitation has been paid.
- o. A requirement that the PCPs who serve Participants 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 Participant's PCP medical record. For details on access requirements, see Exhibit AAA of this agreement, Provider Network Composition/Service Access.
- p. A requirement that PCPs who serve Participants under the age of twenty-one (21) report Encounter Data associated with EPSDT screens, using a format approved by the Department, to the CHC-MCO within ninety (90) days from the date of service.
 - (1) A requirement that PCPs contact new Participants 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 CHC-MCO must require the PCP to contact Participants 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 CHC-MCO any such Participants

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 CHC-MCO. The PCP must also be required to document the reasons for noncompliance, where possible, and to document its efforts to bring the Participant's care into compliance with the standards. PCPs shall be required to contact all Participants 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 to arrange appointments.

- q. A requirement that the CHC-MCO include in all capitated Provider Agreements a clause which requires that should the Provider terminate its agreement with the CHC-MCO, for any reason, that the Provider provide services to the Participants assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.
- r. A requirement that ensures each physician providing services to Participants 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.
- s. 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 CHC-MCO and the physician or physician group.
- t. A requirement for cooperation with the CHC-MCO's and DHS' Recipient Restriction Program.
- u. A requirement that healthcare 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 (Mare) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and healthcare workers and includes effective measures for the detection, control and prevention of Healthcare-Associated Infections.

A provision that the CHC-MCO's Utilization Management (UM) Departments are mandated by the Department to monitor the progress of a Participant's inpatient hospital stay. This must be accomplished by the CHC-MCO's UM department receiving appropriate clinical information from the hospital that details the Participant's admission information, progress to date, and any pertinent data within two (2) business days from the time of admission. The CHC-MCOs Provider must agree to the CHC-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 CHC-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 CHC-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 Participant medical records, including obtaining any required written Participant 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 CHC-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. Requirements that Providers follow CHC-MCO requirements for ongoing communication with Participants' Service Coordinators.
- y. Requirements that Providers return Participant calls within three (3) business days of receipt.

The CHC-MCO may not enter into a Provider Agreement that prohibits the Provider from contracting with another CHC-MCO or that prohibits or penalizes the CHC-MCO for contracting with other Providers.

The CHC-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 CHC-MCO within the time frames specified in Section VIII.B.1 of this agreement, Encounter Data Reporting

**EXHIBIT DDD(1)
COVERED SERVICES LIST**

The CHC Program Service Package includes but is not limited to all Medicaid FFS physical health services identified in the Medicaid State Plan and CHC 1915(c) Waiver services.

CHC Covered Physical Health Services	
Category	Category
Inpatient Hospital Services	Clinic Services
Inpatient Acute Hospital	Independent Clinic
Inpatient Rehab Hospital	Maternity – Physician, Certified Nurse Midwives, Birth Centers
Outpatient Hospital Clinic Services	Renal Dialysis Services
Outpatient Hospital Clinic	Ambulatory Surgical Center (ASC) Services
Outpatient Hospital Short Procedure Unit	Dental Services
Federally Qualified Health Center / Rural Health Clinic	Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders
Other Laboratory and X-ray Service	Prescribed Drugs, Dentures, and Prosthetic Devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
Laboratory	Prescribed Drugs
Radiology (For example: X-rays, MRIs, CTs)	Dentures
Nursing Facility Services	Prosthetic Devices
Skilled Nursing Facility	Eyeglasses
Family Planning Clinic, Services, and Supplies	Diagnostic, Screening, Preventive, and Rehabilitative Services
Physician Services	Tobacco Cessation
Primary Care Provider	Therapy (Physical, Occupational, Speech) - Rehabilitative
Physician Services and Medical and Surgical Services provided by a Dentist	Certified Registered Nurse Practitioner Services
Medical care and any other type of remedial care	Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary
Podiatrist Services	Ambulance Transportation
Optometrist Services	Non-Emergency Medical Transport
Chiropractor Services	Emergency Room
Home Health Services	Hospice Care
Home Healthcare Including Nursing, Aide and Therapy	
Medical Supplies	
Durable Medical Equipment	

CHC Covered Physical Health Services	
Category	Category
Therapy (Physical, Occupational, Speech)	Definitions for Physical Health Services may be found in the Pennsylvania Medicaid State Plan at: http://www.dhs.state.pa.us/publications/medicaidstateplan/
Community Health Choices LTSS Benefits	
Adult Daily Living	Participant-Directed Community Supports
Assisted Living Services	Participant-Directed Goods and Services
Assistive Technology	Personal Assistance Services
Career Assessment	Personal Emergency Response System
Community Integration	Pest Eradication
Community Transition Services	Participant-Directed Community Supports
Employment Skills Development	Residential Habilitation
Home Adaptations	Respite
Home Delivered Meals	Service Coordination
Home Health Services (including Home Health Aide, Nursing, PT, OT, Speech and Language Therapy)	Specialized Medical Equipment and Supplies
Job Coaching	Structured Day Hospital
Job Finding	TeleCare
Non-Medical Transportation	Therapeutic and Counseling Services
Nursing Facility Services	Vehicle Modifications
Nursing Home Services	

EXHIBIT DDD(2)
COVERED SERVICES
Long-Term Services and Supports
Service Definitions

Adult Daily Living

Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant. Adult Daily Living includes two (2) components: Basic Adult Daily Living services and Enhanced Adult Daily Living services.

Basic Adult Daily Living services are comprehensive services provided to meet the needs noted above in a licensed center. Per licensing regulations under Title 6 PA Code, Chapter 11, Subchapter A, and 11.123 Core Services, the required core services for these settings include personal assistance, nursing in accordance with regulation, social and therapeutic services, nutrition and therapeutic diets and emergency care for participants. Basic Adult Daily Living services can be provided as either a full day or a half day. The individual's service plan initiates and directs the services they receive while at the center.

In addition to providing Basic Adult Daily Living services, Enhanced Adult Daily Living services must include the following additional service elements:

- **Nursing Services:** In addition to the requirements found in the Older Adult Daily Living Center (OADLC) Regulations § 11.123 (2), a Registered Nurse (RN) must be available on-site one (1) hour weekly for each enrolled waiver participant. At a minimum, each waiver participant must be observed every other week by the RN with the appropriate notations recorded in the participant's service plan, with the corresponding follow-ups being made with the participant, family, or physician.
- **Staff to Participant Ratio of 1:5.**
- **Operating Hours:** open a minimum of eleven (11) hours daily during the normal work week. A normal work week is defined as Monday through Friday.
- The guidelines for the required specialized services for the OADLC provider to include physical therapy, occupational therapy, speech therapy, and medical services can be found in Subchapter B, § 11.402.
- Enhanced Adult Daily Living services can be provided as either a full day or a half day.
- Adult Daily Living providers that are certified as Enhanced receive the Enhanced full day or Enhanced half day rate for all participants attending the Enhanced center.

As necessary, Adult Daily Living may include assistance in completing activities of daily living and instrumental activities of daily living. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits.

This service must be provided in accordance with 42 CFR §441.301(c)(4) and (5), which outlines allowable settings for home and community-based waiver services. Services can

be provided as either a full day or half day. Providers may bill for one (1) day when Basic or Enhanced Adult Daily Living services are provided for four (4) or more hours in a day. Providers must bill for a half day when Basic or Enhanced services are provided for fewer than four (4) hours in a day.

Assisted Living

Assisted Living services are supportive and health-related services provided or coordinated by an Assisted Living provider. Assisted Living services enable the participant to remain integrated in the community and ensure the health, welfare and safety of the participant. Assisted Living services include assistance with activities of daily living and instrumental activities of daily living; personal laundry; central storage of medication and medication management/administration; housekeeping (homemaker); scheduled transportation for waiver and social services; services to accompany the individual into the community; essential shopping; support with financial matters; twenty-four hour (24-hour) supervision, monitoring and emergency response; social and recreational activities, basic cognitive support; grooming, wellness program, memory loss program, personal and attendant care services; and nursing tasks including performance of simple measurements and tests to monitor a participant's medical condition and ambulation. In accordance with Pennsylvania Code Chapter 2800, participants will receive a package of services based upon need as determined through an assessment and included in the service plan.

Assisted Living Services are provided in a home-like environment in an Assisted Living residence that complies with 42 CFR §441.301(c)(4) and (5), which outlines allowable setting for home and community-based waiver services. In Assisted Living the provider of services is also the provider of housing, which is licensed by the Pennsylvania Department of Human Services. Assisted Living services are provided in settings that allow for full integration in the community and promote and maintain maximum independence. Assisted Living settings provide full access to typical facilities found in a home, such as kitchens; allow visitors at times convenient to the Participant and offer easy access to resources and activities in the community. Assisted Living settings provide Participants with lockable apartments with living, bathing, cooking, eating and sleeping areas.

Assistive Technology

Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that is needed by the Participant, as specified in the Participant's Individual Service Plan (ISP) and determined necessary in accordance with the Participant's assessment. The service is intended to ensure the health, welfare and safety of the Participant and to increase, maintain or improve a Participant's functioning in communication, self-help, self-direction, life-supports or adaptive capabilities. All items shall meet the applicable standards of manufacture, design and installation. Assistive Technology is limited to:

- Services consisting of purchasing, leasing or otherwise providing for the acquisition of Assistive Technology devices for Participants.
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing Assistive Technology devices. Repairs are covered when it is more cost effective than purchasing a new device.

- Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors and security systems in their room, home or other surroundings.
- Training or technical assistance for the Participant, paid caregiver and unpaid caregiver.
- An independent evaluation of the Assistive Technology needs of a participant. This includes a functional evaluation of the Assistive Technology needs and appropriate services for the participant in his/her customary environment
- Extended warranties.
- Ancillary supplies, software and equipment necessary for the proper functioning of Assistive Technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices that assist Participants with a need identified through the evaluation described below

If the Participant receives Speech, Occupational or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Assistive Technology, the Assistive Technology must be consistent with the Participant's behavior support plan or Speech, Occupational or Physical Therapy service. Assistive Technology devices must be recommended by an independent evaluation or physician's prescription. This service excludes those items that are not of direct medical or remedial benefit to the Participant. Recreational items are also excluded.

Career Assessment

Career Assessment is an individualized employment assessment used to assist in the identification of potential career options based upon the interests and strengths of the Participant. Services support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant.

Career Assessment is an individualized employment assessment that includes:

- Conducting a review of the Participant's work and volunteer history, interests and skills, which may include information gathering or interviewing.
- Conducting situational assessments to assess the Participant's interest and aptitude in a particular type of job.
- Identifying types of jobs in the community that match the Participant's interests, strengths and skills.
- Developing a Career Assessment Report that specifies recommendations regarding the Participant's needs, interests, strengths, and characteristics of potential work environments.

The service also includes transportation as an integral component, such as transportation to a situational assessment during the delivery of Career Assessment.

Career Assessment services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the Participant. Documentation in accordance with Department requirements must be maintained in the file by the Supports Coordinator and updated with each

reauthorization to satisfy the State assurance that the service is not otherwise available to the Participant under other federal programs.

Career Assessment does not include supports to continue paid or volunteer work once it is obtained. Career Assessment services may only occur once per service plan year and payment will be made only for a completed assessment.

Community Integration

Community Integration is a short-term, goal-based support service designed to assist Participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community. Community integration can include cueing and on-site modeling of behavior to assist the Participant in developing maximum independent functioning in community living activities.

Community Integration is goal-based and situational to assist individuals in achieving maximum function during life-changing events such as a transition from a Nursing Facility, moving to a new community or from a parent's home, or a change in condition that requires new skill sets. Services and training must focus on specific skills and be related to the expected outcomes outlined in the participant's service plan. Services must be provided at a 1:1 ratio.

Community Integration goals must be reviewed and/or updated at least quarterly by the Service Coordinator in conjunction with the Participant to assure that expected outcomes are met and the service plan is modified accordingly. The length of service should not exceed thirteen (13) weeks on new plans. If the Participant has not reached the goal at the end of (thirteen)13 weeks, then documentation of the justification for continued training on the desired outcome must be incorporated into the ISP at the time of the quarterly review. If the Participant has not reached his/her CI goals by the end of twenty-six (26) weeks, the goals need to change or it is concluded that the individual will not independently complete the goal and the SC must assess for a more appropriate service to meet the Participant's need. Each distinct goal may not remain on the ISP for more than twenty-six (26) weeks. No more than 32 units per week for one CI goal will be approved in the ISP. If the Participant has multiple CI goals, no more than 48 units per week will be approved in the ISP.

Community Integration cannot be billed simultaneously with Residential Habilitation, Structured Day Habilitation or Personal Assistance Services.

Community Transition Services

Community Transition Services are one-time expenses for Participants that make the transition from an institution to their own home, apartment or family/friend living arrangement. Community Transition Services may be used to pay the necessary expenses for a Participant to establish his or her basic living arrangement and to move into that arrangement. The following are categories of expenses that may be incurred:

- Equipment, essential furnishings and initial supplies. Examples—e.g. household products, dishes, chairs, tables.
- Moving Expenses.
- Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement.

- Set-up fees or deposits for utility or service access, Examples – e.g. telephone, electricity, heating
- Items for personal and environmental health and welfare (Examples - personal items for inclement weather, pest eradication, allergen control, one-time cleaning prior to occupancy).

Excluded items include:

- Ongoing payment for rent or mortgage expenses.
- Food, regular utility charges and/or household appliances or items that are intended for purely for diversion/recreational purposes.

- Supports or activities provided to obtain the items.

Services available under Assistive Technology, Home Adaptations, and Specialized Medical Equipment and Supplies.

- Community Transition Services are limited to an aggregate of \$4,000 per Participant, per lifetime.

Employment Skills Development

Employment Skills Development services provide learning and work experiences, including volunteer work, where the Participant can develop strengths and skills that contribute to employability in paid employment in integrated community settings. Services are aimed at furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage.

Employment Skills Development services are designed to:

- Be individually tailored to directly address the Participant's employment goals as identified in the needs assessment and included in the service plan. If the Participant has received a Career Assessment that has determined that the Participant is in need of acquiring particular skills in order to enhance their employability, those identified skills development areas must be addressed within the Participant's service plan and by the Employment Skills Development service.
- Enable each Participant to attain the highest level of work in the most integrated setting and with the job matched to the Participant's career goals, interests, strengths, priorities, abilities and capabilities, while following applicable federal and State wage guidelines.
- Support acquisition of skills needed to obtain competitive, integrated employment in the community.
- Develop and teach general, translatable skills including, but not limited to, the ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; basic workplace requirements, like adherence to time and attendance expectations; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety; and training to enable the effective use of transportation resources.
- Provide and support the acquisition of skills necessary to enable the Participant to obtain competitive, integrated work where the compensation for the Participant is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by Participants without disabilities, which is considered to be the optimal outcome of Employment Skills Development services.

Support may be provided to Participants for unpaid volunteer placement and training experiences, which may be provided in community-based settings. Skills development as a part of placement and training may occur as a one to one training experience or in a group setting in accordance with Department requirements.

Employment Skills Development includes transportation as an integral component of the service, for example, transportation to a volunteer or training activity. The Employment Skills Development service Provider is responsible for providing (directly or through contractual arrangements) transportation between the Participant's home and the employment site or meeting site except when the Participant receives Residential Supports, or Assisted Living services, and after a determination that no more cost-effective means of transportation is available. The inclusion of transportation will depend upon the needs of the Participant as determined by an assessment, the Supports Coordinator and service plan team.

Employment Skills Development may be provided in facilities licensed under PA Code 2390, as well as a variety of unlicensed community-based settings outside of the Participant's home. Participants receiving Employment Skills Development services must have measureable employment-related goals in their service plan.

Employment Skills Development services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the Participant. Handicapped employment, as defined in Title 55, Chapter 2390, may not be funded through the waiver. Waiver funding is not available for the provision of Employment Skills Development (e.g., sheltered work performed in a facility) where Participants are supervised in producing goods or performing services under contract to third parties.

Employment Skills Development services are limited to twenty-four (24) continuous months, at which time the Participant should be able to pursue Job Finding, Job Coaching or another service setting where they may utilize skills they have gained. Total combined hours for Employment Skills Development, and Job Coaching services are limited to fifty (50) hours in a calendar week. Employment Skills Development services are not a pre-requisite for Job Finding or Job Coaching.

Financial Management Services

Financial Management Services (FMS) include fiscal-related services to Participants' choosing to exercise employer and/or budget authority. FMS reduce the employer-related burden for Participants while making sure Medicaid and Commonwealth funds used to pay for services and supports as outlined in the Participant's individual service plan are managed and disbursed appropriately as authorized. The FMS provider must operate as either a qualified Vendor Fiscal/Employer Agent (F/EA) or as a qualified Government Fiscal/Employer Agent (F/EA). The F/EA must:

- Have an FMS policies and procedures manual, that includes the policies, procedures and internal controls that describe the proper operation of the F/EA, that are in

accordance with federal, state, and local tax, labor, workers compensation and program rules and regulations.

- Enroll participants in FMS and apply for and receive approval from the IRS to act as an agent on behalf of the Participant.
- Provide orientation and skills training to Participants on required documentation for all directly hired support workers, including the completion of federal and State forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation.
- Conduct criminal background checks and when applicable, child abuse clearances, on potential employees.
- Distribute, collect and process support worker timesheets as verified and approved by the Participant.
- Prepare and issue support workers' payroll checks, as approved in the Participant's Individual Support Plan.
- Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations.
- Broker workers' compensation for all support workers through the an appropriate agency.
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws.
- Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually.
- Assist in implementing the state's quality management strategy related to FMS.
- Establish an accessible customer service system for the Participant and the Service Coordinator.
- Assist Participants in verifying support workers citizenship or alien status.
- Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only).
- Provide written financial reports to the Participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the Participant, Service Coordinator, and OLTL.

FMS is reimbursed on a per-member per-month basis with a one-time start-up fee for all new Participants that enroll for FMS. The one-time start-up fee applies to new Participants and will only be paid once in a lifetime per Participant. The initial start-up fee covers the lengthy process of enrolling Participants as a common law employee. The one-time start-up fee and the ongoing per-member per-month service fee may not be billed simultaneously.

Home Adaptations

Home Adaptations are physical adaptations to the private residence of the Participant, as specified in the Participant's individual service plan (ISP) and determined necessary in accordance with the Participant's assessment, to ensure the health, welfare and safety of the Participant, and enable the Participant to function with greater independence in the home. This includes primary egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home. Home Adaptations consist

of installation, repair, maintenance, permits, necessary inspections, extended warranties for the adaptations. Adaptations to a household are limited to the following:

- Ramps from street, sidewalk or house.
- Installation of specialized electric and plumbing systems that is necessary to accommodate the medical equipment and supplies necessary for the health, welfare and safety of the Participant.
- Vertical lifts.
- Portable or track lift systems. A portable lift system is a standing structure that can be wheeled around. A track lift system involves the installation of a “track” in the ceiling for moving a Participant with a disability from one location to another.
- Handrails and grab-bars in and around the home.
- Accessible alerting systems for smoke/fire/carbon monoxide for Participants with sensory impairments.
- Outside railing to safely access the home.
- Widened doorways, landings and hallways.
- Swing-clear and expandable offset door hinges.
- Flush entries and leveled thresholds.
- Slip resistant flooring.
- Kitchen counter, sink and other cabinet modifications (including brackets for appliances).
- Bathroom adaptations for bathing, showering, toileting and personal care needs.
- Stair gliders and stair lifts. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely.
- Raised electrical switches and sockets.
- Other adaptations, subject to approval, to address specific assessed needs as identified in the service plan.

All adaptations to the home shall be provided in accordance with applicable building codes. Home Adaptations shall meet standards of manufacture, design and installation. Home Adaptations must be an item of modification that the family would not be expected to provide to a family member without a disability or specialized needs. Materials and equipment must be based on the Participant’s need as documented in the ISP.

This service does not include, but requires, an independent evaluation. Depending on the type of adaptation, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech, hearing and language therapist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to Provider qualifications. Such assessments may be covered through another waiver service, as appropriate. Home adaptations must be obtained at the lowest cost.

Building a new room is excluded. Specialized Medical Equipment and Supplies is excluded. Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the Participant this includes items that are not up to code. Adaptations that add to the total square footage of the home are excluded from this benefit, except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an

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existing bathroom.

Rented property adaptations must meet the following:

- There is a reasonable expectation that the Participant will continue to live in the home.
- Written permission is secured from the property owner for the adaptation.
- The landlord will not increase the rent because of the adaptation.
- There is no expectation that waiver funds will be used to return the home to its original state.

This service may not be included on the same service plan as Residential Habilitation.

Home Delivered Meals

The Home Delivered Meals service provides meals that meet at least one-third (1/3) of the Dietary Reference Intakes to people in their private homes. Home Delivered Meals provides meals to Participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. Home Delivered Meals must be specified in the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the Participant. Participants may receive more than one meal per day, but they cannot receive meals that constitute a “full nutritional regimen” (three meals per day).

All meals must be consistent with a prescribed menu approved by a dietician and, in accordance with the menu:

- May consist of hot, cold, frozen, dried, canned, fresh or supplemental foods.
- Can either be a hot, cold, frozen or shelf-stable meal.

Home Delivered Meals are provided only during those times when neither the Participant nor anyone else in the household is able or available to provide them, and where no other relative, caregiver, community/volunteer agency or third-party payer is able to provide, or be responsible for, their provision. Meals provided as part of this service shall not constitute a full nutritional regimen (three meals per day). Transportation for the delivery of meals is included in the service cost and will not be reimbursed separately.

Home Health Services

Home Health Services consist of the following components: Home Health Aide Services, Nursing Services, Physical Therapy, Occupational Therapy and Speech and Language Therapy.

1. Home Health Aide Services

Home Health Aide services are direct services prescribed by a physician to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. The physician’s order must be obtained every sixty (60) days for continuation of service. Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. The registered nurse

supervisor must reassess the Participant's situation in accordance with 55 PA Code Chapter 1249, §1249.54. Home Health Aide activities include, personal care, performing simple measurements and tests to monitor a participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist

Home Healthcare Aide services cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, or Respite Services.

2. Nursing Services

Nursing services are direct services prescribed by a physician that are needed by the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Nursing services are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. The physician's order must be obtained every sixty (60) days for continuation of service. Nursing services are individual, and can be continuous, intermittent, or short-term based on individual's assessed need.

3. Physical Therapy

Physical Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. Physical Therapy can be provided by a licensed physical therapist or physical therapist assistant as prescribed by a physician, and in accordance with the Physical Therapy Practice Act (63 P.S. §1301 et seq.).

4. Occupational Therapy

Occupational Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order must be obtained every sixty (60) days for continuation of service. Occupational Therapy services can be provided by a licensed occupational therapist or an occupational therapist assistant in accordance with the Occupational Therapy Practice Act (63 P.S. §1501 et seq.)

5. Speech and Language Therapy

Speech and Language Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and development of a home program for caretakers to implement the recommendations

of the therapist are included in the provision of Speech and Language Therapy services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. Speech and Language Therapy services are provided by a licensed American Speech Language Hearing Associate or certified speech-language pathologist in accordance with applicable State standards including the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech language system. Speech and Language Therapy services also include the examination for, and adapting and use of augmentative and alternative communication strategies.

Job Coaching

Job Coaching services are individualized services providing supports to Participants who need ongoing support to learn a new job and maintain a job in a competitive employment arrangement in an integrated work setting in a position that meets job and career goals. Participants in a competitive employment arrangement receiving Job Coaching services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Job Coaching can also be used to support Participants who are self-employed. Job Coaching services are necessary, as specified in the service plan, to support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant. Job Coaching provides two components in accordance with an assessment: Intensive Job Coaching and Extended Follow-along.

Intensive Job Coaching includes on-the-job training and skills development; assisting the Participant with development of natural supports in the workplace; and coordinating with employers or employees, coworkers and customers, as necessary. Intensive Job Coaching includes assisting the Participant in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training and diversity training to the specific business where the Participant is employed. Intensive Job Coaching provides support to assist Participants in stabilizing in an integrated situation (including self-employment) and may include activities on behalf of the Participant when the Participant is not present to assist in maintaining job placement. Participants receiving Intensive Job Coaching require on-the-job support for more than twenty percent (20%) of their work week at the outset of the service, phasing down to twenty percent (20%) per week during the Intensive Job Coaching period (at which time, Extended Follow-along will be provided if ongoing support is needed). Job Coaching supports within this range should be determined based on the Participant's needs.

Intensive Job Coaching for the same employment site and/or position may only be authorized for up to 6 months and may be reauthorized for additional 6 month periods, upon review with the service planning team. Intensive Job Coaching may only be reauthorized twice, for a total of 18 consecutive months of Intensive Job Coaching support for the same employment site and/or position. Intensive Job Coaching is recommended for new employment placements or may be reauthorized for the same location after a period of Extended Follow-along, due to change in circumstances (new work responsibilities, Community HealthChoices Agreement Effective January 1, 2017

personal life changes, etc.).

Extended Follow-along is ongoing support available for an indefinite period as needed by the Participant to maintain their paid employment position once they have been stabilized in their position (receiving less than 20% onsite support for at least four weeks). Extended Follow-along support may include reminders of effective workplace practices and reinforcement of skills gained during the period of Intensive Job Coaching. Once transitioned to Extended Follow-along, Providers are required to make at least two (2) visits per month, up to a maximum of two-hundred forty (240) hours per service plan year. This allows an average of twenty (20) hours per month to manage difficulties which may occur in the workplace and the limit may be used for the participant over an annual basis, as needed. If circumstances require more than that amount per service plan year, the service must be billed as Intensive Job Coaching.

The Job Coaching service provider is responsible for providing (directly or through contractual arrangements) transportation between the Participant's home and the employment site or meeting site except when the Participant receives Residential Supports, or Assisted Living services, and after a determination that no more cost-effective means of transportation is available. The inclusion of transportation will depend upon the needs of the Participant as determined by the Supports Coordinator and service plan team.

Job Finding

Job Finding is an individualized service that assists Participants to obtain competitive, integrated employment paid at or above the minimum wage. Job Finding identifies and/or develops potential jobs and assists the Participant in securing a job that fits the Participant's skills and preferences and employer's needs. If the Participant has received a Career Assessment, the results of that assessment must be addressed within the Participant's service plan and by the Job Finding service.

Job Finding, which may include prospective employer relationship building, is time-limited. Job Finding requires authorization up to ninety (90) days, with re authorization every (90) days, for up to one (1) year. At each ninety (90) day interval, the service plan team will meet to clarify employment goals and expectations and review the job finding strategy. The service also includes transportation as an integral component of the service, such as to a job interview, during the delivery of Job Finding.

Job Finding does not include activities covered through Job Coaching once employment is obtained. Job Finding does not include skills training to qualify for a job.

Non-Medical Transportation

Non-Medical Transportation services enable Participants to gain access to waiver services as specified in the individualized service plan. This service is offered in addition to medical transportation services required under 42 CFR 440.170 (a) (if applicable), and shall not replace them. Non-Medical Transportation services include mileage reimbursement for drivers and others to transport a Participant and/or the purchase of tickets or tokens to secure transportation for a Participant. Non-Medical Transportation must be billed per one-way trip or billed per item, for example a monthly bus pass. Transportation services must

be tied to a specific objective identified on the Participant's service plan.

Non-medical Transportation services may only be authorized on the service plan after an individualized determination that the method is the most cost-effective manner to provide needed Transportation services to the Participant, and that all other non-Medicaid sources of transportation which can provide this service without charge (such as family, neighbors, friends, community agencies) have been exhausted.

Non-Medical Transportation does not cover reimbursement to the Participant or another individual when driving the Participant's vehicle. Non-Medical Transportation does not pay for vehicle purchases, rentals, modifications or repairs. Non-Medical Transportation cannot be provided at the same time as Adult Daily Living services with transportation. An individual cannot provide both Personal Assistance Services and Non-Medical Transportation simultaneously.

Nursing Home Transition

Nursing Home Transition services are those transition services that are necessary to enable individuals to leave an institution and receive waiver services in their home and/or in the community. Nursing Home Transition services assist institutionalized individuals that have resided in an institution for at least ninety (90) consecutive or a barrier (including but not limited to; lack of informal or family supports, housing, etc.) and; are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Nursing Home Transition Services are provided while the individual is in the institution, up to one hundred eighty (180) days prior to discharge, and are to be claimed as delivered on the day of discharge from the institution.

The following transition activities are essential functions of the Nursing Home Transition Coordinator ; The following pre-transition activities are essential functions of the Nursing Home Transition Coordinator ; Identifying, educating, and assisting Participants enrolled with Money Follows the Person (MFP), acting as a liaison between the facility where the Participant will be transitioning from and the Independent Enrollment Broker for waiver services, performing a comprehensive assessment for the appropriateness of a transition from an institution to the community which gathers information about the need for health services, social supports, housing, transportation, financial resources and other needs, providing information to the Participant about community resources and assisting the individual, family, NF staff and others to ensure timely and coordinated access to Medicaid services, Behavioral Health services, financial counseling and other services to meet needs, assessing the needs and supports of the Participant transitioning to determine the support network availability, adequacy of living arrangements, financial status, employment status, and training needs, assisting in finding and securing housing, including the completion of housing applications and securing required documentation (e.g., social security card, birth certificate, prior rental history), working with private landlords, housing authorities, Regional Housing Coordinators or other housing entities, assessing the need for any home modifications that may need to be complete prior to the Participant transitioning to the community; this includes acting as a liaison between the home modification broker, contractor, and physical and occupational therapists, assist or act behalf of the Participant

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in obtaining needed documentation or resources with Social Security, social services, community agencies, assist or coordinate training in budget management, being a good tenant, coordinating the Participants move to the community and educating the individual on how to retain housing, coordinating with Community Transition Services (CTS) available in the waiver by assisting in obtaining household supplies (including furniture) moving expenses, security deposits rental fee/deposits and health as safety costs (pest eradication etc.), assisting the individual, family ,NF staff and others in the development of the Community Living Plan, including services provided through NF, add on services, medical services, behavioral health services and primary care, ensure the individuals “transition plan” is integrated and coordinated to ensure a safe discharge and prevent hospital admissions or re-institutionalizations, developing and recording the activities for transition, monitoring transition activities, providing information to the individual about community resources, assisting the Participant and family members in applying for qualified services (Medicaid, food stamps, home mods, etc.), coordinating with medical Providers to ensure a safe and healthy discharge, coordinating the date of discharge which includes notifying the Waiver Enrollment Entity of the date of discharge.

Participant-Directed Community Supports

Participant-Directed Community Supports will be offered to Participants utilizing budget authority. Participant-Directed Community Supports are specified by the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the Participant. The Participant is the common law employer of the individual worker(s) providing services; workers are recruited, selected, hired and managed by the Participant. Services include assisting the Participant with the following:

- Basic living skills such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living.
- Health maintenance activities such as bowel and bladder routines, assistance with medication, ostomy care, catheter care, wound care and range of motion activities.
- Improving and maintaining mobility and physical functioning.
- Maintaining health and personal safety.
- Carrying out household chores such as shopping, laundry, cleaning and seasonal chores.
- Preparation of meals and snacks.
- Accessing and using transportation (If providing transportation, the support services worker must have a valid driver’s license and liability coverage as verified by the F/EA).
- Participating in community experiences and activities.

Participant-Directed Community Supports may not be provided at the same time as Home Health Aide Services, Respite, Personal Assistance Services and Participant-Directed Goods and Services.

Participant-Directed Goods and Services

Participant-Directed Goods and Services are services, equipment or supplies limited to Participants that are utilizing Budget Authority for Participant-directed service. Participant-directed goods and services are purchased from the Participant’s Individual Spending Plan.

These items must address an identified need in the Participant's traditional service plan (including improving and maintaining the individual's opportunities for full participation in the community) and meet the following requirements. The item or service would meet one or more of the following:

- Decrease the need for other Medicaid services.
- Promote or maintain inclusion in the community.
- Promote the independence of the Participant.
- Increase the individual's health and safety in the home environment.
- Develop or maintain personal, social, physical or work-related skills.
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support or
- Fulfill a medical, social or functional need as identified in the Participant's individual service plan.

Participant-Direct Goods and Services does not include personal items and services not related to the disability, groceries, rent or mortgage payments, entertainment activities, or utility payments; may not be provided at the same time as Home Health Aide Services, Personal Assistance Services, and Participant-Directed Community Supports; and are limited to instances when the Participant does not have personal funds to purchase the item or service and the item or service is not available through another source.

Personal Assistance Services

Personal Assistance Services primarily provide hands-on assistance to Participants that are necessary, as specified in the service plan, to enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant. This service will be provided to meet the Participant's needs, as determined by an assessment, in accordance with Department requirements and as outlined in the Participant's service plan. Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability. These services include: Care to assist with activities of daily living (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the Participant to perform a task, and providing supervision to assist a Participant who cannot be safely left alone. Health maintenance activities provided for the Participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's service plan and permitted under applicable State requirements. Routine support services, such as meal planning, keeping of medical appointments and other health regimens needed to support the Participant. Assistance and implementation of prescribed therapies. Overnight Personal Assistance Services provide intermittent or ongoing awake, overnight assistance to a Participant in their home for up to eight hours. Overnight Personal Assistance Services require awake staff.

Personal Assistance may include assistance with the following activities when incidental to personal assistance and necessary to complete activities of daily living: Activities that are incidental to the delivery of Personal Assistance to assure the health, welfare and safety of the P such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service.

Services to accompany the Participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks.

Personal Assistance services are provided by a Home Care Agency and must be Licensed by the PA Department of Health, per 28 PA Code Part IV, Subpart H, Chapter 611 (Home Care Agencies and Home Care Registries), under Act 69.

Personal Emergency Response System (PERS)

PERS is an electronic device which enables waiver Participants to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals, as specified. The PERS vendor must provide 24 hour staffing, by trained operators of the emergency response center, 365 days a year.

PERS services are limited to those individuals who: Live alone, are alone for significant parts of the day as determined in consideration of their health status, disability, risk factors, support needs and other circumstances., live with an individual that may be limited in their ability to access a telephone quickly when a Participant has an emergency, or would otherwise require extensive in-person routine monitoring and assistance. Installation, repairs, monitoring and maintenance are included in this service.

Pest Eradication

Pest eradication services will be available to make a Participant’s home fit for the Participant to live there. Pest Control Services are intended to aid in maintaining an environment free of insects, rodents and other potential disease carriers to enhance safety, sanitation and cleanliness of the Participant’s residence. The service may be considered for inclusion in the Individual Service Plan (ISP) for a Participant transitioning to the community. It can also be made available on an ongoing basis if necessary as determined by the Service Coordinator (SC) and documented in the ISP. That documentation needs to include the amount, duration and scope of services as determined by the SC. The service cannot be made available as a preference of the Participant to remove something on a property that has no impact on the Participant living there.

Residential Habilitation

Residential Habilitation Services are delivered in provider owned, rented/leased or operated settings. They can be provided in Licensed and unlicensed settings.

Licensed Settings are settings in which four or more individuals reside and are licensed as Personal Care Homes (reference 55 PA Code Chapter 2600). Unlicensed settings are provider owned, rented/leased or operated settings with no more than three residents.

Residential Habilitation services are provided for up to 24 hours a day. Residential Habilitation includes supports that assist participants with acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. These services are individually tailored supports that can include activities in environments designed to foster the acquisition of skills, appropriate behavior, greater

independence and personal choice. Supports include cueing, on-site modeling of behavior, and/or assistance in developing or maintaining maximum independent functioning in community living activities, including domestic and leisure activities. Residential Habilitation also includes community integration, personal assistance services and night-time assistance. This includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (i.e., cooking, housework, and shopping).

Transportation is provided as a component of the Residential Habilitation service, and is therefore reflected in the rate for Residential Habilitation. Providers of (unlicensed and licensed) Residential Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their individual support plans (ISPs). This includes transportation to and from day habilitation and employment services.

Licensed settings may not exceed a licensed capacity of more than 8 unrelated individuals. Both licensed and unlicensed settings must be community-based as well as maintain a home-like environment. A home-like environment provides full access to typical facilities found in a home such as a kitchen and dining area, provides for privacy, allows visitors at times convenient to the individual, and offers easy access to resources and activities in the community. Residences are expected to be located in residential neighborhoods in the community. Participants have access to community activities, employment, schools or day programs.

This service must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based waiver services. Settings cannot be located on the grounds of a Nursing Facility, Intermediate Care Facility (ICF), Institute for Mental Disease or Hospital. Instead they must be located in residential neighborhoods in the community.

Respite

Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, or the home of relative, friend, or other family and are provided in quarter hour units. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.

Service Coordination

Service Coordination identifies, coordinates and assists Participants to gain access to needed waiver services and State Plan services, as well as non-Medicaid funded medical, social, housing, educational and other services and supports. Service Coordination includes the primary functions of providing information to Participants and facilitating access, locating, coordinating and monitoring needed services and supports for waiver Participants. Service Coordinators are responsible to: Inform Participants about the waiver, required needs assessments, the Participant-centered planning process, service alternatives, service delivery options (opportunities for Participant-direction), roles, rights, risks and

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responsibilities, inform Participants on fair hearing rights and assist with fair hearing requests when needed and upon request, and ensuring the health, welfare and safety of the Participant on on-going basis.

Service Coordinators are also responsible to collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the Participant-centered service plan, conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements, assist the Participant and his/her person-centered service planning team in identifying and choosing willing and qualified providers, and coordinate efforts and prompt the Participant to ensure the completion of activities necessary to maintain waiver eligibility, explore coverage of services to address Participant identified needs through other sources, including services provided under the State Plan, Medicare and/or private insurance or other community resources, actively coordinate with other individuals and/or entities essential in the physical and/or behavioral care delivery for the Participant, including HealthChoices care coordinators, to ensure seamless coordination between physical, behavioral and support services.

Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies are services or items that provide direct medical or remedial benefit to the Participant and are directly related to a Participant's disability. These services or items are necessary to ensure health, welfare and safety of the Participant and enable the Participant to function in the home, community, or nursing facility with greater independence. This service is intended to enable Participants to increase, maintain, or improve their ability to perform activities of daily living. Specialized Medical Equipment and Supplies are specified in the Participant's service plan and determined necessary in accordance with the Participant's assessment.

Specialized Medical Equipment and Supplies includes: Devices, controls or appliances, specified in the service plan, that enable Participants to increase, maintain or improve their ability to perform activities of daily living, equipment repair and maintenance, unless covered by the manufacturer warranty, items that exceed the limits set for Medicaid State plan covered services, rental Equipment. In certain circumstances, needs for equipment or supplies may be time-limited.

Non-Covered Items: All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream), items covered under third party payer liability, items that do not provide direct medical or remedial benefit to the Participant and/or are not directly related to a participant's disability, food, food supplements, food substitutes (including formulas), and thickening agents; eyeglasses, frames, and lenses; dentures, any item labeled as experimental that has been denied by Medicare and/or Medicaid, recreational or exercise equipment and adaptive devices for such.

This service does not include, but requires, an independent evaluation and a physician's prescription. The independent evaluation may be conducted by an occupational therapist; a speech, hearing or language therapist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through one of the following services

offered through the waiver; Physical Therapy, Occupational Therapy, or Speech Therapy, or the State Plan as appropriate.

Hearing Aids require, but this service does not cover, an evaluation conducted by a physician certified by the American Board of Otolaryngology. Hearing aids must be purchased from and fitted by a licensed audiologist, licensed physician, or registered hearing aid fitter in association with a registered hearing aid dealer.

Specialized Medical Equipment and Supplies exclude Assistive Technology

Structured Day Habilitation

Structured Day Habilitation Services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Structured Day Habilitation Services provide waiver Participants comprehensive day programming to acquire more independent functioning and improved cognition, communication, and life skills. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice as well as provide the supports necessary for mood and behavioral stability with therapeutic goals according to the written plan of care for the individual.

Services include social skills training, sensory/motor development, and education/elimination of maladaptive behavior. Services are directed at preparing the Participant for community reintegration, such as teaching concepts such as compliance, attending to task, task completion, problem solving, safety, communication skills, money management, and shall be coordinated with all services in the service plan. Services include assistance with activities of daily living including whatever assistance is necessary for the purpose of maintaining personal hygiene.

Services must be separate from the Participant's private residence or other residential living arrangement. Providers may, however, provide Structured Day Habilitation Services in the community, a Participant's private residence or other residential living arrangement if the room used is used for the sole purpose of these services. The provider must operate the Structured Day Habilitation Services for a minimum of four (4) hours per day up to a maximum of eight (8) hours per day on a regularly scheduled basis for one (1) or more days per week or as specified in the Participant's service plan. Structured Day Habilitation Services are distinguished from Adult Daily Living Services by the therapeutic nature of the program. Structured day habilitation services include the direct services provided by direct care staff and any supervision of the licensed care staff. The direct services must be personal care or directed toward the acquisition of skills. Supervision of Participants is not Medicaid reimbursable.

Telecare

TeleCare integrates social and healthcare services supported by innovative technologies to sustain and promote independence, quality of life and reduce the need for nursing home placement. By utilizing in-home technology, more options are available to assist and support individuals so that they can remain in their own homes and reduce the need for re-hospitalization. TeleCare services are specified by the service plan, as necessary to enable the Participant to promote independence and to ensure the health, welfare and safety of the Participant and are provided pursuant to consumer choice. TeleCare includes: 1) Health Status Measuring and Monitoring TeleCare Service, 2) Activity and Sensor Monitoring TeleCare Service, and 3) Medication Dispensing and Monitoring TeleCare Services.

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Health Status Measuring and Monitoring TeleCare Services: uses wireless technology or a phone line, including electronic communication between the Participant and healthcare provider focused on collecting health related data, i.e., vital signs information such as pulse/ox and blood pressure that assists the healthcare provider in assessing the Participant's condition) and providing education and consultation; must be ordered by a primary physician, physician assistant, or nurse practitioner; includes installation, daily rental, daily monitoring and training of the Participant, their representative and/or employees who have direct Participant contact; monitoring service activities must be provided by trained and qualified home health staff in accordance with required provider qualifications; and have a system in place for notification of emergency events to designated individuals or entities.

Activity and Sensor Monitoring TeleCare Service: employs sensor-based technology on a 24 hour/7 day basis by remotely monitoring and passively tracking Participants' daily routines and may report on the following: wake up times, overnight bathroom usage, bathroom falls, medication usage, meal preparation and room temperature; includes installation, monthly rental, monthly monitoring, and training of employees who have direct Participant contact; and ensures there is a system in place for notification of emergency events to designated individuals.

Medication Dispensing and Monitoring TeleCare Service: assists Participants by dispensing and monitoring medication compliance; and utilizes a remote monitoring system personally pre-programmed for each Participant to dispense, monitor compliance and provide notification to the provider or family caregiver of missed doses or non-compliance with medication therapy.

Therapeutic and Counseling Services

Therapeutic and counseling services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community. Therapeutic and counseling services are provided by professionals and/or paraprofessionals in cognitive rehabilitation therapy, counseling, nutritional counseling and behavior management. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the Participant in the implementation of the plan. This service may be delivered in the Participant's home or in the community as described in the service plan.

- Cognitive rehabilitation therapy services focus on the attainment/re-attainment of cognitive skills. The aim of therapy is the enhancement of the Participant's functional competence in real-world situations. The process includes the use of compensatory strategies, and use of cognitive orthotics and prostheses. Services include consultation, ongoing counseling, and coaching/cueing performed by a certified Cognitive Rehabilitation Therapist.
- Counseling services are non-medical counseling services provided to Participants in order to resolve individual or social conflicts and family issues. While counseling services may include family members, the therapy must be on behalf of the

Participant and documented in his/her service plan. Services include initial consultation and ongoing counseling performed by a licensed psychologist, licensed social worker, or licensed professional counselor. If there is a mental health or substance abuse diagnosis, including adjustment disorder, the State Plan, through the Office of Mental Health and Substance Abuse Services, will cover the visit outside of the home and community-based services waiver up to pre-specified limits. Counseling services are utilized only once State Plan limitations have been reached, no diagnosis is present or the service is deemed to not be Medically Necessary or not making meaningful progress under State Plan standards.

- Nutritional Consultation assists the Participant and/or their paid and unpaid caregivers in developing a diet and planning meals that meet the Participant's nutritional needs, while avoiding any problem foods that have been identified by a physician. The service may include initial assessment and reassessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the Participant, caregiver and any providers in the implementation of the plan. Services include counseling performed by a Registered Dietitian or a Certified Nutrition Specialist. Nutritional Consultation services may be delivered in the Participant's home or in the community, as specified in the service plan. The purpose of Nutritional Consultation services is to improve the ability of Participants, paid and/or unpaid caregivers and providers to carry out nutritional interventions. Nutritional counseling services are limited to 90-minutes (6 units) of nutritional consultations per month. Home health agencies that employ licensed and registered dietitians may provide nutritional counseling.
- Behavior therapy services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family members and direct service providers. Services include consultation, monitoring the implementation of the behavioral support plan and revising the plan as necessary. Behavior therapy services are provided by a licensed psychologist, licensed social worker, behavior specialist, or licensed professional counselor. A masters level clinician without licensure, certification or registration, must be supervised by a licensed psychologist, licensed social worker, licensed professional counselor or licensed behavior analyst.

Vehicle Modifications

Vehicle modifications are modifications or alterations to an automobile or van that is the participant's means of transportation in order to accommodate the special needs of the participant. Vehicle modifications are modifications needed by the participant, as specified in the service plan and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant and enable the participant to integrate more fully into the community.

The following are specifically excluded: modifications or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the participant, purchase or lease of a vehicle with or without existing adaptations, regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications, the waiver cannot be used to purchase vehicles for participants, their families or legal guardians.

Vehicle modifications funded through the waiver are limited to the following: vehicular lifts, portable ramps when the sole purpose of the ramp is for the participant to access the vehicle, interior alterations to seats, head and leg rests and belts, customized devices necessary for the participant to be transported safely in the community, including driver control devices, modifications needed to accommodate a participant's special sensitivity to sound, light or other environmental conditions, raising the roof or lowering the floor to accommodate wheelchairs, the vehicle must be less than five (5) years old, and have less than 50,000 miles for vehicle modification requests over \$3,000.

All vehicle modifications shall meet applicable standards of manufacture, design and installation.