

## **SECTION I: INCORPORATION OF DOCUMENTS**

### **A. Operative Documents**

1. This agreement is comprised of the following documents, which are listed in the order of precedence in the event of a conflict between documents:
2. This document consisting of its Recitals and Section **[Will be adjusted for the final Agreement]** of the document and its Appendices 3-**[Will be adjusted for the final Agreement]** and its Exhibits A - **[Will be adjusted for the final Agreement]**
3. RFP Number 12-15 attached as Appendix 1 to the agreement
4. CHC-MCOs Proposal, attached as Appendix 2 to the agreement

### **B. Operational Updates and Department Communications**

#### **1. CHC Operations Memos (MC OPS Memos)**

The Department will issue CHC OPS Memos via the Intranet supporting CHC to provide clarifications to requirements pertaining to CHC.

#### **2. Intranet**

CHC-MCOs must routinely check the Intranet supporting CHC for CHC operational procedures and policies.

## **SECTION III: RELATIONSHIP OF PARTIES**

### **A. Term of Agreement**

The term of this Agreement will commence on January 1, 20xx and will have an initial term of X years, provided that no court order, administrative decision, or action by the federal or state government is outstanding which prevents the commencement of the Agreement. The Department has the option to extend this Agreement for an additional X year period upon the same terms and conditions. DHS will notify the CHC-MCO of its election to exercise the renewal option in writing at least one hundred twenty (120) days prior to the expiration of the then current term provided, however, that the Department's right to exercise any such renewal option shall not expire unless and until the CHC-MCO has given the Department written notice of the Department's failure to timely exercise its renewal option and has provided a ten (10) day opportunity from the Department's receipt of the notice to cure the failure. If the Department exercises its option, it will promptly commence rate discussions with the CHC-MCO.

### **B. If the Department has exercised its option to extend and the CHC-MCO**

and the Department are unable to agree upon terms for the extension, the Agreement will continue on the same terms and conditions for a period of one hundred twenty (120) days after the expiration of the Initial Term unless the Agreement has been terminated in accordance with Exhibit D.

**C. Nature of Agreement**

The CHC-MCO must provide for all Covered Services and related services to Participants through qualified Providers in accordance with this Agreement.

**SECTION IV: APPLICABLE LAWS AND REGULATIONS**

**A. Certification and Licensing**

The CHC-MCO must require its Network Providers to comply with all certification and licensing laws and regulations applicable to the profession or entity. The CHC-MCO may not employ or enter into a contractual relationship with a Provider who is precluded from participation in the Medical Assistance Program or other federal health care program. The CHC-MCO must screen all Providers at the time of hire or contracting; and thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in federal health care programs.

CHC-MCOs must use the streamlined credentialing process that the Department develops, in conjunction with the CHC-MCOs.

**1. National Accreditation**

The CHC-MCO must be NCQA accredited or accredited by a national accreditation body and obtain such accreditation within the accreditation body's specified timelines. A CHC-MCO applying for accreditation must select an accreditation option and notify the accrediting body of the accreditation option chosen.

If the CHC-MCO is accredited as of the start date of this Agreement, the CHC-MCO shall maintain accreditation throughout the period of this Agreement. If the CHC-MCO is not accredited as of the start date of this Agreement, the CHC-MCO shall obtain accreditation no later than the end of the second full calendar year of operation and shall maintain accreditation for the duration of this Agreement. Accreditation obtained under the NCQA Full Accreditation Survey or Multiple Product Survey options will be acknowledged by the Department. The Department will accept the use of the NCQA Corporate Survey process, to the extent deemed allowable by NCQA, in the NCQA accreditation of the CHC-

## MCO.

Failure to obtain accreditation and failure to maintain accreditation thereafter shall be considered a breach of this Agreement. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of notification from the accreditation body and may result in termination of this Agreement.

The CHC-MCO must submit the final hard copy Accreditation Report for each accreditation cycle within ten (10) days of receipt of the report. Updates of accreditation status, based on annual HEDIS scores must also be submitted within ten (10) days of receipt.

### **B. Specific to Medical Assistance Program**

The CHC-MCO must participate in the Medical Assistance Program, and arrange for the provision of those Covered Services essential to the health and support of its Participants, and comply with all federal and Pennsylvania laws generally and specifically governing participation in the Medical Assistance Program. The CHC-MCO must provide services in the manner prescribed by 42 U.S.C. §300e(b), and warrants that the organization and operation of the CHC-MCO is in compliance with 42 U.S.C. §300e(c). The CHC-MCO must comply with all applicable rules, regulations, and Bulletins promulgated under such laws including, but not limited to, 42 U.S.C. §300e; 42 U.S.C. §§1396 et seq.; 62 P.S. §§101 et. seq.; 42 C.F.R. Parts 431 through 481 and 45 C.F.R Parts 74, 80, and 84, and the Department regulations as specified in Exhibit A, Managed Care Regulatory Compliance Guidelines.

### **C. Specific to Medicare**

The CHC-MCO must be a Related Party to a CMS approved Full Benefit Dual Eligible Special Needs Plan (D-SNP) for the duration of this Agreement.

### **D. General Laws and Regulations**

1. The CHC-MCO must comply with Titles VI and VII of the Civil Rights Act of 1964, 42 U.S.C. §§2000d et seq. and 2000e et seq.; Title IX of the Education Amendments of 1972, 20 U.S.C. §§1681 et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§701 et seq.; the Age Discrimination Act of 1975, 42 U.S.C. §§6101 et seq.; the Americans with Disabilities Act, 42 U.S.C. §§12101 et seq.; the Health Insurance Portability and Accountability Act of 1996 (HIPAA Regulations); the Pennsylvania Human Relations Act of 1955, 71 P.S. §§941 et seq.; and Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. §§991.2102 et seq.; and Drug and Alcohol Use and Dependency Coverage Act 106 of 1989, 40

P.S. §§908-1 et seq.

2. The CHC-MCO must comply with all applicable laws, regulations, and policies of the Pennsylvania DOH and the PID.

The CHC-MCO must comply with applicable Federal and State laws that pertain to Participant rights and protections.

3. The CHC-MCO and its subcontractors must respect the conscience rights of individual Providers, as long as said conscience rights are made known to the CHC-MCO in advance, and comply with the current Pennsylvania laws prohibiting discrimination on the basis of the refusal or willingness to provide health care services on moral or religious grounds as outlined in 40 P.S. §901.2121 and §991.2171; 43 P.S. §955.2 and 18 Pa. C.S. §3213(d).

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, the CHC-MCO must furnish information about the services not covered in accordance with the provisions of 42 CFR §438.102(b)

- To the Department
- With its Proposal in response to the RFP
- Whenever it adopts the policy during the term of the Agreement.

The CHC-MCO must provide this information to potential Participants before and during Enrollment. This information must be provided to Participants within thirty (30) days after adopting the policy with respect to any particular service.

4. Nothing in this Agreement shall be construed to permit or require the Department to pay for any services or items which are not or have ceased to be compensable under the laws, rules and regulations governing the Medical Assistance Program at the time such services are provided.
5. The CHC-MCO must comply with all applicable Federal regulations, including 42 C.F.R. §§438.726 and 438.730 describing conditions under which CMS may deny payments for new Participants.

#### **E. Limitation on the Department's Obligations**

The obligations of the Department under this Agreement are limited and subject to the availability of funds.

#### **F. Health Care Legislation, Regulations, Policies and Procedures**

The CHC-MCO must comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in the Medical Assistance Program including any changes to 1915(b) or (c) Waivers and any changes to MIPPA agreements.

## **SECTION VI: PROGRAM OUTCOMES AND DELIVERABLES**

Prior to the enrollment of potential participants and the operational implementation of this agreement, the Department will conduct Readiness Reviews activities, to the CHC-MCO's ability to comply with this Agreement. The CHC-MCO must cooperate with all the Readiness Review activities, including on site reviews, conducted by the Department. If the Department determines the CHC- MCO has not demonstrated readiness to provide services as required by this agreement, the department will not permit the enrollment of Potential Participants with the CHC-MCO and may extend the time period for the Readiness Review or not operationalize this agreement.

## **SECTION VIII: REPORTING REQUIREMENTS**

### **A. General**

The CHC-MCO must comply with state and federal reporting requirements that are set forth in this Agreement, and provided in guidance from the Department.

The CHC-MCO must certify the data that must be certified under 42 CFR 438.604 submitted to the Department, whether in written or electronic form. Such certification must be submitted concurrently with the data and must be based on the knowledge, information and belief of the Chief Executive Officer (CEO), Chief Financial Officer (CFO) or an individual who has delegated authority to sign for, and who reports directly to the CEO or CFO in accordance with 42 CFR Part 438.604.

The CHC-MCO agrees to provide the certification in the manner described by the Department.

### **B. Systems Reporting**

The CHC-MCO must submit electronic files and data as specified by the Department. To the extent possible, the Department will provide reasonable advance notice of such reports.

Exhibit CC, Data Support for CHC-MCOs, provides a listing of these and other reports provided to and by the MCOs. Information on the submission of the Department's data files is available on the Intranet supporting CHC.

**1. Encounter Data Reporting**

The CHC-MCO must record Encounter Data and submit it to the Department. The CHC-MCO shall only submit Encounter Data for its Participants.

The CHC-MCO must maintain appropriate systems to obtain all necessary data from its Providers to ensure its ability to comply with the Encounter Data reporting requirements. The failure of a Provider or Subcontractor to provide the CHC-MCO with necessary Encounter Data shall not excuse the CHC-MCO's noncompliance with this requirement.

The CHC-MCO must record the Encounter Data in a format prescribed by DHS. DHS will provide sixty days advance written notice of any changes to Encounter Data requirements.

**a. Data Format**

The CHC-MCO must submit Encounter Data to the Department pursuant to protocols to be established by the Department.

i. Encounter File Specifications

ii. The CHC-MCO must adhere to the file size and format specifications provided by the Department. CHC-MCOs must also adhere to the Encounter file submission schedule provided by the Department.

The CHC-MCO must provide Encounter Data files in the following ASC X12 transactions:

- 837 Professional
- 837P - Drug
- 837I - Inpatient
- 837I – Outpatient
- 837I – LTC
- 837I – Outpatient Drug
- 837 Dental
- NCPDP batch files

**b. Timing of Data Submittal**

iii. Provider Claims

The CHC-MCO must require Providers to submit claims CHC-MCO within one hundred eighty (180) days after the date of service.

The CHC-MCO may require more prompt submissions of Claims or Encounter records in Provider Agreements and Subcontracts. Claims adjudicated by a third party vendor must be provided to the CHC-MCO by the end of the month following the month of adjudication.

iv. Encounter Submissions

All Encounter records except pharmacy transactions must be submitted and determined acceptable by the Department on

or before the last calendar day of the third month after the payment/adjudication calendar month in which the CHC-MCO paid/adjudicated the Claim. Pharmacy transactions must be submitted and approved in PROMISe™ within 30 days following the adjudication date.

Encounter records sent to the Department are considered acceptable when they pass all Department edits.

The CHC-MCO must correct and return all Encounter Records that the Department denies. Denied Encounter records must be resubmitted as a “new” Encounter record within the timeframe referenced above.

Corrections and resubmissions must pass all edits before they are accepted by the Department.

Failure of Subcontractors to submit Encounter Data timely shall not excuse the CHC-MCO’s noncompliance with this requirement.

v. **Response Files**

The CHC-MCO’s Encounter Data system must be able 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.

c. **Data Completeness**

The CHC-MCO is responsible for submission of data each time a Participant has an Encounter with a Provider. The CHC-MCO must have a monitoring program in place that:

- i. Demonstrates that all Claims and Encounters submitted to the CHC-MCO by the Providers, including Subcontractors, are submitted accurately and timely as Encounters to the Department. In addition, demonstrates that denied Encounters are resolved and/or resubmitted;

- ii. Evaluates Provider and Subcontractor compliance with contractual reporting requirements; and
- iii. Demonstrates the CHC-MCO has processes in place to act on information from the monitoring program and takes appropriate action to ensure full compliance with Encounter Data reporting to the Department.

The CHC-MCO must submit an annual Data Completeness Plan for advance written approval. This Plan must include the three elements listed above.

**d. Financial Sanctions**

Assessment of financial penalties is based on the identification of penalty occurrences. Encounter Data Penalty occurrences/assessments of financial penalties are outlined in Exhibit XX of this Agreement, Encounter Data Submission Requirements and Penalty Applications.

**e. Data Validation**

The CHC-MCO must assist the Department, or the Department's designee, in validation of Encounter Data by making available medical records and Claims data as requested.

**f. Release of Encounter Data**

All Encounter Data for Participants is the property of the Department. The CHC-MCO may use this data for the sole purpose of operating the CHC Program under this Agreement.

**g. Drug Rebate Supplemental File**

The CHC-MCO is required to submit a complete, accurate and timely monthly file containing supplemental data for NCPDP transactions used for the purpose of drug rebate dispute resolution. The file must be submitted by the 15<sup>th</sup> day of the month following the month in which the drug transaction was processed in PROMISe as specified on the Intranet supporting CHC.

**2. Third Party Liability Reporting**

Third Party Resources identified by the CHC-MCO or its subcontractors, which do not appear on the Department's TPL

database, must be supplied to the Department's Division of TPL within two weeks of its receipt by the CHC-MCO. The Department will contact the CHC-MCO when the validity of a resource is in question. The CHC-MCO shall verify inconclusive resource information within two (2) business days of notification by the Department that the resource information is in dispute. Unless the verification notification is requested on the last business day of the week, then the CHC-MCO must respond by the close of business that day to avoid a potential access to care issue for the Participant. The method of reporting shall be by electronic submission via a batch file or by hardcopy document, whichever is deemed most convenient and efficient by the CHC-MCO for its individual use. For electronic submissions, the CHC-MCO must follow the required report format, data elements, and tape specifications supplied by the Department. For hardcopy submissions, the CHC-MCO must use an exact replica of the TPL resource referral form supplied by the Department. Submissions lacking information key to the TPL database update process will be considered incomplete and will be returned to the CHC-MCO for correction and subsequent resubmission.

### **3. PCP Assignment**

The CHC-MCO must provide a file through the Department to (PROMISe™) of PCP assignments for all its Participants.

The CHC-MCO must provide this file at least weekly or more frequently if requested by the Department. The CHC-MCO must ensure that the PCP assignment information is consistent with all requirements specified by the Department by utilizing the response report provided by the Department. The CHC-MCO must use this report to reconcile and correct any errors. Information on the PCP file submission is available on the Intranet supporting CHC.

### **4. Provider Network**

The CHC-MCO must provide a file through the Department, to the Department's PROMISe™ contractor, of its entire Provider Network, including the network of its subcontractors.

The CHC-MCO must provide this file monthly. The CHC-MCO must ensure the information is consistent with all requirements specified by the Department by utilizing the response report provided by the Department. The CHC-MCO must use this report to reconcile and correct any errors. Information on the Provider Network file submission is available on the Intranet supporting CHC.

### **5. Alerts**

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

Enrollment/Alert file: pregnancy, death, and return mail alerts.

The CHC-MCO must provide this file weekly. The CHC-MCO must ensure the information is consistent with all requirements specified by the Department. Information on the submission of alerts on the Weekly Enrollment/Alert File is on the Intranet supporting CHC.

### **C. Operations Reporting**

The CHC-MCO is required to submit such reports as specified by the Department to enable the Department to monitor the CHC-MCO's internal operations and service delivery. These reports include, but are not limited to, the following:

#### **1. Fraud and Abuse**

The CHC-MCO must submit to the Department quarterly statistical reports which relate to its Fraud and Abuse detection and sanctioning activities regarding Providers. The quarterly report must include information for all situations where a Provider action caused an overpayment to occur. The quarterly report must identify cases under review (including approximate dollar amounts), Providers terminated due to Medicare/Medicaid preclusion, and overpayments recovered.

### **D. Financial Reports**

The CHC-MCO agrees to submit such reports as specified by the Department to assist the Department in assessing the CHC-MCO's financial viability and to ensure compliance with this Agreement.

The Department will distribute financial reporting requirements to the CHC-MCO. The CHC-MCO must furnish all financial reports timely and accurately, with content in the format prescribed by the Department. This includes, but is not limited to, the CHC financial reporting requirements issued by the Department.

### **E. Equity**

Not later than May 25, August 25, and November 25 of each agreement year, the CHC-MCO must provide the Department with:

- A copy of quarterly reports filed with PID.
- A statement that its Equity is in compliance with the Equity requirements or is not in compliance with the Equity requirements.

- If Equity is not in compliance with the Equity requirements, the CHC-MCO must supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve fiscal health.

Not later than March 10 of each agreement year, the CHC-MCO must provide the Department with:

- A copy of unaudited annual reports filed with PID.
- A statement that its Equity is in compliance with the Equity requirements or is not in compliance with the Equity requirements.
- If Equity is not in compliance with the Equity requirements, the CHC-MCO must supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve fiscal health.

#### **F. Claims Processing Reports**

The CHC-MCO must provide the Department with monthly Claims processing reports with content and in a format specified by DHS. The reports are due on the fifth (5<sup>th</sup>) calendar day of the second (2<sup>nd</sup>) subsequent month. Claims returned by a web-based clearinghouse (example- WebMD Envoy) are not considered as claims received and would be excluded from claims reports.

Failure to submit a Claims processing report timely that is accurate and fully compliant with the reporting requirements shall result in the following penalties: \$200 per day for the first ten (10) calendar days from the date that the report is due and \$1,000 per day for each calendar day thereafter.

#### **G. Presentation of Findings**

The CHC-MCO must obtain advance written approval from the Department before publishing or making formal public presentations of statistical or analytical material based on its CHC Participant.

#### **H. Sanctions**

1. The Department may impose sanctions for noncompliance with the requirements under this Agreement and failure to meet applicable requirements in Sections 1932, 1903(m), and 1905(t) of the Social Security Act and in accordance with Sections 42 CFR 438.700; 438.702; and 438.704 in addition to any penalties described in Exhibit D of this Agreement, Standard Grant Terms and Conditions for Services, and in Exhibit E of this Agreement, DHS Addendum to

Standard Contract Terms and Conditions. The sanctions which can be imposed shall depend on the nature and severity of the breach, which the Department, in its reasonable discretion, will determine as follows:

- a. Imposing civil monetary penalties of a minimum of \$1,000.00 per day for noncompliance;
  - b. Requiring the submission of a corrective action plan;
  - c. Limiting Enrollment of new Participants;
  - d. Suspension of payments;
  - e. Temporary management subject to applicable federal or state law; and/or
  - f. Termination of the Agreement: The Department has the authority to terminate a CHC-MCO Agreement and enroll that entity's Participants in another CHC-MCO or provide their Participants' Medical Assistance benefits through other options included in the State plan.
2. Where this Agreement provides for a specific sanction for a defined infraction, the Department may, at its discretion, apply the specific sanction provided for the noncompliance or apply any of the general sanctions set forth in Section VIII.H of this Agreement, Sanctions. Specific sanctions contained in this Agreement include the following:
- a. Claims Processing: Sanctions related to Claims processing are provided in Section VII D.2 of this Agreement, Sanctions.
  - b. Report or File, exclusive of Audit Reports: If the CHC-MCO fails to provide any report or file that is specified by this Agreement by the applicable due date, or if the CHC-MCO provides any report or file specified by this Agreement that does not meet established criteria, a subsequent payment to the CHC-MCO may be reduced by the Department. The reduction shall equal the number of days that elapse between the due date and the day that the Department receives a report or file that meets established criteria, multiplied by the average Per-Member-Per-Month Capitation rate that applies to the first (1<sup>st</sup>) month of the Agreement year. If the CHC-MCO provides a report or file on or before the due date, and if the Department notifies the CHC-MCO after the fifteenth (15<sup>th</sup>) calendar day after the due date that the report or file does not meet established criteria, no reduction in payment shall apply to the sixteenth (16<sup>th</sup>) day after the due date

through the date that the Department notifies the CHC-MCO.

- c. Encounter Data Reporting: The penalties related to the submission of Encounter Data are set forth in Section VIII.B of this Agreement, Systems Reports, and Exhibit XX of this Agreement, Encounter Data Submission Requirements and Penalty Applications.
  - d. Marketing: The sanctions for engaging in unapproved marketing practices are described in Section V.F.3 of this Agreement, CHC-MCO Outreach Activities.
  - e. Access Standard: The sanction for noncompliance with the access standard is set forth in Exhibit AAA of this Agreement Provider Network Composition/Service Access, Part 4, Compliance with Access Standards.
  - f. Subcontractor Prior Approval: The CHC-MCO's failure to obtain advance written approval of a Subcontract will result in the application a penalty of one (1) month's Capitation rate for a categorically needy adult female TANF consumer for each day that the subcontract was in effect without the Department's approval.
- c. Outpatient Drug Encounters: The civil monetary penalties for non-compliance with outpatient drug encounter data timeliness is set forth in Exhibit BBB, Outpatient Drug Services.

#### **I. Non-Duplication of Financial Penalties**

If the Department assesses a financial penalty pursuant to one (1) of the provisions of Section VIII.H of this Agreement, Sanctions, it will not impose a financial sanction pursuant to Section VIII.H with respect to the same infraction.

### **SECTION IX: REPRESENTATIONS AND WARRANTIES OF THE CHC-MCO**

#### **A. Accuracy of Proposal**

The CHC-MCO warrants that the representations and information in its Proposal are accurate and complete in all material respects. The CHC-MCO must notify the Department within ten (10) Business Days, of any material fact, event, or condition which arises or is discovered subsequent to the date of the submission of its Proposal, which affects the truth, accuracy, or completeness of such representations and information.

## **B. Disclosure of Interests**

The CHC-MCO must disclose to the Department information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The CHC-MCO must require its network providers to disclose complete ownership, control, and relationship information from all Network Providers.

The CHC-MCO warrants that the members of its governing body and its officers and directors have no interest and will not acquire any interest, direct or indirect, which conflicts with the performance of its services hereunder. The CHC-MCO will not knowingly employ any person having such interest.

The Department may terminate this agreement based on the CHC-MCO's failure to properly disclose required information and may recover as overpayments, any payments improperly made by the CHC-MCO.

## **C. Disclosure of Change in Circumstances**

The CHC-MCO must notify the Department in writing of all changes affecting the delivery of care, the administration of its program, or its performance of Agreement requirements. The CHC-MCO must notify the Department in writing no later than 45 days prior to any significant change to the manner in which services are rendered to Participants, including but not limited to procurement or termination of a Provider pursuant to this Agreement.

The CHC-MCO will report to the Department, as well as the Departments of Health and Insurance, within ten (10) Business Days of the CHC-MCO's notice of same, circumstances that may have a material adverse effect upon financial or operational conditions of the CHC-MCO or CHC-MCO's parent(s), including but not limited to the following:

1. Suspension, or debarment, or exclusion from federally funded healthcare programs of CHC-MCO, CHC-MCO's parent(s), or any Affiliate or Related Party of either, by any state or the federal government;
2. Having a person who is debarred or suspended, or excluded act as a director, officer, or partner of the CHC-MCO with beneficial ownership of more than five percent (5%) of the CHC-MCO's Equity who has been debarred from participating in procurement activities under federal regulations.
3. Notice of suspension or debarment or exclusion from participation in healthcare program or notice of an intent to suspend, debar, or exclude issued by any state or the federal government to CHC-MCO,

CHC-MCO's parent(s), or any Affiliate or Related Party; and

4. Any lawsuits or investigations by any federal or state agency involving CHC-MCO, CHC-MCO's parent(s), or any Affiliate or Related Party.

## **SECTION X: TERMINATION AND DEFAULT**

### **A. Termination by the Department**

The Department may terminate this agreement as provided in Section 18 of Exhibit D, Standard Grant Terms and Conditions for Services and this section.

#### **1. Termination for Convenience Upon Notice**

The Department may terminate this Agreement at any time for convenience upon giving one hundred twenty (120) days advance written notice to the CHC-MCO. The effective date of the termination shall be the last day of the month in which the one hundred twentieth (120<sup>th</sup>) day falls. The requirement of one hundred twenty days advance notice does not apply if this is replaced by another agreement to operate a CHC Program in the same zone.

#### **2. Termination for Cause**

The Department may terminate this Agreement for cause upon forty-five (45) days written notice, which notice shall set forth the grounds for termination and, with the exception of termination. The Department will provide the CHC-MCO with forty-five (45) days in which to implement corrective action and cure the deficiency. If corrective action is not implemented to the satisfaction of the Department within the forty-five (45) day cure period, the termination shall be effective at the expiration of the forty-five (45) day cure period. In addition to the provisions of Section 16 of Exhibit D, Standard Grant Terms and Conditions for Services, "default":

- a. An act of theft or Fraud against the Department, any state agency, or the Federal Government; or
- b. An adverse material change in circumstances as described in Section IX.C, Disclosure of Change in Circumstances.

#### **3. Termination Due to Unavailability of Funds/Approvals**

### **B. Termination by the CHC-MCO**

The CHC-MCO may terminate this Agreement upon giving one hundred twenty (120) days advance written notice to the Department. The effective date of the termination shall be the last day of the month in which the one hundred twentieth (120<sup>th</sup>) day falls.

## **C. Responsibilities of the CHC-MCO Upon Termination**

### **1. Continuing Obligations**

Termination or expiration of this Agreement shall not discharge the CHC-MCO of obligations with respect to services or items furnished prior to termination, including retention of records and verification of overpayments or underpayments. The Department's payment obligations to the CHC-MCO or the CHC-MCO's payment obligations to its subcontractors and Providers for services provided prior to the termination or expiration of this agreement survive the termination or expiration.

Upon any termination or expiration of this Agreement, in accordance with the provisions in this section, the CHC-MCO must:

- a. Provide the Department with all information deemed necessary by the Department within thirty (30) days of the request;
- b. Be financially responsible for MA Claims with dates of service through the expiration or termination, except as provided in c. below, including those submitted within time limits;
- c. Be financially responsible for hospitalized patients through the date of discharge or thirty-one (31) days after termination or expiration of this Agreement, whichever is earlier;
- d. Be financially responsible for services rendered through 11:59 p.m. on the date of termination, except as provided in c. above or f. below, for which payment is denied by the CHC-MCO and subsequently approved upon appeal by the Provider;
- e. Be financially responsible for Participant appeals of adverse decisions rendered by the CHC-MCO concerning services requested prior to termination or expiration that would have been provided but for the denial which are overturned at a DHS Fair Hearing or Grievance proceeding; and
- f. Arrange for the orderly transfer of patient care and patient records to those Providers who will be assuming care for the

Participants.

## **2. Notice to Participants**

If this Agreement is terminated, or expires without a new Agreement in place, the CHC-MCO must notify all Participants of such termination or expiration at least forty-five (45) days in advance of the effective date of termination or expiration, if practical. The CHC-MCO must make notices available in an accessible format for participants with visual impairments and in the relevant language for Participants with limited English proficiency. The CHC-MCO must coordinate the continuation of care prior to termination or expiration for Participants who are undergoing treatment for an acute condition.

## **3. Submission of Invoices**

Upon termination or expiration, the CHC-MCO must submit to the Department all outstanding invoices for allowable services rendered prior to the date of termination in the form stipulated by the Department no later than forty-five (45) days from the effective date of termination or expiration. The Department will not make payment for invoices submitted after forty five (45) days. This does not apply to submissions and payments in Appendices 3a – 3g.

## **4. Termination Requirements**

Within 180 days of expiration or termination of the Agreement, the CHC-MCO must also provide the Department with all outstanding Encounter Data. The Department will withhold ten percent (10%) of one (1) month's Capitation payment until the Department determines that the CHC-MCO has complied with this requirement. The Department will not unreasonably delay or deny a determination of compliance. The Department will provide its determination to the CHC-MCO by the first (1<sup>st</sup>) day of the fifth (5<sup>th</sup>) month after the Agreement ends. If the Department determines that the CHC-MCO has not complied, the Department will provide subsequent determinations by the first (1<sup>st</sup>) day of each subsequent month.

## **D. Transition at Expiration or Termination of Agreement**

If the CHC-MCO and the Department have not entered into a new Agreement, the Department will develop a transition plan. During the transition period, the CHC-MCO must comply with the requirements of the plan and must cooperate with any subsequent CHC-MCO and the Department. The Department will consult with the CHC-MCO regarding the transition plan, including information requirements and relationship between the CHC-MCOs. The length of the transition period shall be no less than three (3) months and no more than six (6) months in duration.

The CHC-MCO is responsible for the costs relating to the transfer of materials and responsibilities as a normal part of doing business with the Department.

The Department will define the information required during this period and time frames for submission, and may solicit input from the CHC-MCOs involved.

## **SECTION XI: RECORDS**

### **A. Financial Records Retention**

1. The CHC-MCO must maintain and must cause its subcontractors to maintain all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity pursuant to this Agreement in accordance with the standards and procedures specified in Section V.O.5 of this Agreement, Records Retention.
2. The CHC-MCO agrees to include the requirements set forth in Section XIII in this Agreement, Subcontractual Relationships, in all contracts it enters with subcontractors under the CHC Program, and to ensure that all persons and/or entities with whom it so contracts agree to comply with said provisions.

### **B. Operational Data Reports**

The CHC-MCO must maintain and must cause its subcontractors to maintain all source records for data reports in accordance with the procedures specified in Section V.O.5 of this Agreement, Records Retention.

### **C. Medical Records Retention**

The CHC-MCO must maintain and must cause its subcontractors to maintain all medical records in accordance with the procedures outlined in Section V.O.5 of this Agreement, Records Retention.

The CHC-MCO must provide Participants' medical records, subject to this Agreement, to the Department or its contractor(s) within twenty (20) Business Days of the Department's request. Copies of such records must be mailed to the Department if requested.

### **D. Review of Records**

1. The CHC-MCO must make all records relating to the CHC Program, including but not limited to the records referenced in this Section,

available for audit, review, or evaluation by the Department, federal agencies or their designees. Such records shall be made available on site at the CHC-MCO's chosen location, subject to the Department's approval, during normal business hours or through the mail. The Department will, to the extent required by law, maintain as confidential any confidential information provided by the CHC-MCO.

2. In the event that the Department or federal agencies request access to records, subject to this Agreement, after the expiration or termination of this Agreement or at such time that the records no longer are required by the terms of this Agreement to be maintained at the CHC-MCO's location, but in any case, before the expiration of the period for which the CHC-MCO is required to retain such records, the CHC-MCO, at its own expense, must send copies of the requested records to the requesting entity within thirty (30) days of such request.

## **SECTION XII: SUBCONTRACTUAL RELATIONSHIPS**

### **A. Compliance with Program Standards**

With the exception of Provider Agreements, the CHC-MCO must comply with the procedures set forth in Section V.O.3, Contracts and Subcontracts and in Exhibit II, Required Contract Terms for Administrative Subcontractors.

Prior to the award of a contract or Subcontract, the CHC-MCO must disclose to the Department in writing information on ownership interests of five percent (5%) or more in any entity or Subcontractor.

All contracts and Subcontracts must be in writing and must contain all items as required by this Agreement.

The CHC-MCO must require its subcontractors to provide written notification of a denial, partial approval, reduction, or termination of service or coverage, or a change in the level of care, according to the standards outlined in Exhibit M(1), Quality Management and Utilization Management Program Requirements using the denial notice templates provided on the Intranet supporting CHC. In addition, the CHC-MCO must include in its contracts or Subcontracts that cover the provision of medical services to the CHC-MCO's Participants the following provisions:

1. A requirement for cooperation with the submission of all 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.

2. Language which requires compliance with all applicable federal and state laws.
3. Language which prohibits gag clauses which would limit the subcontractor from disclosure of Medically Necessary or appropriate health care information or alternative therapies to Participants, other Health Care Providers, or to the Department.
4. A requirement that ensures that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Participants.
5. The definition of Medically Necessary as outlined in Section II of this Agreement, Definitions.
6. The CHC-MCO must require, if applicable, that its Subcontractors adhere to the standards for Network composition and adequacy.
7. Should the CHC-MCO use a subcontracted utilization review entity, the CHC-MCO must require that its subcontractors process each request for benefits in accordance with Section V.B.1 of this Agreement, General Prior Authorization Requirements.
8. Should the CHC-MCO subcontract with an entity to provide any information systems services, the Subcontract must include provisions for a transition plan in the event that the CHC-MCO terminates the Subcontract or enters into a Subcontract with a different entity. This transition plan must include information on how the data shall be converted and made available to the new subcontractor. The data must include all historical Claims and service data.

The CHC-MCO must make all necessary revisions to its Subcontracts to be in compliance with the requirements set forth in Section XIII.A of this Agreement, Compliance with Program Standards. Revisions may be completed as contracts and Subcontracts become due for renewal provided that all contracts and Subcontracts are amended within one (1) year of execution of this Agreement with the exception of the Encounter Data requirements, which must be amended immediately, if necessary, to ensure that all subcontractors are submitting Encounter Data to the CHC-MCO within the time frames specified in Section VIII.B of this Agreement, Systems Reports.

## **B. Consistency with Regulations**

The CHC-MCO must require all subcontracts to be consistent, as may be

applicable, with Department of Health regulations governing HMO Contracting with Integrated Delivery Systems at 28 Pa. Code §§ 9.721 – 9.725 and Pennsylvania Insurance Department regulations at 31 Pa. Code §§ 301.301 – 301.314.

### **SECTION XIII: CONFIDENTIALITY**

- A. The CHC-MCO must comply with all applicable federal and state laws regarding the confidentiality of Participant records, including medical records. The CHC-MCO must also cause each of its subcontractors to comply with all applicable federal and state laws regarding the confidentiality of medical records. The CHC-MCO must comply with the Management Information System and System Performance Review (SPR) Standards, available on the Intranet supporting CHC, regarding maintaining confidentiality of data. The federal and state laws with regard to confidentiality of medical records include, but are not limited to: Mental Health Procedures Act, 50 P.S. 7101 et seq.; Confidentiality of HIV-Related Information Act, 35 P.S. 7601 et seq.; 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information); and the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. 1690.101 et seq., 42 U.S.C. 1396a(a)(7); 62 P.S. 404; 55 Pa. Code 105.1 et seq.; and 42 CFR 431 et seq.
- B. The CHC-MCO must be liable for any state or federal fines, financial penalties, or damages levied upon the Department for a breach of confidentiality due to the negligent or intentional conduct of the CHC-MCO in relation to the CHC-MCO's systems, staff, or other area of responsibility.
- C. The CHC-MCO agrees to return all data and material obtained in connection with this Agreement and the implementation thereof, including confidential data and material, at the Department's request. No material can be used by the CHC-MCO for any purpose after the expiration or termination of this Agreement. The CHC-MCO also agrees to transfer all such information to a subsequent CHC-MCO at the direction of the Department.
- D. The CHC-MCO is entitled to receive all information relating to the health status of its Participants in accordance with applicable confidentiality laws.

### **SECTION XIV: INDEMNIFICATION AND INSURANCE**

#### **A. Indemnification**

- 1. In addition to Section 14 of Exhibit D, Standard Grant Terms and Conditions for Services, the CHC-MCO must indemnify and hold the Department and the Commonwealth of Pennsylvania, their respective employees, agents, and representatives harmless against any and all liabilities, losses, settlements, Claims, demands,

and expenses of any kind (including, but not limited to, attorneys' fees) which may result or arise out of any dispute by and between the CHC-MCO and its subcontractors with Participants, agents, clients, in the performance or omission of any act or responsibility assumed by the CHC-MCO pursuant to this Agreement.

2. In addition to Section 14 of Exhibit D, Standard Grant Terms and Conditions for Services, the CHC-MCO must indemnify and hold harmless the Department and the Commonwealth of Pennsylvania from any audit disallowance imposed by the federal government resulting from the CHC-MCO's failure to follow state or federal rules, regulations, or procedures unless prior authorization was given by the Department. The Department shall provide timely notice of any disallowance to the CHC-MCO and allow the CHC-MCO an opportunity to participate in the disallowance appeal process and any subsequent judicial review to the extent permitted by law. Any payment required under this provision shall be due from the CHC-MCO upon notice from the Department. The indemnification provision hereunder shall not extend to disallowances which result from a determination by the federal government that the terms of this Agreement are not in accordance with federal law. The obligations under this paragraph shall survive any termination or cancellation of this Agreement.

## **B. Insurance**

The CHC-MCO must maintain for itself, each of its employees, agents, and representatives, general liability and all other types of insurance in such amounts as reasonably required by the Department and all applicable laws. In addition, the CHC-MCO must require that each of the Network Providers with which the CHC-MCO contracts maintains professional malpractice and all other types of insurance in such amounts as required by all applicable laws. The CHC-MCO must provide to the Department, upon the Department's request, certificates evidencing such insurance coverage.

## **SECTION XV: DISPUTES**

In the event of a dispute between the parties to this Agreement, the Project Officer for the Department will make a determination in writing of his or her interpretation and will send the determination to the CHC-MCO. The determination is final and binding on the CHC-MCO and unreviewable unless the CHC-MCO files a written appeal with the Department's Bureau of Hearings and Appeals. The CHC-MCO must file an appeal of an appealable agency action regarding this agreement in accordance with 67 Pa.C.S. §§101-11006 and implementing regulations at 55 Pa.Code Chapter 41.

## **SECTION XVI: GENERAL**

**A. Suspension From Other Programs**

If the CHC-MCO learns that a Network Provider is suspended or excluded from participation in any federally funded healthcare Program of this or another state or the federal government the CHC-MCO must promptly notify the Department, in writing, of such suspension or exclusion.

The CHC-MCO may not make any to a Provider for services rendered during the period in which the Provider was suspended excluded from participation in any federally funded healthcare program.

**B. Rights of the Department and the CHC-MCO**

The rights and remedies of the Department provided herein shall not be exclusive and are in addition to any rights and remedies provided by law.

Except as otherwise stated in Section XVI of this Agreement, Disputes, the rights and remedies of the CHC-MCO provided herein shall not be exclusive and are in addition to any rights and remedies provided bylaw.

**C. Invalid Provisions**

Any provision of this Agreement which is in violation of any state or federal law or regulation shall be deemed amended to conform with such law or regulation, pursuant to the terms of this Agreement, except that if such change would materially and substantially alter the obligations of the parties under this Agreement, any such provision shall be renegotiated by the parties. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions hereof.

**D. Notice**

Any written notice to any party under this Agreement shall be deemed sufficient if delivered personally, or by facsimile, telecopy, electronic or digital transmission (provided such delivery is confirmed), or by recognized overnight courier service (e.g., DHL, Federal Express, etc.), with confirmed receipt, or by certified or registered United States mail, postage prepaid, return receipt requested, sent to the address set forth below or to such other address as such party may designate by notice given pursuant to this section:

To the Department via U.S. Mail:

Department of Human Services  
Director, Bureau of Managed Care Operations  
P.O. Box 2675  
Harrisburg, Pennsylvania 17105

To the Department via UPS, FedEx, DHL or other delivery service:

Department of Human Services  
Director, Bureau of Managed Care Operations

With a Copy to:

Department of Human Services  
Office of Legal Counsel  
3rd Floor West, Health and Welfare Building  
625 Forster Street  
Harrisburg, Pennsylvania 17120  
Attention: Chief Counsel

To the CHC-MCO – See Appendix 4 of this Agreement, CHC-MCO Information, for name and address.

**E. Counterparts**

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

**F. Headings**

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

**G. No Third Party Beneficiaries**

This Agreement does not, nor is it intended to, create any rights, benefits, or interest to any third party, person, or organization.

CY 2017 Community HealthChoices Agreement DRAFT

**EXHIBIT A  
Managed Care Regulatory Compliance Guidelines**

The following apply to all managed care organizations under contract with the Office of Long-Term Living:

- All federal and state laws, including but not limited to 55 Pa.Code Chapters 52 and 1101-1249
- Non-compensable or non-covered services (managed care organizations may provide additional services beyond Medical Assistance Fee for Service (FFS), but must cover, at a minimum, those services on the fee schedule in the same amount, duration and scope as the Fee for Service Program.)
- Scope of Benefits based on Participant’s eligibility (as determined by the County Assistance Office)
- Staff/Provider Licensing/Scope of Practice Requirements
- Frequency of service
- Program standards/quality of care standards
- Provider participation (enrolled as an Medical Assistance Participating Provider)
- Utilization review
- Administrative sanctions
- Definitions

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

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

Where the managed care agreement conflicts with 55 Pa.Code, the agreement is the controlling document.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
<b>Managed care organizations must comply with and require their Long term living home and community-based network service providers to comply with the provisions of 55 Pa.Code Chapter 52, Long-Term Living Home and Community-Based Services, with the following exceptions:</b>	
52.21 Staff training	Outlines the minimum training requirements for providers and provider staff
52.26 (e)	(e) If the SCE is an OHCDS, then the SCE shall be a direct service provider of at least one vendor good or service.
52.27	Service Coordinator Qualifications and Training

52.28 (a)(1) and (b)	(a)(1) The SCE is providing the service as an OHCDS under §52.53 (b) If an SCE operates as an OHCDS, then the SCE may not require a participant to use that OHCDS as a condition to receive the service coordination services of the SCE.
52.41	Provider Billing
52.42	Payment Policies
52.45	Fee Schedule Rates
52.51	Vendor Good or Service Payment
52.52	Subcontracting for a Vendor Good or Service
52.53	Organized Health Care Delivery System
52.64	Payment Sanctions

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
<b>Managed care organizations must comply with and required their network providers to comply with the provisions of 55 Pa.Code Chapter 1101, General Provisions, with the following exceptions:</b>	
1101.21 Definition of "Prior Authorization"	Definitions
1101.21 Definition of "Shared Health Facility", (iv) and (v)	(iv) At least one practitioner receives payment on a fee for service basis. (v) A Provider receiving more than \$30,000 in payment from the Medical Assistance Program during the 12-month period prior to the date of the initial or renewal application of the shared health facility for registration in the Medical Assistance Program.
1101.21 Definition of "Medically Necessary"	A service, item, procedure or level of care that is: (i) Compensable under the Medical Assistance Program. (ii) Necessary to the proper treatment or management of an illness, injury or disability. (iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.
1101.31(b) (13) "...Dental Services as specified in Chapter 1149 (relating to Dentists' Services)."	Benefits, Scope for categorically needy
1101.31(f) Note: The managed care organizations are not required to impose limits that apply in the Fee-for-Service delivery system, although they are permitted to do so. The managed care organizations may not impose limits that are more restrictive than the limits established in the Fee-for-Service system. If the managed care organizations impose limits, their exception process cannot be more restrictive than the process established in §1101.31(f).	Benefits, Exceptions (for limits specified in subsections (b) and (e) - FFS Program Exception Process
1101.33(a) "...If the applicant is determined to be eligible, the Department issues Medical Services Eligibility (MSE) cards that are effective from the first of the month through the last day of the month..."	Recipient Eligibility, Verification of Eligibility (issuance of card)
1101.33(b)	Recipient Eligibility, Services restricted to a single Provider
1101.51(a)	Responsibilities, Ongoing responsibilities of Providers, Recipient freedom of choice of Providers
1101.61	Fees and Payments, Reimbursement policies.
1101.62	Maximum fees
1101.63(b)(1) through (10)	Payment in full, Copayments for Medical Assistance services
1101.63(c)	Payment in full, Medical Assistance deductible
1101.64(b) "...Payment will be made in accordance with established Medical Assistance rates and fees."	Third-party medical resources, Persons covered by Medicare and MA
1101.65	Method of payment
1101.67	Prior Authorization (including timeframes for notice)
1101.68	Invoicing for services
1101.69	Overpayment – underpayment (related to Providers)
1101.69(a)	Establishment of a uniform period for the recoupment of overpayments from Providers (COBRA)
1101.72	Invoice adjustment
1101.83	Restitution and repayment (related to Providers for payments that should not have been made)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
<b>Managed care organizations are not required to adhere to the provisions of 55 Pa.Code Chapter 1102, Shared Health Facilities. Managed care organizations are responsible for establishing their own Provider networks.</b>	
<b>Managed care organizations must comply with and require their network pharmacy providers to comply with the provisions of 55 Pa.Code Chapter 1121, Pharmaceutical Services, with the following exceptions:</b>	
1121.2	Definitions of AWP, Compounded Prescription, Pricing Service, Federal Upper Limit, CMS Multi-source Drug, State MAC, and Usual and Customary Charge
1121.52(a)(6)	Payment conditions for various services (indication for “brand medically necessary”)
1121.52(b)	Payment conditions for various services (prenatal vitamins)
1121.53(a)	Limitations on payment (not exceeding UCC to general public)
1121.53(b)(1)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(b)(2)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(c)	Limitations on payment (34 day supply or 100 units, total authorization not exceeding 6 months’ or five refill supply)
1121.53(f)	Limitations on payment (Payment to pharmacy for prescriptions dispensed to a recipient in either a skilled nursing facility, an intermediate care facility or an intermediate care facility for the mentally retarded and specific scripts not included in the limitation)
1121.55	Method of payment. (relating to the Department’s payment to pharmacies)
1121.56	Drug cost determination.
<b>Managed care organizations must comply with and require their network providers of medical supplies to comply with the provisions of 55 Pa.Code Chapter 1123, Medical Supplies, with the following exceptions:</b>	
1123.1 “and the Medical Assistance Program fee schedule”	Policy. (Payment for medical supplies is subject to this chapter, Chapter 1101 (relating to general provisions) and the limitations established in Chapter 1150 (relating to Medical Assistance Program payment policies) and the Medical Assistance Program fee schedule.
1123.13(a) and (b).	Inpatient services.
1123.22(1).	Scope of benefits for the medically needy. (“Medical supplies which have been prescribed through the School Medical Program...”)
1123.51 “and the Medical Assistance Program fee	Payment for Medical Supplies. General payment policy.
1123.53	Hemophilia products.
1123.54 “in accordance with the limitations described in this section and the maximum fees listed in Chapter 1150 (relating to Medical Assistance program payment policies) and the Medical Assistance Program fee schedule”	Orthopedic shoes, molded shoes and shoe inserts (Relating to payment when prescribed for eligible persons to approved Medical Assistance Providers)
1123.54(1) through (5).	Orthopedic shoes, molded shoes and shoe inserts (Relating to prior approval, conditions for payment, payment for modifications necessary for the application of a brace or splint, payment for repairs w/o a prescription or prior authorization, and payment for orthopedic shoes only if the recipient is 20 years of age or younger.”
1123.55(a) “The prescription shall contain the cardiopulmonary diagnosis”	Oxygen and related equipment. (Relating to payment conditions)
1123.55(b) and (c).	Oxygen and related equipment. (Relating to prior authorization and prescription inclusion requirements)
1123.55(d) “and recertification shall be kept by the Provider”	Oxygen and related equipment. (“A physician shall recertify orders for oxygen at least every 6 months and recertification shall be kept by the Provider.”)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1123.56(a)(1) through (3)	Vision aids. ("Payment for eyeglasses is made only if the recipient is 20 years of age or younger and the eyeglasses have been one of the following...")
1123.56(b)(1) through(3)	Vision aids. ("Payment for low vision aids is made only if the recipient is categorically needy or if the recipient is medically needy and the low vision aid has been one of the following...")
1123.56(c)	Vision aids. ("Payment for eye prostheses will be made only if the recipient is categorically needy.")
1123.58(1) and (2)	Prostheses and orthoses.
1123.60(a) through (i)	Limitations on payments.
1123.61 (1) through (8) and (10)	Noncompensable services and items. (Relating to when payment will not be made. (9) is not excluded, as it relates to items prescribed or ordered by a practitioner who has been barred or suspended during an administrative action from participation in the Medical Assistance Program.)
1123.62	Method of payment.
<b>Managed care organizations are not required to adhere to the provisions of <u>Medical Assistance Bulletin 05-86-02</u>, Durable Medical Equipment Warranties.</b>	
<b>Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 05-87-02</u>, Coverage of Motorized Wheelchairs, with the following exceptions: - requiring Prior Authorization at the State level. - Page 2, number 7.</b>	
<b>Managed care organizations are to adhere to the provisions of <u>Medical Assistance Bulletin 1123-91-01</u>, EPSDT – OBRA '89 with the following exceptions: - Page 3 – Vision Services – the “age of 21” and the Medical Assistance fee schedule do not apply. - Page 3 – Dental Services – the “age of 21” and the Medical Assistance fee schedule do not apply. - Page 3 – Hearing Services – the “age of 21” and the Medical Assistance fee schedule do not apply. - Page 3 – “and use of existing Medical Assistance Program Fee Schedule”</b>	
<b>Managed care organizations are not required to adhere to the provisions of <u>Medical Assistance Bulletin 05-85-02</u>, Policy Clarification for Services Provided to Hospitalized Recipients Under the DRG Payment System.</b>	
<b>Managed care organizations must comply with and require their network ambulatory surgical center and hospital short procedure unit providers to comply with the provisions of 55 Pa.Code Chapter 1126, Ambulatory Surgical Center and Hospital Short Procedure Unit Services, with the following exceptions:</b>	
1126.51(f) through (h) and (k) through (m)	Payment for Same Day Surgical Services. General payment policy. ((f-h)Relating to submission of invoices to the Department, consideration if ASC or SPU has fee schedule based on patient's ability to pay that the Department will consider it as the usual and customary charge, and the Department's payment being the lesser of the facility's charge to general public to be the most frequent charge to the self-paying public for the same service.) and (k-m relating to payment when patient in conjunction with same day service are transferred to a hospital due to complications and when patients due to complications must be transferred to inpatient hospital care)
1126.52(a) and (b)	Payment criteria. (Relating to the Department's maximum reimbursement and developed fees.)
1126.53(b)	Limitations on covered procedures. (Relating to limits for appropriate same day surgical procedures for same day surgery but are not yet included in the established list of covered ASC/SPU services.)
1126.54(a)(7)	Procedures and medical care performed in connection with sex reassignment.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1126.54(a)(11) through (13) and (b)	Noncompensable services and items. (“...The Department does not pay ASCs and SPUs for services directly or indirectly related to, or in conjunction with...diagnostic tests and procedures that can be performed in a clinic or practitioner’s office and diagnostic tests and procedures not related to the diagnosis”; “Services and items for which full payment equal to or in excess of the Medical Assistance fee is available through Medicare or other financial resources or other health insurance programs”; “Services and items not ordinarily provided to the general public”; and “...if the admission to the ASC or SPU is not certified under the Department’s utilization review process applicable to the type of Provider furnishing the
<b>Managed care organizations must comply with and must require their network Birth Center providers to comply with the requirements of 55 Pa.Code Chapter 1127, Birth Center Services, with the following</b>	
1127.51(d)	Payment for Birth Center Services. General payment policy. (“Claims shall be submitted to the Department under the Provider handbook.”)
1127.52(a) through (c)	Payment criteria. (Relating to the Department’s establishment of maximum reimbursement fees and payment methodology)
1127.52(d) “The birth center visit fee shall be the amount equal to that of the midwives’ or physicians’ visit fee under the Medical Assistance Program fee	Payment criteria. (Relating to termination of birth center services during prenatal care)
1127.52(e) “The amount of the payment is 50% of the third trimester rate of payment.”	Payment criteria (to payment if complications develop during labor and patient is transferred to a hospital)
1127.53(c)	Limitations on payment.
<b>Managed care organizations must comply with and must require their network renal dialysis facility providers to comply with the provisions of 55 Pa.Code Chapter 1128, Renal Dialysis Facilities, with the</b>	
1128.51(a) “and the Medical Assistance Program fee schedule”	Payment for Renal Dialysis Services. General payment policy.
1128.51(b)	General payment policy. (“A fee determined by the Department is paid for support services provided to an eligible recipient during the course of a dialysis procedure.”)
1128.51(c) “and for billings”	General payment policy. (“The dialysis facility is considered the Provider regardless of whether the facility is operated directly by the enrolled Provider or through contract between the Provider and other organizations or individuals. The enrolled Provider is responsible for the delivery of the service and for billings.”)
1128.51(d) “up to the amount of the Medical Assistance fee, if the Medicare 80% payment and the amount billed to Medical Assistance does not exceed the	General payment policy. (“The Department will pay for the unsatisfied portion of the Medicare deductible and remaining 20% coinsurance up to the amount of the Medical Assistance fee, if the Medicare 80% payment and the amount billed to Medical Assistance does not exceed the
1128.51(f) through (i), (k) and (l)	General payment policy. (Relating to what is included in the fee paid to the facility, procedures fees are applicable to, Department’s consideration of Provider’s usual and customary charge if facility has a fee schedule based on patient’s ability to pay, and the Department’s payment for dialysis services shall be considered payment in full.)
1128.51(m) “Payment shall be made in accordance with §1128.52 (relating to payment criteria).”	General payment policy. (“If a dialysis facility voluntarily terminates the Provider agreement, payment is made for services provided prior to the effective date of the termination of the Provider agreement. Payment shall be made in accordance with §1128.52 (relating to payment criteria).”)
1128.51(n)	General payment policy. (Relating to payment to out-of-State dialysis facility.)
1128.52	Payment criteria.
1128.53(a) through (e)	Limitations on payment.
1128.53(f) “Payment for backup visits to the facility is limited to no more than 15 in one calendar year”	Limitations on payment.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1128.53(g)	Limitations on payment. (Relating to payment for nonexpendable equipment or installation of equipment necessary for home dialysis)
1128.54(1)	Noncompensable services and items. (“The Department does not pay dialysis facilities for: (1) Services that do not conform to this chapter.”)
1128.54(4) through (7)	Noncompensable services and items. (Relating to Diagnostic or therapeutic procedures solely for experimental, research or educational purposes; procedures not listed in the Medical Assistance Program fee schedule; services that are not medically necessary; and services provided to recipients who are hospital inpatients.)
<b>Managed care organizations must comply with and must require their network rural health clinic providers to comply with the provisions of 55 Pa.Code Chapter 1129, Rural Health Clinic Services, with the following exceptions:</b>	
1129.51(b) and (c)	Payment for Rural Health Clinic Services. General payment policy. (Relating to payment for rural health clinic services made on the basis of an all-inclusive visit fee established by the Medicare carrier. When the cost for a service provided by the clinic is included in the established visit fee, the practitioner rendering the service shall not bill the Medical Assistance Program for it separately; and adjustment to the all-inclusive visit fee when Medicare determines the difference between the total payment due and the total payment made. The Department will make a lump sum payment for the amount due.)
1129.52	Payment policy for Provider rural health clinics.
1129.53	Payment policy for independent rural health clinics.
<b>Managed care organizations must comply with and must require their network hospice providers to comply with 55 Pa.Code Chapter 1130, Hospice Services, with the following exceptions:</b>	
1130.22(4) “...Department’s...specified in Appendix A.” <b>Note: The Provider must have a Certification of Terminal Illness form containing the information found in Appendix A. The Provider is not required to use the Department’s Certification of Terminal Illness form.</b>	Duration of coverage. Certification form. (Relating to certification of terminal illness carried out using the Department’s certification of terminal illness form.)
1130.41(a) “...specified in Appendix B.” <b>NOTE: The Provider must have an Election statement containing the information found in Appendix B. The Provider is not required to use the Department’s Election statement.</b>	Election of hospice care. Election statement. (Relating to filing of the Election statement by the recipient or recipient’s representative.)
1130.41(c) “specified in Appendix C.” <b>Note: The Provider must have a Change of Hospice statement containing the information found in Appendix C. The Provider is not required to use the Department’s Change of Hospice statement.</b>	Election of hospice care. Change of designated hospice. (Relating to the ability to the ability to change hospices once in each certification period.)
1130.42(a) “specified in Appendix D.” <b>Note: The Provider must have a Revocation statement containing the information found in Appendix D. The Provider is not required to use the Department’s Revocation statement.</b>	Revocation of hospice care. Right to revoke. (Relating to the ability of the recipient or recipient’s representative to revoke the election of hospice care at any time utilizing the revocation statement.)

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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.54(a)(1) through (3)	Payment conditions for inpatient services. (Relating to when a physician is eligible to bill the Department for services provided to a hospitalized recipient.)
1141.54(f)	Payment conditions for inpatient services. (Relating to inpatient physicians' services billed to the Department shall be performed by the physician, an RN, PA or midwife under the physician's direct supervision.)
1141.55(b)(1) "MA 31"; "in accordance with all instructions in the Provider Handbook"; and "See Appendix A for a facsimile of the Consent Form and the Provider Handbook for detailed instructions on its completion." <b>NOTE: A consent form is required and must contain all the information found in Appendix A.</b>	Payment conditions for sterilizations. (Relating to consent requirements and use of the MA31 Consent Form.)
1141.55(c) "MA 31"  1141.55(c)(2) "in accordance with instructions in the Provider Handbook"  1141.55(c)(3) "in accordance with instructions in the Provider Handbook"	Payment conditions for sterilizations. ("A Consent Form, Medical Assistance 31, is considered to be completed correctly only if all of the following requirements are met:")  Payment conditions for sterilizations. ("The person obtaining informed consent has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given."  Payment conditions for sterilizations. ("Any other witness or interpreter has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given.")
1141.56(a)(3) "See the Provider Handbook for a facsimile of the Patient Acknowledgement Form for Hysterectomy, Medical Assistance 30, and for instructions on its completion."	Payment conditions for hysterectomies. (Relating to Patient Acknowledgement Form for Hysterectomy Medical Assistance 30)
1141.57(a)(2) "and the incident was reported to a law enforcement agency or to a public health service within 72 hours of its occurrence in the case of rape and within 72 hours of the time the physician notified the patient that she was pregnant in the case of incest. A law enforcement agency means an agency or part of an agency that is responsible for the enforcement of the criminal laws, such as a local police department or sheriff's office. A public health service means an agency of the Federal, State, or local government or a facility certified by the Federal government as a Rural Health Clinic that provides health or medical services except for those agencies whose principal function is the performance of abortions."	Payment conditions for necessary abortions (Where the recipient was the victim of rape or incest)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
<p>1141.57(a)(2)(i) "with the Medical Services Invoice along with documentation signed by an official of the law enforcement agency or public health service to which the rape or incest was reported. The documentation shall include the following":</p> <p>1141.57(a)(2)(i)(A) and (B)</p>	<p>Payment conditions for necessary abortions (Payment will be made only if a licensed physician submits a signed "Physician Certification for an Abortion" form, as set forth in Appendix B.)</p> <p>(A) All of the information specified in subparagraph (ii).</p> <p>(B) A statement that the report was signed by the person making the report.</p>
<p>1141.57(a)(2)(ii)(A) through (D)</p>	<p>Payment conditions for necessary abortions (report of rape or incest)</p>
<p>1141.57(c)</p>	<p>Abortions after the first 12 weeks</p>
<p>1141.59(1) through (5)</p>	<p>Payment for Physician Services, Noncompensable services, Procedures not listed in the Medical Assistance program fee schedule. Medical services or surgical procedures performed on an inpatient basis that could have been performed in the physician's office, the clinic, the emergency room, or a short procedure unit without endangering the life or health of the patient, Medical or surgical procedures designated in the Medical Assistance program fee schedule as outpatient procedures, Dental rehabilitation and restorative services, Diagnostic tests, for which a patient was admitted, that may be performed on an outpatient basis; tests not related to the diagnosis and treatment of the illness for which the patient was admitted; tests for which there is no medical justification.</p>
<p>1141.59(7) and (8)</p>	<p>Payment for Physician Services, Noncompensable services, Hysterectomy performed solely for the purpose of rendering an individual incapable of reproducing, Acupuncture, medically unnecessary surgery, insertion of penile prosthesis, gastroplasty for morbid obesity, gastric stapling or ileo-jejunal shunt—except when all other types of treatment of morbid obesity have failed—</p>
<p>1141.59(10) and (11)</p>	<p>Services to inpatients that no longer require acute inpatient care and surgical procedures and medical care provided in connection with sex reassignment.</p>
<p>1141.59 (14) through (16)</p>	<p>Diagnostic pathological examinations of body fluids or tissues, Services and procedures related to the delivery within the antepartum period and postpartum period, Medical services or surgical procedures performed in a short procedure unit that could have been appropriately and safely performed in the physician's office, the clinic, or the emergency room without endangering the life or health of the patient.</p>
<p>1141.60</p>	<p>Payment for medications dispensed or ordered in the course of an office visit.</p>
<p><b>Managed care organizations must comply with and must require their network midwife providers to comply with the requirements of 55 Pa.Code Chapter 1142, Midwives' Services, with the following exceptions:</b></p>	
<p>1142.51 "and the Medical Assistance payment fee</p>	<p>General payment policy for Midwife services</p>
<p>1142.52(2) "billed to the Department"</p>	<p>General payment policy for Midwife services</p>
<p>1142.55(1) through (4)</p>	<p>Noncompensable Midwife services. Procedures not listed in the fee schedule in the Medical Assistance Program fee schedule, More than 12 midwife visits per recipient per 365 days. Services and procedures furnished by the midwife for which payment is made to an enrolled physician, rural health clinic, hospital or independent medical clinic. Services and procedures for which payment is available through other public agencies or private insurance plans as described in § 1101.64 (relating to third party medical resources (TPR)).</p>
<p><b>Managed care organizations must comply with and must require their network podiatrist providers to comply with the requirements of 55 Pa.Code Chapter 1143, Podiatrists' Services, with the following exceptions:</b></p>	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1143.2 Definition of "Medically-necessary"	A term used to describe those medical conditions for which treatment is necessary, as determined by the Department, and which are compensable under the Medical Assistance Program.
1143.2 Definition of "Non-emergency medical services."	A compensable podiatrists' service provided for conditions not requiring immediate medical intervention in order to sustain the life of the person or to prevent damage to health.
1143.51 "and the Medical Assistance Program fee schedule" and "as specified in	General Payment Policy
1143.53	Payment conditions for outpatient services.
1143.54	Payment conditions for inpatient hospital services.
1143.55(1),(2) and (4)	Payment conditions for diagnostic X-ray services performed in the podiatrist's office.
1143.56	Payment conditions for orthopedic shoes, molded shoes and shoe inserts (enrolled medical suppliers). Refers to 1123.54
1143.57	Limitations on payment for podiatrist visits and x-rays.
1143.58(a)(1) through (12)	Noncompensable services and items for podiatry services. (1) Services and items not listed in the Medical Assistance Program fee schedule. (2) Fabricating or dispensing orthopedic shoes, shoe inserts and other supportive devices for the feet. (3) Casting for shoe inserts. (4) Medical services or surgical procedures performed on an inpatient basis that could have been performed in the podiatrist's office, the emergency room, or a short procedure unit without endangering the life or health of the patient. (5) Medical or surgical procedures designated in the fee schedule in Chapter 1150 (relating to Medical Assistance Program payment policies) and the Medical Assistance Program fee schedule as outpatient procedures. (6) Medical services or surgical procedures performed on an inpatient basis if the Department denies payment to the hospital for the days during which the podiatrist's care is rendered. (7) Services rendered in the emergency room of a hospital if the recipient is admitted to the hospital as an inpatient on the same day or the service is a nonemergency medical service. (8) Treatment of flat foot. (9) Treatment of subluxations of the foot. (10) Routine foot care, including the cutting or removal of corns, callouses, the trimming of nails and other routine hygienic care. (11) Physical therapy. (12) Diagnostic or therapeutic procedures for experimental, research or educational purposes.
1143.58(a)(13) "as specified in § 1101.62 (relating to maximum fees)"	Compensable podiatrist services if full payment is available from another
1143.58(b)	Noncompensable services and items. Payment is not made for sneakers, sandals etc, even if prescribed by a podiatrist.
<b>Managed care organizations must comply with and must require their certified registered nurse practitioner network providers to comply with the requirements of 55 Pa.Code Chapter 1144, Certified Registered Nurse Practitioner Services, with the following exceptions:</b>	
1144.42(b) "to the Department"	Ongoing responsibilities of Providers
1144.52(1)	Payment conditions for CRNP services. CRNP employee
1144.52(2) "billed to the Department"	Payment conditions for CRNP services. CRNP employee
1144.52(3)	Payment conditions for CRNP services. CRNP employee
1144.53(1), (2), and (4)	Noncompensable services. Procedures not listed in the Medical Assistance Program fee schedule. Services and procedures furnished by the CRNP for which payment is made to an enrolled medical service Provider or practitioner. The same service and procedure furnished to the same recipient by a CRNP and physician.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
<b>Managed care organizations must comply with and must require their network chiropractor providers to comply with the requirements of 55 Pa.Code Chapter 1145, Chiropractor's Services, with the following</b>	
1145.11	Types of services covered. Evaluation by means of examination. Treatment by means of manual manipulation of the spine.
1145.12	Services are covered when rendered in the chiropractors' office, the home of the patient or in a skilled nursing or intermediate care facility.
1145.13	Chiropractors' services are not covered when rendered in a location in a hospital.
1145.14	Payment will not be made for treatment other than manipulation of the spine, physical therapy, traction, physical examinations, and consultations.
1145.51 "and the Medical Assistance Program fee schedule" and "Chiropractors' services shall be billed in the name of the chiropractor	Payment policy for chiropractor services.
1145.54	Noncompensable services. Payment will not be made to a chiropractor for 1) Orthotics, 2) Prosthetics, 3) Medical supplies, 4) X-rays, 5) Services not included in Chapter 1150
<b>Managed care organizations must comply with and must require their network optometrist providers to comply with the requirements of 55 Pa.Code Chapter 1147, Optometrists' Services, with the following</b>	
1147.2 Delete the following portion included in the definition of eyeglasses: "untinted."	Definitions - <i>Eyeglasses</i> —A pair of untinted prescription lenses and a frame.
1147.12 "Outpatient optometric services are compensable when provided in the optometrist's office, the office of another optometrist during the other optometrist's temporary absence from practice, a hospital, a nursing home or in the patient's home when the patient is physically incapable of coming to the optometrist's office." "and the Medical Assistance Program Fee Schedule"	Outpatient services
1147.13 "and the Medical Assistance Program Fee	Inpatient services
1147.14(1)	Non-covered services: Orthoptic training.
1147.23 "only" and "They are not eligible for eyeglasses, low vision aids or eye prostheses. However, State Blind Pension recipients are eligible for eye prostheses if they are also categorically needy."	Scope of benefits for State Blind pension recipients.
1147.51 "and §§ 1147.53 and 1147.54 (relating to limitations on payment; and noncompensable services and items)" and "and the Medical Assistance Program fee schedule" and "Optometric services shall be billed in the name of the optometrist providing the service."	General payment policy for optometric services
1147.53	Limitations on payments for optometric services
1147.54	Noncompensable optometric services and items
<b>Managed care organizations must comply with and must require their network dentist providers to comply with the requirements of 55 Pa.Code Chapter 1149, Dentists' Services, with the following exceptions:</b>	
1149.1 "and the Medical Assistance Program Fee	Dental services general policy
1149.43(6)	Radiographs are requested by the Department for prior authorization purposes

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1149.43(9) through (11)	Pathology reports are required for surgical excision services. Pre-operative X-rays are required for surgical services. Postoperative X-rays are required for endodontic procedures.
1149.51 "and the Medical Assistance Program Fee Schedule" and "The following payment policies are applicable	General payment policy for dental services
1149.51(1) and (2)	General payment policy for dental services
1149.52	Payment conditions for various dental services
1149.54 "and the Medical Assistance Program Fee Schedule" 1149.54 (1) through (7)	Payment policies for orthodontic services
1149.55(1) 1149.55(5) through (8)	Payment conditions for orthodontic services
1149.56	Payment limitations for orthodontic services
1149.57	Noncompensable dental services and items
<b>Managed care organizations must comply with and must require their network providers to comply with the requirements of 55 Pa.Code Chapter 1150, Medical Assistance Program Payment Policies, with the</b>	
1150.2 Definitions of PSR and Second Opinion program	Definitions
1150.51(a) "Payment will be made to Providers. Payment may be made to practitioners' professional corporations or partnerships if the professional corporation or partnership is composed of like practitioners. Payment will be made directly to practitioners if they are members of professional corporations or partnerships composed of unlike practitioners. Practitioners who render services at eligible Provider hospitals, either through direct employment or through contract, may direct that payment be made to the eligible Provider hospital." <b>and</b> "Payment will not be made for services that are not medically necessary."  1150.51(b)  1150.51(c) "facilities and practitioners rendering services which require a PSR or second opinion, or both" and "funeral directors"  1150.51(d) "which is contained in the Provider's Handbook" and the following"  1150.51(d)(1) "all-inclusive"  1150.51(d) (2) through (8)  1150.51(e) through (h)	General Medical Assistance Program Payment policies
1150.52	Payment for Anesthesia services
1150.54	Payment for Surgical Services
1150.55	Payment for Obstetrical Services

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1150.56	Payment for Medical Services
1150.56a	Payment Policy for Consultations
1150.57	Payment for Diagnostic Services and Radiation Therapy
1150.58	Prior authorization for services in the Medical Assistance Program Fee
1150.59	PSR Program
1150.60	Second Opinion Program
1150.61	Guidelines for Fee Schedule changes
1150.62	Payment levels and notice of rate setting changes
<p>1150.63</p> <p>1150.63(a) Delete the word "Department"</p> <p>1150.63(b) Delete the word "Department". Also delete in second sentence "the practitioner may either ...by mail."</p> <p>1150.63(c) Delete the first two sentences: The CAO shall ...consultants. The office of MA...decision."</p> <p>1150.63(d)Delete the word "Department"</p>	<p>Waiver of General Payment Policies. The plan must adhere to the following section, except:</p>
<p><b>Managed care organizations must comply with and must require their network providers of inpatient psychiatric services to comply with the requirements of 55 Pa.Code Chapter 1151, Inpatient Psychiatric Services, with the</b></p>	
1151.34	Inpatient Psychiatric Services, Provider Participation, Changes of ownership or control
1151.41(b)	Payment for inpatient psychiatric services, Readmission within 24 hours after discharge
1151.41(c) (1) and (2)	Payment for Inpatient Psychiatric Services, Admitted and discharged the same calendar day
1151.41(d), (i) and (j)	Payment for Preadmission diagnostics, transfer to another facility due to strike, payment for studies related to the patient's condition not preprinted regimen.
1151.42 (a), (c) and (d)	Payment methods and rates
1151.43(a) and (b)	Limitations on payments
1151.45(2) and (3)	Nonallowable costs, costs related to a noncompensable item, costs related to preadmission diagnostics
1151.46	Payment rate calculations for FY 1993-94 and 1994 - 95
<p>1151.48(a)(2)through (6), (9) through (16) and (18) through (20)</p>	<p>Noncompensable services and items, experimental procedures and services, inpatient treatment for diagnostic testing that could be done as outpatient, inpatient care if payment is available from another source, services not normally provided to the public, methadone maintenance, days of inpatient care that the patient was absent due to training, meetings or conferences, unnecessary inpatient care, and days of care that are not certified or failure to apply for a court-ordered commitment.</p>
1151.52	Payment for capital costs not included in the base year
1151.53	Billing requirements for inpatient psychiatric services
1151.54	Disproportionate share payments
<p><b>Managed care organizations must comply with and must require their network providers outpatient psychiatric services to comply with the requirements of 55 Pa.Code Chapter 1153, Outpatient</b></p>	
1153.1 "and the Medical Assistance	Outpatient psychiatric services, general policy
1153.2 Psychiatric outpatient clinic services -- "listed in the Medical Assistance Program	Definitions

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1153.2 Psychiatric partial hospitalization -- "listed in the Medical Assistance Program Fee Schedule" and "and a maximum of six hours in a	Definitions
1153.11 "as specified in the Medical Assistance Program Fee Schedule"	Types of Outpatient Psychiatric Services
1153.12 "specified in the Medical Assistance Program Fee Schedule"	Coverage of outpatient Psychiatric services
1153.14(2), (3), (9) and(13)	Noncovered services: cancelled appointments, covered services not rendered, Psychiatric outpatient clinic services and psychiatric partial hospitalization provided on the same day to the same patient, and Services not specifically included in the Medical Assistance Program Fee Schedule
1153.21 "in the Medical Assistance Program Fee	Scope of benefits for the categorically needy
1153.22 "in the Medical Assistance Program Fee	Scope of benefits for the medically needy
1153.23 "in the Medical Assistance Program Fee	Scope of benefits for State Blind Pension recipients
1153.51 "and the Medical Assistance Program Fee	Payment for Outpatient Psychiatric clinic and partial hospitalization
1153.52(a)(2) "Separate billings for these additional services are not	Additional interviews with other staff may be included as part of the examination but shall be included in the psychiatric evaluation fee.
1153.52(d) "listed in the Medical Assistance Program Fee Schedule"	Psychiatric clinic services provided in the home.
1153.53	Limitations on payments
1153.53a	Request for waiver of hourly limits
1153.54	Noncompensable services and items
<b>Managed care organizations must comply with and must require their network hospital providers to comply with of 55 Pa.Code Chapter 1163, Inpatient Hospital Services, Subchapter A, Acute Care General Hospitals Under the Prospective Payment System, with the following exceptions:</b>	
1163.32	Hospital Units excluded from the DRG prospective payment system
1163.41	General participation requirements for general hospitals and out of state hospitals for Commonwealth recipients
1163.51 (a) through (s)	General payment policy for hospital services
1163.52 through 1163.59	Prospective payment methodology, assignment of DRG, prospective capital reimbursement system, payments for direct medical education, outliers, payment policy for readmissions and transfers, and noncompensable services and items and outlier days.
1163.60(b)(1) "in accordance with the instructions in the Provider	Informed consent for voluntary sterilization
1163.60(c)(2) "in accordance with the instructions in the Provider	The person obtaining informed consent signs and dates the form on same day informed consent was obtained.
1163.60(c)(3) "in accordance with the instructions in the Provider	Another witness or interpreter must sign the consent form.
1163.62 (a) (2) through 1163.65	Payment conditions for abortions if the recipient was a victim of rape or incest, billing, cost reports and payment for out of state services.
1163.67	Disproportionate share payments
1163.70 through 1163.71	Changes of ownership or control and scope of utilization review process
1163.72 (a), (c) through (g)	General utilization review, admissions, day and cost outliers.
1163.73 through 1163.75 (6) and (8) through (12)	Hospital utilization review plan, requirements for hospital utilization review committees, and responsibilities for hospital utilization review committees.
1163.76 through 1163.77	Written plan of care within 2 days of admission and Admission review requirements within 24 hours of admission
1163.78a and 1163.78b	Review requirements for day outliers and cost outliers
1163.92 (a) through (f)	Administrative sanctions

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1163.122	Determination of DRG relative values
1163.126	Computation of hospital specific computation rates
<b>Managed care organizations must comply with and must require their network hospital providers to comply with the requirements of 55 Pa.Code Chapter 1163, Inpatient Hospital Services, Subchapter B, Hospitals and Hospital Units Under Cost Reimbursement Principles, with the following exceptions:</b>	
1163.402 Definition of "certified day"	Definitions
1163.451 (a) through (g), (i), (k) through	General payment policy
1163.452	Payment methods and rates
1163.453 (a) and (c)	Allowable and nonallowable costs, allowable costs for inpatient services, payment not higher than hospital's customary charge
1163.453 (d) (2) through (9)	Costs not allowable under the Medical Assistance Program
1163.453 (e) and (f)	Allowable costs
1163.454	Limitations on payment
1163.455 (a)(1) through (5) and (7) through (16)	Noncompensable inpatient services
1163.455 (b) and (c)	Noncompensable inpatient services
1163.457	Payment policies relating to out of state hospitals
1163.458	Payment policies relating to same calendar day admissions and discharges
1163.459	Disproportionate share payments
1163.481(b) and (c)	Utilization review sanctions
1163.511	Change of ownership or control
<b>Managed care organizations must comply with and must require their network private nursing facility providers to comply with require their network providers to comply with the requirements of 55 Pa.Code Chapter 1187, with the following exceptions:</b>	
1187.2	Definitions: Accrual basis, Allowable Costs, Amortization-administrative costs, Amortization-capital costs, Audited MA-11 cost reports, Benefits, fringe, Benefits, nonstandard or nonuniform, CMI-Case-Mix Index, Classifiable data element, CMI Report, Cost Centers, Depreciated Replacement Cost, Depreciations, DME-Durable medical equipment, Facility MA CMI, Financial Yield Rate, Fixed property, Interest, Investment Income, MA day of care, MA-11, MSA group-Metropolitan, Statistical Area, Medicare Provider Reimbursement Manual (Centers for Medicare and Medicaid Services (CMS) Pub. 15-1), Moveable Property, NIS-Nursing Information System, Net operating costs, New nursing facility, Peer Groups, Pennsylvania Case-Mix Payment System, Per diem rate, Picture date, Price, Private Pay rate, Private pay resident, Related services and items, RUG-III-Resource Utilization Group, Version III, Real estate tax cost, Rebasing, Related Party, Reorganized nursing facility, Resident day, Total Facility CMI, Year one of implementation, Year two of implementation, Year three of
1187.21(4)	"Payment will be based on criteria found in § 1187.101(b) (relating to general payment policy)" does not apply.
1187.22(6)	Assure and verify that the information contained on the quarterly CMI report is accurate for the picture date.
1187.22(12)	File an acceptable cost report with the Department within the time limit specified in § 1187.73 or § 1187.75 (relating to annual reporting; and final reporting).
1187.23	Nursing facility incentives and adjustments.
1187.33(a)(5)	Requirements relating to the correction, verification and submission of the CMI report to the Department
1187.33(a)(6)(i)-(iii)	Contents of the CMI report
1187.33(b)(1)-(3)	Sanctions for failure to comply with resident assessment data
Subchapter E in its entirety	Allowable Program Costs and Policies (1187.51 through 1187.61)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Subchapter F except for 1187.78 (relating to accountability requirements related resident personal fund management) and 1187.79 (relating to auditing requirements related to resident personal fund management) which shall apply. Note CHC-MCO may also audit resident personal fund accounts.	Cost Reporting and Audit Requirements (1187.71 through 1187.77, and 1187.80)
Subchapter G in its entirety	Rate Setting (1187.91 through 1187.98)
1187.102(e)	Reporting allowable Medicare Part B-type costs.
1187.104 Note - Hospital reserved days and therapeutic leave days are covered benefits. CHC MCOs must provide at least up to the FFS 15 consecutive day per hospitalization for hospital reserved days, and at least up to the FFS 30 calendar day for therapeutic leave days if included in Participant's care plan and ordered by a physician.	Limitations on payment for reserved beds. (Payment rate, payment limitations and maximum days do not apply to MCOs.)
1187.105	Limitations on payment for prescription drugs.
1187.106 Note - MCO must make payment arrangements for alternative care in the event NF residents must be relocated due to strike or disaster situation.	Limitations on payment during strike or disaster situations requiring resident evacuation.
1187.107	Limitations on resident care and other resident related cost centers.
1187.108	Gross adjustments to nursing facility payments.
1187.109	Medicare upper limit on payment.
1187.110	Private pay rate adjustment.
1187.111	Disproportionate share incentive payments.
1187.112	[Reserved].
1187.113	Capital component payment limitation.
1187.113a	Nursing facility replacement beds—statement of policy.
1187.113b	Capital cost reimbursement waivers—statement of policy.
1187.114	Adjustments relating to sanctions and fines.
1187.115	Adjustments relating to errors and corrections of nursing facility payments.
1187.116	[Reserved].
1187.117	Supplemental ventilator care and tracheostomy care payments.
1187.141	Nursing facility's right to appeal and to a hearing.
Subchapter K in its entirety	Exceptional Payments for Nursing Facility Services (1187.151 through 1187.158).
<b>Managed care organizations must comply with and must require their network county nursing facility providers to comply with require their network providers to comply with the requirements of 55 Pa.Code Chapter 1189, with the following exceptions:</b>	
1189.1	Policy.
1189.2	Definitions.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Subchapter B in its entirety	Allowable Program Costs and Policies (1189.51 through 1189.55)
Subchapter C except for 1189.73 (relating to accountability requirements related resident personal fund management) and 1189.74 (relating to auditing requirements related to resident personal fund management) which shall apply. Note CHC-MCO may also audit resident personal fund accounts.	Cost Reporting and Audit Requirements (1189.71 through 1189.73, and 1187.75)
Subchapter D in its entirety	Rate setting (1189.91 and 1189.92)
1189.102(e)	Reporting allowable Medicare Part B-type costs.
1189.103 Note - Hospital reserved days and therapeutic leave days are covered benefits. CHC MCOs must provide at least up to the FFS 15 consecutive day per hospitalization for hospital reserved days, and at least up to the FFS 30 calendar day for therapeutic leave days if included in Participant's care plan and	Limitations on payment for reserved beds. (Payment rate, payment limitations and maximum days do not apply to MCOs.)
1189.104 Note - MCO must make payment arrangements for alternative care in the event NF residents must be relocated due to strike or disaster situation.	Limitations on payment during strike or disaster situations requiring resident evacuation.
1189.105	Incentive payments.
1189.108	County nursing facility supplementation payments.
1189.114	County nursing facility's right to appeal and to a hearing.
<b>Managed care organizations must comply with and require their network providers of clinic and emergency room services to comply with the requirements of 55 Pa.Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions:</b>	
1221.43 through 1221.45	Participation requirements for hospital clinics and emergency rooms for higher reimbursement rate, additional participation requirements for independent clinics, and additional participation requirements for medical school clinics.
1221.51 and 1221.52	General payment policy for clinic and emergency room services and payment conditions for various services.
1221.55 (b) (1). NOTE: A consent form is required and must contain all of the information found in Appendix A to 55 PA Code Chapter 1141	Voluntary informed consent for sterilizations
1221.57(a) (2) and 1221.57(c). NOTE: CHC-MCO must comply with Medical Assistance Bulletin 99- 95-09	Payment conditions for necessary abortions for victims of rape or incest
1221.58 and 1221.59	Limitations on payments and noncompensable services and items

**Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletins related to 55 PA Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions:**

- 11-95-04
- 11-95-10
- 11-95-12

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
<b>Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1223, Outpatient Drug and Alcohol Clinic Services, with the following exceptions:</b>	
1223.1 “and the Medical Assistance fee schedule”	Payment for specific medically necessary outpatient drug and alcohol clinic services rendered to eligible recipients by drug/alcohol outpatient clinics.
1223.11 “as specified in the fee schedule in the Medical Assistance program fee schedule”	Medical Assistance Program coverage for outpatient drug/alcohol clinics is limited to professional medical and psychiatric services.
1223.12 "specified in the Medical Assistance program fee schedule"; "and the Medical Assistance program fee schedule"; and "fee for service"	Outpatient drug and alcohol clinic services
1223.14 (3) and (4)	Noncovered services: Cancelled appointments and Covered services that have not been rendered.
1223.14(6) “and the Medical Assistance program fee schedule”	Noncovered services: Vocational rehabilitation; day care; drug/alcohol or mental health partial hospitalization; reentry programs, occupational or recreational therapy; Driving While Intoxicated (DWI) or Driving Under the Influence Programs or Schools; referral, information or education services; experimental services; training; administration; follow-up or aftercare; program evaluation; case management; central intake or records; shelter services; research; drop-in, hot-line or social services; inpatient nonhospital or occupational program services, or any other service or program not specifically identified as a covered service in Chapter 1150.
1223.14 (8) and (9)	Drug/alcohol outpatient clinic services provided to residents of treatment institutions. outpatient clinic services provided to residents of inpatient nonhospital and shelter facilities. outpatient clinic services provided to patients receiving psychiatric partial hospitalization services or drug/alcohol partial hospitalization services
1223.14(14)	Methadone maintenance clinic services provided before the date of the physician’s comprehensive medical examination, diagnosis and treatment plan.
1223.21 “in the Medical Assistance Program	Scope of services for the categorically needy
1223.22 “in the Medical Assistance Program	Scope of services for the medically needy
1223.23 “in the Medical Assistance Program	Scope of services for State Blind Pension recipients
1223.51 “and the Medical Assistance program fee schedule”	General payment policy for outpatient drug/alcohol clinic services
1223.52(a)(2) and (a)(3) “Separate billings for these interviews are not compensable.”	Additional interviews with other staff
1223.52(a)(5) “listed in the Medical Assistance Program Fee Schedule”	Diagnostic psychological services
1223.52(c) “Separate billings for these interviews are not compensable.”	Interviews or consultations with family members alone, without the presence of the family member with a drug/alcohol abuse or dependence problem, are considered to be part of the family psychotherapy fee.
1223.53	Limitations on Payment for outpatient drug and alcohol clinic services
1223.54(2) “and the Medical Assistance program fee schedule”	Items and services not listed as compensable in Chapter 1150
<b>Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1225, Family Planning Clinic Services, with the following exceptions:</b>	

1225.1 “and the Medical Assistance	General provisions
1225.51 “and the Medical Assistance Program fee	General payment policy
1225.54(2)	Noncompensable family planning services
<b>Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1229, Health Maintenance Organizations Services, with the following exceptions:</b>	
NONE	
<b>CITATION/SPECIFIC EXCLUSION</b>	<b>REGULATORY LANGUAGE DESCRIPTION</b>
<b>Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1230, Portable X-Ray Services, with the following exceptions:</b>	
1230.1 “and the Medical Assistance	General provisions
1230.51 “and the Medical Assistance fee	General payment policy for portable x-ray services
1230.52(b) “and the Medical Assistance Program fee schedule”	Payment for transporting portable X-ray equipment from the Provider’s office to the place of service
1230.53 (a) through (c)	Portable x-ray services, Provider maximum payment, payment for transportation of portable x-ray equipment and electrocardiogram services
1230.54 (1)	Noncompensable services, procedures not listed in the Medical Assistance Program fee schedule
<b>Managed care organizations are to adhere to the requirements of Medical Assistance Bulletin 99-94-08 (relating to 55 Pa. Code Chapter 1239, Medical Case Management), Medical Assistance Case Management Services for Recipients Under the Age of 21, with the following exceptions:</b>	
<ul style="list-style-type: none"> <li>▪ Discussion</li> <li>▪ Page 2, paragraph 3 "The OMAP reserves the right to limit the number of recipients in a case manager's caseload."</li> <li>▪ Page 3, Payment for case management services covered by this bulletin, 1 through 3 and 4 c through f</li> </ul>	
<b>Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1241, Early and Periodic Screening, Diagnosis and Treatment Program, with the following exceptions:</b>	
1241.2 Definition of “Administrative contractors”	Definitions
1241.42(1) “or to the CAO for supportive help in locating an appropriate Provider”	If not licensed or equipped to render the necessary treatment or further diagnosis, the screening Provider shall refer the individual to an appropriate enrolled practitioner or facility.
1241.51	Payment to the Provider
1241.53	Limitations on payments
1241.54 (a) (1) through (5)	Noncompensable services and items
1241.54 (b) (1) through (5)	Noncompensable services and items
<b>Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1243, Outpatient Laboratory Services, with the following exceptions:</b>	
1243.51 “and the Medical Assistance Program fee	General payment policy for outpatient laboratory services
1243.52(b) “billed to the Department”	Laboratory services billed to the Department will be based on the written request of the practitioner
1243.53 (a)	The fees listed in the Medical Assistance Program fee schedule are the
1243.54 (1) and (2)	Noncompensable services
<b>Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1245, Ambulance Transportation, with the following exceptions:</b>	
1245.1 “and the Medical Assistance Program fee schedule”	General provisions for payment of ambulance transportation to eligible beneficiaries
1245.21 “and the Medical Assistance Program fee	Scope of services for the categorically needy
1245.22 “and the Medical Assistance Program fee	Scope of services for the medically needy
1245.23 “and the Medical Assistance Program fee	Scope of services for State Blind Pension recipients

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1245.51 (b)	Ambulance services which obtain Voluntary Ambulance Service Certification (VASC) from the Department of Health will be reimbursed at a higher rate than non-VASC certified services
1245.52(1)	Payment conditions for ambulance transportation, medically necessary
1245.52(3) through (5)	Transportation to the nearest appropriate medical facility and medical services/supplies invoice.
1245.53	Limitations on payment for ambulance service when more than one patient is transported. Payment is made for transportation of the patient whose destination is the greatest distance. No additional payment is allowed for the additional person.
1245.54(1) through (7)	Noncompensable services and items relating to ambulance transportation.
<b>Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1249, Home Health Agency Services, with the following exceptions:</b>	
1249.51 “and the Medical Assistance Program fee	General payment policy for Home Health Services
1249.55(b)	Payment conditions for medical supplies. Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care services. Payment for these supplies is included in the comprehensive fee.
1249.57	Payment conditions for maternal
1249.58	Payment conditions for travel costs
1249.59	Limitations on payments for home health agency services

**EXHIBIT B (1)**  
**CHC-MCO PAY FOR PERFORMANCE PROGRAM**

For 2017, the Department will implement a Pay for Performance Incentive to CHC-MCOs that help Participants successfully complete the financial eligibility redetermination process with their local CAOs. The Department may implement additional Pay for Performance incentives in later years.

## **EXHIBIT D STANDARD TERMS AND CONDITIONS**

### **1. TERM**

The term of the Agreement shall commence on the Effective Date and shall end on the Expiration Date identified in the Agreement, subject to the other provisions of the Agreement. The Agreement shall not be a legally binding Agreement until fully executed by the CHC-MCO and by the Commonwealth and all approvals required by Commonwealth and federal procurement procedures have been obtained. No agency employee has the authority to verbally direct the commencement of any work under this Agreement. The Commonwealth may, upon notice to the CHC MCO, extend the term of the Agreement for up to three (3) months upon the same terms and conditions, which will be utilized to prevent a lapse in Agreement coverage and only for the time necessary, up to three (3) months, to enter into a new Agreement.

**2. Reserved.**

**3. Reserved.**

### **4. ENVIRONMENTAL PROVISIONS**

In the performance of the Agreement, the CHC-MCO shall minimize pollution and shall strictly comply with all applicable environmental laws and regulations.

**5. Reserved.**

### **6. COMPENSATION/EXPENSES**

The CHC-MCO shall be required to perform the specified services at the prices provided for in the Agreement. All services shall be performed within the time periods specified in the Agreement. The CHC-MCO shall be compensated only for work performed to the satisfaction of the Commonwealth. The CHC MCO shall not be paid travel or per diem expenses.

**7. Reserved.**

### **8. PAYMENT**

The CHC-MCO agrees that the Commonwealth may set off the amount of any state tax liability or other obligation of the CHC-MCO or its subsidiaries to the Commonwealth against any payments due the CHC-MCO under any Agreement with the Commonwealth.

### **9. TAXES**

The Commonwealth is exempt from all excise taxes imposed by the Internal Revenue Service and has accordingly registered with the Internal Revenue Service to make tax free purchases under Registration No. 23740001-K. With the exception of purchases of the following items, no exemption certificates are required and none will be issued: undyed diesel fuel, tires, trucks, gas guzzler emergency vehicles, and sports fishing equipment. The Commonwealth is also exempt from Pennsylvania state sales tax, local sales tax, public transportation assistance taxes and fees and vehicle rental tax. The Department of Revenue regulations provide that exemption certificates are not required for sales made to governmental entities and none will be issued. Nothing in this paragraph is meant to exempt a construction Contractor from the payment of any of these taxes or fees which are required to be paid with respect to the purchase, use, rental, or lease of tangible personal property or taxable services used or transferred in connection with the performance of a construction Contract.

### **10. WARRANTY**

The CHC-MCO warrants that all services performed by the CHC MCO, its agents and

subcontractor shall be performed in a professional and workmanlike manner and in accordance with prevailing professional and industry standards. Unless otherwise stated in the Agreement, all services are warranted for a period of one year following completion of performance by the CHC-MCO and acceptance by the Commonwealth. The CHC-MCO shall correct any problem with the service without any additional cost to the Commonwealth.

#### **11. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY**

The CHC-MCO warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of the Agreement which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to the Commonwealth. The CHC-MCO shall defend any suit or proceeding brought against the Commonwealth on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of the Agreement. This is upon condition that the Commonwealth shall provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, the Commonwealth may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by the Commonwealth at the CHC-MCO's written request, it shall be at the CHC-MCO's expense, but the responsibility for such expense shall be only that within the CHC-MCO's written authorization. The CHC-MCO shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the CHC-MCO or the Commonwealth may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of the Agreement. If any of the products provided by the CHC-MCO in such suit or proceeding are held to constitute infringement and the use is enjoined, the CHC-MCO shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If the CHC-MCO is unable to do any of the preceding, it will remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of the Commonwealth, only those items of equipment or software which are held to be infringing, and to pay the Commonwealth: 1) any amounts paid by the Commonwealth towards the purchase of the product, less straight line depreciation; 2) any license fee paid by the Commonwealth for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee representing the time remaining in any period of maintenance paid for. The obligations of the CHC-MCO under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the CHC-MCO without its written consent.

#### **12. OWNERSHIP RIGHTS**

The Commonwealth shall have unrestricted authority to reproduce, distribute, and use any submitted report, data, or material, and any software or modifications and any associated documentation that is designed or developed and delivered to the Commonwealth as part of the performance of the Agreement.

#### **13. ASSIGNMENT OF ANTITRUST CLAIMS**

The CHC-MCO and the Commonwealth recognize that in actual economic practice, overcharges by the CHC-MCO's suppliers resulting from violations of state or federal antitrust laws are in fact borne by the Commonwealth. As part of the consideration for the award of the Agreement, the CHC-MCO assigns to the Commonwealth all right, title and interest in and to any claims the CHC-MCO now has, or may acquire, under state or federal antitrust laws relating to the products and services which are the subject of this Agreement.

#### **14. HOLD HARMLESS PROVISION**

The CHC-MCO shall hold the Commonwealth harmless from and indemnify the Commonwealth against any and all claims, demands and actions based upon or arising out of any activities performed by the CHC-MCO and its employees and agents under this Agreement and shall, at the request of the Commonwealth, defend any and all actions brought against the Commonwealth based upon any such claims or demands.

#### **15. AUDIT PROVISIONS**

In addition to its other audit requirements, the Commonwealth shall have the right, at reasonable times and at a site designated by the Commonwealth, to audit the books, documents and records of the CHC-MCO to the extent that the books, documents and records relate to costs or pricing data for the Agreement. The CHC-MCO will maintain records which will support the prices charged and costs incurred for the Agreement. The CHC-MCO shall preserve books, documents, and records that relate to costs or pricing data for the Agreement for a period of five (5) years from date of final payment. The CHC-MCO shall give full and free access to all records to the Commonwealth and its authorized representatives.

## 16. DEFAULT

- a. The Commonwealth may, subject to the provisions of Paragraph 17, Force Majeure, and in addition to its other rights under the Agreement, declare the CHC-MCO in default by written notice to the CHC-MCO, and terminate as provided Paragraph 18, Termination Provisions, the whole or any part of this Agreement for any of the following reasons:
  - 1) Failure to begin services within the time specified in the Agreement or as otherwise specified;
  - 2) Failure to perform the services with sufficient labor, equipment, or material to insure the completion of the specified work in accordance with the Agreement terms;
  - 3) Unsatisfactory performance of services;
  - 4) Discontinuance of services without approval;
  - 5) Failure to resume services, which has been discontinued, within a reasonable time after notice to do so;
  - 6) Insolvency or bankruptcy;
  - 7) Assignment made for the benefit of creditors;
  - 8) Failure or refusal within 10 days after written notice, to make payment or show cause why payment should not be made, of any amounts due for materials furnished, labor supplied or performed, for equipment rentals, or for utility services rendered;
  - 9) Failure to protect, to repair, or to make good any damage or injury to property;
  - 10) Theft or fraud involving the Commonwealth or the federal government;
  - 11) An adverse material change in circumstances as describe in Section IX of the Agreement;
  - 12) Notification by PID or DOH that the CHC-MCO's authority to operate has been suspended, limited or revoked or has expired and will not be renewed;
  - 13) Failure to obtain national accreditation certification; or
  - 14) Breach of any provision of the Agreement.
- b. In the event that the Commonwealth terminates this Agreement in whole or in part, the Commonwealth may procure, upon such terms and in such manner as it determines, services similar or identical to those so terminated, and the CHC-MCO shall be liable to the Commonwealth for any reasonable excess costs for such similar or identical services included within the terminated part of the Agreement.
- c. If the Agreement is terminated, the Commonwealth, in addition to any other rights provided in this paragraph, may require the CHC-MCO to transfer title and deliver immediately to the Commonwealth in the manner and to the extent directed by the Department, such partially completed work, including, where applicable, reports, working papers and other documentation, as the CHC-MCO has specifically produced or specifically acquired for the performance of such part of the Agreement as has been terminated. Except as provided below, payment for completed work accepted by the Commonwealth shall be at the Agreement price. Except as provided below, payment for partially completed work including, where applicable, reports and working papers, delivered to and accepted by the Commonwealth shall be in an amount agreed upon by the CHC-MCO and the Department. The Commonwealth may withhold from amounts otherwise due the CHC-MCO for such completed or partially completed works, such sum as the Department determines to be necessary to protect the Commonwealth against loss.

- d. The rights and remedies of the Commonwealth provided in this paragraph are not exclusive and are in addition to any other rights and remedies provided by law or under the Agreement.

## 17. FORCE MAJEURE

Neither party will incur any liability to the other if its performance of any obligation under this Agreement is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but aren't limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, general strikes throughout the trade, and freight embargoes.

The CHC-MCO shall notify the Commonwealth orally within five (5) days and in writing within ten (10) days of the date on which the CHC-MCO becomes aware, or should have reasonably become aware, that such cause would prevent or delay its performance. Such notification shall (i) describe fully such cause(s) and its effect on performance, (ii) state whether performance under the Agreement is prevented or delayed and (iii) if performance is delayed, state a reasonable estimate of the duration of the delay. The CHC-MCO shall have the burden of proving that such cause(s) delayed or prevented its performance despite its diligent efforts to perform and shall produce such supporting documentation as the Commonwealth may reasonably request. After receipt of such notification, the Commonwealth may elect either to cancel the Agreement or to extend the time for performance as reasonably necessary to compensate for the delay.

In the event of a declared emergency by competent governmental authorities, the Commonwealth by notice to the CHC-MCO, may suspend all or a portion of the Agreement.

## 18. TERMINATION PROVISIONS

a. The Commonwealth has the right to terminate the Agreement for any of the following reasons. Termination shall be effective upon written notice to the CHC-MCO and in accordance with the Agreement terms.

- 1) **TERMINATION FOR CONVENIENCE:** Upon 120 days written notice, the Commonwealth may terminate the Agreement for its convenience if the Commonwealth determines termination to be in its best interest. The effective date of the termination will be the last day of the month in which the 120<sup>th</sup> day fall. The CHC-MCO shall be paid for services satisfactorily completed prior to the effective date of the termination, but in no event shall the CHC-MCO be entitled to recover loss of profits.
- 2) **NON-APPROPRIATION:** The Commonwealth's obligation to make payments during any Commonwealth fiscal year succeeding the current fiscal year shall be subject to availability and appropriation of funds. When funds (state and/or federal) are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal year period, the Commonwealth shall have the right to terminate the Agreement. The CHC MCO shall be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the supplies or services delivered under this Agreement. Such reimbursement shall not include loss of profit, loss of use of money, or administrative or overhead costs. The reimbursement amount may be

paid for any appropriations available for that purpose

- 3) **TERMINATION FOR CAUSE:** The Commonwealth may terminate the Agreement for default under Paragraph 16, Default or other cause as specified in the Agreement or by law, by providing written notice of default to the CHC-MCO and the CHC-MCO fails to cure the failure within 45 days of the notice or such longer time as may be approved by the Commonwealth. The Department will set forth in the grounds for the termination in the notice and will If it is later determined that the Commonwealth erred in terminating the Agreement for cause, then, at the Commonwealth's discretion, the Agreement shall be deemed to have been terminated for convenience under the Subparagraph 18.a.

**b. TERMINATION BY THE CHC-MCO.** The CHC-MCO may terminate this Agreement upon 120 days advance written notice to the Commonwealth. The effective date of the termination will be the last day of the month in which the 120<sup>th</sup> days falls.

19. **Reserved.**

## 20. **ASSIGNABILITY AND SUBGRANTING**

- a. Subject to the terms and conditions of this Paragraph 20, this Agreement shall be binding upon the parties and their respective successors and assigns.
- b. The CHC-MCO shall not subcontract with any person or entity to perform all or any part of the services to be performed without the prior written consent of the Department, which consent may be withheld at the sole and absolute discretion of the Department.
- c. The CHC-MCO may not assign, in whole or in part, the Agreement or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of the Department, which consent may be withheld at the sole and absolute discretion of the Department.
- d. The CHC-MCO may, without the consent of the Department, assign its rights to payment to be received under the Agreement, provided that the CHC-MCO provides written notice of such assignment to the Department together with a written acknowledgement from the assignee that any such payments are subject to all of the terms and conditions of the Agreement.
- e. For the purposes of this Agreement, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the CHC-MCO provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company.
- f. Any assignment consented to by the Department shall be evidenced by a written assignment agreement executed by the CHC-MCO and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of the Agreement and to assume the duties, obligations, and responsibilities being assigned.
- g. A change of name, following which the CHC-MCO's federal identification number remains unchanged, shall not be considered to be an assignment. The CHC-MCO shall give the Department written notice of any such change of name.

## 21. **NONDISCRIMINATION/SEXUAL HARASSMENT CLAUSE**

During the term of the Agreement, the CHC-MCO agrees as follows:

- a.** In the hiring of any employee(s) for the manufacture of supplies, performance of work, or any other activity required under the agreement or any subgrant, contract, or subcontract, the CHC-MCO, a subgrantee, a contractor, a subcontractor, or any person acting on behalf of the CHC-MCO shall not discriminate in violation of the Pennsylvania Human Relations Act (PHRA) and applicable federal laws against any citizen of this Commonwealth who is qualified and available to perform the work to which the employment relates.
- b.** The CHC-MCO, any subgrantee, contractor or any subcontractor or any person on their behalf shall not in any manner discriminate in violation of the PHRA and applicable federal laws against or intimidate any of its employees.
- c.** The CHC-MCO, any subgrantee, contractor or any subcontractor shall establish and maintain a written nondiscrimination and sexual harassment policy and shall inform their employees of the policy. The policy must contain a provision that sexual harassment will not be tolerated and employees who practice it will be disciplined. Posting this Nondiscrimination/Sexual Harassment Clause conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where the grant services are performed shall satisfy this requirement.
- d.** The CHC-MCO, any subgrantee, contractor or any subcontractor shall not discriminate in violation of the PHRA and applicable federal laws against any subgrantee, contractor, subcontractor or supplier who is qualified to perform the work to which the Agreement relates.
- e.** The CHC-MCO and each subgrantee, contractor and subcontractor represents that it is presently in compliance with and will maintain compliance with all applicable federal, state, and local laws and regulations relating to nondiscrimination and sexual harassment. The CHC-MCO and each subgrantee, contractor and subcontractor further represents that it has filed a Standard Form 100 Employer Information Report (“EEO-1”) with the U.S. Equal Employment Opportunity Commission (“EEOC”) and shall file an annual EEO-1 report with the EEOC as required for employers subject to Title VII of the Civil Rights Act of 1964, as amended, that have 100 or more employees and employers that have federal government contracts or first-tier subcontracts and have 50 or more employees. The CHC-MCO, any subgrantee, any contractor or any subcontractor shall, upon request and within the time periods requested by the Commonwealth, furnish all necessary employment documents and records, including EEO-1 reports, and permit access to their books, records, and accounts by the granting agency and the Bureau of Small Business Opportunities (BSBO), for the purpose of ascertaining compliance with the provisions of this Nondiscrimination/Sexual Harassment Clause.
- f.** The CHC-MCO, any subgrantee, contractor or any subcontractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every agreement, contract or subcontract so that those provisions applicable to subgrantees, contractors or subcontractors will be binding upon each subgrantee, contractor or subcontractor.
- g.** The CHC-MCO’s and each subgrantee’s, contractor’s and subcontractor’s obligations pursuant to these provisions are ongoing from and after the effective date of the agreement through the termination date thereof. Accordingly, the CHC-

MCO and each subgrantee, contractor and subcontractor shall have an obligation to inform the Commonwealth if, at any time during the term of the agreement, it becomes aware of any actions or occurrences that would result in violation of these provisions.

- h. The Commonwealth may cancel or terminate the agreement and all money due or to become due under the agreement may be forfeited for a violation of the terms and conditions of this Nondiscrimination/Sexual Harassment Clause. In addition, the Department may proceed with debarment or suspension and may place the CHC-MCO, subgrantee, contractor, or subcontractor in the Contractor Responsibility File.

## 22. INTEGRITY PROVISIONS

It is essential that those who have agreements with the Commonwealth observe high standards of honesty and integrity. They must conduct themselves in a manner that fosters public confidence in the integrity of the Commonwealth contracting and procurement process.

1. **DEFINITIONS.** For purposes of these Integrity Provisions, the following terms shall have the meanings found in this Section:
  - a. **“Affiliate”** means two or more entities where (a) a parent entity owns more than fifty percent of the voting stock of each of the entities; or (b) a common shareholder or group of shareholders owns more than fifty percent of the voting stock of each of the entities; or c) the entities have a common proprietor or general partner.
  - b. **“Consent”** means written permission signed by a duly authorized officer or employee of the Commonwealth, provided that where the material facts have been disclosed, in writing, by prequalification, bid, proposal, or contractual terms, the Commonwealth shall be deemed to have consented by virtue of the execution of this contract.
  - c. **“Contractor”** means the individual or entity, that has entered into this Agreement with the Commonwealth.
  - d. **“Contractor Related Parties”** means any affiliates of the Contractor and the Contractor’s executive officers, Pennsylvania officers and directors, or owners of 5 percent or more interest in the Contractor.
  - e. **“Financial Interest”** means either:
    - (1) Ownership of more than a five percent interest in any business; or
    - (2) Holding a position as an officer, director, trustee, partner, employee, or holding any position of management.
  - f. **“Gratuity”** means tendering, giving, or providing anything of more than nominal monetary value including, but not limited to, cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. The exceptions set forth in the [Governor’s Code of Conduct](#), [Executive Order 1980-18](#), the *4 Pa. Code* §7.153(b), shall apply.
  - g. **“Non-bid Basis”** means an agreement awarded or executed by the Commonwealth

with Contractor without seeking bids or proposals from any other potential bidder or offeror.

2. In furtherance of this policy, Contractor agrees to the following:
  - a. Contractor shall maintain the highest standards of honesty and integrity during the performance of this Agreement and shall take no action in violation of state or federal laws or regulations or any other applicable laws or regulations, or other requirements applicable to Contractor or that govern procurement with the Commonwealth.
  - b. Contractor shall establish and implement a written business integrity policy, which includes, at a minimum, the requirements of these provisions as they relate to the Contractor activity with the Commonwealth and Commonwealth employees and which is made known to all Contractor employees. Posting these Integrity Provisions conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where the services are performed shall satisfy this requirement.
  - c. Contractor, its affiliates, agents, employees and anyone in privity with Contractor shall not accept, agree to give, offer, confer, or agree to confer or promise to confer, directly or indirectly, any gratuity or pecuniary benefit to any person, or to influence or attempt to influence any person in violation of any federal or state law, regulation, executive order of the Governor of Pennsylvania, statement of policy, management directive or any other published standard of the Commonwealth in connection with performance of work under this Agreement except as provided in this Agreement.
  - d. Contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material under this Agreement, unless the financial interest is disclosed to the Commonwealth in writing and the Commonwealth consents to Contractor's financial interest prior to Commonwealth execution of the Agreement. Contractor shall disclose the financial interest to the Commonwealth at the time of proposal submission, or if no bids or proposals are solicited, no later than Contractor's submission of the Agreement signed by Contractor.
  - e. Contractor certifies to the best of its knowledge and belief that within the last five (5) years Contractor or Contractor Related Parties have not:
    - (1) been indicted or convicted of a crime involving moral turpitude or business honesty or integrity in any jurisdiction;
    - (2) been suspended, debarred or otherwise disqualified from entering into any contract with any governmental agency;
    - (3) had any business license or professional license suspended or revoked;
    - (4) had any sanction or finding of fact imposed as a result of a judicial or administrative proceeding related to fraud, extortion, bribery, bid rigging, embezzlement, misrepresentation or anti-trust; and
    - (5) been, and is not currently, the subject of a criminal investigation by any federal, state or local prosecuting or investigative agency and/or civil anti-trust investigation by any federal, state or local prosecuting or investigative agency.

If Contractor cannot so certify to the above, then it must submit along with its bid, proposal or agreement a written explanation of why such certification cannot be made and the Commonwealth will determine whether an Agreement may be entered into with the Contractor. The Contractor's obligation pursuant to this certification is ongoing from and after the effective date of the Agreement through the termination date thereof. Accordingly, the Contractor shall have an obligation to immediately notify the Commonwealth in writing if at any time during the term of the Agreement if becomes aware of any event which would cause the Contractor's certification or explanation to change. Contractor acknowledges that the Commonwealth may, in its sole discretion, terminate the Agreement for cause if it learns that any of the certifications made herein are currently false due to intervening factual circumstances or were false or should have been known to be false when entering into the Agreement.

Contractor shall comply with the requirements of the *Lobbying Disclosure Act (65 Pa.C.S. §13A01 et seq.)* regardless of the method of award. If this Agreement was awarded on a Non-bid Basis, Contractor must also comply with the requirements of the *Section 1641 of the Pennsylvania Election Code (25 P.S. §3260a)*.

- f. When Contractor has reason to believe that any breach of ethical standards as set forth in law, the Governor's Code of Conduct, or these Integrity Provisions has occurred or may occur, including but not limited to contact by a Commonwealth officer or employee which, if acted upon, would violate such ethical standards, Contractor shall immediately notify the project officer or the Office of the State Inspector General in writing.
- g. Contractor, by submission of its proposal and/or execution of this Agreement and by the submission of any bills, invoices or requests for payment pursuant to the Agreement, certifies and represents that it has not violated any of these Integrity Provisions in connection with the submission of the proposal, during any negotiations or during the term of the Agreement, to include any extensions thereof. Contractor shall immediately notify the Commonwealth in writing of any actions for occurrences that would result in a violation of these Integrity Provisions. Contractor agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of the State Inspector General for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the Commonwealth that results in the suspension or debarment of the Contractor. Contractor shall not be responsible for investigative costs for investigations that do not result in the Contractor's suspension or debarment.
- h. Contractor shall cooperate with the Office of the State Inspector General in its investigation of any alleged Commonwealth agency or employee breach of ethical standards and any alleged Contractor non-compliance with these Integrity Provisions. Contractor agrees to make identified Contractor employees available for interviews at reasonable times and places. Contractor, upon the inquiry or request of an Inspector General, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Office of the State Inspector General to Contractor's integrity and compliance with these provisions. Such information may include, but shall not be limited to, Contractor's business or financial records, documents or files of any type or form that refer to or concern this contract. Contractor shall incorporate this paragraph in any agreement, contract or subcontract it enters into in the course of

the performance of this agreement solely for the purpose of obtaining subcontractor compliance with this provision. The incorporation of this provision in a subcontract shall not create privity of contract between the Commonwealth and any such subcontractor, and no third party beneficiaries shall be created thereby.

- i. For violation of any of these Integrity Provisions, the Commonwealth may terminate this and any other Agreement with Contractor, claim liquidated damages in an amount equal to the value of anything received in breach of these Provisions, claim damages for all additional costs and expenses incurred in obtaining another contractor to complete performance under this Agreement, and debar and suspend Contractor from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or non-use of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.

## **23. RESPONSIBILITY PROVISIONS**

- a. The CHC-MCO certifies, for itself and all its subgrantees and subcontractors, that as of the date of its execution of this Agreement, that neither it, nor any subgrantees, subcontractors nor any suppliers are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority and, if the CHC-MCO cannot so certify, then it agrees to submit, along with its Proposal, a written explanation of why such certification cannot be made.
- b. The CHC-MCO also certifies, that as of the date of its execution of the Agreement, it has no tax liabilities or other Commonwealth obligations.
- c. The CHC-MCO's obligations pursuant to these provisions are ongoing from and after the effective date of the Agreement through the termination date thereof. Accordingly, the CHC-MCO shall have an obligation to inform the Commonwealth if, at any time during the term of the Agreement, it becomes delinquent in the payment of taxes, or other Commonwealth obligations, or if it or any of its subgrantees or subcontractors are suspended or debarred by the Commonwealth, the federal government, or any other state or governmental entity. Such notification shall be made within 15 days of the date of suspension or debarment.
- d. The failure of the CHC-MCO to notify the Commonwealth of its suspension or debarment by the Commonwealth, any other state, or the federal government shall constitute an event of default.
- e. The CHC-MCO agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of State Inspector General for Investigations of the its compliance with the terms of this or any other agreement between the CHC-MCO and the Commonwealth, which results in the suspension or debarment of the CHC-MCO. Such costs shall include, but shall not be limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The CHC-MCO shall not be responsible for investigative costs for investigations that do not result in the CHC-MCO's suspension or debarment.

f. The CHC-MCO may obtain a current list of suspended and debarred Commonwealth entities by either searching the internet at <http://www.dgs.state.pa.us> or contacting the:

Department of General Services  
Office of Chief Counsel  
603 North Office Building  
Harrisburg, PA 17125  
Telephone No. (717) 783-6472  
FAX No. (717) 787-9138

#### **24. AMERICANS WITH DISABILITIES ACT**

- a. Pursuant to federal regulations promulgated under the authority of The Americans With Disabilities Act, 28 C.F.R. § 35.101 et seq., the CHC-MCO understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Agreement or from activities provided for under the Agreement on the basis of the disability. As a condition of accepting this Agreement, the CHC-MCO agrees to comply with the "General Prohibitions Against Discrimination," 28 C.F.R. § 35.130, and all other regulations promulgated under Title II of The Americans With Disabilities Act which are applicable to all benefits, services, programs, and activities provided by the Commonwealth of Pennsylvania through Agreements with outside entities.
- b. The CHC-MCO shall be responsible for and agrees to indemnify and hold harmless the Commonwealth of Pennsylvania from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the Commonwealth of Pennsylvania as a result of the CHC-MCO's failure to comply with the provisions of subparagraph (a) above.

**25. Reserved.**

#### **26. COVENANT AGAINST CONTINGENT FEES**

The CHC-MCO warrants that no person or selling agency has been employed or retained to solicit or secure the Agreement upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except 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 Commonwealth may terminate the Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

#### **27. APPLICABLE LAW**

This Agreement shall be governed by and interpreted and enforced in accordance with the laws of the Commonwealth of Pennsylvania (without regard to any conflict of law's provisions) and the decisions of the Pennsylvania courts. The CHC-MCO consents to the jurisdiction of any court of the Commonwealth of Pennsylvania and any federal courts in Pennsylvania, waiving any claim or defense that such forum is not convenient or proper. The CHC-MCO agrees that any such court shall have in personam jurisdiction over it, and consents to service of process in any manner authorized by Pennsylvania law.

## **28. INTEGRATION**

The Agreement, including all referenced documents, constitutes the entire agreement between the parties. No agent, representative, employee or officer of either the Commonwealth or the CHC-MCO has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with the Agreement, which in any way can be deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of the Agreement. No modifications, alterations, changes, or waiver to the Agreement or any of its terms shall be valid or binding unless accomplished by a written amendment signed by both parties.

## **29. CHANGE ORDERS**

The Commonwealth may issue change orders at any time during the term of the Agreement or any renewals or extensions thereof: 1) to increase or decrease the quantities resulting from variations between any estimated quantities in the Agreement and actual quantities; 2) to make changes to the services within the scope of the Agreement; 3) to notify the CHC-MCO that the Commonwealth is exercising any renewal or extension option; or 4) to modify the time of performance that does not alter the scope of the Agreement to extend the completion date beyond the Expiration Date of the Agreement or any renewals or extensions thereof. Any such change order shall be in writing signed by the Project Officer. The change order shall be effective as of the date appearing on the change order, unless the change order specifies a later effective date. Such increases, decreases, changes, or modifications will not invalidate the Agreement, nor, if performance security is being furnished in conjunction with the Agreement release the security obligation. The CHC-MCO will provide the service in accordance with the change order.

## **30. RIGHT TO KNOW LAW 8-K-1580**

- a. The CHC-MCO and its subgrantees and subcontractors understands that this Agreement and records related to or arising out of the Agreement are subject to requests made pursuant to the Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, (“RTKL”). For the purpose of these provisions, the term “the Commonwealth” shall refer to the Department.
- b. If the Commonwealth needs the CHC-MCO, subgrantee or subcontractor’s assistance in any matter arising out of the RTKL related to this Agreement, it shall notify the CHC-MCO, subgrantee, or subcontractor using the legal contact information provided in the Agreement. The CHC-MCO, subgrantee, or subcontractor at any time, may designate a different contact for such purpose upon reasonable prior written notice to the Commonwealth.
- c. Upon written notification from the Commonwealth that it requires assistance in responding to a request under the RTKL for information related to this Agreement that may be in the CHC-MCO, a subgrantee or subcontractor’s possession, constituting, or alleged to constitute, a public record in accordance with the RTKL (“Requested Information”), CHC-MCO shall:
  1. Provide the Commonwealth, within ten (10) calendar days after receipt of written notification, access to, and copies of, any document or information in the CHC-MCO, subgrantee or subcontractor’s possession arising out of this Agreement that the Commonwealth reasonably believes is Requested Information and may be a public record under the RTKL; and
  2. Provide such other assistance as the Commonwealth may reasonably request, in order to comply with the RTKL with respect to this Agreement.
- d. If the CHC-MCO, subgrantee or subcontractor considers the Requested Information to include a request for a Trade Secret or Confidential Proprietary Information, as those terms are defined by the RTKL, or other information that the CHC-MCO, subgrantee or subcontractor considers exempt from production under the RTKL, the CHC-MCO, subgrantee or subcontractor must notify the Commonwealth and provide, within seven (7) calendar days of receiving the written notification, a written statement signed by a representative of the CHC-

MCO, subgrantee or subcontractor explaining why the requested material is exempt from public disclosure under the RTKL.

- e. The Commonwealth will rely upon the written statement in denying a RTKL request for the Requested Information unless the Commonwealth determines that the Requested Information is clearly not protected from disclosure under the RTKL. Should the Commonwealth determine that the Requested Information is clearly not exempt from disclosure, the CHC-MCO, subgrantee or subcontractor shall provide the Requested Information within five (5) business days of receipt of written notification of the Commonwealth's determination.
- f. If the CHC-MCO, subgrantee or subcontractor fails to provide the Requested Information within the time period required by these provisions, the CHC-MCO shall indemnify and hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of the failure, including any statutory damages assessed against the Commonwealth.
- g. The Commonwealth will reimburse the CHC-MCO, subgrantee or subcontractor for any costs associated with complying with these provisions only to the extent allowed under the fee schedule established by the Office of Open Records or as otherwise provided by the RTKL if the fee schedule is inapplicable.
- h. The CHC-MCO, subgrantee or subcontractor may file a legal challenge to any Commonwealth decision to release a record to the public with the Office of Open Records, or in the Pennsylvania Courts, however, the CHC-MCO, subgrantee or subcontractor shall indemnify the Commonwealth for any legal expenses incurred by the Commonwealth as a result of such a challenge and shall hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of the CHC-MCO, subgrantee or subcontractor's failure, including any statutory damages assessed against the Commonwealth, regardless of the outcome of such legal challenge. As between the parties, the CHC-MCO, subgrantee and subcontractor waive all rights or remedies that may be available to it as a result of the Commonwealth's disclosure of Requested Information pursuant to the RTKL.
- i. The CHC-MCO, subgrantee and subcontractor's duties relating to the RTKL are continuing duties that survive the expiration of this Agreement and shall continue as long as the Requested Information is in its possession.

## Specific Federal Regulatory Cites for Managed Care Agreements

Citation	Requirement
<a href="#">1903(m)(4)(B)</a>	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
<a href="#">42 CFR 438.6(f)(2)(ii)</a>	The CHC-MCO will report all identified provider-preventable conditions in a form or frequency, which may be specified by the State.
<a href="#">ARRA 5006(a)</a> <a href="#">State Medicaid Director Letter SMD #10-001 01/22/2010</a>	The CHC-MCO is prohibited from imposing enrollment fees, premiums, or similar charges on Indians served by an Indian health care 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).
<a href="#">ARRA 5006(d)</a> <a href="#">SMD 10-001</a>	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.
<a href="#">ARRA 5006(d)</a> <a href="#">SMD 10-001</a>	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.

<a href="#">ARRA 5006(d)</a> <a href="#">SMD 10-001</a>	<p>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</p>
Citation	Requirement
<a href="#">42 CFR 438.6(f)(2)(i)</a> <a href="#">42 CFR 434.6(a)(12)(i)</a> <a href="#">42 CFR 447.26(b)</a>	<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"> <li>(i) Is identified in the State Plan</li> <li>(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</li> <li>(iii) Has a negative consequence for the beneficiary</li> <li>(iv) Is auditable</li> <li>(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.</li> </ul>
<a href="#">42 CFR 438.6(f)(2)(ii)</a> <a href="#">42 CFR 434.6(a)(12)(ii)</a>	<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>
<a href="#">1916(a)(2)(D)</a> <a href="#">1916(b)(2)(D)</a> <a href="#">42 CFR 438.108</a> <a href="#">42 CFR 447.50-57</a> <a href="#">State Medicaid Director Letter SMDL #06-015 6/16/2006</a>	<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>

<a href="#">1903(i) final sentence</a> <a href="#">1903(i)(2)(A)</a>	<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
<a href="#">1903(i) final sentence</a> <a href="#">1903(i)(2)(B)</a>	<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>
<a href="#">1903(i) final sentence</a> <a href="#">1903(i)(2)(C)</a>	<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>
<a href="#">1903(i) final sentence</a> <a href="#">1903(i)(16)</a>	<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>

<a href="#">1903(i) final sentence</a> <a href="#">1903(i)(17)</a>	<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>
<b>Citation</b>	<b>Requirement</b>
<a href="#">1903(i) final sentence</a> <a href="#">1903(i)(18)</a>	<p>The CHC-MCO shall not make payment with respect to any amount expended for home health care 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.</p>
<a href="#">1903(t)</a> <a href="#">42 CFR 495.332 (d)(2)</a> <a href="#">42 CFR 438.6(c)(5)(iii)</a> <a href="#">42 CFR 495.332 (d)(2)</a> <a href="#">42 CFR 438.6(c)(5)(iii)</a> <a href="#">42 CFR 495.304</a> <a href="#">42 CFR 495.310(c)</a> <a href="#">42 CFR 447.253(e)</a> <a href="#">42 CFR 495.370(a)</a> <a href="#">SMD# 09-006, Attachment A</a> <a href="#">1903(t)(6)(A)(ii)</a>	<p>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).</p>
<a href="#">1903(t)(6)(A)(ii)</a> <a href="#">495.310(k)</a> <a href="#">495.332(c)(9)</a>	<p>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.</p>
<b>Citation</b>	<b>Requirement</b>

[1124\(a\)\(2\)\(A\)](#)  
[1903\(m\)\(2\)\(A\)\(viii\)](#)  
[1903\(t\)\(6\)\(A\)\(ii\)](#)  
[42 CFR 455.100-103](#)  
[42 CFR 455.104\(b\)](#)

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:

- 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 of 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 (55Pa. 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 health care services, day care and education to children under the age of 18, if the services are funded by Federal programs whether directly or through State and Local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.

#### **H. MEDICARE/MEDICAID REIMBURSEMENT**

1. To the extent that services are furnished by contractors, subcontractors, or organizations related to the 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 health care 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 born 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 subclause 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 Public Welfare's 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 new policy, the facility will not be able to contract with this provider and will need to procure the services from another source.

s. **ACT 13 APPLICATION TO CHC-MCO**

CHC-MCO shall be required to submit with their bid information obtained within the preceding one-year period for any personnel who will have or may have direct contact with residents from the facility or unsupervised access to their personal living quarters in accordance with the following:

1. Pursuant to 18 Pa.C.S. Ch. 91 (relating to criminal history record information) a report of criminal history information from the Pennsylvania State Police or a statement from the State Police that their central repository contains no such information relating to that person. The criminal history record information shall be limited to that which is disseminated pursuant to 18 Pa.C.S. 9121(b)(2) (relating to general regulations).
2. Where the applicant is not, and for the two years immediately preceding the date of application has not been a resident of this Commonwealth, the Department shall require the applicant to submit with the application a report of Federal criminal history record information pursuant to the Federal Bureau of Investigation's under Department of State, Justice, and Commerce, the Judiciary, and Related Agencies Appropriation Act, 1973 (Public Law 92-544, 86 Stat. 1109). For the purpose of this paragraph, the applicant shall submit a full set of fingerprints to the State Police, which shall forward them to the Federal Bureau of Investigation for a national criminal history check. The information obtained from the criminal record check shall be used by the Department to determine the applicant's eligibility. The Department shall insure confidentially of the information.
3. The Pennsylvania State Police may charge the applicant a fee of not more than \$10 to conduct the criminal record check required under subsection 1. The State Police may charge a fee of not more than the established charge by the Federal Bureau of Investigation for the criminal history record check required under subsection 2.

The CHC-MCO shall apply for clearance using the State Police Background Check (SP4164) at its 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 H

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

#### **A. GENERAL REQUIREMENT**

The CHC-MCOs must submit to the Department all written policies and procedures for the Prior Authorization of services. The CHC-MCO may require Prior Authorization for any services that require Prior Authorization in the Medical Assistance Fee-for-Service (FFS) Program. The CHC-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for determining if the service is Medically Necessary. The CHC-MCO must receive advance written approval from the Department to require the Prior Authorization of any services not currently required to be Prior Authorized under the FFS Program. For each service to be Prior Authorized, the CHC-MCO must submit for the Department's review and approval the written policies and procedures in accordance with the guidelines described below. The policies and procedures must:

- Be submitted in writing, for all new and revised criteria, prior to implementation;
- Be approved by the Department in writing prior to implementation;
- Adhere to specifications of the Community HealthChoices RFP, Community HealthChoices Agreement, federal regulations, and applicable policy in Medical Assistance General Regulations, Title 55, PA. Code Chapter 1101 and DHS regulations;
- Ensure that Covered Services are Medically Necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- Adhere to the applicable requirements of Centers for Medicare and Medicaid Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- Include an expedited review process to address those situations when an item or service must be provided on an urgent basis.
- Specify that Person-Centered Service Plans serve as prior authorization for the services outlined therein.

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

Community HealthChoices Agreement Effective January 1, 2017 H-

approval. Failure of the CHC-MCO to comply may result in sanctions and/or penalties by the Department.

The Department defines prior authorization as:

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

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

## **B. GUIDELINES FOR REVIEW**

### **1. Basic Requirements:**

- a. The CHC-MCO must identify individual service(s), medical item(s), and/or therapeutic categories of drugs to be Prior Authorized.
- b. If the Prior Authorization is limited to specific populations, the CHC-MCO must identify all populations who will be affected by the proposal for Prior Authorization.

### **2. Medically Necessary Requirements:**

- a. The CHC-MCO must describe the process to validate medical necessity for:
  - covered care and services;
  - procedures and level of care;
  - medical or therapeutic items.
- b. The CHC-MCO must identify the source of the criteria used to review the request for Prior Authorization of services. The criteria must be consistent with the CHC Agreement definition for a service or benefit that is Medically Necessary. All criteria must be submitted to the Department for evaluation and approval under URCAP prior to implementation.
- c. For CHC-MCOs, if the criteria being used are:
  - Purchased and licensed, the CHC-MCO must identify the vendor;
  - Developed/recommended/endorsed by a national or state health care Provider association or society, the CHC-MCO must identify the association or society;
  - Based on national best practice guidelines, the CHC-MCO must identify the source of those guidelines;

- Based on the medical training, qualifications, and experience of the CHC-MCO's Medical Director or other qualified and trained practitioners, the CHC-MCO must identify the individuals who will determine if the service or benefit is Medically Necessary.
- d. CHC-MCO guidelines to determine medical necessity of all drugs that require prior authorization must be posted for public view on the CHC-MCO's website. This includes, but is not limited to, guidelines to determine medical necessity of both specific drugs and entire classes of drugs that require prior authorization for health and safety reasons, non-formulary designations, appropriate utilization, quantity limits, or mandatory generic substitution. The guidelines must specify all of the conditions that the CHC-MCO reviewers will consider when determining medical necessity including requirements for step therapy.
  - e. The CHC-MCO must identify the qualification of staff that will determine if the service is Medically Necessary. Health Care Providers, qualified and trained in accordance with the CMS Guidelines, the RFP, the Community HealthChoices Agreement, and applicable legal settlements must make the determination of Medically Necessary services.

For children under the age of twenty-one (21), requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Participant's condition or disease determines:

- That the prescriber did not make a good faith effort to submit a complete request, or
  - That the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.
- f. The CHC-MCO must outline how the Service Planning process with IDT approach will ensure that Medically Necessary services specified in the Person-Centered Service Plan are authorized by virtue of inclusion in the Person-Centered Service Plan and processed into all appropriate systems.
  - g. In accordance with Section V.B., the CHC-MCO will outline what PCSP changes during the period covered by the PCSP may be made by the Participant and Service Coordinator without IDT involvement and which must be made by the CHC-MCO in accordance with the CHC-MCO Prior Authorization plan.
  - h. For LTSS, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver.
  - i.

### 3. Administrative Requirements

- a. The CHC-MCO's written policies and procedures must identify the time frames

for review and decisions and the CHC-MCO must demonstrate that the time frames are consistent with the following required maximum time frames:

- Immediate: Inpatient Place of Service Review for emergency and urgent admissions.
  - 24 hours: All drugs; and items or services which must be provided on an urgent basis.
  - 48 hours: (following receipt of required documentation): Home Health Services.
  - 21 days: All other services.
- b. The CHC-MCO's written policies and procedures must demonstrate how the CHC-MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.
- c. The CHC-MCO's written policies and procedures must explain how Prior Authorization data will be incorporated into the CHC-MCO's overall Quality Management plan.

#### 4. Notification, Grievance, and DHS Fair Hearing Requirements

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

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

For purposes of tracking care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the CHC-MCO may choose to establish a process or protocol requiring notification prior to service delivery. This process must not involve any approvals/denials or delays in receiving the service. The CHC-MCO must notify Providers of this notification requirement. This process may not be administratively cumbersome to Providers and Participants. These situations need not comply with the other Prior Authorization requirements contained in this Exhibit.

## EXHIBIT M(1)

### **QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS**

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

- A. Contain a written program description, work plan, evaluation and policies/procedures that meet requirements outlined in the agreement;
- B. Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the CHC-MCO in collaboration with the Department;
- C. Be based on statistically valid clinical and financial analysis of Encounter Data, Participant demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and other data that allows for the identification of prevalent medical conditions, barriers to care and racial/ethnic disparities to be targeted for quality improvement, case and disease management initiatives;
- D. Allow for the continuous evaluation of its activities and adjustments to the program based on these evaluations;
- E. Demonstrate sustained improvement for clinical performance over time; and
- F. Allow for the timely, complete, and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including HEDIS and CAHPS as outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).
- G. Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the CHC-MCO or the Department that:
  - 1) Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;
  - 2) Allow for submission of improvement plans, as determined by and within time frames established by the Department. Failure by the CHC-MCO to comply with the requirements and improvement actions requested by the Department may result in the application of penalties and/or sanctions as outlined in Section VIII.H, Sanctions, of the Agreement.

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

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

- A. Adhere to current Medicaid CMS guidelines.
- B. Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and techniques of peer review.
- C. Ensure that that all QM and UM activities and initiatives undertaken by the CHC-MCO are based upon clinical and financial analysis of Encounter Data, Participant demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and/or other identified areas.
- D. Contain policies and procedures which provide for the ongoing review of the entire scope of care provided by the CHC-MCO assuring that all demographic groups, races, ethnicities, care settings and types of services are addressed.
- E. Contain a written program description that addresses all standards, requirements and objectives established by the Department and that describes the goals, objectives, and structure of the CHC-MCO's QM and UM programs. The written program description must, at a minimum:
  - 1) Include standards and mechanisms for ensuring the accessibility of primary care services, specialty care services, urgent care services, and Participant services in accordance with timeframes outlined in Exhibit AAA, Provider Network Composition/Service Access of the Agreement.
  - 2) Distinct policies and procedures regarding LTSS and shall specify the responsibilities and scope of the authority of Service Coordinators in authorizing LTSS and in submitting authorizations to Providers.
  - 3) Include mechanisms for planned assessment and analysis of the quality of care provided and the utilization of services against formalized standards, including but not limited to:
    - a) Primary, secondary, and tertiary care;
    - b) Preventive care and wellness programs;
    - c) Acute and/or chronic conditions;
    - d) Emergency Department utilization and ED diversion efforts
    - e) Dental care
    - f) LTSS
    - g) Service Coordination; and

- h) Continuity of care.
  - 4) Allow for the timely, accurate, complete collection and clinical and financial analysis of Encounter Data and other data including, but not limited to, HEDIS, CAHPS, and Pennsylvania Performance Measures.
  - 5) Allow for systematic analysis and re-measurement of barriers to care, the quality of care provided to Participants, and utilization of services over time.
- F. Provide a comprehensive written evaluation, completed on at least an annual basis, that details all QM and UM program activities including, but not limited to:
- a) Studies and activities undertaken; including the rationale, methodology and results
  - b) Subsequent improvement actions; and
  - c) Aggregate clinical and financial analysis of Encounter, HEDIS, CAHPS, Pennsylvania Performance Measures, and other data on the quality of care rendered to Participants and utilization of services.
- G. Include a work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, including, but not limited to:
- 1) Data collection and analysis;
  - 2) Evaluation and reporting of findings;
  - 3) Implementation of improvement actions where applicable; and
  - 4) Individual accountability for each activity.
- H. Provide for aggregate and individual analysis and feedback of Provider performance and CHC-MCO performance in improving access to care, the quality of care provided to Participants and utilization of services.
- I. Include mechanisms and processes which ensure related and relevant operational components, activities, and initiatives from the QM and UM programs are integrated into activities and initiatives undertaken by other departments within the CHC-MCO including, but not limited to, the following:
- 1) Provider Relations;
  - 2) Participant Services; and
  - 3) Management Information Systems
- J. Include procedures for informing both physician and non-physician Providers about the written QM and UM programs, and for securing cooperation with the QM and UM programs in all physician and non-physician Provider agreements.
- K. Include procedures for feedback and interpretation of findings from analysis of

quality and utilization data to Providers, health professionals, CHC-MCO staff, and Medical Assistance Consumers/family members.

- L. Include mechanisms and processes which allow for the development and implementation of CHC-MCO wide and Provider specific improvement actions in response to identified barriers to care, quality of care concerns, and over-utilization, under-utilization and/or mis-utilization of services.
- M. The CHC-MCO shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures.
- Pre-admission certification process for non-emergency admissions;
  - A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CHC-MCO shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a member can be transferred to a contract facility in the network, if presently in a non-contract facility;
  - Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;
  - Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and
  - Prospective review of same day surgery procedures.
- N. The CHC-MCO shall ensure that reimbursement of nursing facility care is provided for Participants who have been determined to be eligible for reimbursement of nursing facility care for the period specified. The CHC-MCO shall monitor the Participant's condition for ongoing care and potential discharge back to community living.
- O. The CHC-MCO shall utilize the following guidelines in identifying and managing care for members who are determined to have excessive and/or inappropriate ED utilization:
- Review ED utilization data, at a minimum, every six (6) months to identify members with utilization exceeding the threshold defined as six (6) or more visits in the defined six (6) month period (January through June

- and July through December);
  - For members whose utilization exceeds the threshold of ED visits defined above in the previous six (6) month period, the CHC-MCO shall conduct appropriate follow-up to identify the issues causing frequent ED utilization and determine appropriate next steps.
  - As appropriate, make contact with members whose utilization exceeded the threshold of ED visits in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization.
  - Assess the most likely cause of high utilization and develop a PCSP based on results of the assessment for each member.
- P. The CHC-MCO shall comply with any applicable federal and state laws or rules related to length of hospital stay.
- Q. In addition to meeting the reporting requirement for oversight and monitoring of the program, the CHC-MCO must report all information required for rapid cycle evaluation, as outlined by the Department. The CHC-MCO must also comply with all implementation monitoring and oversight requirements. The CHC-MCO must comply with any program policy changes resulting from the Department's rapid cycle, implementation monitoring, or other evaluation of the CHC Program.

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

- A. The Governing Body:
- 1) Has formally designated an accountable entity or entities, within the CHC-MCO to provide oversight of QM and UM program activities or has formally decided to provide such oversight as a committee, e.g. Quality Management Committee.
  - 2) Regularly receives written reports on the QM and UM program activities that describe actions taken, progress in meeting objectives and improvements made. The governing body formally reviews, on at least an annual basis, a written evaluation of the QM and UM program activities that includes studies undertaken, results of studies, and subsequent improvement actions taken. The written evaluation must include aggregate clinical and financial analysis of quality and utilization data, including HEDIS, CAHPS, and Pennsylvania Performance Measures.
  - 3) Documents actions taken by the governing body in response to findings

from QM and UM program activities.

B. The Quality Management Committee (QMC):

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

- a) Demonstrate that the QMC has oversight responsibility and input, including review and approval, on all QM and UM program activities;
- b) Ensure membership on the QMC and active participation by individuals representative of the composition of the CHC-MCO's Providers; and
- c) Provide for documentation of the QMC's activities, findings, recommendations, and actions.

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

C. The Director of LTSS ensures the provision of LTSS in accordance with the requirements outlined in this Agreement and the CHC 1915(c) Waiver.

D. The Director of Quality Management serves as liaison and is accountable to the governing body and Quality Management Committee for all QM and UM activities and initiatives.

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

F. The Medical Director:

- 1) Is available to the CHC-MCO's medical staff for consultation on referrals, denials, Complaints and problems;
- 2) Is directly involved in the CHC-MCO's recruiting and credentialing activities;
- 3) Is familiar with local standards of medical practice and nationally accepted standards of practice;
- 4) Has knowledge of due process procedures for resolving issues between Network Providers and the CHC-MCO administration, including those related to medical decision making and utilization review;
- 5) Is available to review, advise and take action on questionable hospital admissions, Medically Necessary days and all other medical care and medical cost issues;
- 6) Is directly involved in the CHC-MCO's process for prior authorizing or

denying services and is available to interact with Providers on denied authorizations;

- 7) Has knowledge of current peer review standards and techniques;
- 8) Has knowledge of risk management standards;
- 9) Is directly accountable for all Quality Management and Utilization Management activities and
- 10) Oversees and is accountable for:
  - a) Referrals to the Department and appropriate agencies for cases involving quality of care that have adverse effects or outcomes; and
  - b) The processes for potential Fraud and Abuse investigation, review, sanctioning and referral to the appropriate oversight agencies.

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

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

A. The QM and UM programs must include professionally developed practice guidelines/standards of care that are:

- 1) Written in measurable and accepted professional formats,
- 2) Based on scientific evidence; and
- 3) Applicable to Providers for the delivery of certain types or aspects of health care.

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

C. Practice guidelines and clinical indicators must address the full range of health care and LTSS needs of the populations served by the CHC-MCO. The areas addressed must include, but are not limited to:

- 1) Adult preventive care;
- 2) LTSS;

- 3) Pediatric and adolescent preventive care with a focus on EPSDT services;
  - 4) Obstetrical care including a requirement that Participants be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;
  - 5) Selected diagnoses and procedures relevant to the enrolled population;
  - 6) Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the CHC-MCO's Participant; and
  - 7) Preventive dental care.
- D. The QM and UM programs must provide practice guidelines, clinical indicators and medical record keeping standards to all Providers and appropriate subcontractors. This information must also be provided to Participants upon request.
- E. The CHC-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, LTSS Providers, and Providers of ancillary services not less than every two years (i.e. medical record audits). These methodologies must, at a minimum:
- 1) Demonstrate the degree to which PCPs, specialists, and dental Providers are complying with clinical and preventive care guidelines adopted by the CHC-MCO;
  - 2) Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO;
  - 3) Allow for the tracking and trending of individual and CHC-MCO wide Provider performance over time;
  - 4) Include active mechanisms and processes that allow for the identification, investigation and resolution of quality of care concerns, including events such as Health Care-Associated Infections and medical errors; and
  - 5) Include mechanisms for detecting instances of over-utilization, under-utilization, and mis-utilization;
- F. The QM and UM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:
- 1) Processes that allow for the identification, investigation and resolution of quality of care concerns including Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care patterns;
  - 2) Processes for tracking and trending problematic patterns of care;
  - 3) Use of progressive sanctions as indicated;
  - 4) Person(s) or body responsible for making the final determinations regarding

quality problems; and

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

- a) Education;
- b) Follow-up monitoring and re-evaluation;
- c) Changes in processes, structures, forms;
- d) Informal counseling;
- e) Procedures for terminating the affiliation with the physician or other health professional or Provider;
- f) Assessment of the effectiveness of the actions taken; and
- g) Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care).

- G. The QM and UM programs must include methodologies that allow for the identification, verification, and timely resolution of inpatient and outpatient quality of care concerns, Participant quality of care complaints, over-utilization, under-utilization, and/or mis-utilization, access/availability issues, and quality of care referrals from other sources;
- H. The QM and UM programs must contain procedures for Participant satisfaction surveys that are conducted on at least an annual basis including the collection of annual Participant satisfaction data through application of the CAHPS instrument as outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS). The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys and reserves the right to implement a CAHPS or CAHPS-like survey at a later date.
- I. The QM and UM programs must contain procedures for Provider satisfaction surveys to be conducted on at least an annual basis. Surveys are to include PCPs, and specialists, dental Providers, hospitals, and Providers of ancillary services.
- J. Each CHC-MCO will be required to comply with requirements for Performance Improvement Projects (PIPs) as outlined in Exhibit M(2) External Quality Review.
- K. The QM and UM programs must contain procedures for measuring Participant and Provider satisfaction with LTSS Service delivery.

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

- A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web-based electronic formats) profiles comparing the average medical care utilization rates of the Participants of each PCP to the average utilization rates of all CHC-Community HealthChoices Agreement Effective January 1, 2017

MCO Participants. The CHC-MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to:

- 1) Utilization information on Participant Encounters with PCPs;
  - 2) Specialty Claims;
  - 3) Prescriptions;
  - 4) Inpatient stays;
  - 5) Nursing Facility use;
  - 6) Community-based LTSS use;
  - 7) Emergency room use;
  - 8) Clinical indicators for preventive care services (i.e., mammograms, immunizations, pap smear, etc.); and
  - 9) Clinical indicators for EPSDT requirements.
- B. The CHC-MCO must have mechanisms and processes for profiling all Providers using risk adjusted diagnostic data for profiles.
- C. The CHC-MCO must have mechanisms and processes for aggregate trending of changes to person centered service plans, and reporting aggregate data to the Department
- D. The QM and UM programs must implement statistically valid methodologies for analysis and follow-up of semi-annual practitioner utilization profiles for patterns and instances of over-utilization, under-utilization, and mis-utilization across the continuum of care, as well as, trending of Provider utilization patterns over time. Follow up includes but is not limited to Provider education, Provider improvement plans, and Provider sanctions as necessary.
- E. The QM and UM programs must at least annually, provide for verification of Encounter reporting rates and accuracy and completeness of Encounter information submitted by PCPs.

**Standard V:** The CHC-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for Participants identified. The CHC-MCO must have a Complex Case Management Program and a Disease Management Program that must:

- A. Include mechanisms and processes that ensure the active collaboration and coordination of care and services for identified members.
- B. Include mechanisms and processes that allow for the identification of conditions to be targeted for case/disease and health management programs and that allow for the assessment and evaluation of the effectiveness of these programs in improving outcomes for and meeting the needs of individuals with targeted conditions.
- C. Include care guidelines and/or protocols for appropriate and effective management of individuals with specified conditions. These guidelines must be written in measurable and accepted professional formats and be based on scientific evidence.
- D. Include performance indicators that allow for the objective measurement and analysis of individual and CHC-MCO wide performance in order to demonstrate progress made in improving access and quality of care.
- E. Include mechanisms and processes that lead to healthy lifestyles such as weight loss program memberships, gym memberships and asthma camps.
- F. The CHC-MCO agrees to comply with Department requirements and procedures related to the Enhanced Medical Home (EMH) model. EMH model is a system of care that provides access to a primary care provider, as well as targeted care management support for members at high risk of using acute medical services. There are four Pillars of the EMH model with which the CHC-MCO would be expected to participate:
  - Embedded Service Coordinators in high volume practices (HVPs)
  - Working with HVP(s) to achieve NCQA Medical Home recognition
  - Transition of Care (TOC) nurses to work with high volume health systems
  - Participation with regional learning network collaboratives

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

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

- B. Other CHC-MCOs;
- C. The CHC-MCO and Medicare D-SNPs whether aligned or not aligned;
- D. The CHC-MCO and HealthChoices BH-MCOs;
- E. The CHC-MCOs and Physical Health HealthChoices MCOs
- F. The CHC-MCO and the Department's Fee For Service Program; and
- G. The CHC-MCO and other third party insurers
- H. The CHC-MCOs and LIFE providers
- I. The CHC-MCOs and Lottery funded services

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

- A. Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the CHC-MCO.
- B. Have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.
- C. Document evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.
- D. Make available to the Department, and its authorized representatives, any and all records, documents, and data detailing its oversight of delegated QM and UM program functions.
- E. Must ensure that delegated entities make available to the Department, and its authorized representatives, any and all records, documents and data detailing the delegated QM and UM program functions undertaken by the entity of behalf of the CHC-MCO.
- F. Compensation and payments to individuals or entities that conduct Utilization Management activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Participant.

**Standard VIII:** The QM/UM program must have standards for credentialing/ recredentialing Providers to determine whether all Providers, who provide health

services or LTSS in the Commonwealth and are under contract to the CHC-MCO, are qualified to perform their services.

- A. The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department's requirements outlined in this Agreement and through guidance to plans. Recredentialing activities must be conducted by the CHC-MCO at least every three (3) years. Criteria must include, but not be limited to, the following:
- 1) Appropriate license or certification as required by Pennsylvania state law;
  - 2) Verification that Providers have not been suspended, terminated or entered into a settlement for voluntary withdrawal from the Medicaid or Medicare Programs;
  - 3) Verification that Providers and/or subcontractors have a current Provider Agreement and an active PROMISe™ Provider ID issued by the Department;
  - 4) Evidence of malpractice/liability insurance;
  - 5) A valid Drug Enforcement Agency (DEA) certification;
  - 6) Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach;
  - 7) Consideration of quality issues such as Participant Complaint and/or Participant satisfaction information, sentinel events and quality of care concerns.
- B. For purposes of credentialing and recredentialing, the CHC-MCO must perform a check on all PCPs and other physicians by contacting the National Practitioner Data Bank (NPDB). If the CHC-MCO does not meet the statutory requirements for accessing the NPDB, then the CHC-MCO must obtain information from the Federation of State Medical Boards
- C. Appropriate PCP qualifications:
- 1) Seventy-five to 100% of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics;
  - 2) No more than 25% of the Network consists of PCPs without appropriate residencies but who have, within the past seven years, five years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas

described; and

- 3) No more than 10% of the Network consists of PCPs who were previously trained as specialist physicians and changed their areas of practice to primary care, and who have completed Department-approved primary care retraining programs.
  - 4) A PCP must have the ability to perform or directly supervise the ambulatory primary care services of Participants;
  - 5) Membership of the medical staff with admitting privileges of at least one general hospital or an acceptable arrangement with a PCP with admitting privileges;
  - 6) Demonstrate evidence of continuing professional medical education;
  - 7) Attend at least one CHC-MCO sponsored Provider education training session as outlined in Section V.R.2, Provider Education, of the Agreement.
- D. Assurance that any CRNP, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team, is performing under the scope of their respective licensure; and
- E. As part of the Provider release form, the potential Provider must agree to release all Medical Assistance records pertaining to sanctions and/or settlement to the CHC-MCO and the Department.
- F. The Department will recoup from the CHC-MCO any and all payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by the CHC-MCO in a manner that is not consistent with the Provider's licensure. In addition, the CHC-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.
- G. The CHC-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the CHC-MCO's credentialing practices.
- H. Any economic profiles used by the CHC-MCOs to credential Providers should be adjusted to adequately account for factors that influence utilization independent of the Provider's clinical management, including Participant age, Participant sex, Provider case-mix and Participant severity. The CHC-MCO must report any utilization profile that it utilizes in its credentialing process and the methodology that it uses to adjust the profile to account for non-clinical management factors at the time and in the manner requested by the Department.
- I. In the event that a CHC-MCO renders an adverse credentialing decision, the CHC-MCO must provide the affected Provider with a written notice of the decision. The

notice should include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors. All credentialing decisions made by the CHC-MCO are final and may not be appealed to the Department.

- J. The CHC-MCO must meet the following standards related to timeliness of processing new Provider applications for credentialing.
  - 1) The CHC-MCO must begin its credentialing process upon receipt of a Provider's credentialing application if the application contains all required information.
  - 2) The CHC-MCO may not delay processing the application if the Provider does not have an MAID number that is issued by the DHS. However, the CHC-MCO cannot complete its process until the Provider has received its MAID number from DHS.
  - 3) Provider applications submitted to the CHC-MCO for credentialing must be completed within sixty (60) days of receipt of the application packet if the information is complete.

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

- A. The UM program must contain policies and procedures for Prospective, Concurrent, and Retrospective review determinations of medical necessity.
- B. A Person Centered Service Plan shall be developed and implemented for all NFCE Participants and others who request or require Service Coordination. The CHC-MCO shall audit a sample of the PCSPs to demonstrate compliance with the requirements of the QM/UM program. The CHC-MCO must use a protocol to select the PCSP that has been submitted to and reviewed by the Department. Audit results must be submitted to the Department as part of the Annual QAPI Program Evaluation.
- C. The UM program must allow for determinations of medical necessity that are consistent with the CHC Program definition of Medically Necessary:

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

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

- 1) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability;
- 2) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability;
- 3) The service or benefit will, assist the 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.

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

- 1) Meet the CHC Program's definition of Medically Necessary;
- 2) Contain timeframes for decision making or cross reference policies on time frames for decision making that meet requirements outlined in Section V.B, Prior Authorization of Services, of the Agreement.
- 3) Contain language or cross reference policies and procedures of notifying Participants of adverse decisions and how to file a Complaint/Grievance/DHS Fair Hearing;
- 4) Comply with state/federal regulations;
- 5) Comply with CHC RFP and other contractual requirements;
- 6) Specify populations covered by the policy;
- 7) Contain an effective date; and
- 8) Be received under signature of individuals authorized by the plan.

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

- 1) Not contain any definition of medical necessity that differs from the CHC definition of Medically Necessary;
  - 2) Allow for determinations of medical necessity that are consistent with the CHC Program definition of Medically Necessary;
  - 3) Allow for the assessment of the individual's current condition and response to treatment and/or co-morbidities, psychosocial, environmental and/or other needs that influences care;
  - 4) Provide direction to clinical reviewers on how to use clinical information gathered in making a determination to approve, deny, continue, reduce or terminate a service;
  - 5) Be developed using a scientific based process;
  - 6) Be reviewed at least annually and updated as necessary; and
  - 7) Provide for evaluation of the consistency with which reviewers implement the criteria on at least an annual basis.
- F. The CHC-MCO must ensure that Prior Authorization and Concurrent review decisions:
- 1) Are supervised by a physician or Health Care practitioner with appropriate clinical expertise in treating the Participant's condition or disease;
  - 2) That result in a denial may only be made by a licensed physician;
  - 3) Are made in accordance with established time-frames outlined in the agreement for routine, urgent, or emergency care; and
  - 4) Are made by clinical reviewers using the CHC definition of medical necessity.
- G. The CHC-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, and medical supplies. The CHC-MCO must have written policies and procedures that address how Participants and Providers can make contact with the CHC-MCO to receive instruction or Prior Authorization, as necessary
- H. Additional Prior Authorization requirements can be found in Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the CHC Program.
- I. The CHC-MCO must ensure that utilization records document efforts made to obtain all pertinent clinical information and efforts to consult with the prescribing

Provider before issuing a denial based upon medical necessity.

- J. The CHC-MCO must ensure that sources of utilization criteria are provided to Participants and Providers upon request.
- K. The UM program must contain procedures for providing written notification to Participants of denials of medical necessity and terminations, reductions and changes in level of care or placement, which clearly document and communicate the reasons for each denial. These procedures must:
  - 1) Meet requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.
  - 2) Provide for written notification to Participants of denials, terminations, reductions and changes in medical services at least ten (10) days before the effective date.
  - 3) Include notification to Participants of their right to file a Complaint, Grievance or DHS Fair Hearing as outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.
- L. The CHC-MCO must agree to comply with the Department's utilization review monitoring processes, including, but not limited to:
  - 1) Submission of a log of all denials issued using formats to be specified by the Department.
  - 2) Submission of denial notices for review as requested by the Department
  - 3) Submission of utilization review records and documentation as requested by the Department
  - 4) Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.
  - 5) Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department prior to implementation.

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

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

- C. Adverse credentialing/recredentialing decisions
- D. Provider Terminations

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

- A. The QM and UM program must have procedures which describe how findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to individuals within the CHC-MCO for use in conjunction with other related activities such as:
  - 1) CHC-MCO Provider Network changes;
  - 2) Benefit changes;
  - 3) Medical management systems (e.g., pre-certification);
  - 4) Practices feedback to Providers; and
  - 5) Service Coordination or Service Planning changes.

**Standard XII:** The CHC-MCO must have written policies and procedures for conducting prospective and retrospective DUR that meet requirements outlined in Exhibit BBB(2), Drug Utilization Review Guidelines.

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

- A. The CHC-MCO must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for medical records that promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.
- B. Medical record standards must meet or exceed medical record keeping requirements contained in 55 Pa. Code Section 1101.51(d)(e) of the Medical Assistance Manual and medical record keeping standards adopted by DOH.
- C. Additional standards for patient visit data must, at a minimum, include the following:
  - 1) History and physical that is appropriate to the patient's current condition;
  - 2) Treatment plan, progress and changes in treatment plan;
  - 3) Diagnostic tests and results
  - 4) Therapies and other prescribed regimens;

- 5) Disposition and follow-up;
  - 6) Referrals and results thereof;
  - 7) Hospitalizations;
  - 8) Reports of operative procedures and excised tissues; and
- D. All other aspects of patient care.
  - E. The CHC-MCO must have written policies and procedures to assess the content of medical records for legibility, organization, completion and conformance to its standards.
  - F. The CHC-MCO must ensure access of the Participant to his/her medical record at no charge and upon request. The Participant's medical records are the property of the Provider who generates the record.
  - G. The Department and/or its authorized agents (i.e., any individual or corporation or entity employed, contracted or subcontracted with by the Department) shall be afforded prompt access to all Participants' medical records whether electronic or paper. All medical record copies are to be forwarded to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. The Department is not required to obtain written approval from a Participant before requesting the Participant's medical record from the PCP or any other agency.
  - H. Medical records must be preserved and maintained for a minimum of five years from expiration of the CHC-MCO's contract. Medical records must be made available in paper form upon request.
  - I. When a Participant changes PCPs, the CHC-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PCP within seven business days from receipt of the request. In emergency situations, the CHC-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.
  - J. When a Participant changes CHC-MCOs, the CHC-MCO must facilitate the transfer of his/her medical and service planning records or copies of medical and service planning records to the new CHC-MCO within seven business days from the effective date of enrollment in the gaining CHC-MCO. In emergency situations, the CHC-MCO must facilitate the transfer of medical and service planning records as soon as possible from receipt of the request.

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

- A.
- B. The CHC-MCO must have a written policy that recognizes the rights of Participants outlined in Exhibit EEE.

- C. The CHC-MCO must have a written policy that addresses Participant's responsibility for cooperating with those providing health care services. This written policy must address Participant's responsibility for:
- 1) Providing, to the extent possible, information needed by professional staff in caring for the Member; and
  - 2) Following instructions and guidelines given by those providing health care services.
  - 3) Participants shall provide consent to managed care plans, Health Care Providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For these purposes, Participants will remain anonymous to the greatest extent possible.
- D. The CHC-MCO's policies on Participant rights and responsibilities must be provided to all Network Providers.
- E. Upon enrollment, Participants must be provided with a written statement that includes information on the following:
- 1) Rights and responsibilities of Participants;
  - 2) Benefits and services included as a condition of participation, and how to obtain them, including a description of:
    - a) Any special benefit provisions (for example, co-payment, higher deductibles, rejection of Claim) that may apply to services obtained outside the system; and
    - b) The procedures for obtaining Out-of-Area Services;
    - c) Charges to Participants if applicable;
    - d) Benefits and services excluded.
    - e) Provisions for after-hours, urgent and emergency coverage;
    - f) The CHC-MCO's policy on referrals for specialty care;
    - g) CHC-MCO Procedures for notifying, in writing, those Participants affected by denial, termination or change in any benefit or service including denials, terminations or changes in level of care or placement;
    - h) Procedures for appealing decisions adversely affecting the Participant's coverage, benefits or relationship to the CHC-MCO;
    - i) Information about DHS's Hotline functions;
    - j) Procedures for changing practitioners;
    - k) Procedures for disenrolling from the CHC-MCO;
    - l) Procedures for filing Complaints and/or Grievances; and DHS Fair Hearings; and
    - m) Procedures for recommending changes in policies and services.

- F. The CHC-MCO must have policies and procedures for resolving Participant Complaints and Grievances that meet all requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Processes. These procedures must include mechanisms that allow for the review of all Complaints and Grievances to determine if quality of care issues exists and for appropriate referral of identified issues.
- G. Opportunity must be provided for Participants to offer suggestions for changes in policies and procedures.
- 1) The CHC-MCO must take steps to promote accessibility of services offered to Participants. These steps must include identification of the points of access to primary care, specialty care and hospital services. At a minimum, Participants are given information about:
- How to obtain services during regular hours of operation;
  - How to obtain after-hours, urgent and emergency care; and
  - How to obtain the names, qualifications, and titles of the Health Care Provider providing and/or responsible for their care.
- H. Participant information (for example, Participant brochures, announcements, and handbooks) must be written in language that is readable and easily understood.
- I. The CHC-MCO must make vital documents disseminated to English speaking members available in alternate languages, upon request of the member. Documents may be deemed vital if related to the access of LEP persons to programs and services.

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

- A. The CHC-MCO must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM and UM programs.
- B. The CHC-MCO must adhere to all systems requirements as outlined in Section V.O.7, Management Information Systems, and Section VIII.B, Systems Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the Intranet supporting CHC.
- C. The CHC-MCO must adhere to all Encounter Data requirements as outlined in Section VIII.B.1, Encounter Data Reporting, of the Agreement.



## EXHIBIT M(2)

### EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(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. The requirements for EQR were further outlined in 42 CFR Parts 433 and 438; External Quality Review of Medicaid Managed Care Organizations. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Participants. "Quality", as it pertains to EQR, means the degree to which a CHC-MCO maintains or improves the health outcomes of its Participants through its structural and operational characteristics and through the provision of services. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight. The Department requires as part of the EQR process the CHC-MCOs:

- A. Actively participate in planning and developing the measures to be utilized with the Department and the EQRO. The Medical Assistance Advisory Committee will be given an opportunity to provide input into the measures to be utilized.
- B. Accurately, completely and within the required timeframe identify eligible Participants to the EQRO.
- C. Correctly identify and report the numerator and denominator for each measure.
- D. Actively encourage and require Providers, including subcontractors, to provide complete and accurate Provider medical records within the timeframe specified by the EQRO.
- E. Demonstrate how the results of the EQR are incorporated into the Plan's overall Quality Improvement Plan and demonstrate progressive improvements during the term of the contract.
- F. Improve Encounter Data in an effort to decrease the need for extensive Provider medical record reviews.
- G. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.
- H. Ensure that data, clinical records and workspace located at the CHC-MCO's work site are available to the independent review team and to the Department, upon request.

- I. Participate in Performance Improvement Projects whose target areas are dictated by the Department to address key quality areas of focus for improvements. The CHC-MCO will comply with the PIP timelines as prescribed by the EQRO.
  1. The CHC-MCO shall perform at least two (2) clinical and three (3) non-clinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.
  2. The CHC-MCO shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for performance improvement projects are documented.
  3. The CHC-MCO shall identify benchmarks and set achievable performance goals for each of its PIPs. The CHC-MCO shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.
  4. The CHC-MCO shall report on PIPs as required in the Reporting Requirements. For Performance Improvement Project topics that are conducted in the assigned Zone of the State. The CHC-MCO shall submit one Performance Improvement Project Summary Report that includes Zone-specific data and information, including *improvement strategies* as required by CMS.
  5. After three (3) years, the CHC-MCO shall, using evaluation criteria established by the Department, determine if one or all of the PIPs should be continued.



## Exhibit M(3)

### Critical Incident Reporting and Management and Provider Preventable Conditions Reporting

#### Critical Incident Reporting to the Department

CHC-MCOs must and must require their network providers and subcontractors to report critical events or incidents via a standard file transaction incorporated in the Enterprise Incident Management System.

The CHC-MCO must develop and implement a critical incident reporting system for Providers to report critical incidents.

The following are critical incidents:

- Death (other than by natural causes);
- Serious injury that results in emergency room visits, hospitalizations, or death;
- Hospitalization except in certain cases, such as hospital stays that were planned in advance;
- Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities;
- Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but not necessarily limited to:
  - Physical abuse, defined as a physical act by an individual that may cause physical injury to a participant;
  - Psychological abuse, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade or demean a participant;
  - Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
  - Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant;
- Neglect, which includes the failure to provide a participant the reasonable care that he or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is 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, is a form of neglect;
- Exploitation, which includes the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self or others;

- Restraint, which includes 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 are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights;
- Service interruption, which includes any event that results in the participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization; and
- Medication errors that that result in hospitalization, an emergency room visit or other medical intervention.

The CHC-MCO must cooperate and require its network providers to cooperate with an investigation of critical incidents.

### **Critical Incident Reporting Requirements for Providers**

Providers must report in accordance with applicable requirements.

The CHC-MCO must require providers to cooperate with the Department investigation of critical incidents.

### **Provider Preventable Conditions**

The CHC-MCO must require all Network Providers to identify provider preventable conditions as defined in 42 CFR § 447.26 and may not pay for services related to provider preventable conditions unless the condition existed prior to the initiation of treatment for the patient. The CHC-MCO must submit all identified Provider Preventable Conditions in a form or frequency as required by the Department.

## EXHIBIT M(4)

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

Annually, the CHC-MCO must complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusions from the complete Medicaid HEDIS data set must be childhood related and pregnancy related measures. The HEDIS measure results must be reported separately for each Zone in which the CHC-MCO operates. The CHC-MCO must contract with an NCQA certified HEDIS auditor to validate the processes of the CHC-MCO in accordance with NCQA requirements. Audited HEDIS results must be submitted to the Department, NCQA and the Department's EQRO annually by June 15 of each calendar.

The CHC-MCO must utilize the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA. If, in the event the CHC-MCO fails to pass the medical record review for any given standard and NCQA *mandates* administrative data must be submitted instead of hybrid, the administrative data may be used.

The CHC-MCO must submit to the Department by June 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported"

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

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

The Department requires that the CHC-

MCOs:

- A. Must produce rates for all Medicaid reporting measures, with the exclusion of the behavioral health measures, unless otherwise specified by the Department.
- B. Must follow NCQA specifications as outlined in the HEDIS Technical Specifications clearly identifying the numerator and denominator for each measure.
- C. Must have all HEDIS results validated by an NCQA-licensed vendor. The Department currently contracts with an NCQA-licensed entity to validate the MCOs' HEDIS results used in public reporting. The MCO may utilize these validation results for other purposes such as pursuit of accreditation. The

Department may at some future date relinquish the direct contracting of NCQA validation activities.

- D. Must assist with the HEDIS validation process by the Department's NCQA licensed contractor.
- E. Must demonstrate how HEDIS results are incorporated into the MCO's overall Quality Improvement Plan.
- F. Must submit validated HEDIS results annually on June 15<sup>th</sup> unless otherwise specified by the Department.

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

The CHC-MCO must conduct a CAHPS survey. The MCO must enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CHC-MCO's vendor must perform the CAHPS adult and HCBS survey using the most current CAHPS version specified by NCQA. Survey results must be reported to the Department. The survey results must be reported separately for each Zone in which the MCO operates. Survey results must be submitted to the Department, NCQA and the Department's EQRO annually by June 15 of each calendar year beginning in 2016.

The CHC-MCO must submit annually the Relative Resource Use (RRU) data to the Department within ten (10) business days of receipt from NCQA. The CHC-MCO must submit both the Regional and National RRU results.

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

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

- A. Must conduct both an Adult and HCBS CAHPS survey using the current version of CAHPS.
- B. Must include all Medicaid core questions in both surveys.
- C. Must add the following supplemental dental care questions, one through three, from the Supplemental Items for Adult/HCBS Questionnaires to both the Adult and HCBS CAHPS surveys and questions four and five to the HCBS CAHPS survey:

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

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

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

D4. What are the major difficulties you have in seeing a dentist as often as you need?

- I have trouble getting transportation to my dentist
- I forget to go
- I do not like dentists
- It is difficult to schedule an appointment
- My dentist does not have convenient office hours
- I have to wait too long in the waiting room
- I am afraid or nervous to go
- I don't have time
- I don't have someone to watch my other children
- I can't take time off from work
- I don't know how to find a dentist
- I cannot find an office with handicap accessibility
- I have trouble finding a dentist who speaks my language
- I have trouble getting orthodontic (braces) care
- The dentists I call do not accept my insurance
- Medicaid does not cover dentists
- None of the above. I haven't had any difficulty in seeing a dentist
- Other (write in)

D5. Which of the following would help you see the dentist more often?

- Help with transportation to the dentist
- Reminders to visit the dentist
- More dentists to choose from
- More convenient office hours
- Dentists that speak my language
- Help in finding a dentist
- Better communication about benefits from my child's health plan
- Education about good dental care
- None of the above. I see the dentist as often as I like.
- Other (write in)

D6. What are the major difficulties for providing dental services in LTSS settings and for the LTSS population?

- Willingness of dentists to see participants in the home
- Willingness of dentists to see participants in a Nursing facilities
- Willingness of dentists to accommodate individuals with disabilities
- Other

- D. Must add the following supplemental question from the Supplemental Items for the Adult Questionnaires to the Adult CAHPS survey:
- H16. Have you had a flu shot since September 1, 20xx?
- E. Must forward CAHPS data to the Department both electronically and hardcopy in an Excel file in the format determined by the Department.
- F. Must submit validated CAHPS results annually on June 15th unless otherwise specified by the Department.

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

## **EXHIBIT N**

### **NOTICE OF DENIAL**

A written notice of denial including reasons for denial must be issued to the Participant for the following:

- a. The denial or limited authorization of a requested service, including the type or level of service.
- b. The reduction, suspension or termination of a previously authorized service.
- c. The denial of a requested service because it is not a covered service for the Participant.
- d. The denial of a requested service but approval of an alternative service.

Please refer to Templates N(1) through N(6) for denial notices and N(7), Request for Additional Information Letter template on the Intranet supporting CHC.

EXHIBIT N(1)

**STANDARD DENIAL NOTICE – COMPLETE DENIAL**

[DATE] [This MUST be the date the notice is mailed]

RE: [Member's name and DOB]

Dear [Member Name]:

[CHC MCO Name] has reviewed the request for [*identify SPECIFIC service/item*] submitted by [*prescriber's name*] on behalf of [*patient name*] on [date]. After physician review, the request for service/item is:

Denied completely because: [*Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.*]

This decision will take effect on [date].

**To continue getting services**

If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint, grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:**

**1) Request Criteria**

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

*CHC MCO Name and Address*

**2) File a Complaint or Grievance**

You may file a complaint or grievance with [CHC MCO Name] **within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days [*CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.*] from when we receive it.

To file a complaint or grievance:

- Call [CHC MCO Name] at [Phone #/Toll-free TTY #]; or
- Send your complaint or grievance to [CHC MCO Name] at the following address:

#### 16.1 CHC MCO Address for filing complaint or grievance

##### To ask for an early decision

If your doctor or dentist believes that waiting ( ) days [CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [CHC MCO Name] at [Phone #/Toll-free TTY #];  
**AND**
- Your doctor or dentist must fax a signed letter to [CHC MCO fax #] explaining why taking 30 days to decide your complaint or grievance could harm your health.

[CHC MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

### 3) Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Public Welfare. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Public Welfare  
Office of Medical Assistance Programs  
HealthChoices Program/Complaint, Grievance and Fair Hearing  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

### **To ask for an early decision**

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

### **CHC MCO Address for records information**

#### **4) Get a second opinion**

You may get a second opinion from a provider in the [CHC MCO Name] network. Call your PCP or [CHC MCO Name] at [Phone #/Toll-free TTY #] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

#### **5) Get Help with Grievances, Complaints, or Fair Hearings**

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [CHC MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 ([www.phlp.org](http://www.phlp.org)) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 ([www.palegalaid.net](http://www.palegalaid.net))

cc: Prescribing Provider

**CHC MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:**

**The information in this notice is available in other languages and formats by calling [CHC MCO Name] at [Phone #/Toll-free TTY #].**

EXHIBIT N(2)

**STANDARD DENIAL NOTICE – PARTIAL APPROVAL OF REQUESTED SERVICE/ITEM**

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear [Member Name]:

[CHC MCO Name] has reviewed the request for [*identify SPECIFIC service/item*] submitted by [*prescriber's name*] on behalf of [*patient name*] on [date]. After physician review, the request for service/item is:

Approved other than as requested as follows: **[Describe the level, frequency, and duration of service approved and the level, frequency, and duration of service denied.]**

The service or item is not approved as requested because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

This decision will take effect on [date].

**To continue getting services**

If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint, grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:**

**1) Request Criteria**

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

*CHC MCO Name and Address*

**2) File a Complaint or Grievance**

You may file a complaint or grievance with **[CHC MCO Name]** **within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your complaint or grievance to **[CHC MCO Name]** at the following address:

## **16.2 CHC MCO Address for filing complaint or grievance**

### **To ask for an early decision**

If your doctor or dentist believes that waiting ( ) days *[CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]**;  
**AND**
- Your doctor or dentist must fax a signed letter to **[CHC MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

**[CHC MCO Name]** will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

### **3) Request a Fair Hearing**

You may ask for a Fair Hearing from the Department of Public Welfare. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:  
Department of Public Welfare  
Office of Medical Assistance Programs  
HealthChoices Program/Complaint, Grievance and Fair Hearing  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see Member handbook for more details).

### **To ask for an early decision**

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328.
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

You may receive the approved service or item while your complaint, grievance, or request for a Fair Hearing is being decided.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

### **CHC MCO Address for records information**

#### **4) Get a second opinion**

You may get a second opinion from a provider in the **[CHC MCO Name]** network. Call your PCP or **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

#### **5) Get Help with Grievances, Complaints, or Fair Hearings**

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- **[CH- MCO Name]** at **[Phone #/Toll-free TTY#]**

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

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- Pennsylvania Health Law Project at 1-800-274-3258 ([www.phlp.org](http://www.phlp.org)) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 ([www.palegalaid.net](http://www.palegalaid.net))

cc: Prescribing Provider

**CHC-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]**

**The information in this notice is available in other languages and formats by calling [CHC MCO Name] at [Phone #/Toll-free TTY #].**

EXHIBIT N(3)

**STANDARD DENIAL NOTICE – APPROVAL OF  
DIFFERENT SERVICE/ITEM**

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear [Member Name]:

[CHC MCO Name] has reviewed the request for [*identify SPECIFIC service/item*] submitted by [*prescriber's name*] on behalf of [*patient name*] on [date]. After physician review, the request for service/item is:

Denied as requested, but the following service/item is approved: **[Describe the specific service/item approved, including the level, frequency, and duration of service.]**

A different service or item is approved because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

This decision will take effect on [date].

**To continue getting services**

If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint, grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:**

**1) Request Criteria**

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

*CHC MCO Name and Address*

## **2) File a Complaint or Grievance**

You may file a complaint or grievance with **[CHC MCO Name]** **within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your complaint or grievance to **[CHC MCO Name]** at the following address:

### **16.3 CHC MCO Address for filing complaint or grievance**

#### **To ask for an early decision**

If your doctor or dentist believes that waiting ( ) days *[CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]**;  
**AND**
- Your doctor or dentist must fax a signed letter to **[CHC MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

**[CHC MCO Name]** will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

## **3) Request a Fair Hearing**

You may ask for a Fair Hearing from the Department of Public Welfare. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Public Welfare  
Office of Medical Assistance Programs  
HealthChoices Program/Complaint, Grievance and Fair Hearing  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see Member handbook for more details).

### **To ask for an early decision**

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328.
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

You may receive the approved service or item while your complaint, grievance, or request for a Fair Hearing is being decided.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

### **CHC MCO Address for records information**

#### **4) Get a second opinion**

You may get a second opinion from a provider in the **[CHC MCO Name]** network. Call your PCP or **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

#### **5) Get Help with Grievances, Complaints, or Fair Hearings**

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- **[CHC-MCO Name]** at **[Phone #/Toll-free TTY#]**

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

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- Pennsylvania Health Law Project at 1-800-274-3258 ([www.phlp.org](http://www.phlp.org)) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 ([www.palegalaid.net](http://www.palegalaid.net))

cc: Prescribing Provider

**CHC MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]**

**The information in this notice is available in other languages and formats by calling [CHC MCO Name] at [Phone #/Toll-free TTY #].**

EXHIBIT N(4)

**STANDARD BENEFIT LIMIT EXCEPTION (BLE)  
DENIAL NOTICE – COMPLETE DENIAL**

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear [Member Name]:

[CHC MCO Name] has reviewed the benefit limit exception request for [*identify SPECIFIC service/item*] submitted by [*prescriber's name*] on behalf of [*patient name*] on [*date*]. After physician review, the request for benefit limit exception is:

Denied completely because: [*Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.*]

This decision will take effect on [*date*].

**To continue getting services**

If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:**

**1) Request Criteria**

You may request a copy of the benefit limit exception criteria or other rules on which the decision was based by sending a written request to:

*CHC MCO Name and Address*

**2) File a Complaint or Grievance**

You may file a complaint or grievance with [CHC MCO Name] **within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than

( ) days [CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.] from when we receive it.

To file a complaint or grievance:

- Call [CHC MCO Name] at [Phone #/Toll-free TTY #]; or
- Send your complaint or grievance to [CHC MCO Name] at the following address:

#### 16.4 CHC MCO Address for filing complaint or grievance

##### To ask for an early decision

If your doctor or dentist believes that waiting ( ) days [CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [CHC MCO Name] at [Phone #/Toll-free TTY #];  
**AND**
- Your doctor or dentist must fax a signed letter to [CHC MCO fax #] explaining why taking 30 days to decide your complaint or grievance could harm your health.

[CHC MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

### 3) Request a Fair Hearing

#### INSTRUCTIONS FOR RECIPIENT FAIR HEARING REQUEST

If you have not yet received the service, you may ask for a Fair Hearing from the Department of Public Welfare. If you have already received the service, then you may ask for a fair hearing if your provider told you, before you got the service, that you would have to pay for the service if an exception was not granted. If your provider did not tell you that you might have to pay for the service, then the provider may not bill you for the service and you should not file an appeal.

Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Public Welfare  
Office of Medical Assistance Programs  
HealthChoices Program/Complaint, Grievance and Fair Hearing  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

**CHC MCO Address for records information**

**To ask for an early decision**

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

The provider may use the provider dispute process in the provider agreement with [CHC MCO Name].

**4) Get a second opinion**

You may get a second opinion from a provider in the [CHC MCO Name] network. Call your PCP or [CHC MCO Name] at [Phone #/Toll-free TTY #] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

**5) Get Help with Grievances, Complaints, or Fair Hearings**

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [CHC MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 ([www.phlp.org](http://www.phlp.org)) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 ([www.palegalaid.net](http://www.palegalaid.net))

### INSTRUCTIONS FOR PROVIDER APPEAL

Providers may use the provider dispute resolution process as described in their provider contract with [CHC MCO Name].

cc: Prescribing Provider

**CHC MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]**

**The information in this notice is available in other languages and formats by calling [CHC MCO Name] at [Phone #/Toll-free TTY #].**

EXHIBIT N(5)

**STANDARD BENEFIT LIMIT EXCEPTION (BLE)**  
**DENIAL NOTICE – PARTIAL APPROVAL OF REQUESTED**  
**SERVICE/ITEM**

[DATE] [This MUST be the date the notice is mailed]

RE: [Member's name and DOB]

Dear [Member Name]:

[CHC MCO Name] has reviewed the benefit limit exception request for [identify SPECIFIC service/item] submitted by [prescriber's name] on behalf of [patient name] on [date]. After physician review, the request for benefit limit exception is:

Approved other than as requested as follows: [Describe the level, frequency, and duration of service approved and the level, frequency, and duration of service denied.]

The service or item is not approved as requested because: *[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]*

This decision will take effect on [date].

**To continue getting services**

If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:**

**1) Request Criteria**

You may request a copy of the benefit limit exception criteria or other rules on which the decision was based by sending a written request to:

*CHC MCO Name and Address*

## **2) File a Complaint or Grievance**

You may file a complaint or grievance with **[CHC MCO Name]** **within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your complaint or grievance to **[CHC MCO Name]** at the following address:

### **16.5 CHC MCO Address for filing complaint or grievance**

#### **To ask for an early decision**

If your doctor or dentist believes that waiting ( ) days *[CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]**;  
**AND**
- Your doctor or dentist must fax a signed letter to **[CHC MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

**[CHC MCO Name]** will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

## **3) Request a Fair Hearing**

### **INSTRUCTIONS FOR RECIPIENT FAIR HEARING REQUEST**

If you have not yet received the service, you may ask for a Fair Hearing from the Department of Public Welfare. If you have already received the service, then you may ask for a fair hearing if your provider told you, before you got the service, that you would have to pay for the service if an exception was not granted. If your provider did not tell you that you might have to pay for the service, then the provider may not bill you for the service and you should not file an appeal.

Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;

- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Public Welfare  
Office of Medical Assistance Programs  
HealthChoices Program/Complaint, Grievance and Fair Hearing  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

#### **CHC MCO Address for records information**

##### **To ask for an early decision**

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

The provider may use the provider dispute process in the provider agreement with [CHC MCO Name].

#### **4) Get a second opinion**

You may get a second opinion from a provider in the [CHC MCO Name] network. Call your PCP or [CHC MCO Name] at [Phone #/Toll-free TTY #] to get a referral for a second opinion. Asking for a

second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

### **5) Get Help with Grievances, Complaints, or Fair Hearings**

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [CHC MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 ([www.phlp.org](http://www.phlp.org)) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 ([www.palegalaid.net](http://www.palegalaid.net))

### INSTRUCTIONS FOR PROVIDER APPEAL

Providers may use the provider dispute resolution process as described in their provider contract with [CHC MCO Name].

cc: Prescribing Provider

**CHC MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:**

**The information in this notice is available in other languages and formats by calling [CHC MCO Name] at [Phone #/Toll-free TTY #].**

EXHIBIT N(6)

**STANDARD BENEFIT LIMIT EXCEPTION (BLE)**  
**DENIAL NOTICE – APPROVAL OF DIFFERENT SERVICE/ITEM**

[DATE] [This MUST be the date the notice is mailed]

RE: [Member's name and DOB]

Dear [Member Name]:

[CHC MCO Name] has reviewed the benefit limit exception request for [identify SPECIFIC service/item] submitted by [prescriber's name] on behalf of [patient name] on [date]. After physician review, the request for benefit limit exception is:

Denied as requested, but the following service/item is approved: [Describe the specific service/item approved, including the level, frequency, and duration of service.]

A different service or item is approved because: [Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]

This decision will take effect on [date].

**To continue getting services**

If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:**

**1) Request Criteria**

You may request a copy of the benefit limit exception criteria or other rules on which the decision was based by sending a written request to:

*CHC MCO Name and Address*

## **2) File a Complaint or Grievance**

You may file a complaint or grievance with **[CHC MCO Name]** **within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your complaint or grievance to **[CHC MCO Name]** at the following address:

### **16.6 CHC MCO Address for filing complaint or grievance**

#### **To ask for an early decision**

If your doctor or dentist believes that waiting ( ) days *[CHC MCO: Insert 30 unless CHC MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[CHC MCO Name]** at **[Phone #/Toll-free TTY #]**;  
**AND**
- Your doctor or dentist must fax a signed letter to **[CHC MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

**[CHC MCO Name]** will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

## **3) Request a Fair Hearing**

### **INSTRUCTIONS FOR RECIPIENT FAIR HEARING REQUEST**

If you have not yet received the service, you may ask for a Fair Hearing from the Department of Public Welfare. If you have already received the service, then you may ask for a fair hearing if your provider told you, before you got the service, that you would have to pay for the service if an exception was not granted. If your provider did not tell you that you might have to pay for the service, then the provider may not bill you for the service and you should not file an appeal.

Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;

- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Public Welfare  
Office of Medical Assistance Programs  
HealthChoices Program/Complaint, Grievance and Fair Hearing  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

#### **CHC MCO Address for records information**

##### **To ask for an early decision**

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

The provider may use the provider dispute process in the provider agreement with [CHC MCO Name].

#### **4) Get a second opinion**

You may get a second opinion from a provider in the [CHC MCO Name] network. Call your PCP or [CHC MCO Name] at [Phone #/Toll-free TTY #] to get a referral for a second opinion. Asking for a

second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

### **5) Get Help with Grievances, Complaints, or Fair Hearings**

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [CHC MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 ([www.phlp.org](http://www.phlp.org)) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 ([www.palegalaid.net](http://www.palegalaid.net))

### INSTRUCTIONS FOR PROVIDER APPEAL

Providers may use the provider dispute resolution process as described in their provider contract with [CHC MCO Name].

cc: Prescribing Provider

**CHC MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:**

**The information in this notice is available in other languages and formats by calling [CHC MCO Name] at [Phone #/Toll-free TTY #].**

**REQUEST FOR ADDITIONAL INFORMATION LETTER**

[Date Letter Mailed (Date of Request for additional information)]

Member Name

Address

City, State Zip

Member ID: \*\*\*\*\*

Subject: Request for Additional Information from Your Provider

Dear [Member Name]:

**[CHC MCO Name]** received a request for **[describe specific services/items]** from **[provider name]** on **[date received]**.

In order to decide if this service is Medically Necessary for you, **[CHC MCO Name]** has requested the following additional information from your provider by **[date]**:

**[List specific information requested]**

**[CHC MCO Name]** will make a decision on the requested services within 2 business days after receiving the additional information from your provider. **[CHC MCO Name]** will notify you in writing within 2 business days after making its decision.

If we do not receive the additional information within 14 days, the decision to approve or deny the service will be made, based on the available information. **[CHC MCO Name]** will notify you in writing within 2 business days after we should have received the additional information.

If you have any questions, please contact Member Services at **[CHC MCO Phone #/Toll-free TTY #]**.

Sincerely,

**[CHC MCO Name]**

cc: prescribing provider

**[CHC MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract].**

**The information in this notice is available in other languages and formats by calling [CHC MCO Member service's #/Toll-free TTY # ].**

## **EXHIBIT ZZ AUTOMATIC ASSIGNMENT**

Any Participant who does not select a CHC-MCO will be subject to the auto-assignment process as described below. The auto-assignment process does not negate the Participant's option to change his/her CHC-MCO.

Individuals will be assigned to plans that align with the way in which they are currently receiving their services.

- First, if a Participant is residing in a nursing facility at the time of enrollment, they will be assigned to a plan in which their nursing facility is a Network Provider.
- Second, a Participant enrolled in a D-SNP will be assigned to a CHC-MCO aligned with their D-SNP.
- Third, if the Participant is transferring from Health Choices, and the HC-MCO is also contracted as CHC-MCO, and the Participant has not made a CHC-MCO selection, the Participant will be enrolled in the affiliated CHC-MCO.
- Last, if a Participant is receiving HCBS and their HCBS provider is contracted with a CHC plan, the Participant will be enrolled in that plan. Plan assignment will follow automatic assignment logic after these conditions are exhausted.

If none of the above conditions apply, an eligible Participant who has not made a CHC-MCO selection and who has a case record that also includes another active member in the case with an active CHC-MCO record will be assigned to that same CHC-MCO. These Participants will not count toward the percentages designated for auto-assignment. Participants in a family unit will be assigned together to a CHC-MCO. All remaining eligible Participants, who have not voluntarily selected a CHC-MCO, will be considered in the pool of Participants who will be equally auto- assigned to CHC-MCOs. The formula will direct an equal distribution of the auto- assignment pool in all Zones monthly based on the number of CHC-MCOs in the Zone. For example, if there are five CHC-MCOs in the Zone, each CHC-MCO would receive 20%.

### **A. Participant Re-Assignment Following Resumption of Eligibility:**

Participants who lose eligibility and regain it within six (6) months will automatically be re-enrolled in their previously selected CHC-MCO, as long as the Participant's eligibility status or geographical residence is still valid for participation in that same CHC-MCO.

If the Participant loses eligibility and regains it after six (6) months, s/he may be enrolled in the same CHC-MCO as the payment name, the case payment name or any other Participant in the case that has an active CHC-MCO record. If there is no active CHC-MCO record in the case, s/he will automatically become enrolled in a CHC-MCO through the automatic assignment process.

Prior to the future begin date for the auto-assigned CHC-MCO, the Participant may select a different CHC-MCO and override the auto-assigned CHC-MCO by contacting the IEE. When the Participant contacts the IEE to make this change, it will be the IEE's responsibility to enroll the Participant in the CHC-MCO of his/her choice. The IEE will process the enrollment into the new CHC-MCO through the weekly enrollment process.

**B. Continuing Enrollment When Moving Between Zones:**

Eligible Participants who move from one CHC Zone to another will remain in the CHC-MCO in which they were enrolled prior to their move, if the CHC-MCO is also operational in the Zone to which they move.

***The Department reserves the right to reassess the distribution process and to modify it in accordance with sound programmatic management principles. The Department shall institute such modifications at any time following appropriate notification to the CHC-MCOs via executive correspondence.***

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**Exhibit EEE**  
**Participants' Rights and Responsibilities**

**PARTICIPANTS' RIGHTS** Each CHC-MCO must have written policies regarding the enrollee rights specified in this Exhibit

Each CHC-MCO must comply with any applicable Federal and State laws that pertain to enrollee rights, and its staff and affiliated providers must take those rights into account when furnishing services to enrollees.

A participant has the right to:

- Receive information in accordance with 42 C.F.R. § 438.10 (relating to limited English proficiency, alternative format and substantive and procedural requirements);
- Be treated with respect and with due consideration for his or her dignity and privacy;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
- Participate in decisions regarding his or her care and services, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her service records, and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526; and
- Be furnished services in accordance with §§ 438.206 through 438.210.

The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 C.F.R. § 438.10(f)(6)(xii) (relating to State Plan benefits).

Each Participant is free to exercise his or her rights, and the exercise of those rights may not adversely affect the way the CHC-MCO and its providers treat the enrollee.

CHC-MCO must comply with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

**PARTICIPANTS' RESPONSIBILITIES**

CHC Participants have the following responsibilities:

- To review Covered Items and Services and the rules around getting Covered Items and Services;
- To tell Providers that they are enrolled in a CHC-MCO and show their CHC-MCO ID card;
- To treat Providers and employees of the CHC-MCO with respect and to refrain from any type of abusive behavior towards Providers or employees of the CHC-MCO;
- To communicate problems immediately to the CHC-MCO;
- To keep appointments or notify the Service Coordinator if an appointment cannot be kept;
- To supply accurate and complete information to the CHC-MCO's employees;
- To actively participate in PCSP development and implementation;
- To notify the CAO and the CHC-MCO of any changes in income and assets. Assets include bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, and any other assets;
- To ask questions and request further information regarding anything not understood;
- To use the CHC-MCO's Network Providers for services included in the CHC-MCO Benefit Package;
- To notify the CHC-MCO of any change in address or lengthy absence from the area;
- To comply with all policies of the CHC-MCO as noted in the Participant Handbook;
- If sick or injured, to call their doctors, the nurse hotline, or their service coordinators for direction right away;
- In case of emergency, to call 911; and
- If Emergency Services are required out of the service area, to notify the CHC-MCO as soon as possible.

**Exhibit FFF**  
**MIPPA Agreement Requirements**

The CHC-MCO must operate an aligned D-SNP concurrently with its CHC-MCO. This D-SNP will be required to enter into a MIPPA Agreement with the Department. The MIPPA Agreement will address the eight elements required of all MIPAA agreements,<sup>1</sup> and will also include additional requirements to ensure the greatest possible coordination between the CHC-MCO and the D-SNP including, but not limited to, the following.

**General Provisions**

- a. CHC-MCOs will be required to have a companion D-SNP in place and ready to enroll as of the same dates and service areas as the CHC-MCOs.
- b. The goal of the CHC-MCO and its companion D-SNP is to provide a coordinated experience from the perspective of Full Dual Eligible Participants who enroll in both. This includes, but is not limited to, an integrated assessment and care coordination process that spans all Medicaid and Medicare services.
- c. Administrative integration is expected to evolve over the life of the CHC program. The CHC-MCO will cooperate fully with the Department and CMS in their ongoing efforts to streamline administration of the two programs which may include, but is not limited to, coordinated readiness reviews, monitoring, enrollment, member materials and appeals processes.

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<sup>1</sup> CMS Medicare Managed Care Manual, Chapter 16b, Section 40.5.1 (Revised 11/28/14). Available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>  
Community HealthChoices Agreement Effective January 1, 2017

**Exhibit GGG**  
**Performance Measures and Data Elements**

This section details the performance measures that demonstrate the level to which the CHC MCO succeeds in achieving quality and operational objectives. Exhibit GGG (1) lists the key performance measures. These performance measures will be used to measure outcomes and results and will generate reliable data on the quality, effectiveness, and efficiency of the CHC MCO. Data elements listed in GGG(2) will be used for inputs and resources in that performance measurement and will be part of the evaluation process for quality, effectiveness, and efficiency.

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**Exhibit GGG(1)**  
**Performance Measures**

	MEASURE	Origin of Measure	Type of Measure	Target Population
<b>CMS Star Rating</b>				
1	Network Nursing Facilities Rated in Each CMS Star Rating of 1, 2, 3, 4, or 5	CMS	Network	Facility
2	Number of Nursing Facilities Achieving or Maintaining 4 or 5 Star Ratings	CMS	Outcome	Facility
3	Number of Nursing Facilities Increasing Star Rating	CMS	Outcome	Facility
<b>DOH Nursing Home Licensing</b>				
4	Number of DOH Reported Adverse Events with G or Greater Severity	PA DOH	Outcome	Facility
5	Number of Confirmed Preventable Serious Adverse Events (PSAEs)	OLTL	Outcome	Facility
<b>Adult Protective Services, Older Adult Protective Services</b>				
6	Number of Confirmed Adult & Older Adult Protective Service Events (not reported as DOH Adverse Events or PSAEs)	OLTL	Outcome	Facility and Community
<b>MDS (Minimum Dataset)</b>				
7	Residents Admitted to Nursing Facility (Goal is to decrease percentage)	OLTL	UR	Community
8	Average Length of Stays (mean and median) for Short Term Admissions (Goal is to Decrease)	OLTL	UR	Facility
9	Average Length of Stays (mean and median) for Long Term Admissions (Goal is to Decrease)	OLTL	UR	Facility
10	Nursing home paid days per 1000 member month.	OLTL	UR	Facility
11	Residents Transitioned from Nursing Facility to Community	OLTL	Outcome	Facility
12	Average Time to Transition Members from Nursing Facility to Community	OLTL	Process	Facility
13	Unplanned Readmission to Nursing Facility within 7 days of Nursing Facility Discharge	OLTL	Process	Facility
14	Unplanned Readmission to Nursing Facility within 30 days of Nursing Facility Discharge	OLTL	Outcome	Facility
15	Acute hospital unplanned admission within 7 days of discharge from nursing facility	OLTL	Outcome	Facility
16	Acute hospital unplanned admission within 30 days of discharge from nursing facility	OLTL	Outcome	Facility
17	Unexpected Death within 7 days of Nursing Facility Discharge	OLTL	Outcome	Facility
18	Unexpected Death within 30 days of Nursing Facility Discharge	OLTL	Outcome	Facility
19	Residents Self-Report Moderate to Severe Pain	CMS	Outcome	Facility
20	Residents with Pressure Ulcers New or Worsen	CMS	Outcome	Facility
21	High-Risk Residents with Pressure Ulcers	CMS	Outcome	Facility
22	Residents Assessed and Appropriately Given Seasonal Influenza Vaccine	CMS	Outcome	Facility
23	Residents Assessed and Appropriately Given the Pneumococcal Vaccine	CMS	Outcome	Facility
24	Residents Who Have Depressive Symptoms	CMS	Outcome	Facility

25	Residents Newly Receiving Antipsychotic Medicine	CMS	Outcome	Facility
26	Residents Who Received An Antipsychotic Medication	CMS	Outcome	Facility
27	Residents Physically Restrained	CMS	Outcome	Facility
28	Residents Experiencing One or More Falls with Major Injury	CMS	Outcome	Facility
29	Residents Whose Need for Help with Activities of Daily Living Has Increased (Goal is to lower percentage)	CMS	Outcome	Facility
<b>HEDIS® (Health Effectiveness Data and Information Set) Measures</b>				
30	Adult (age 21 and over) *HEDIS® Measures excluding pregnancy	HEDIS®	Outcome	Facility & Community
<b>HEDIS® (Health Effectiveness Data and Information Set) Related State Measures</b>				
31	Annual Dental Visit	HEDIS®	Outcome	Facility & Community
32	Colorectal Cancer Screening			
33	Care for Older Adults (SNP) only			
34	Osteoporosis Management for Women Who Had a Fracture			
35	Medication Reconciliation Post-Discharge			
36	Non-Recommended PSA-Based Screening in Older Men			
37	Potentially Harmful Drug-Disease Interactions in the Elderly			
38	Use of High-Risk Medications in the Elderly			
39	Fall Risk Management			
40	Management of Urinary Incontinence in Older Adults			
41	Osteoporosis Testing in Older Women			
42	Physical Activity in Older Adults			
43	Flu Vaccinations for Adults Ages 65 and Older			
44	Pneumococcal Vaccination Status for Older Adults			
45	Plan All-Cause Readmissions			
46	Inpatient Hospital Utilization			
47	Emergency Department Utilization			
48	Hospitalization for Potentially Preventable Complications			
49	HEDIS Follow-up after Hospitalization (FUH) for Mental Illness (7 day FUH & 30 day FUH)			
<b>CAHPS (Consumer Assessment of Health Care Provision and Systems) and State Measures</b>				
50	CAHPS adult indicators	CAHPS®	Member Exp.	Community
<b>Other Client Survey</b>				
51	Member Satisfaction Similar to the *MHSIP Measures for Access, Quality/Appropriateness, Outcomes, Participation in Treatment Planning, General Satisfaction, Social Connectedness, & Functioning	*SAMHSA & DHS OMHSAS	Member Exp.	Members Receiving BH Services
<b>Provider Database</b>				
52	Presence of Adequate Network of Appropriately Credentialed Providers/Caregivers	OLTL	Outcome	Facility & Community

<b>Provider Satisfaction Survey</b>				
53	Provider Satisfaction Survey: Uniform Questions to Be Developed with MCO Input/OLTC Approval within One Year	OLTL	Provider Exp.	PCPs, Specialists, In-Home Caregivers
<b>NCI (National Core Indicator)</b>				
54	National Core Indicator (NCI) Issues of Health, Welfare, & Rights, System Performance, Staff Stability,& Family Indicators	HSRI	Member Exp.	Community
<b>Independent Enrollment Entity (IEE)</b>				
55		OLTL	Process	Facility & Community
<b>Clinical Eligibility Determination</b>				
56	data not defined			
<b>Care Management Database</b>				
57	Member Civil and Human Rights are Protected	Department Workgroup	Outcome	Facility & Community
58	Members are Offered Participation in Disease Management Programs to Maintain or Improve Current Health Status	Department Workgroup	Outcome	Community
59	Members are Provided a Choice of Providers	Department Workgroup	Outcome	Facility & Community
60	Members are Provided with a Choice of Services	Department Workgroup	Outcome	Facility & Community
61	Members Goals are Achieved	Department Workgroup	Outcome	Facility & Community
62	Member Specific Emergency/Disaster Plans are Developed	Department Workgroup	Outcome	Facility & Community
63	Members Have a Back-up Plan for Delivery of Services	Department Workgroup	Outcome	Community
64	Members have Knowledge and Access to Appeal/Complaint Grievance Rights	Department Workgroup	Outcome	Facility & Community
65	Members have the Choice of Participant-Directed Services	Department Workgroup	Outcome	Community
66	Timeliness of Care Plan Completion	OLTL	Process	Facility & Community
67	Timely Frequency of Care Coordination	OLTL	Process	Facility & Community
68	Timeliness of Notice Prior to Care Plan Revision	OLTL	Process	Facility & Community
69	Members are Given a Choice Between Institutional Care and Community-Based Services	Department Workgroup	Outcome	Facility & Community

70	Member Service Plans Include Methods and Goals to Transition to the Community and Least Restrictive Environment	Department Workgroup	Outcome	Community
71	Member Transition Plans Address All Services Necessary to Safely Transition to the Community, Including Housing, Transportation, Caregivers, and Identification of Barriers and Strategies to Overcome	Department Workgroup	Outcome	Facility
72	The MCO Provides Support for HCBS Paid & Unpaid Caregivers	National Quality Forum		Community
73	Member Services are Non-Discriminatory, Equitably Delivered, and Made Available to a Broad Array of Individuals	Department Workgroup	Outcome	Facility & Community
74	Member Service Plans Address Personal Goals for Independence, & Community and Social Connectedness	Department Workgroup	Outcome	Community
75	Appropriate Coordination of Care with Physical Health, Behavioral Health & LTS Providers	OLTL	Outcome	Community
76	Member requested services denied by MCO	OLTL	Data	Facility & Community
77	Member services reduced by MCO			
78	Member Service Telephone Lines are Accessible and Answered Timely	NCQA	Process	Facility & Community
79	Members Wanting to Work are Working	Department Workgroup	Outcome	Community
80	Number/Percent of Members Residing in Community	OLTL	UR	Community
81	Number/Percent of Members Residing in Nursing Facilities	OLTL	UR	Facility
82	Residents Admitted to Nursing Facility (Goal is to decrease percentage)	OLTL	UR	Community
83	Average Length of Stays (mean and median) for Short (<=180 days)and Long Term Admissions(181+ days) (Goal is to Decrease)	OLTL	UR	Facility
84	Residents Transitioned from Nursing Facility to Community (Excluding Short Stays)	OLTL	Outcome	Facility
85	Average Time to Transition Members from Nursing Facility to Community (Excluding Short Stays)	OLTL	Process	Facility
86	Unplanned Readmission to Nursing Facility within 7 days of Nursing Facility Discharge	OLTL	Process	Facility
87	Unplanned Readmission to Nursing Facility within 30 days of Nursing Facility Discharge	OLTL	Process	Facility
88	Acute hospital unplanned admission within 7 days of discharge from nursing facility	OLTL	Process	Facility
89	Acute hospital unplanned admission within 30 days of discharge from nursing facility	OLTL	Process	Facility
90	Unexpected Death within 7 days of Nursing Facility Discharge	OLTL	Process	Facility
91	Unexpected Death within 30 days of Nursing Facility Discharge	OLTL	Process	Facility
92	Member Transition Plans Address All Services Necessary to Safely Transition to the Community, Including Housing, Transportation, Caregivers, and Identification of Barriers and Strategies to Overcome	Department Workgroup	Outcome	Facility
93	Hospital admissions			
94	Unplanned Readmission to Hospital or Unexpected Death within 7 and 30 days of Hospital Discharge	OLTL	Outcome	Community

95	Member Needs for Special Assistive Devices are Met, i.e., Wheelchairs, Communication Devices, Skin Care Supports, etc. (MCOs to Report Numbers for Each Type of Special Equipment Provided Costing \$5,000 or More for Purchase/Rental in NF and Community Separately)	Department Workgroup	Outcome	Facility & Community
96	Members Have a Back-up Plan for Delivery of Services	Department Workgroup	Outcome	Community
97	Members choosing consumer directed services			
98	unpaid caregiver info			
99	transportation services			
100	affordable and accessible housing info			
101	respite info			
<b>EIM (Enterprise Incident Management)</b>				
102	Complaints per 1,000 Members Served	OLTL	Data	Facility & Community
103	Level 1 Grievances per 1,000 Members Served	OLTL	Data	Facility & Community
104	Level 1 Grievances per Number of Denials	OLTL	Data	Facility & Community
105	Level 2 Complaints per Number of 1st Level Complaints	OLTL	Data	Facility & Community
106	Level 2 Grievances per Level 1 Grievances	OLTL	Data	Facility & Community
107	Appeals, Complaints, & Grievances are Resolved Timely	OLTL	Data	Facility & Community
108	Timely Incident Reporting	OLTL	Process	Facility & Community
109	Claim handling measures to be added.			

**\*Key:**

**HEDIS®: Health Effectiveness Data & Information Set**  
**CAHPS®: Consumer Assessment of Health Care Provision and Systems**

*“Confidential: The contents of this document are internal pre-decisional records of the DHS and individuals receiving and reviewing this document must not provide this information to any other person without written permission. 65 P.S. § 67.708 (b) (10).”*

**Exhibit GGG(2)**  
**Data Elements - Demographics**

<b>Demographics</b>		
Last Name		
First Name		
MI		
Suffix		
Gender	male	
	female	
	transgender	
Ethnicity	Hispanic or Latino	
	not Hispanic or Latino	
	unknown	
Race	White	
	Black or African American	
	American Indian or Alaska Native	
	Asian	
	Native Hawaiian or Other Pacific Islander	
SSN		
MCI Number		
MA Number		
category of assistance		
program status		
SAMS ID		
Medicare?	yes	
	no	
Medicare Number		
third party payor resources	yes	
	no	
third party payor resource info		
Birth Date		
Type of Residence	apartment	
	assisted living	
	community shared living arrangement	
	domiciliary care	
	group home	
	homeless	
	mobile home	
	nursing facility	
	own home	
	rented home	
	personal care home	
relative's home/apartment		
shelter		

	specialized rehab facility	
	state institution	
	subsidized housing	
	other	
	unknown	
If subsidized housing, type	low income housing tax credits	
	housing choice vouchers	
	Section 811	
	USDA rural housing funds	
	Veterans Affairs housing funds	
	funds for home modifications	
	funds for assistive technology as it relates to housing	
	other	
Living Arrangement	lives alone	
	lives with spouse only	
	lives with spouse and children	
	lives with child(ren) but not spouse	
	lives with significant other	
	lives with other family member(s)	
	lives with friends	
	homeless	
	Other	
	unknown	
Marital Status	divorced	
	legally separated	
	married	
	single	
	widowed	
	other	
	unavailable	
Veteran?	yes	
	no	
spouse/widow of veteran	yes	
	no	
Communication Assistance	hearing impaired	
	interpreter	
	large print	
	picture book	
	visually impaired	
	sign language	yes/no, type
	language	
	language and mechanical	
	mechanical	
	no assistance	

	unknown	
	unable to communicate	
Primary Language		
Secondary Language or ESL		
Residential address	street address line 1	
	street address line 2	
	city	
	state	
	zip	
	county	
rural	yes	
	no	
home telephone		
cell phone		
email address		
mailing address	street address line 1	
	street address line 2	
	city	
	state	
	zip	
emergency contact	county	
	name	
	relationship	
	street address line 1	
	street address line 2	
	city	
	state	
	zip	
	telephone	
alternate telephone		
used NHT services	yes	
	no	
latest transition date		
MFP	yes	
	no	
date of death	date	
death reason	accident	
	illness	
	natural causes	
	suicide	
	other	

**Exhibit GGG(3)**  
**Data Elements – Needs Screening**

- Participant has not been seen by a physician within the past year
- Participant self-identifies medical needs that are not being met;
- Participant self-identifies social or LTSS needs that are not being met;
- Participant has one or more condition that may incur higher morbidity without intervention and coordination;
- Participant requires coordination and communication among Network Providers and/or Out-of-Network Providers or between Providers and other service delivery systems;
- Participant requires assistance to schedule or make arrangements for appointments or services, including arranging for transportation to and from appointments;
- Participant needs for language, communication, or mobility accommodations;
- Participant needs to be accompanied or assisted while seeking or receiving care by an individual who may act on the Participant's behalf;
- Participant has any condition, event or life circumstance that inhibits a Participant's access to any necessary service or support needed to address their medical condition or maintain their current level of functioning; and
- Participant needs assistance with ADLs or IADLs.

**Exhibit GGG(4)**  
**Data Elements – Comprehensive Needs Assessment**

Will the needs assessment be standardized? - group says yes				
<b>Needs Assessment</b>				
assessment information	PSA ID or Provider MPI			
	reason for assessment	initial assessment		
		annual recertification		
		change in consumer condition		
	where was consumer interviewed	domiciliary care home		
		home		
		home of relative/caregiver		
		hospital		
		mental health facility		
		nursing facility		
		office		
		personal care home		
		state intellectual disability center		
		other		
	face to face	yes		
		no		
	date of interview			
	consumer participation	yes		
		no		
	others present	spouse		
		domestic partner		
		other family member		
		legal guardian		
power of attorney				
friend				
other			name relationship	
assessor	name			
	agency			
	phone			
Medical	has consumer received treatment as a patient (ER or admitted) in a hospital in the past 12 months	yes		
		no		
		dates		
	in the past 12 mo, how many times has consumer stayed overnight in hospital	number of days		
	why was the consumer hospitalized			
	has the consumer resided in a nursing facility in the past 12 months	yes		

		no	
	in the past 12 months, how many days was the consumer a resident of a nursing facility	number of days	does not include respite
	why did the consumer stay in a nursing facility in the past 12 months		does not include respite
	consumer's primary physician		
	primary physician phone		
SLUMS	consumer's current level of consciousness	alert	
		confused	
		distractible	
		drowsy	
		inattentive	
		preoccupied	
		comatose	
		persistent vegetative state	
	trouble with memory	yes	
		no	
	able to complete SLUMS exam	yes	
		no	
	total score		
	highest grade completed in school	0-12	
	highest educational degree	<HS	
		HS grad or GED	
		associates degree	
		bachelor's degree	
		doctoral degree	
		other	
assessor conclusion	normal		
	MNCD - mild neurocognitive disorder		
	mild dementia		
	moderate dementia		
	severe dementia		
respiratory	respiratory diagnoses	none	
		asthma	
		chronic obstructive pulmonary disease	
		emphysema	
		pulmonary edema	
		respiratory failure	
		other	
	respiratory treatments	none	

		medications	
		oxygen	
		respiratory treatments	
		suctioning	
		tracheostomy/trach care	
		ventilator/vent care	
		other	
	Do diagnoses affect individual's ability to function?	yes	
		no	
	is individual able to self-manage care of condition	yes	
	no		
	unable to determine		
heart/circulatory systems	heart/circulatory system diagnoses	none	
		afib	
		anemia	
		ascites	
		CAD - coronary artery disease	
		DVT -deep vein thrombosis	
		heart failure	
		hypertension	
		PE - pulmonary embolus	
		PVD/PAD -peripheral vascular/artery disease	
		other	
	treatment for heart/circulatory system	none	
		cardiac rehabilitation	
		compression device, Hed hose, ace bandage wrap(s)	
		medications	
		pacemaker	
		special diet	
		other	
	does diagnoses affect individual's ability to function?	yes	
		no	
is individual able to self-manage care of condition	yes		
	no		
	unable to determine		
gastrointestinal	gastrointestinal diagnoses	none	
		Barret's esophagus	
		Crohns disease	
		diverticulitis	
		GERD	
		hernia	
		IBS - irritable bowel syndrome	

		laryngeal reflux disease	
		other	
	treatment for gastrointestinal diagnosis	none	
		aspiration precautions	
		feeding tube	
		medications	
		ostomy	
		speech therapy	
		TPN- total parenteral nutrition	
		other	
	does diagnoses affect individual's ability to function?	yes	
		no	
	is individual able to self-manage care of condition	yes	
		no	
		unable to determine	
musculoskeletal	musculoskeletal diagnoses	none	
		ambulatory dysfunction	
		amputation	details
		arthritis	type
		contracture(s)	
		fracture(s)	details
		joint deformity	
		limited range of motion	
		paraplegia	
		muscle dystrophy	
		osteoporosis	
		poor balance	
		quadriplegia	
		spasms	
		spinal stenosis	
		weakness	
		other	
	treatment for musculoskeletal diagnoses	none	
		assistive devices	document
		brace(s)	
		cast	
		elevate legs	
		medications	
		physical occupational therapy	
		prosthesis(es)	
		splint	
		traction	
		other	
does diagnoses affect individual's ability to function?	yes		
	no		

	is individual able to self-manage care of condition	yes		
		no		
		unable to determine		
skin	skin diagnoses	none	affected LCDtions, highest known ulcer stage	
		dry skin		
		incision (surgical)		
		psoriasis		
		rash		
		ulcer		
		wound		
		other		
	treatments for skin diagnoses	none		
		debridement		
		medications		
		pressure relieving devices		
		surgery		
		unna boot(s)		
		wound dressing		
		wound therapy		
		wound VAC		
		other		
		does diagnoses affect individual's ability to function?	yes	
			no	
	is individual able to self-manage care of condition	yes		
		no		
		unable to determine		
endocrine/metabolic	endocrine/metabolic diagnoses	none		
		ascites		
		cirrhosis		
		diabetes mellitus (DM) insulin dependent		
		diabetes mellitus (DM) non-insulin dependent		
		diabetic neuropathy		
		hypoglycemia		
		thyroid disorder		
	other			
	treatments for endocrine/metabolic diagnoses	none		
		blood transfusions		
		blood sugar monitoring		
		medications		
		special diet		
other				
do diagnoses affect individual's ability to function?	yes			
	no			

	is individual able to self-manage care of condition	yes		
		no		
		unable to determine		
cancer	cancer diagnoses	yes		
		no		
	cancer stage	unstageable		
		stage 1		
		stage 2		
		stage 3		
		stage 4		
		unknown		
	all diagnoses	basal cell		
		bile duct		
		bladder		
		bone		
		brain		
		breast		
		cervical		
		colon		
		colorectal		
		endometrial		
		esophageal		
		gallbladder		
		gastric		
		Hodgkin's disease		
		kidney		
		leukemia		
		liver		
		lung		
		lymphatic		
		multiple myeloma		
		non-Hodgkin's lymphoma		
		oral		
		ovarian		
		pancreatic		
		prostate		
sarcoma				
skin				
testicular				
throat				
thyroid				
uterine				
vaginal				
other				
current treatments for cancer	none			

		aspiration precautions	
		bone marrow transplant	
		chemo/radiation therapy	
		chemotherapy	
		hospice care	
		indwelling catheter/services	
		maintenance/preventative skin care	
		medications	
		occupational therapy	
		ostomy/related services	
		oxygen	
		palliative care	
		physical therapy	
		radiation	
		respiratory therapy	
		restorative care	
		speech therapy	
		suctioning	
		surgery	
		transfusion(s)	
tube feedings/TPN			
other			
	does diagnoses affect individual's ability to function?	yes	
		no	
	is individual able to self-manage care of condition	yes	
	no		
	unable to determine		
neurological	neurological diagnoses	none	
		ALS	
		Alzheimer's disease	
		autism	
		cerebral palsy	
		CVS/TIA/stroke	
		dementia (non Alzheimer's)	
		multiple sclerosis	
		muscular dystrophy	
		neuropathy	
		Parkinson's disease	
		seizure disorder	
		TB I - traumatic brain injury	
		other	
		treatments for neurological diagnoses	none
	no treatment available		
braces			

		cervical collar	
		cognitive/behavioral therapy	
		electrical stimulation device	
		medications	
		seizure precautions	
		therapy other	
		traction	
		other	
	is the individual able to communicate	yes	
		no	
	individual's cognitive state	appears to be cognitively intact	
		executive functioning impaired	
		inability to follow commands	
		poor long term memory	
		poor short term memory	
		slow response to questions	
		other	
does diagnoses affect individual's ability to function?	yes		
	no		
is individual able to self-manage care of condition	yes		
	no		
	unable to determine		
intellectual developmental disability	does the individual have diagnosis of intellectual/developmental disability (IDD) from birth to 22nd birthday or known to ID system	yes	
		no	
	do diagnoses affect individual's ability to function?	yes	
		no	
	is individual able to self-manage care of condition	yes	
		no	
unable to determine			
psychiatric	psychiatric diagnoses	none	
		anxiety disorders	
		bipolar disorders	
		depressive disorders	
		disruptive impulse control/conduct disorders	
		eating disorders	
		obsessive compulsive disorders	
		personality disorders	
		schizophrenia/other psychiatric disorders	
		sleep/wake disorders	
		somatic symptom/related disorders	
		trauma, stress/related disorders	

		other	
	treatment for psychiatric diagnoses	none	
		no treatment available	
		ECT - electroconvulsive therapy	
		medications	
		outpatient psychiatric care	
		other	
	does diagnoses affect individual's ability to function?	yes	
		no	
	is individual able to self-manage care of condition	yes	
no			
unable to determine			
behaviors	does the individual present any behavioral signs/symptoms	yes	
		no	
		unable to determine	
	does the individual exhibit physical behavioral symptoms toward others?	yes	
		no	
	specify all types of aggressive physical behavior toward others	biting	
		hair pulling	
		hitting	
		kicking	
		picking	
		scratching	
		sexual acting out/behavior	
		spitting	
	other		
	does the aggressive physical behavior toward others interfere with the individual's ability to function daily	yes	
		no	
	does the individual exhibit aggressive physical behavioral symptoms towards self	yes	
		no	
	specify all types of aggressive physical behavior towards self	biting	
		hair pulling	
		hitting	
		kicking	
		picking	
scratching			
spitting			
other			
does the aggressive physical behavior towards self-interfere with the individual's ability to	yes		

	function daily	no	
	does the individual exhibit verbal aggressive behavior toward others	yes	
		no	
	specify all types of aggressive verbal behavior symptoms toward others	cursing	
		screaming	
		threatening	
		other	
	does the aggressive verbal behavior towards others interfere with the individual's ability to function daily	yes	
		no	
	does the individual exhibit any general aggressive verbal behavior symptoms not specifically directed toward self or others	yes	
		no	
	select all general aggressive verbal behaviors	disruptive sounds	
		yelling out	
		other	
	does the general aggressive verbal behavior interfere with the individuals's ability to function daily?	yes	
		no	
	does the individual exhibit any other behavior symptoms?	yes	
		no	
	specify all other types of behaviors	fecal smearing	
		hoarding	
		pacing	
		public disrobing	
		rummaging	
		Sundowner's syndrome	
		other	
	do the other types of behaviors interfere with the individual's ability to function daily?	yes	
		no	
other medical information	has the individual exhibited elopement behavior in the past 6 months?	never	
		daily	
		less than once a month	
		several times a week	
		several times a month	
		once a month	
		other	
	does the individual require supervision	yes	
		no	
	how long can the individual be routinely left alone?	indefinitely	
		entire day and overnight	
		eight hours or more - day or night	

		eight hours or more - daytime only	
		four hours or more - day or night	
		four hours or more - daytime only	
		less than four hours	
		cannot be left alone	
	why does the individual require supervision?	cognitive diagnosis	
		general physical condition	
		environmental issue	
		other	
	can the individual evacuate their home in the event of a fire?	yes	
no			
frailty score	are you tired?	yes	
		no	
	can you walk up a flight of stairs?	yes	
		no	
	can you walk a city block?	yes	
		no	
	do you have more than 5 illnesses?	yes	
		no	
	have you lost more than 5% of your weight in the past year?	yes	
		no	
depression/life satisfaction	are you basically satisfied with your life?	yes	
		no	
	do you often get bored?	yes	
		no	
	do you often feel hopeless?	yes	
		no	
	do you prefer to stay at home, rather than going out and doing new things?	yes	
		no	
	do you ever have feelings of worthlessness?	yes	
		no	
medication management	does the individual take any prescribed medications	yes	
		no	
	does the individual have a central venous line?	yes	
		no	
medications	prescribed	name	multiple
		dose	
		unit type	
		form	
		frequency	
		PRN	
		# taken	
		drug code	
comments			

	does the individual take all medications as prescribed?	yes		
		no		
	over the counter	name		multiple
		dose		
		form		
		frequency		
		PRN		
		# taken		
		drug code		
		comments		
	does the individual have any allergies or adverse reactions to any medication?	yes		
		no		
	reactions or side affects	list		
	what is the individual's ability level to manage medication?	independent		
		limited assistance		
total assistance				
if limited assistance, indicate all types needed for medication management	assistance with self-injections; independent with oral medications			
	coaxing			
	medication dispenser			
	set up/prepackaged			
	verbal reminders			
	other			
height/weight	what is the individual's height			
	what is the individual's weight			
	what is the individual's weight type?	normal height/weight appropriate		
		morbidly obese		
		obese		
		overweight		
unable to determine				
pain	does the individual report pain?	yes		
		no		
	Location of the pain	back		
		bone		
		chest		
		head		
		hip		
		incision site		
		knee		
		soft tissue (muscle)		
		stomach		
other joint				
other				

	indicate the level of pain the individual reports	scale 0-10	
	indicate the frequency the individual reports the pain	less than daily	
		daily - one episode	
		daily - multiple episodes	
		continuous	
		other	
	select all current treatments for pain diagnoses	none	
		acupuncture	
		chiropractic care/services	
		exercises	
		heat/cold applications	
		massage	
		medications	
		pain management center	
		physical therapy	
		other	
	does the pain affect the individual's ability to function?	yes	
		no	
ADLS	bathing	independent	
		limited assistance	
		total assistance	
	dressing	independent	
		limited assistance	
		total assistance	
	grooming/personal hygiene	independent	
		limited assistance	
		total assistance	
	if limited assistance, indicate all types needed for grooming/personal hygiene	assistance with the use of equipment or assistive devices	
		encouragement, cueing, or coaxing	
		guided maneuvering of limbs	
		setup	
		supervision	
		other	
	eating	independent	
		limited assistance	
		total assistance	
		does not eat	
	if limited assistance, indicate all types needed for eating	assistance with the use of equipment or assistive devices	
		encouragement, cueing, or coaxing	
		guided maneuvering of limbs	
		setup	

		supervision	
		other	
	if does not eat, indicate type of nutritional intake	IV fluids	
		NPO (nothing by mouth)	
		parenteral nutrition	
		tube feedings/TPN	
		other	
	transfer	independent	
		limited assistance	
		total assistance	
	if limited assistance, indicate all types needed for transfer	assistance with the use of equipment or assistive devices	
		encouragement, cueing, or coaxing	
		guided maneuvering of limbs	
		setup	
		supervision	
		other	
	toileting	independent	
		limited assistance	
		total assistance	
		self-management of indwelling catheter or ostomy	
	if limited assistance, indicate all types needed for toileting	assistance on or off bed pan	
		assistance with incontinence products	
		assistance with the use of equipment or assistive devices	
		clothing maneuvers/adjustment	
		personal hygiene post toileting	
		setup	
		supervision	
		transfer to toilet	
bladder continence	continent - complete control , no type of catheter or urinary collection device		
	usually continent - incontinence episodes once a week or less		
	incontinent - inadequate control, multiple daily episodes		
	continent - with indwelling catheter		
bowel management	continent - complete control , no type of ostomy device		
	usually continent - incontinence episodes once a week or less		

		incontinent - inadequate control, multiple daily episodes	
		continent - with ostomy	
	walking	independent	
		limited assistance	
		total assistance	
	if limited assistance, indicate all types needed for walking	assistance with the use of equipment or assistive devices	
		encouragement, cueing, or coaxing	
		guided maneuvering of limbs	
		setup	
		supervision	
other			
mobility	bedbound	yes	
		no	
		unable to determine	
	indoor mobility	independent	
		limited assistance	
		total assistance	
	if limited assistance, indicate all types for indoor mobility	assistance with the use of equipment or assistive devices	
		encouragement, cueing, or coaxing	
		guided maneuvering of limbs	
		setup	
		supervision	
		other	
	outdoor mobility	independent	
		limited assistance	
		extensive/total assistance	
	if limited assistance, indicate all types for outdoor mobility	assistance with the use of equipment or assistive devices	
		encouragement, cueing, or coaxing	
		guided maneuvering of limbs	
		setup	
		supervision	
		other	
	stair mobility	independent	
limited assistance			
extensive/total assistance			
if limited assistance, indicate all types for stair mobility	assistance with the use of equipment or assistive devices		
	encouragement, cueing, or coaxing		
	guided maneuvering of limbs		

		setup	
		supervision	
		other	
	what is the individual's weight bearing status?	full weight bearing	
		non-weight bearing	
		partial weight bearing	
		toe touch weight bearing	
		unable to determine	
	select all that affect the individual's mobility	none	
		ambulation dysfunction	
		aphasia	
		fatigues easily	
		muscle stiffness	
		pain management center	
poor balance			
rigidity			
shuffling gait			
spasms			
tremors/twitches			
other			
falls	at risk of falling	yes	
		no	
		unable to determine	
	select the number of times the individual has fallen in the last 6 months	none	
		1	
		2	
	reasons for falls	3 or more	
		accidental	
		environmental	
medical			
IADLs	meal preparation	other	
		independent	
		limited assistance	
	housework	total assistance	
		independent	
		limited assistance	
	laundry	total assistance	
		independent	
		limited assistance	
	shopping	total assistance	
		independent	
		limited assistance	
transportation	total assistance		
	independent		
		limited assistance	

		total assistance		
	money management	independent		
		limited assistance		
		total assistance		
	telephone	independent		
		limited assistance		
		total assistance		
	home management	independent		
		limited assistance		
		total assistance		
	level of care determination (LCD) assessment	what level of care did the physician recommend?	LTSS eligible	
			LTSS ineligible	
evaluation not required				
date LCD signed				
date LCD received				
was the medical evaluation requested but not received?		yes		
		no		
what is the level of care determination for this individual?		NFCE - nursing facility clinically eligible		
	NFI - nursing facility ineligible			
	NFCE - no physician document received			
Individual's place of service preference	does the individual want to be served in the community	yes		
		no		
	individual's preferred residential setting	home		
		domiciliary care home		
		personal care home		
		other		
	if NFI, preferred community service program	CSP-NFI - caregiver support program		
		OPTIONS - NFI		
Other				
LOC authentication	name of assessor			
	date assessor's signature			
	RN reviewing form			
	date RN review			
	assessment supervisor who reviewed and approved level of care			
	date supervisor approved			
	date level of care issued			

**Exhibit GGG(5)**  
**Data Elements – Enrollment**

**CHC Enrollment**

	CHC rollout	
	moved from non CHC area	
	moved from other CHC zone	
	in nursing facility, new MA eligible	
Enrollment reason	new dual status	
	new CHC eligibility	
	Disenrollment from LIFE program	
	changed MCO provider	yes/no why?
	Southwest	
	Southeast	
Zone	Lehigh Capital	
	Northwest	
	Northeast	
	HCBS	
Prior status setting (Converting Participants)	Facility-Based	
	Non-LTSS	
Medicare?	Part A	
	Part B	
	Part D	
	no	
D-SNP	yes	
	no	
	Aging	
	Independence	
HCBS waivers	CommCare	
	OBRA	
	Attendant Care	
	yes	
LIFE	no	
	yes	
LTSS?	no	
transition to CHC date		
MCO placement	MCO provider	
MCO assignment date		
MCO choice	MCO provider	
MCO effective date		
	yes	
MCO Disenrollment	no	
	name	
MCO disenroll from		
disenrollment date		
disenrollment reason		

MCO enrollment to  
MCO effective date

**CHC Disenrollment**

reason

moved out of zone  
no longer MA eligible  
no longer Medicare eligible  
no longer in nursing home  
no longer LTSS  
went to LIFE program  
deceased  
other

MCO close date  
MA close date  
Medicare close date  
LTSS close date

client timely appeal

yes  
no

appeal date  
closure notification date

**Exhibit GGG(6)**  
**Data Elements – Care Plan**

<b>Care Plan</b>				
	review start date			
	review complete date			
	prior review date			
	reason for review	new client		
		quarterly review		
		annual review		
		significant change in client health status		
		change in living situation		
		client request		
		incident		
	notice sent prior to review?	yes		
		no		
	others at Care Plan review	spouse		
		domestic partner		
		other family member		
		legal guardian		
		power of attorney		
		friend		
		other		name
			relationship	
	consumer participation	yes		
no				
consumer's current level of consciousness	alert			
	confused			
	distractible			
	drowsy			
	inattentive			
	preoccupied			
	comatose			
	persistent vegetative state			
contact information	name			
	relationship			
	address, phone			
	power of attorney			
	legal guardian			
	payee			
Informal Caregiver(s)	name		multiple	
	relationship			
	lives	in same home		
		outside home		

	amount of support	frequency/duration (hours/days)	calendar with units and clock times each day
	time of day	total units/week	
	overnight?		
	discuss choice between institutional and HCBS care	yes	
		no	
	does the consumer want to be served in the community	yes	
		no	
	does the consumer have a residence in the community	yes	
		no	
	if the consumer has a residence in the community, does the consumer wish to return/remain in his/her current residence	yes	
		no	
		uncertain	
	does this require home modifications?	yes	
		no	
	rate the consumers physical environment	good overall	
		one or two negative features	
		substandard overall	
		substandard and potentially hazardous	
hazardous			
<b>education/vocational</b>	level of education		
	current employment status		
	current occupation, if employed		
	employer		
	job title		
	hours		
	hourly pay		
	date started		
	desires employment		
	accommodations needed		
	accommodations made		
<b>Goals</b>	goal/desired outcome	employment	need to expand list - for each goal need to complete data below
		education	
		return home	
		community involvement	
		hire own caregivers	
		live safely at home	
		other	
	identified need		
	action step/service		
	provider/responsible party		
preferences			

	frequency/duration (hours/days)	calendar with units each day	
	total hours/week		
	barriers/risks		
	mitigation strategy		
<b>Services</b>	adult daily living	These services would be incorporated into the goals as appropriate	
	assisted living		
	assistive technology		
	behavior consultation		
	career assessment		
	cognitive rehabilitation therapy		
	community transition		
	counseling		
	day habilitation		
	health wellness & disease management counseling, training, peer support		
	home adaptations		
	home delivered meals		
	home health aide		
	home repairs		
	homemaker chore		
	hospice		
	job coaching		
	job finding		
	medical transport		
	non-medical transportation		
	nursing		
	nutritional consultation		
	occupational therapy		
	orientation & mobility		
	palliative care		
	participant-directed community supports		
	participant- directed goods and services		
	personal assistance		
	pest control		
	physical therapy		
residential supports			
respite			
shared living/adult foster care			
specialized medical equipment and supports			

	specialized services - NF residents only - training, peer counseling, advocacy, support groups		
	speech therapy		
	support service worker		
	supports broker		
	supports coordination		
	targeted case management		
	telecare		
	transitional group employment		
	unaddressed needs/risks/barriers	for each	
	mitigation strategy		
	additional supports		
	service start date		
	service end date		
	member directed services		
	Services My Way		
	provider choice		
	participants strengths		
	personal interests		
	health and safety risks		
assistive devices	wheelchair		recommend a dropdown/ checkbox here with a fill-in for other. We can provide a more detailed list from Endeca
	cane		
	power chair		
	walker		
	specialized bed		
	other		
Backup	informal caregiver(s)	contact phone	
		contact email	
		formal - other provider agency name	
	Agency backup information for each service	contact person	
		contact person phone	
		contact person email	

	backup used	who provided	
		dates/times	
		services missed because backup failure	
		reason need backup	
		incident result of no backup	
	service denials	service requested	
		client timely appeal	
	service reductions	service requested	
		client timely appeal	
	primary physician	name	
		telephone	
		date latest physical	
		appointment dates	
		follow-up activities	
	specialty physicians	name	
		specialty	
		appointment dates	
		follow-up activities	
	receiving MH services	provider	
		type service	
		follow-up activities	
		date	
	MCO telephone accessibility		
	tobacco use	yes	
		no	
	if yes, does member use oxygen	yes	
		no	
	safety mitigation		
	excess alcohol use	yes	
		no	
	mitigation		
	illicit drug use	yes	
		no	
	mitigation		
	risks not addressed		
	mitigation strategy		

**Exhibit GGG(7)**  
**Data Elements – Nursing Home**

How do we capture participant experience here, as well?		
Why would we want to capture this information separately?		
<b>Nursing Home</b>		
<b>Facility Information</b>	facility name	
	facility county	
	MA provider number	
	MPI number	
	facility address	
	facility zip	
	facility phone	
	national provider identifier (NPI)	
	DOH license number	
<b>Admission</b>	admission date	
	admission reason	short term rehab
		lack of caregiver support
		was discharged from nursing facility too soon
		hospitalized cannot return home
		client choice
	readmission from earlier stay?	yes
		no
	discharge date from earlier stay	date
	anticipated LOS	short term
		long term
	MA start date	date
	MA end date	
	Medicare start date	
	Medicare end date	
MCO start date	date	
MCO end date		
admission from	home	
	hospital	
	other NH	
<b>Ongoing</b>	pain level	none
		moderate
		severe
	new pressure ulcers	yes
		no
	worsening pressure ulcers	yes
		no
	high risk resident	yes
no		

	given influenza vaccine date		
	given pneumococcal vaccine date		
	depressive symptoms		
	receiving antipsychotic medicine	ongoing	
		new	
	physically restrained		
	date restrained		
	restrained incident reported		
	major fall		
	injury		
	fall result	dr visit	
		ER visit	
		hospitalization	
increased need for assistance with ADLs			
<b>Transition</b>	want to return home	yes	
		no	
	if no, barriers		cognitive impairment
			consumer requested
			consumer relocated out of service area
			could not locate appropriate housing arrangement
			could not secure affordable housing
			death
			funding
			guardian refused participation
			lack of formal/informal support
			mental health issues
			physical health issues
			poor credit or lack of credit history
			service needs greater than what could be adequately provided in community
		unwilling to follow care plan	
		other	
	date want to transition	date	
	90 or more days	yes	
		no	
	barriers	yes	
		no	
	barrier to overcome	family issues	
home modifications			
housing			
lack of formal/informal support			
lack of funding			
service provider availability			

		unaware of services/lack of information
		other
	NHT	yes
		no
	agency responsible for transition	name
	agency MPI number	
	scheduled discharge date	date
	actual discharge date	date
	discharge reason	short term stay, plan to return home
		move to another nursing facility
		move to psychiatric hospital
		move to inpatient rehab facility
		barriers overcome
		no longer need NH LOC
		end of life hospice care
		deceased
		other
	need services after transition	
	transition to existing housing	yes
		no
	need assistance with housing	yes
		no
	how was housing located	family
		friend
		housing authority
		newspaper
		PA Apartment locator
		regional housing coordinator assistance (RHC)
		other
	date housing secured	
	type of housing	apartment
		assisted living
		domiciliary care
		house
		personal care home
		subsidized housing
		other
		unavailable
	living arrangement	lives alone
		lives with spouse only
		lives with child(ren) but not spouse
		lives with other family members
		other
		don't know

	home modifications	yes
		no
	type modifications	doorways widened
		kitchen/bathroom modifications
		ramp
		stair guide
		walk-in shower
other		
MFP	MFP	yes
		no
	barriers specific to MFP	did not choose MFP qualified residence
		no longer MA eligible
		no longer HCBS eligible
		reconsideration about candidates participation
	qualified residence	apartment leased by consumer, not assisted living
		apartment leased by consumer, assisted living
		home owned by consumer
		home owned by family member
		group home of no more than 4 people
	live with family members	yes
		no
	housing supplement	yes
		no
	housing supplement types	low income housing tax credits
		HOME dollars
		CDBG funds
		housing choice vouchers
		housing trust funds
		sections811
		202 funds
		USDA rural housing funds
veterans affairs housing funds		
funds for home modifications		
funds for assistive technology related to housing		
other		
	SNHT	consumer reimbursement, OPTIONS program
		environmental mod, home mod or adaptation
		HDM - lunch
		home support, housekeeping

		Med equip adaptive device
		med equip supplies - consumable
		med equip supplies - durable equipment
		NHT equipment, furnishings, initial supplies
		NHT personal environmental safeguards
		NHT moving expenses
		NHT security deposits
		NHT utility setup fee or deposit
		PAS agency model - basic needs
		PERS - monthly fee
		personal care
	ER or physician visit within 30 days of discharge	
	days from discharge	
	provider	name
		MPI
	reason	
	deceased within 7 days of discharge	yes
		no
	date of death	date

**Exhibit GGG(8)**  
**Data Elements – Hospitalization**

Do we just want to limit this data collection to hospitalization (i.e. do we want to capture PT, home health, etc.)		
<b>Facility Information</b>	facility name	
	facility county	
	MA provider number	
	MPI number	
	facility address	
	facility zip	
	facility phone	
<b>Admission</b>	admission date	
	admission reason	accident
		illness
		planned surgery/treatment
		prior hospitalization discharge too soon
	readmission from earlier stay?	yes
		no
discharge date from earlier stay	date	
diagnosis		
procedure		
<b>Discharge</b>	discharge date	
	discharge reason	hospitalization no longer required
		death
		death
	discharge to	home
		another hospital
		nursing facility rehab
		nursing facility habilitation
		psychiatric hospital
		hospice
		deceased
	other	
ER or physician visit within 30 days of discharge		
provider	name	
	MPI	
days from discharge		
reason for visit		
deceased within 7 days of discharge	yes	

		no
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**Exhibit GGG(9)**  
**Data Elements – Incidents and Complaints**

<b>Incidents and complaints</b>		
	incident type	
	incident severity	
	incident date/time	
	involved parties	
	reported to	DHS
		DOH
		PDA
		Adult Protective Services
		Older Adult Protective Services
		Long-Term Care Ombudsman
	outcome	
	entered into EIM	yes
		no
	date/time entered into EIM	
	client injury	yes
		no
	client death	yes
		no
	client complaint	yes
		no
Complaints	denials	service
		reason
		date if denial
	level 1 complaint	service
		reason
		responsible party
		date
	level 1 grievance	service
		reason
		responsible party
		date
	level 2 complaint	service
		reason
		responsible party
		date
	level 2 grievance	service
		reason
		responsible party
		date

	appeals	type
		phases and dates